

California's Safety Nets and The Need to Improve Local Collaboration in Care for the Uninsured: Counties, Clinics, Hospitals and Local Health Plans

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Introduction

This report looks at safety net financing and infrastructure resources to care for the uninsured. It provides inter-county and inter-regional comparisons. California's safety net is full of big holes and in serious danger for its patients and itself from the combination of economic slowdown, growing numbers of uninsured, rising health costs and the inability of state and federal lawmakers to forge any progress on financing and coverage for California's 6.5 million uninsured.

Who is the safety net? In California, it includes counties, community clinics, some private hospitals and doctors who see large percentages of uninsured patients and some health plans who have designed innovative coverage plans for the uninsured. These separate independent fiefdoms need to better collaborate. Finally we want to introduce the concept of the invisible safety net, care to the uninsured that is not tracked by data because the data is not collected.

To pose the question early that will occur as you read this report, where do uninsured individuals get their care in those counties where reported access for the uninsured to county health programs, to community clinics or to hospitals is very low, or do the residents receive no care? Do they go to clinics, hospitals or doctors in neighboring Nevada, Oregon, or Mexico for their care? Do they go to a clinic or hospital in a neighboring county? Are there individual practitioners with large numbers of uninsured patients paying cash for their services? How much care for uninsured Central Valley and Central Coast patients for example occurs in public hospitals in the Bay Area or metropolitan Los Angeles? Are public hospitals acting de facto as regional, rather than as county hospitals? These questions are not answerable by data but rather by the collective experience of the uninsured and their providers in these counties. Without any reliable data whatsoever, it is exceedingly difficult for federal and state policy makers and philanthropic funders to identify who is providing care to the uninsured, what their financial needs might be and to design appropriate policy solutions.

Why is the safety net important? A recent study conducted by the Annals of Internal Medicine estimated that of the 47 million people in the United States who are uninsured, nearly 16 million have been diagnosed with a chronic condition and in urgent and too often unmet need of medical care.¹ The safety net is where they are able to get care, though too often in an uncoordinated and episodic fashion.

How many uninsured are there? There are over 6.5 million Californians (over the course of a year) and 4.9 million (at a point in time) who are uninsured.²

Although California had a rare opportunity to cover many of the uninsured in 2007-08, ABX1 1 (Nunez) failed in the Senate Health Committee in January 2008. The safety net was divided on the merits of the proposed reforms, in part due to fears of losing safety net funding to finance the coverage expansion for the uninsured, in part due to fears of losing current uninsured patients and in part due to a preference for other grander or more incremental solutions.

¹ Reed Abelson, Millions With Chronic Disease Get Little to No Treatment, The New York Times (August 5, 2008) at www.NYTimes.com

² UCLA Center for Health Policy Research, California Health Interview Survey 2005 at www.chis.ucla.edu

The problems of caring for the uninsured, however, are not going away and will only grow; as health costs continue to rise, so will the numbers of uninsured. The resources must be forthcoming, but the will to change must also be present. The safety net must become both more forceful and more flexible in articulating their support for reforms and increased resources for their patients' care. The necessary solutions will not eliminate the safety net but will include a redesigned, better-coordinated and more collaborative safety net. This report provides current information as to where local safety nets are strongest and weakest on four measures: county health, clinics, hospitals and local managed care. ITUP's earlier report, "Where are the Uninsured Now: A Ten Year Overview" reviewed progress of the components of the safety net over the last decade; it found that community clinics increased their care to the uninsured by 20%, while county financed care to uninsured patients was declining, and hospital-based care to the uninsured was essentially flat.³

California government is responsible for many of the uninsured at both the state and county levels. The fifty-eight counties in California are responsible for those uninsured who are indigent adults with no minor children living at home (MIAs or medically indigent adults). The 2005 CHIS (California Health Interview Survey) data reports that roughly 3.1 million of the uninsured are adults without children living at home and 47% have incomes of less than 200% of the Federal Poverty Level.⁴

As a baseline for discussion purposes, insured adults under age 65 average four outpatient visits a year and 250 inpatient days per 1000 insured and, their coverage through private insurance costs on average \$4000 annually. Counties spend over \$1.8 billion on 1.2 million users of the county indigent health system and deliver care and services albeit in a highly variable fashion. On average, counties spend \$360 per uninsured state resident – less than 1/10th the cost of private insurance.⁵ They report that they bought (or provided) 411,722 days of inpatient care and 4,412,538 outpatient visits – (84 days per 1000 uninsured and 0.9 visits per uninsured) about 1/3rd and 1/4th respectively the utilization rates of the insured populations.⁶

³ See Fox, Where are the Uninsured Now: A Ten Year Overview (ITUP, January 2007) at <http://www.itup.org/reports.html#uninsured>

⁴ See ITUP, The Safety Net: Caring for California's Uninsured (April 25, 2007) at <http://itup.reports.html#universalcoverage>

⁵ Kim H. Dam and Lucien Wulsin Jr., A Summary of Health Care Financing for Low Income Californians 1998-2008 (August 2008) at <http://itup.org/reports.html> This figure varies based on the number of uninsured; this calculation assumes 4.9 million uninsured (point in time) as opposed to 6.5 million uninsured (course of the year) or 1.4 million (uninsured adults without minor children living at home on incomes of less than 200% of FPL). A recent study of national spending reports that spending for the full year privately insured is \$3915 per annum while spending (including patient payments for the full year uninsured is \$1686 per annum). Hadley, Holahan et al, Covering the Uninsured in 2008: Current Costs, Sources of Payment and Incremental Costs Health Affairs, Web Exclusive (August 25, 2008)

County spending per uninsured MIA (medically indigent adults or uninsured adults with no minor children living at home and incomes of less than 200% of FPL) was \$1235 or \$103 pmpm in 2005. The estimated cost of MediCal and subsidized coverage for this population was \$200 pmpm in the recent Nunez-Schwarzenegger health reform proposal (AB X1 1). Jonathan Gruber, Modeling Health Reform in California February 2, 2007), (May 16, 2007), Population Movement Estimates under AB X1 1 (January 11, 2008) at <http://www.cahealthreform.org>. So counties are spending roughly half of what state coverage would cost for this segment of the uninsured if providers are paid at Medicare rates for their care to this population.

⁶ Brooke Fox and Jolly Mannanal, Overview of the Uninsured: California 2007 at <http://itup.org/reports.html#californiascounties>. We divided the days and visits reported by the counties in their

The state of California is responsible for the uninsured in families and those who are disabled. The CHIS 2005 data reports 1.8 million uninsured parents with children living at home of whom 75% are living on incomes below 200% of the Federal Poverty Level and 43% have incomes between 100 and 200% of FPL.⁷ State programs that serve the indigent uninsured populations are Healthy Families for children and Medi-Cal for families, the elderly and disabled. The state of California spends over \$38 billion on 7.5 million persons receiving coverage through Medi-Cal, Healthy Families, Access for Infants and Mothers (AIM), the Major Risk Medical Insurance Program (MRMIP) and other state programs.³

Safety net providers must navigate these two systems of government and multiple subsets of programs on which their ability to provide care to the uninsured depends. This paper looks at counties, hospitals, clinics, local health plans and the regional variations in their financing and care to the uninsured. In addition, it reviews regional poverty rates, ethnic make-up and unemployment rates. We close this paper with a summary of ITUP reform recommendations on the uninsured and the safety net.

Data discussion

ITUP compiles annual county specific data reports on 48 of the 58 counties (leaving out ten of the smallest). Information in this paper is from the 2005 reports prepared by Brooke Fox and Jolly Mannanal.⁸ The primary data sources for these reports are the Office of Statewide Health Planning and Development (OSHPD) for hospitals⁹ and clinics¹⁰, County Medical Services Program (CMSP)¹¹ and Medically Indigent Care Reporting System (MICRS)¹² for counties¹³,

MICRS (Medically Indigent Care Reporting System) and CMSP reports by 4.9 million uninsured. Average reported county spending per hospital day was \$2000 and per outpatient visit was \$160. Later we discuss the differences between county reports and hospital reports.

⁷ ITUP, *The Safety Net: Caring for California's Uninsured*. California has an option to cover these parents with federal Medicaid matching funds, but has failed to appropriate the General Fund match. California does cover most of the costs of their hospital care through a series of little known aspects of the Medi-Cal program known as share of cost and medically needy coverage that do pay for catastrophic medical care but for little or no preventive services.

⁸ See Brooke Fox and Jolly Mannanal, *Overview of the Uninsured: California 2007* at <http://itup.org/reports.html>. Their reports on six regions and 48 counties are posted at www.itup.org under regional workgroups.

⁹ Office of Statewide Health Planning and Development, "Selected Hospital Annual Financial Data: FY 2004-2005" at www.oshpd.ca.gov/HQAD/Hospital/financial/hospaf.html and Office of Statewide Health Planning and Development, "Hospital Annual Financial Selected Data: Year 30," downloaded on November 1, 2006 from http://www.oshpd.ca.gov/HID/Products/Hospitals/AnnFinanData/SubSets/Selected_Pages/index.html

¹⁰ Office of Statewide Health Planning and Development, "2005 Primary Care Clinics Annual Utilization Data" at <http://oshpd.ca.gov/HQAD/Clinics/clinicsutil.html>

¹¹ California Department of Health Services, Office of County Health Services "County Medical Services Program Summary of Expenditures by Service Type and County, 2004-05" downloaded December 5, 2006 from http://cmspcounties.org/data/county_specific.html

¹² California Department of Health Services, Office of County Health Services "County Health Care Program Expenditures for the Medically Indigent Fiscal Year 2003-2004," and California Department of Health Services, Office of County Health Services, "County Health Services Budget/Actual Data: Fiscal Year 2004-05," received June 15, 2007

¹³ County health data is only as accurate as the county reports to the state, and some county reports are we believe quite inaccurate; however in the aggregate and on a county specific level, it is the only statewide data we have on most county programs for the uninsured.

financial data from the Department of Health Care Services¹⁴, the California Health Interview Survey (CHIS) for the uninsured¹⁵ and census data.¹⁶

¹⁴ California Department of Health Services, Office of County Health Services, “FY 2004-05 Final Maintenance of Effort (MOE) Calculation,” at <http://www.dhs.ca.gov/hisp/ochs/chsu/data.html> California Healthcare for Indigents Program (CHIP) Allocation Summary: FY 2004- 2005,” at <http://www.dhs.ca.gov/hisp/ochs/chsu/data.html> “Rural Health Services Program (RHS) Allocation Summary: FY 2004-2005,” “SB 855 – Actual Payments and Transfers County and Non County Hospitals: Fiscal Year 2004-2005,” received September 21, 2006 and Office of the California Attorney General, “Tobacco Master Settlement Payments to Counties and Cities: 1999-2006” at <http://caag.state.ca.us/tobaccosettlement.html>

¹⁵ UCLA Center for Health Policy Research, California Health Interview Survey 2005 at www.chis.ucla.edu

¹⁶ US Census Bureau, “County Population by Age, Sex, Race and Hispanic Origin; April 1, 2000-July 1, 2005 downloaded on September 21, 2006 from <http://www.census.gov/popest/counties/asrh/CC-EST2005-alldata.html> and U.S. Census Bureau, “PCT141.Ratio of Income in 1999 to Poverty Level,” Census 2000 Summary File (SF 4) – Sample Data, downloaded on November 3, 2004 from <http://factfinder.census.gov>.

Section 1: Counties

County Models

Among the 58 counties in California there are four types of county health systems that serve the indigent adult population with wide variations in funding, access, and eligibility. Provider counties have public hospitals. Payor counties use private providers. Small counties pool their resources to form a uniform Medi-Cal like system. Hybrid counties combine county clinics with private hospitals.

County Roles

Counties pay for care to indigent uninsured adults and they run public health systems. County clinics and public hospitals are major providers of care to uninsured adults as well as to patients in the state's Healthy Families and Medi-Cal programs; in fact the bulk of public hospital revenues come from the Medi-Cal program. Counties also operate managed care plans, Local Initiatives and County Organized Health Systems (COHS), that organize the local safety net into the delivery systems for Medi-Cal families and Healthy Families children. County social service programs determine an individual's Medi-Cal eligibility. Counties conduct outreach for the Healthy Families program, the name for California's State Children's Health Insurance Program (SCHIP).

*County Funding*¹⁷

The state and federal governments are the primary source of funding for county care to the uninsured; county funding is present to varying degrees but less significant.¹⁸ Funding is distributed to counties from Prop 99 (the cigarette tax), realignment funds (from a share of state vehicle licensing fees and sales tax), and federal funds secured by local matches in Medicaid Disproportionate Share Hospital dollars (DSH), Safety Net Care Pool (SNCP) funding, and the Federally Qualified Health Center (FQHC) funding for public clinics.

To receive state Prop 99 and realignment funds there is a required county General Fund match. Some counties overmatch; this is funding in excess of what was actually required from the county. Another portion of the county's General Fund is the county share of the tobacco litigation settlement; however not all counties allocate these funds to health care for the uninsured. County spending on Medi-Cal and uninsured patients serves as the match for federal funds such as DSH and SNCP, which help pay for care to the uninsured; this is known as CPE (certified public expenditures).

¹⁷ A Summary of Health Care Financing for Low Income Californians 1998-2008 (August 2008) at <http://itup.org/reports.html>. In our county-by-county reports, we report on realignment, Proposition 99, county match, tobacco litigation settlement, but not safety care pool or county over-match funding. See county and regional reports at <http://itup.org/regional-workgroups.html>. Ten counties also have three year coverage expansion initiatives; these are separately reported at <http://itup.org/public-private-workgroup.html>

¹⁸ In counties such as Los Angeles and Alameda, local voters approved tax increases to fund care for the uninsured. In Orange County the local voters over-rode the County's Board of Supervisors and allocated tobacco litigation settlement funds for the uninsured. San Francisco County has historically been quite generous in allocating local General Funds for the uninsured and recently the Board approved a tax on employers to help pay for the costs of its new Healthy San Francisco program for all uninsured San Franciscans.

Table 1: County Health Funding by Region and Percent Spent on Care to the Uninsured (2005)¹⁹

Bay Area	\$559,366,000	79.2%
Central Coast	\$116,335,000	28.2%
Central Valley	\$243,947,000	42.7%
North Central	\$160,694,000	80.5%
North Rural	\$99,466,000	108.8%
Southern California	\$1,505,943,000	71.5%
California	\$3,072,182,000	58.9%

Each county system budgets its funding for county public health priorities and the uninsured at their discretion. County funding is inadequate for the tasks at hand, and at the same time highly inequitable as some counties receive and spend two three and four times as much per county uninsured as do other counties. *See Figures 1, 2 and 3 for inter-county comparisons of county funding and spending for their care to the uninsured.*

Table 2: County Financing Variations

	Provider	Payor	Hybrid	CMSP
Realignment	Yes	Yes	Yes	Yes
Prop 99	Yes	Yes	Yes	Yes
Net DSH	Yes	No	No	No
Net SNCP	Yes	No	No	No
County Match	Yes	Yes	Yes	Yes
MAA/TCM	Yes	Yes	Yes	Yes
FQHC	Yes	No	Yes	No

Variability in funding streams for county health systems

Provider Counties

In a county that has a public hospital, county health is funded by realignment, Prop 99, county match, SNCP,

DSH, and FQHC (if applicable to its clinics). Provider counties treat all types of uninsured in their facilities on a first come, first served basis, including adults, children, those with incomes below and above the poverty line, US citizens, legal permanent residents and also those with no legal permanent residency status. Provider counties live within their allocated budgets by queuing patients, rather than by limiting eligibility. The provider counties depend very heavily on Medi-Cal patients and funding, which requires a stiff competition with private providers in order for them to remain financially viable.

¹⁹ Source: California Department of Health Services, Office of County Health Services, "FY 2004-05 Final Maintenance of Effort (MOE) Calculation," California Healthcare for Indigents Program (CHIP) Allocation Summary: FY 2004- 2005," "Rural Health Services Program (RHS) Allocation Summary: FY 2004-2005," "County Health Services Budget/Actual Data: FY 2004-2005," "SB 855 - Actual Payments and Transfers for Counties with a County Hospital: Fiscal Year 2004-2005" and Office of the Attorney General, "Tobacco Master Settlement Payments to Counties and Cities: 1999-2005"

Table 3: County Delivery System Variations

	Provider County	Payor County	Hybrid County	CMSP County
Hospitals	Public	Private	Private	Private
Doctors	Public	Private	Public	Private
Clinics	Public and some private non-profit	Private non-profit	Public and some private non-profit	Private non-profit

Payor Counties

Payor counties have no county hospital or public clinics so the funds are distributed differently. The private hospitals in these counties receive direct funding from the state through private DSH and DSH supplements for their care to the uninsured, and receive direct funding from the county for care to county indigents; there is no coordination of the two funding streams. Not all payor counties distribute the county funds equally; some pay all willing providers while others concentrate all the funding for the county’s uninsured in a single private facility – as a block grant. Most payor counties pay private community clinics for their care to the counties uninsured, but some do not. Payor counties live within their allocated budgets by restricting eligibility to subsets of the uninsured. Eligibility is often limited to adults with an income below either 100% or 200% of the federal poverty level with no minor children living at home. County residents without legal residency status are typically ineligible for health programs in payor counties.

Table 4: County Eligibility Variations²⁰

	Provider	Payor	Hybrid	CMSP
Indigent uninsured adults (MIAs)	Yes, in county facilities	Yes	Yes	Yes
Indigent uninsured children and their parents	Yes, in county facilities	No	Yes, in county clinics	No
Residents without legal permanent residency status	Yes, in county facilities	No	Yes, in county clinics	For emergency care only
Residents of other counties	Yes, in county facilities, but either the uninsured patient or neighboring county must pay	No	No	Yes, if the neighboring county participates in CMSP

Hybrid Counties

²⁰ See California HealthCare Foundation, County Programs for the Medically Indigent (2006) at www.chcf.org County income eligibility varied from a low of 63% to a high of 500% of the federal poverty level. Most cover uninsured adults with incomes up to 200% of FPL, but with cost sharing starting as low as 100% of FPL.

These counties operate a mixed system combining county-reimbursement for private hospitals and county operated outpatient clinics. In the hybrid counties private DSH and DSH supplement funds are distributed directly to those private hospitals that qualify. Most hybrid counties do not fund private non-profit community clinics for their care to the uninsured, but some do. Their eligibility rules may vary for their public clinic patients and private hospital patients such that uninsured children and their parents may receive county care at the county clinic but not at the private hospital. Like provider counties, their clinics live within their allocated budgets by queuing; like payor counties they restrict eligibility for local private hospitals by covering only subsets of the uninsured.

Small Counties

A county qualifies as a small county for CMSP (County Medical Services Program), if its population was less than 300,000 in 1983. This gave those counties the option to contract with the state Department of Health Services to administer county care to the indigent which most but not all did, and the state initially agreed to be at risk for any cost over-runs. These counties pool their funds interchangeably so that in any given year there are inter-county subsidies for those counties who experience a disproportionately high percent of high cost patients in that year.

The 34 CMSP counties operate a uniform fee for service system offering fewer benefits than Medi-Cal, they use a private insurer to pay the bills. All private hospitals, private doctors and private non-profit community clinics are reimbursed for their care to the county’s uninsured..

Hospitals located in small counties receive very little if any DSH funding. CMSP eligibility is limited to low income adults with no minor children living at home; children are not eligible. County residents who lack legal permanent residence can receive emergency benefits only.

Table 5: County Variations in Funding Community Clinics

Provider counties	<i>Yes:</i> Los Angeles, Alameda, San Mateo, San Francisco, and Santa Clara <i>No:</i> Contra Costa, Kern, Riverside, San Bernardino, San Joaquin, Monterey, and Ventura
Payor counties	<i>Yes:</i> Except in Fresno, Merced, and Stanislaus
Hybrid counties	<i>No:</i> Except in Santa Barbara
CMSP counties	<i>Yes</i>

County Funding²¹ and Spending

County indigent health is vastly under-funded, widely diverse and slowly evolving from episodic, emergency room centered care towards managed care delivery systems. *See Figures 2 and 3 for comparison of county funding for the uninsured.* Some counties are extraordinary policy pioneers with strong relationships between clinics, hospitals and local managed care

²¹ In this section, we discuss county health funding through realignment, Proposition 99, county match, net county DSH and Tobacco Litigation settlement. We did not include county safety net care pool funding as we do not have that data broken down by county. We did not include county over-match as there is no reliable state reporting of this county information.

plans; others are not.²² On average counties spent 60% of available funding on care to the uninsured.²³ Some counties spend high percentages of their available funds on care to the uninsured; others do not. *See Figure 1 for variations in the percent of available funds counties spent on care to the uninsured.*

Some counties concentrate their funds on hospital-based services, and others concentrate on outpatient services. On average, 48% of county spending is spent on inpatient care, 40% for outpatient care and 8% for emergency care.²⁴ *See Figure 4 for variations in percentages of spending counties devote to outpatient and hospital-based services.* Access to care in county health systems is highly variable; it depends on the funding and policies of the county in which the uninsured individual resides. *See Figures 9 and 10 for comparisons of access to hospital care purchased/delivered by counties.*

The next section looks at funding available for county health by region. We summarized the data for the region as a whole and for largest and smallest county in each region.

Southern California Region

In 2005, Southern California counties received a total of \$1.5 billion from the following sources: Prop 99, realignment, county match, tobacco settlement, and net county DSH funds.²⁵ In the region as a whole, 71.5% of the total funding went towards care of the uninsured.²⁶ Imperial County had the lowest total county funding in the region whereas Los Angeles had the highest – appropriate given the population size of each county.

In FY 2005, Imperial County spent roughly \$13.9 million on indigent care; 88.0% of the total funds it received were spent on the uninsured.²⁷ In Imperial County the total funding per uninsured county resident was \$408.51.²⁸

During the same fiscal year, Los Angeles County's net spending on public health was \$134.4 million and on care to the indigent was \$761.8 million. Together they totaled \$898.2 million.²⁹

²² See Jay Espejo, Local Coverage Initiatives (Insure the Uninsured Project, November 2007) at <http://itup.org/reports.html> and Jolly Mannanal, Directory of Local Efforts to Expand Health Care Access for the Uninsured (Insure the Uninsured Project, January 2007) at <http://itup.org/reports.html>

²³ Fox and Mannanal, Overview of the Uninsured: California 2007. We included realignment, Prop 99, county match, net county DSH and tobacco litigation settlement in this calculation and divided by the total county spending on the uninsured reported by MICRS (Medically Indigent Care Reporting System) and CMSP (County Medical Services Program).

²⁴ Ibid. Not all counties report outpatient spending and visits in a comparable fashion.

²⁵ Fox and Mannanal, Southern California Regional Overview of the Uninsured (November, 2007) at www.itup.org/regional-workgroups.html

²⁶ Ibid.

²⁷ Fox and Mannanal, Overview of the Uninsured: Imperial County (December, 2007) at <http://itup.org/Workgroups/RegionalWorkgroups/InlandEmpire/inlandempire.html>

²⁸ Ibid. In calculating these figures, we used the uninsured numbers from the California Health Interview Survey 2005 for each county. These figures are based on the numbers of Californians uninsured over the course of the year – 6.5 million.

²⁹ Fox and Mannanal, Overview of the Uninsured: Los Angeles County (December, 2007) at <http://itup.org/Workgroups/RegionalWorkgroups/LosAngeles/losangeles.html> In Los Angeles, the County has separated its public health department into a separate entity from its health department. Nevertheless there are no

Nearly 81% of total realignment, Prop 99, net county DSH, county match and tobacco settlement funding was spent on care to the uninsured. Los Angeles County funding per uninsured county resident totaled \$359.99.³⁰

Bay Area Region

Counties in the Bay Area were allocated a total of \$559.4 million in Prop 99, realignment, county match, tobacco settlement, and net county DSH funds. 79.2% of the total funds were spent on care for the uninsured.³¹ Within the region, Marin County (with the smallest population) had the lowest total county funding, whereas San Francisco County had the highest funding (although it was less populous than Santa Clara, Alameda and Contra Costa, which all had larger populations but less funding).

In 2005, Marin County spent \$11.2 million on care to the indigent.³² Of the total funding, about 57.3% was used on care to the uninsured. Marin, an affluent county, received \$838.95 per uninsured county resident – more than twice as much Imperial County, one of the poorest counties in the state. However CMSP pools funds for small counties so that CMSP funding is spent wherever health care to an eligible uninsured individual is delivered.

In FY 2005, San Francisco spent \$198.7 million, of which \$129 million was spent on care for the indigent and \$69.7 million on net public health spending. 72.7% of the total funding was used for care to the uninsured.³³ Total funding per uninsured county resident was \$1,815.28 – five times as much as in Los Angeles County with one of the highest rates of uninsured in the country.

Central Valley Region

In the Central Valley, counties received \$243.9 million in funds from Prop 99, realignment, county match, net county DSH, and the tobacco settlement.³⁴ Within this region (California's poorest), a far lower share (42.7%) of total funding was spent on health care to uninsured county indigent patients.³⁵ The county with the least funding was Madera, which also has the region's smallest population. Kern County had the most funding, although Fresno County (which closed its county hospital) had a larger population, larger number of uninsured and slightly higher percentage of low-income individuals.

In Madera County a total of \$9.9 million was spent on care to the indigent -- nearly 121.7% of

consistent lines from county to county separating public health from health care to the uninsured. For example where does immunization and preventive care for an uninsured child fall?

³⁰ Ibid.

³¹ Fox and Mannanal, Bay Area Regional Overview of the Uninsured (November, 2007) at <http://itup.org/Workgroups/RegionalWorkgroups/BayArea/bayarea.html>

³² Fox and Mannanal, Overview of the Uninsured: Marin County (December, 2007) at <http://itup.org/Workgroups/RegionalWorkgroups/BayArea/bayarea.html>

³³ Fox and Mannanal, Overview of the Uninsured: San Francisco County (December, 2007) at <http://itup.org/Workgroups/RegionalWorkgroups/BayArea/bayarea.html>

³⁴ Fox and Mannanal, Central Valley Regional Overview of the Uninsured (December 2007) at <http://itup.org/Workgroups/RegionalWorkgroups/CentralValley/CentralValley.html> We do not know why counties in California's poorest region with a high percentage of uninsured would devote a far smaller share of their resources to care for the uninsured than counties in the more affluent Bay Area and Southern California regions.

³⁵ Ibid.

the county's total funding for county health.³⁶ The county received a total of \$266.86 per uninsured county resident.

In Kern County, \$16.0 million was spent on the indigent and \$12.3 million was spent on net public health.³⁷ Funding for Kern County was \$67.9 million from Prop 99, realignment, county match, net county DSH, and the tobacco settlement. Approximately 22% of the total funding was spent on the uninsured patients.³⁸ Kern received \$406.72 per uninsured county resident.

North Central Region

Counties in the North Central region were allocated a total of \$160.7 million in funds from various programs, which include Prop 99, realignment, county match, and tobacco settlement.³⁹ Of this \$160.7 million, nearly 78.6% was spent on care to the uninsured.⁴⁰ In the North Central region the county with the least funding was Yolo County although El Dorado and Napa had smaller populations, meanwhile Sacramento County, the most populous county in the region, had the most funding.

In FY 2005, Yolo County had \$8.5 million in Prop 99, realignment, county match, and tobacco settlement funds.⁴¹ The net public health spending in the county was \$5.2 million and a total of \$4.3 million spent on the uninsured. A total of 50.1% of its funds were spent on care to the uninsured. Yolo County health received \$385.71 per uninsured county resident.

Sacramento County received a total of \$71.0 million in Prop 99, realignment, county match, and tobacco settlement funds.⁴² The net public health spending in the county was \$18.4 million and a total of \$57.2 million spent on the indigent. A total of 80.7% of its funds were spent on care to the uninsured. Sacramento County health received \$394.57 per uninsured county resident.

Central Coast Region

Within the Central Coast region the counties received a total of \$102.1 million in realignment, Prop. 99, county match, tobacco settlement, and net county DSH funds.⁴³ The region as a whole spent a very low (36.0%) of total funding on the uninsured.⁴⁴ San Benito County was the county in the region with the least total county funding as it had the smallest population while Ventura had the most funding in line with its stature as the most populous county in this region.

³⁶ Fox and Mannanal, Overview of the Uninsured: Madera County (December 2007) at <http://itup.org/Workgroups/RegionalWorkgroups/CentralValley/CentralValley.html>

³⁷ Fox and Mannanal, Overview of the Uninsured: Kern County (December 2007) at <http://itup.org/Workgroups/RegionalWorkgroups/CentralValley/CentralValley.html>

³⁸ This could be a reporting error, but if so it has been a reporting error for at least the entire six years of our regional reports.

³⁹ Fox and Mannanal, North Central Regional Overview of the Uninsured (December 2007) at <http://itup.org/Workgroups/RegionalWorkgroups/NorthCentral/northcentral.html>

⁴⁰ Ibid.

⁴¹ Fox and Mannanal, Overview of the Uninsured: Yolo County (December 2007) at <http://itup.org/Workgroups/RegionalWorkgroups/NorthCentral/northcentral.html>

⁴² Fox and Mannanal, Overview of the Uninsured: Sacramento County (December 2007) at <http://itup.org/Workgroups/RegionalWorkgroups/NorthCentral/northcentral.html>

⁴³ Fox and Mannanal, Central Coast Regional Overview of the Uninsured (December 2007) at <http://itup.org/Workgroups/RegionalWorkgroups/CentralCoast/centralcoast.html>

⁴⁴ Ibid.

In FY 2005, San Benito County was allocated a total of \$3.1 million in the form of realignment, Prop 99, county match, and tobacco settlement funds. Of this funding, 103.3% was spent on the uninsured.⁴⁵ County health received a total of \$406.40 per uninsured county resident.

In FY 2004, Ventura County reported spending \$5.0 million of the \$32.9 million it received on care to the medically indigent.⁴⁶ There was net spending of \$6.3 million on public health as well totaling \$14.3 million. Spending on the uninsured was nearly 15.2% of the total county health funding. County health received \$253.88 per uninsured county resident.

North Rural Region

Counties in the North Rural region (California's second poorest region) received a total of \$99.5 million through realignment, Prop 99, county match, and tobacco settlement.⁴⁷ This region spent 107.3% of the total funding on care to the uninsured —the highest percentage in the state.⁴⁸ Within the region Modoc County had the least county health funding because it was the least populous county whereas Butte received the most as it was the most populous.

Modoc County received a total of \$1.4 million in the 2005 FY, \$0.7 million of which was spent on the indigent uninsured.⁴⁹ 47.1% of the county's total county health funding from Prop 99, realignment, county match, and the tobacco settlement was spent on the uninsured. In Modoc County the total funding per uninsured county resident was \$1,076.19.

Butte received \$16.7 million in Prop 99, realignment, county match, and tobacco settlement funds.⁵⁰ In Butte County, \$22.5 million was spent on care to the indigent uninsured -- 135.1% of the total county health funds. The county received \$410.32 per uninsured, county resident.

⁴⁵ Fox and Mannanal, Overview of the Uninsured: San Benito County (December 2007) at <http://itup.org/Workgroups/RegionalWorkgroups/CentralCoast/centralcoast.html>

⁴⁶ Fox and Mannanal, Overview of the Uninsured: Ventura County (December 2007) at <http://itup.org/Workgroups/RegionalWorkgroups/CentralCoast/centralcoast.html> This may be a reporting error as well, but it has persisted during the six years of our regional reports.

⁴⁷ Fox and Mannanal, North Rural Regional Overview of the Uninsured (July 2007) <http://itup.org/Workgroups/RegionalWorkgroups/NorthRural/northrural.html>

⁴⁸ Ibid.

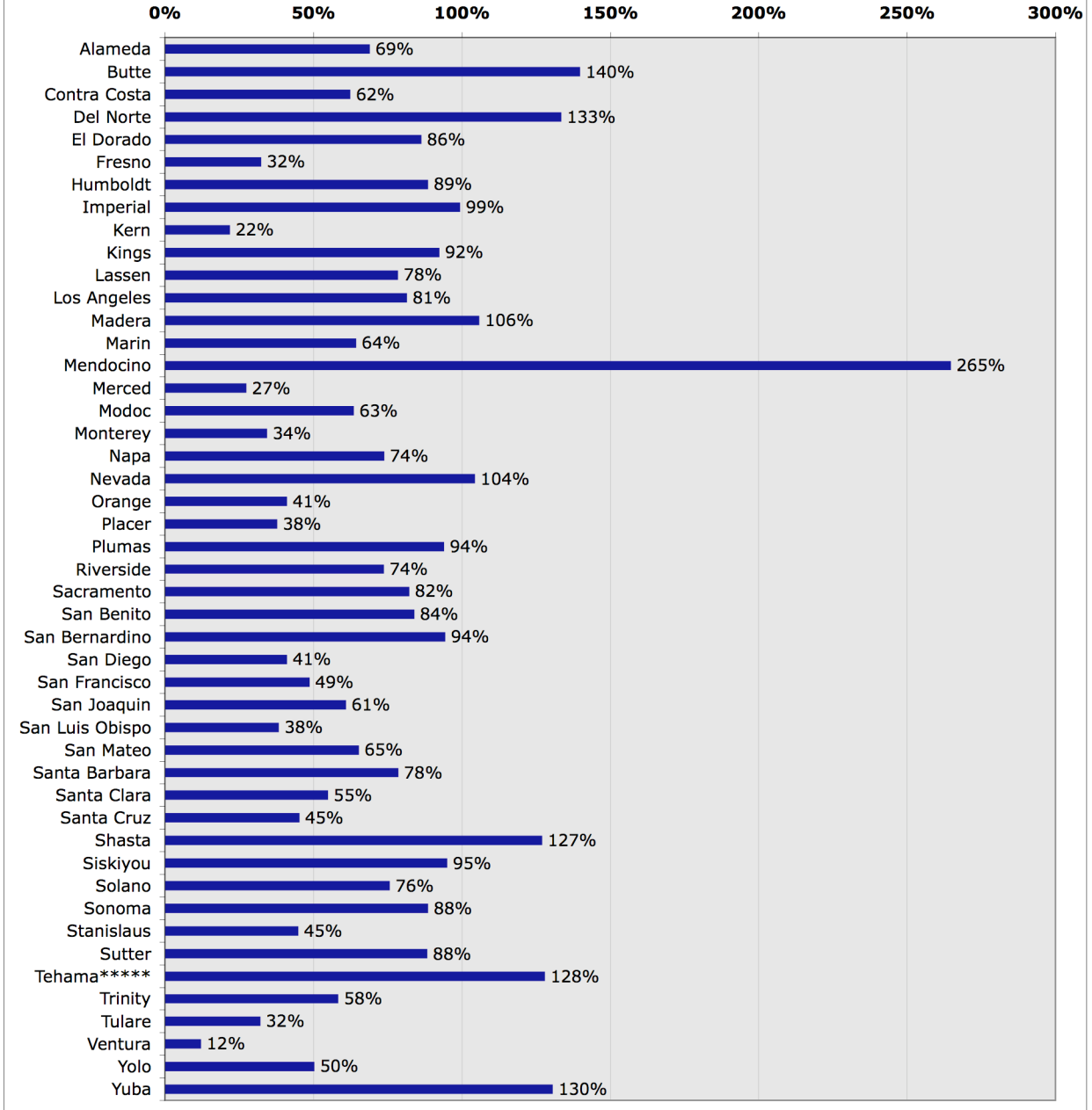
⁴⁹ Fox and Mannanal, Overview of the Uninsured: Modoc County (December 2007) <http://itup.org/Workgroups/RegionalWorkgroups/NorthRural/northrural.html>

⁵⁰ Fox and Mannanal, Overview of the Uninsured: Butte County (December 2007) <http://itup.org/Workgroups/RegionalWorkgroups/NorthRural/northrural.html>

ITUP Safety Net Report

Figure 1: Percent of County Health Funding Spent on the Uninsured

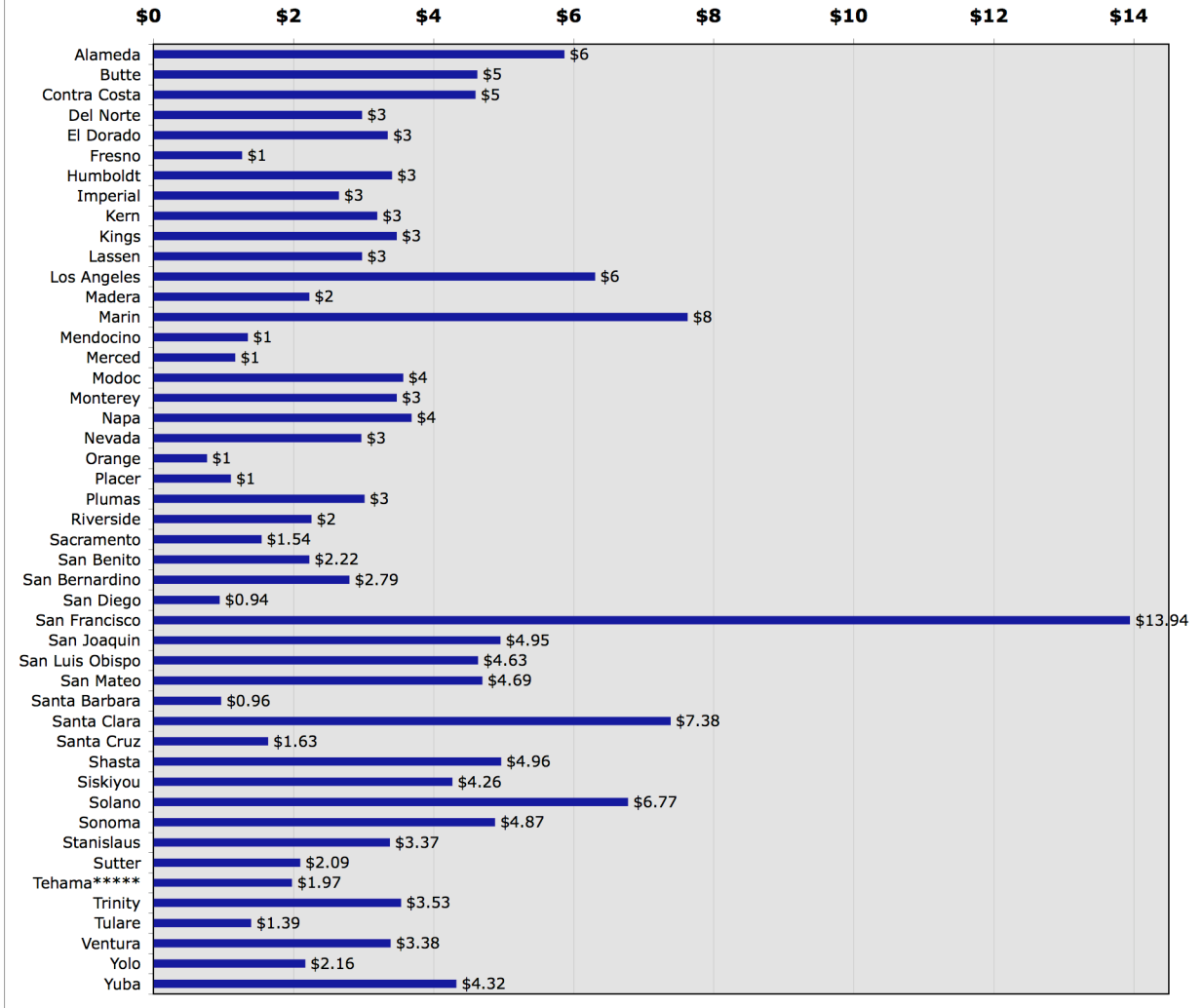
Source: *Programs for the Uninsured: A 48 County Comparison, County Care for the Uninsured in 48 California counties, including statewide numbers (January, 2007); www.itup.org*



ITUP Safety Net Report

Figure 2: Proposition 99 Funds per Uninsured County Resident

Source: *Insure the Uninsured Project, Safety Nets & Coverage Expansion: ITUP Recommendations (July 2007)* at www.itup.org



ITUP Safety Net Report

Figure 3: County Funding Streams per Uninsured County Resident

Source: *Insure the Uninsured Project, Safety Nets & Coverage Expansion: ITUP Recommendations (July 2007)* at www.itup.org

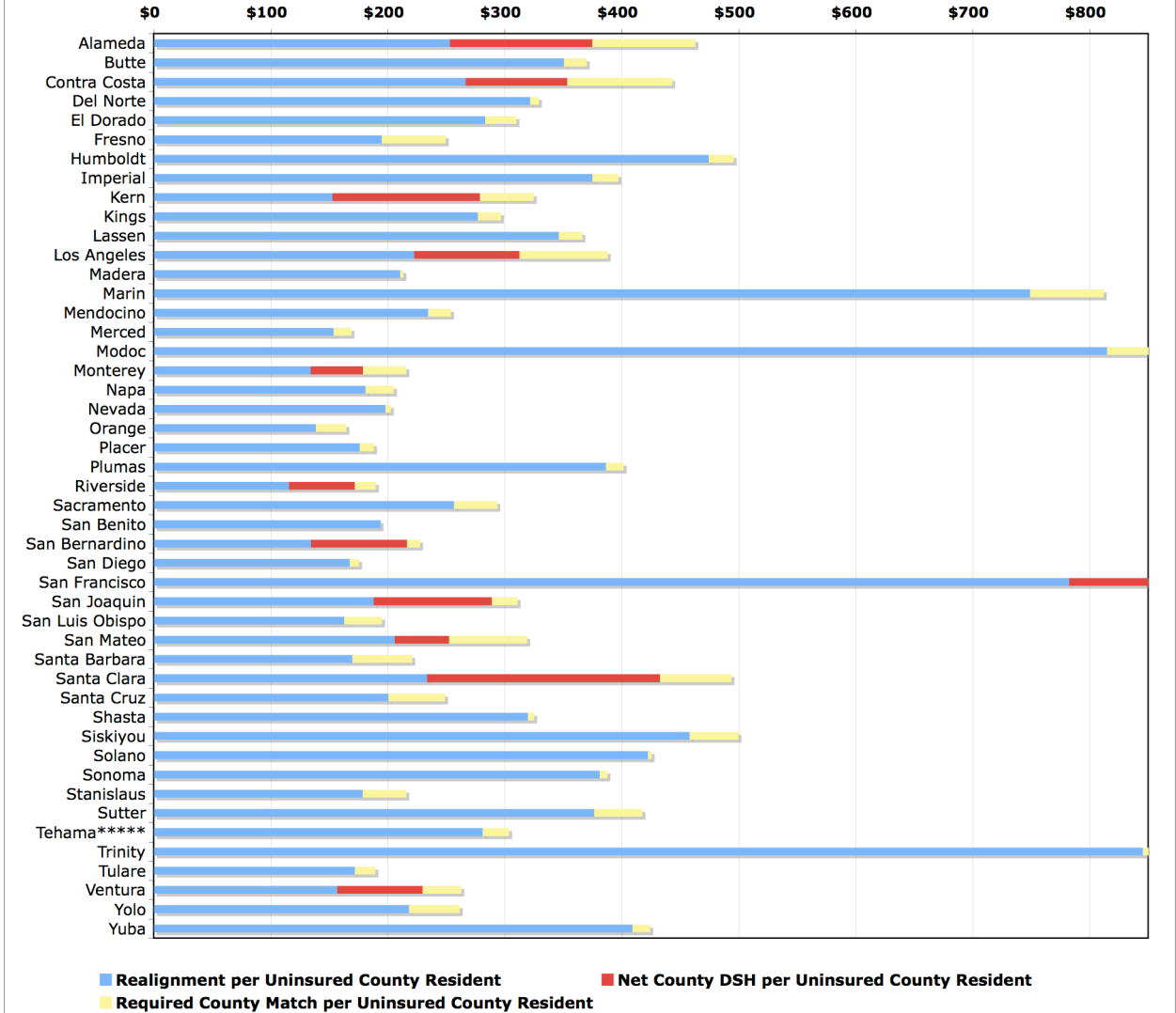
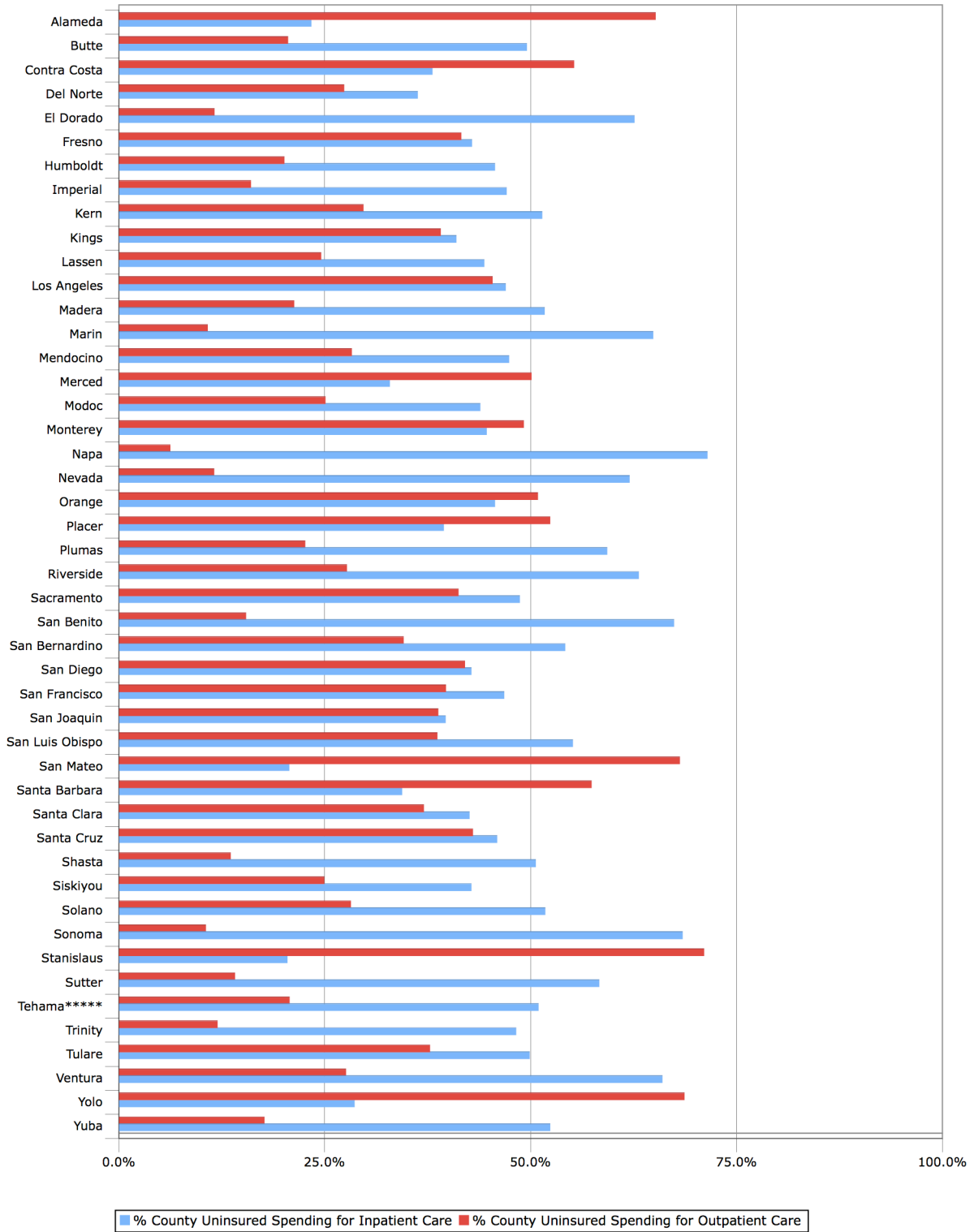


Figure 4: County Funding and Spending on Patient Care for the Uninsured

Source: Programs for the Uninsured: A 48 County Comparison, County Care for the Uninsured in 48 California counties, including statewide numbers (January, 2007); www.itup.org



Section 2: Free and Community Clinics

California's 875 non-profit free and community clinics provide primary care services to a large share of the uninsured population. Over half of the clinics are FQHCs (Federally Qualified Health Centers), which means they receive cost based reimbursement from Medi-Cal and federal funds to assist their missions of care to the uninsured.

Clinics provided more than 5 million patient visits to the uninsured -- over 46% of total visits and about 0.8 visits per uninsured California resident.⁵¹ Clinics received \$326 million from a variety of state and county programs for their care to the uninsured and reported uncompensated care to the uninsured in an amount of \$231 million (over 16% of clinic revenues).⁵²

Clinics experience great variability in their relationship to county indigent systems: some are reimbursed; others are not. *See Figure 7 for a 48 county comparison of county reimbursed and "no pay" visits at community clinics.* Some community clinics serve the same indigent adult population as county clinics do; some are treated as competitors, while others are valued collaborators. Some clinics focus on families or care to children and are essential partners in local managed care systems for families. Some specialize in family planning services for the indigent. While all have a mix of Medi-Cal and uninsured patients, some concentrate on care to the uninsured while others deliver services primarily to Medi-Cal patients. *See Figure 5 for the respective proportions of Medi-Cal and uninsured clinic visits by county.* Some are the sole source of care for their communities while others operate in competitive markets where they vie with private doctors and county clinics for a share of insured Medi-Cal patients. There is wide variation in the magnitude, specialization, sophistication and complexity of clinic operations.

Utilization/Access

Statewide in 2005 patients used 11.6 million visits to free and community clinics in California.⁵³ These community clinics provided care to 3.7 million patients, the bulk of whom lived on incomes below the federal poverty line (FPL).

In California clinics, patients who are uninsured make up the largest percentage of clinic visits at 45.9%; clinics deliver 0.8 visits per uninsured resident, for the most part these are primary care visits although some clinics are expanding into specialty care. *See Figure 6 for the comparative use of clinic care by the uninsured by county.* Of the 6 regions studied, the clinics in the Southern California region had the lowest utilization (visits per uninsured resident) and clinics in the North Rural region had the highest access to clinic services.

⁵¹ Dam, A Summary of Health Care Financing for Low Income Californians 1998-2008 (August 2008) at <http://itup.org/reports.html> By comparison, the average insured California adult sees a doctor four times a year.

⁵² Ibid. We multiplied the number of uninsured visits by the average clinic reimbursement per visit and subtracted all reported payments by the uninsured and by state and county programs for the uninsured.

⁵³ Office of Statewide Health Planning and Development, "2005 Primary Care Clinics Annual Utilization Data" at <http://oshpd.ca.gov/HQAD/Clinics/clinicsutil.html> A total of 850 free and community clinics were included in this analysis.

Table 6: Clinic Visits by Insurance Source by Region⁵⁴

	Medicare	Medi-Cal	Healthy Families	Private	Other Coverage	Uninsured	Total
Bay Area	12.3%	29.6%	1.9%	4.5%	6.5%	45.3%	100%
Central Coast	7.9%	38.0%	1.8%	5.2%	2.2%	45.0%	100%
Central Valley	5.4%	49.0%	2.1%	6.8%	0.6%	36.1%	100%
North Central	7.6%	29.2%	1.5%	6.1%	3.0%	52.6%	100%
North Rural	14.5%	43.0%	2.0%	12.3%	0.8%	27.4%	100%
Southern CA	3.8%	32.1%	2.3%	3.8%	4.2%	53.7%	100%

Source: Office of Statewide Health Planning and Development, "2005 Primary Care Annual Utilization Data."

Southern California Region⁵⁵

The Southern California region was the lowest ranked region in utilization -- 0.7 clinical visits per uninsured resident. In 2005, 1.7 million patients received care from the 351 free and community clinics located throughout the region. The majority of the patients seen in this region are living on incomes below the federal poverty level -- uninsured patients make up 53.7% of the clinic visits and Medi-Cal patients accounted for 32.1% of visits.

Within the region, the county with the lowest number of clinic visits per uninsured resident was San Bernardino at 0.2 visits.⁵⁶ The number of visits to San Bernardino's free and community clinics in 2005 was 168,714 with the largest share of uninsured patients at 38.6% and Medi-Cal patients following at 30.1%. Are the county's uninsured going to the county, private doctors, Riverside or Los Angeles clinics for their primary care?

The county with the most utilization or best access to clinic services (highest number of visits to the uninsured) within the Southern California region was San Diego with 1.2 visits per uninsured. The free and community clinics visits totaled 1.4 million in 2005. Uninsured patients made up the majority of visits with 47.4% and Medi-Cal at 36.7%.

North Rural Region⁵⁷

Of the six regions, clinics in the Northern Rural region provided the most access or highest utilization rate -- 1.3 visits per uninsured resident. Almost 1.1 million visits were made to the 75 free and community clinics located in the region in 2005. In this region, Medi-Cal patients account for the greatest share of clinical visits at 49.0%, while the uninsured patients made up the second largest proportion with 36.1% of clinical visits -- the opposite of the Medi-Cal/uninsured ratio in Southern California clinics, due we assume to the low numbers of practicing physicians for these rural populations. 40.0% of clinic patients had incomes below the FPL, while 33.6% live on incomes between 100% and 200% FPL.

⁵⁴ Fox and Mannanal, California Overview of the Uninsured (2007)

⁵⁵ Fox and Mannanal, Southern California Regional Overview of the Uninsured (November, 2007) at www.itup.org/regional-workgroups.html

⁵⁶ Within this region, San Bernardino, Riverside and Los Angeles all have county clinic networks. In Los Angeles County, community clinics have strong financial ties to the county through the public private partnerships (PPPs), a feature lacking in San Bernardino and Riverside.

⁵⁷ Fox and Mannanal, North Rural Regional Overview of the Uninsured (July 2007) <http://itup.org/Workgroups/RegionalWorkgroups/NorthRural/northrural.html>

Figure 5: Medi-Cal and Uninsured Community Clinic Visits

Source: Office of Statewide Health Planning and Development, "2005 Primary Care Clinics Annual Utilization Data" at <http://oshpd.ca.gov/HQAD/Clinics/clinicsutil.htm>

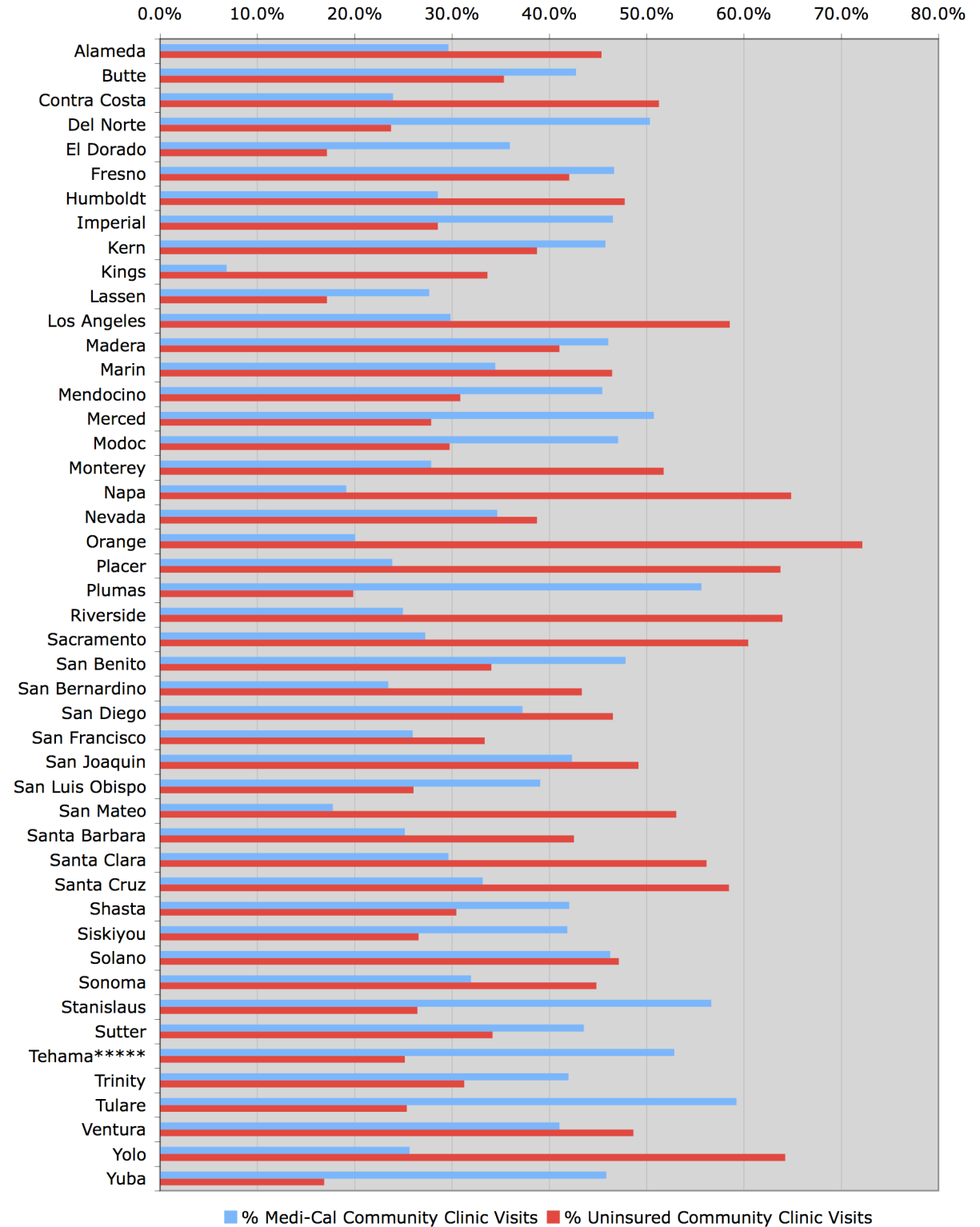
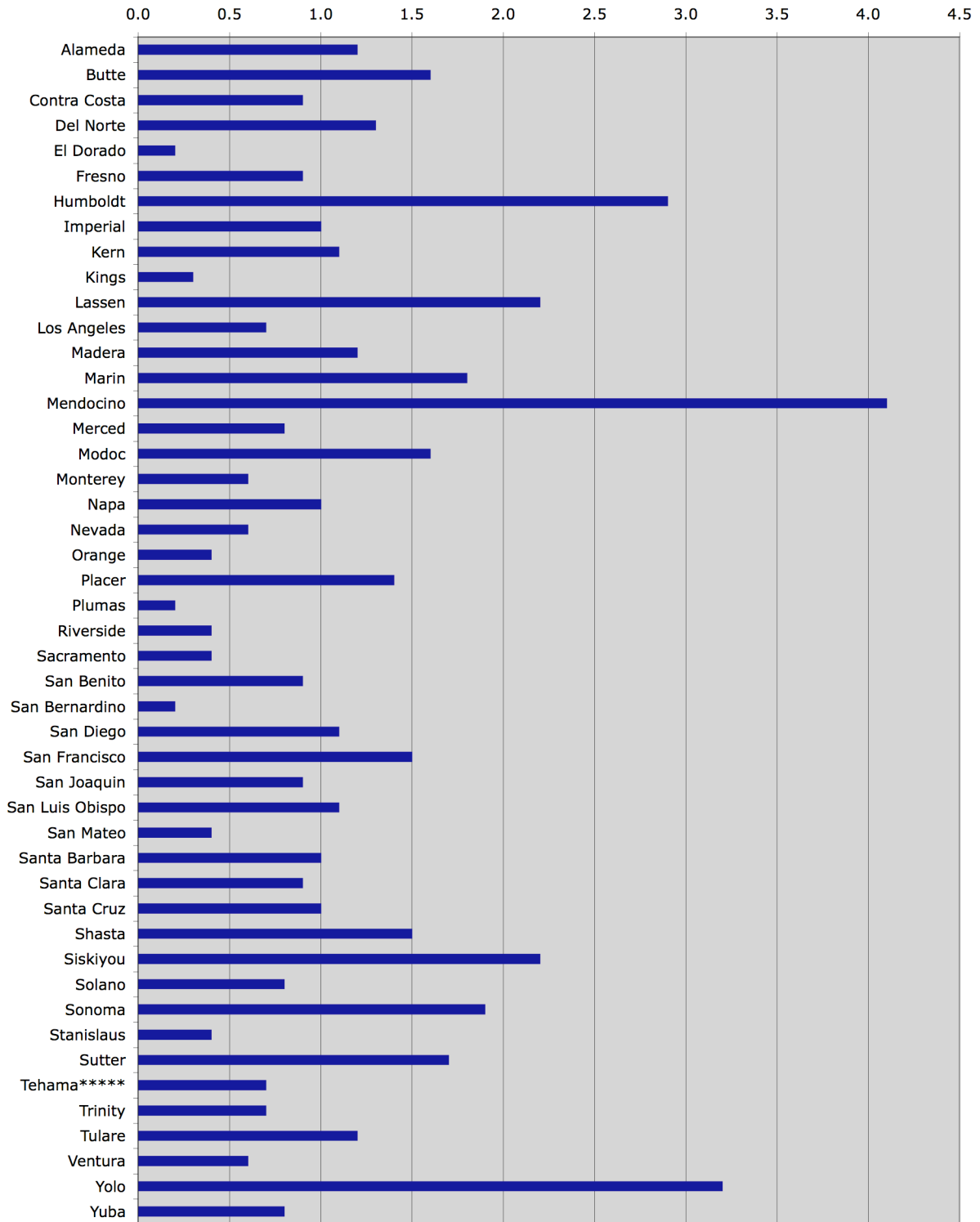


Figure 6: Ratio of Uninsured Visits per Uninsured County Residents

Office of Statewide Health Planning and Development, "2005 Primary Care Clinics Annual Utilization Data" at <http://oshpd.ca.gov/HQAD/Clinics/clinicsutil.htm>



In the North Rural region the county with the lowest number of clinic visits per uninsured resident was Plumas County with 0.2 visits. In this county there were no clinic reports sent into the Office of Statewide Health Planning and Development (OSHPD) in 2005, however there was a community clinic reported one year earlier. The Greenville Rancheria Tribal Health Program delivered 4,619 visits in 2003. Medi-Cal patients made up the majority of visits with 55.6%. The income level of the majority of the clinic patients is not known. Are the uninsured of Plumas going to Lassen, Butte or Nevada for their primary care?

Clinics in Mendocino County had the highest number of visits per uninsured resident in the North Rural region (indeed the state) at 3.6 visits – four times the state average. Are these clinic patients coming in part from neighboring Trinity and Lake counties? In this county there are ten community clinics that offer care. These clinics provided 230,005 patient visits in 2005. Medi-Cal patients made up the largest proportion of the visits in this county with 45.2% and uninsured patients make up 27.7%. Nearly half (48.9%) of the clinics' patients live on incomes below the FPL, while 14.9% are living on incomes between 100-200%.

Central Valley Region⁵⁸

The 118 free and community clinics provided over two million patient visits in the Central Valley in 2005. On average clinics in this region provided 0.8 visits per uninsured patient. The largest share of patient visits was from Medi-Cal patients with 49.0%. 36.1% of visits were from uninsured patients. Seven in ten (72.3%) of clinic patients are living on incomes under the FPL – indicating a far poorer patient mix than in the North Rural region clinics. One in six (16.6%) of clinic patients live on incomes between 100% and 200% FPL in the Central Valley Region.

In the Central Valley region the county with the lowest number of clinic visits per uninsured resident was Kings County with 0.3 visits. These two clinics delivered 21,834 visits in 2005. Medi-Cal patients made up the majority of visits with 44.3% and uninsured patients make up 28.3%. Six in 10 (61%) of clinic patients live on incomes below the federal poverty level, and 19.3 live on incomes between 100% and 200% of FPL. Are the Kings County uninsured going to clinics in Tulare, Fresno or Kern for their primary care or does a local hospital play a major role in their primary care?

Clinics in Madera County provided 1.5 visits per uninsured resident -- the best access in the Central Valley region. In this county there are four community clinics that offer care. These clinics provided 100,869 patient visits in 2005. Medi-Cal patients made up the largest proportion of the visits in this county with 45.6% and uninsured patients make up 44.0%. Seven in ten (71.8%) of the patients live on incomes below the FPL, while 22.4% are living on incomes between 100-200%.

Central Coast Region⁵⁹

In the Central Coast region there are 76 free and community clinics that provided more than 800,000 clinic visits in 2005. The Central Coast region's clinics delivered 1.0 visit per uninsured resident. Uninsured patients make up 45.0% of clinic visits; Medi-Cal patients' share is not far

⁵⁸ Fox and Mannanal, Central Valley Regional Overview of the Uninsured (December 2007) at <http://itup.org/Workgroups/RegionalWorkgroups/CentralValley/CentralValley.html>

⁵⁹ Fox and Mannanal, Central Coast Regional Overview of the Uninsured (December 2007) at <http://itup.org/Workgroups/RegionalWorkgroups/CentralCoast/centralcoast.html>

behind at 38.0%. 66.8% of the clinic patients are living on incomes below the poverty line while 18.8% have incomes between 100% and 200% FPL. In this region, clinics in Ventura County had the lowest ratio of visits per uninsured whereas Santa Cruz produced the highest.

Ventura County has 17 free and community clinics, which provided 175,582 visits in 2005. Clinics in this county delivered a region low of 0.7 visits per uninsured resident. Uninsured patients account for the majority of the visits at 49.7% while Medi-Cal patients' share is 37.1%. Over three-fourths (78.7%) of patients are living on incomes below the poverty line.

The eight free and community clinics in Santa Cruz County provided 1.9 visits per uninsured resident – the best access in the region. These clinics delivered 151,368 clinical visits in 2005. The majority of the visits are by uninsured patients who make up 56.4% of the visits and 32.9% of clinic visits were for Medi-Cal patients. Over six in ten clinic patients (62.6%) are living on incomes below the FPL.

North Central Region⁶⁰

Clinics in the North Central region provided 1.0 visit per uninsured resident – above the statewide average. The 54 free and community clinics in the region accounted for over 750,000 visits in 2005. Uninsured patients make up the majority of patient visits at 53.7% while Medi-Cal's share is at 32.1%. Over half (55.9%) of clinic patients live on incomes below the FPL with 31.2% living on incomes between 100% and 200%. In the North Central region, clinics in El Dorado County had the lowest number of visits per uninsured resident while clinics in Yolo County had the highest utilization.

In El Dorado County there are two community clinics, which provided 35,869 visits in 2005. They delivered 0.4 visits per uninsured resident. In this county, Medi-Cal patients make up the largest share of the visits at 40.7% and Medicare patients account for the second largest share at 19.5% of the visits, followed by the uninsured with 19% of clinic visits. In El Dorado, a surprisingly low 11.2% of the clinic patients have incomes below the FPL. Do uninsured low income El Dorado patients go to Nevada, Placer, or a local hospital for access to primary care services?

Clinics in Yolo County reported 3.3 visits per uninsured resident – more than three times the state average. The county has six community clinics, which provided 119,643 visits in 2005. Uninsured patients account for 60.6%, of visits and Medi-Cal patients account for 27.2%. More than seven in ten (73.1%) of the clinics' patients are living on incomes below the poverty line in Yolo County.

Bay Area Region⁶¹

In the Bay Area region, clinics provided 1.1 visits per uninsured resident. When combined with county outpatient visits, this region offers the best access to care for the uninsured in the state of California. In the region there are 155 free and community clinics, which provided nearly 1.8 million visits in 2005. In the Bay Area the uninsured patients make up the majority of clinic

⁶⁰ Fox and Mannanal, North Central Regional Overview of the Uninsured (December 2007) at <http://itup.org/Workgroups/RegionalWorkgroups/NorthCentral/northcentral.html>

⁶¹ Fox and Mannanal, Bay Area Regional Overview of the Uninsured (November, 2007) at <http://itup.org/Workgroups/RegionalWorkgroups/BayArea/bayarea.html>

visits with 45.3% and Medi-Cal patients are the next largest share at 29.6%. In this region, nearly six in ten (58.2%) of clinic patients live on incomes below the FPL and 21.7% live on incomes between 100% and 200%. Clinics in San Mateo County had the lowest visits per uninsured resident in this region, whereas Marin County clinics had the highest utilization.

Clinics in San Mateo County delivered the regional low of 0.6 visits per uninsured resident. Within the county there are eight free and community clinics that provided 89,631 clinical visits in 2005. Uninsured patients make up the majority (55.3%) of the visits to the clinics while privately insured patients make up the next largest share --19.9%, followed by Medi-Cal – 16.2% of patient visits. In this county, 55.9% of clinic patients live on incomes below the FPL and 15.4% live on incomes between 100% and 200% FPL.

In Marin County, ten community clinics delivered 82,149 visits in 2005. In this county, clinics provided 1.9 visits per uninsured resident – twice the state average; Marin however is the only Bay Area County without a county hospital and its attendant clinics. Of clinics' patients, 64.8% live on incomes below the federal poverty line and uninsured patients make up the majority of patient visits at 52.7%. Medi-Cal patients account for 27.1% of clinic patient visits in this county.

Financing of Free and Community Clinic Services

In 2005 California's clinics received \$1.6 billion in operating revenue; their revenue outpaced their expenses by only \$48.8 million (3%).⁶² Patient fees are the greatest source of clinic revenue, providing 65.5% of total funding. Medi-Cal contributes the greatest proportion of revenue received from patient fees (51.1%). Medi-Cal pays certain clinics for their actual costs of care; these clinics are known as Federally Qualified Health Centers (FQHC) and FQHC look-a-like clinics. Of California's now 875 licensed free and community clinics, 486 (over half) are either FQHC or FQHC look-a-like clinics.

Funding sources for community clinics' care to the uninsured include:

- Federal, state and county government grants and contracts; some county grants such as Ryan White funds are federal funds disbursed at the county level
- State government through the Family PACT, EAPC and CHDP programs and other state grants and contract programs (over one third of clinic visits)
- County governments as reimbursement for their care to county indigent patients and as other grants and contracts (15-20% of clinic visits)
- One third of community clinic visits to the uninsured are not compensated from any state or county program; some are paid by clinic patients on a sliding fee scale; the rest are unpaid.

Some clinics are reimbursed by their counties for care to the uninsured while others have high percentages of no pay visits. *See Figure 7 for a comparison of no pay and county reimbursed clinic visits.* Some rely heavily on Family PACT revenues for their care to the uninsured, and others on patient out pocket payments. *See Figure 8 for a comparison of uninsured visits reimbursed by Family PACT and paid by patients out of pocket.*

⁶² See Brooke Fox and Jolly Mannanal, Overview of the Uninsured: California 2007 at <http://itup.org/reports.html>

Table 7: Clinic Revenues and Expenses, By Region, 2005⁶³

Region	Revenue	Expenses
Bay Area	\$360,502,806	\$356,278,310
Central Coast	\$112,105,663	\$109,487,329
Central Valley	\$242,686,335	\$235,340,239
North Central	\$119,044,882	\$117,962,013
North Rural	\$157,088,907	\$155,441,329
Southern California	\$663,691,561	\$631,777,863
California	\$1,696,804,499	\$1,647,969,330

Table 8: Clinic Revenues (In Thousands), By Payment Source, 2005⁶⁴

Total Revenues	Grants	Medi-Cal	Total Other State	Total County	Self-Pay	Donations	Medicare	Private Insurance
\$1,696,804	\$486,862	\$568,057	\$200,486	\$77,839	\$73,464	\$62,948	\$99,537	\$65,484

Table 9: Clinics' Uninsured Patient Revenues, By Program, 2005⁶⁵

Total clinic patient reimbursements for their care to the uninsured	County ⁶⁶	Self Pay	Family PACT	EAPC	CHDP	Breast Cancer
\$326,095,004	\$59,862,778	\$75,721,004	\$138,800,171	\$22,600,569	\$19,778,205	\$9,332,767

Table 10: Clinics' Uninsured Patient Visits And Revenues by Program, by Region, 2005⁶⁷

	County	Self Pay	Free	Family PACT	EAPC	CHDP	Breast Cancer
Bay Area Visits	17.2%	23.9%	13.6%	31.6%	9.6%	3.2%	1.0%
Bay Area Revenues	37.8%	16.0%	0.4%	34.4%	8.7%	1.9%	0.8%
Central Coast Visits	6.1%	23.9%	4.5%	37.7%	19.4%	7.1%	1.9%
Central Coast Revenues	4.4%	18.6%	-0.2%	50.5%	19.6%	6.2%	1.0%
Central Valley Visits	0.9%	35.1%	4.1%	32.8%	16.3%	8.5%	2.3%
Central Valley Revenues	0.9%	29.5%	0.9%	44.9%	16.2%	6.3%	1.3%
North Central Visits	11.1%	24.5%	9.0%	39.8%	7.7%	6.5%	1.3%
North Central Revenues	14.3%	21.5%	0.0%	44.9%	8.8%	5.8%	0.3%
North Rural Visits	23.0%	27.8%	6.4%	21.6%	16.2%	3.9%	1.2%

⁶³ Office of Statewide Health Planning & Development, "2005 Primary Care Clinics Annual Utilization Data," at <http://oshpd.ca.gov/HQAD/Clinics/clinicsutil.html>

⁶⁴ Dam and Wulsin, A Summary of Health Care Financing for Low Income Californians 1998-2008 Data includes free and community clinics, but not dental clinics. Total Other State includes EAPC, CHDP, Family PACT, Healthy Families & Breast Cancer Programs_"Total County" for 2005 includes County/CMS/PC/MISP, Alameda/SD/LA and Other County Programs "Grants" for 2005 include Federal, State, County/Local and Private Other Revenue Funds SOURCE: OSHPD, Annual Report of Primary Care Clinics; Primary Care Clinic Utilization Data 2005 http://www.oshpd.ca.gov/hid/Products/Hospitals/Utilization/PC_SC_Utilization.html

⁶⁵ A Summary of Health Care Financing for Low Income Californians 1998-2008

⁶⁶ Fox, Overview of the Uninsured: California 2007 This is not the extent of county financing; it includes reported revenues from CMS/PC, MISP, Alameda, Los Angeles and San Diego programs for the uninsured; clinics report receiving \$94,167,149 in county grants and contracts for their services and revenues from "other county programs" as well.

⁶⁷ Fox, Overview of the Uninsured: California

North Rural Revenues	34.6%	20.9%	0.0%	21.1%	18.3%	4.7%	0.5%
Southern CA Visits	27.6%	22.1%	7.6%	26.0%	8.5%	4.7%	3.5%
Southern CA Revenues	35.8%	16.0%	-0.1%	32.6%	8.1%	4.8%	2.9%

Southern California Region⁶⁸

In the Southern California region community clinics received \$663.7 million in operating revenues. The clinics' expenses totaled \$631.8 million. In this region, patient fees account for nearly two-thirds of the total clinic funding. Medi-Cal provides the greatest proportion at 44.9%. Among uninsured patients, self-payment accounts for 16.0% of clinics' uninsured patient revenues, county programs for 35.8%, and Family PACT 32.6%.

Several state programs account for the remaining revenue from uninsured patients such as Breast Cancer, Child Health and Disability Program (CHDP), and Expanded Access to Primary Care (EAPC). In this region, clinics in Imperial County (the least populous and poorest county in the region) had the least revenue and expenses, while clinics in Los Angeles not unsurprisingly had the highest.

In 2005, Imperial County clinics earned \$12.3 million in revenue however the clinics spent \$12.5 million, which created a \$0.2 million deficit. In this county, the largest source of operating revenues comes from patient fees at 73.0%. Medi-Cal account for 58.2% of clinics' patient revenues, while uninsured patients and programs account for 18.6% of patient revenues. The top two funding sources other than patient fees were state and federal grants.

In 2005, Los Angeles County's community clinics earned \$365.8 million in revenues and ran a surplus of \$13.9 million. Like Imperial County, patient fees are the largest source of revenue for Los Angeles County's free and community clinics. In this county patient fees provided 61.1% of the total funding. Medi-Cal is the largest proportion of patient revenues at 45.0% and second, uninsured patients and their programs with 38.5%. Federal and county/local grants were the next biggest financial resources.

Bay Area Region⁶⁹

Clinics in the Bay Area region earned \$360.5 million in operating revenues and had expenses totaling \$356.3 million. Patient fees were the greatest source of revenue in this region accounting for nearly three quarters of clinics' total funding. Medi-Cal accounts for 52.1% of the patient fees. The uninsured patient revenues came through self-payment (16.0%), county programs (37.8%), and Family PACT (34.4%). Other sources are Breast Cancer, CHDP, and EAPC. In this region, clinics in San Mateo County had the lowest revenue and expenses while clinics in Alameda County had the highest.

Clinics in San Mateo County earned \$10.7 million in 2005 when the clinics ran a deficit of \$0.4 million. Patient fees are the largest source of revenues for clinics in San Mateo accounting for 63.5% of their total funding. Medi-Cal accounts for only 28.5% of clinics' revenues from patient fees. The next best sources are state and federal grants and contracts.

⁶⁸ Southern California Regional Overview of the Uninsured (November, 2007)

⁶⁹ Bay Area Regional Overview of the Uninsured (November, 2007)

Clinics in Alameda County earned \$126.4 million in revenues in 2005 and ran a surplus of around \$3.1 million. With patient fees being the major source of clinic revenues, Medi-Cal contributes the majority of the patient revenues with 54.1%, while programs for the uninsured and uninsured patients themselves make up the second largest proportion with 22.2% of patient revenues. Other significant financial resources for these free and community clinics are state and federal grants and contracts.

Central Valley Region⁴⁰

In the Central Valley the community clinics earned \$242.7 million in operating revenues while their expenses totaled \$235.3 million. Patient fees provided nearly three quarters of the total clinic funding. Medi-Cal makes up a high of 64.2% of the revenues from patient fees. For their uninsured patients, clinics relied on self-payment (29.5%), Family PACT (44.9%), county programs, Breast Cancer, CHDP, and EAPC (16.2%). Counties (other than the small CMSP counties) in this region devote few resources to care for the uninsured in free and community clinics, accounting for 0.9% of clinics' uninsured patient revenues. In this region, clinics in Kings County had the lowest revenue and expenses while clinics in Fresno County had the highest.

Clinics in Kings County in 2005 earned \$2.6 million in revenues and broke even. The best revenue source for the clinics was patient fees (74.9%) followed by state and federal contracts and grants. Medi-Cal makes up the largest proportion of patient revenue with 56.6%. The second largest proportion of revenues comes from uninsured patients at 19.0%.

Clinics in Fresno County earned \$61.3 million in revenues and ran a surplus of \$3.1 million. The best source of revenue for the free and community clinics was patient fees, which provide over two-thirds of the total clinic funding; state and federal grants and contracts make up the rest of the top three financial resources. Medi-Cal makes up the largest portion of the clinic patient revenues at 65.4%, and those with no health insurance and their state and county programs contribute 24.3% of patient revenues.

North Rural Region⁷⁰

The clinics in the Northern Rural region earned \$157.1 million in revenues from which they paid their total expenses of \$155.4 million. In this region patient fees provided nearly three quarters of the total funding to the clinics. Medi-Cal patients supply the most revenues from patient fees at 56.2%. Amongst those who are uninsured, self-payment (20.9%), County Medical Services Program (CMSP) (34.6%), Family PACT (21.1%), Breast Cancer, CHDP, and EAPC (18.3%) encompass the revenues. In this region, clinics in sparsely populated Modoc County had the lowest revenue and expenses, while clinics in Mendocino County had the highest.

Earning \$1.3 million in operating revenues in 2005, the clinics in Modoc County ran a surplus of \$13,942. Accounting for 80.6% of clinic revenues were patient fees, trailed by state grants and contracts. Medi-Cal accounts for 63.8% of their patient fees, and the uninsured patients and programs account for 20.7%.

Clinics in Mendocino County earned the highest revenues and had the most expenses within the

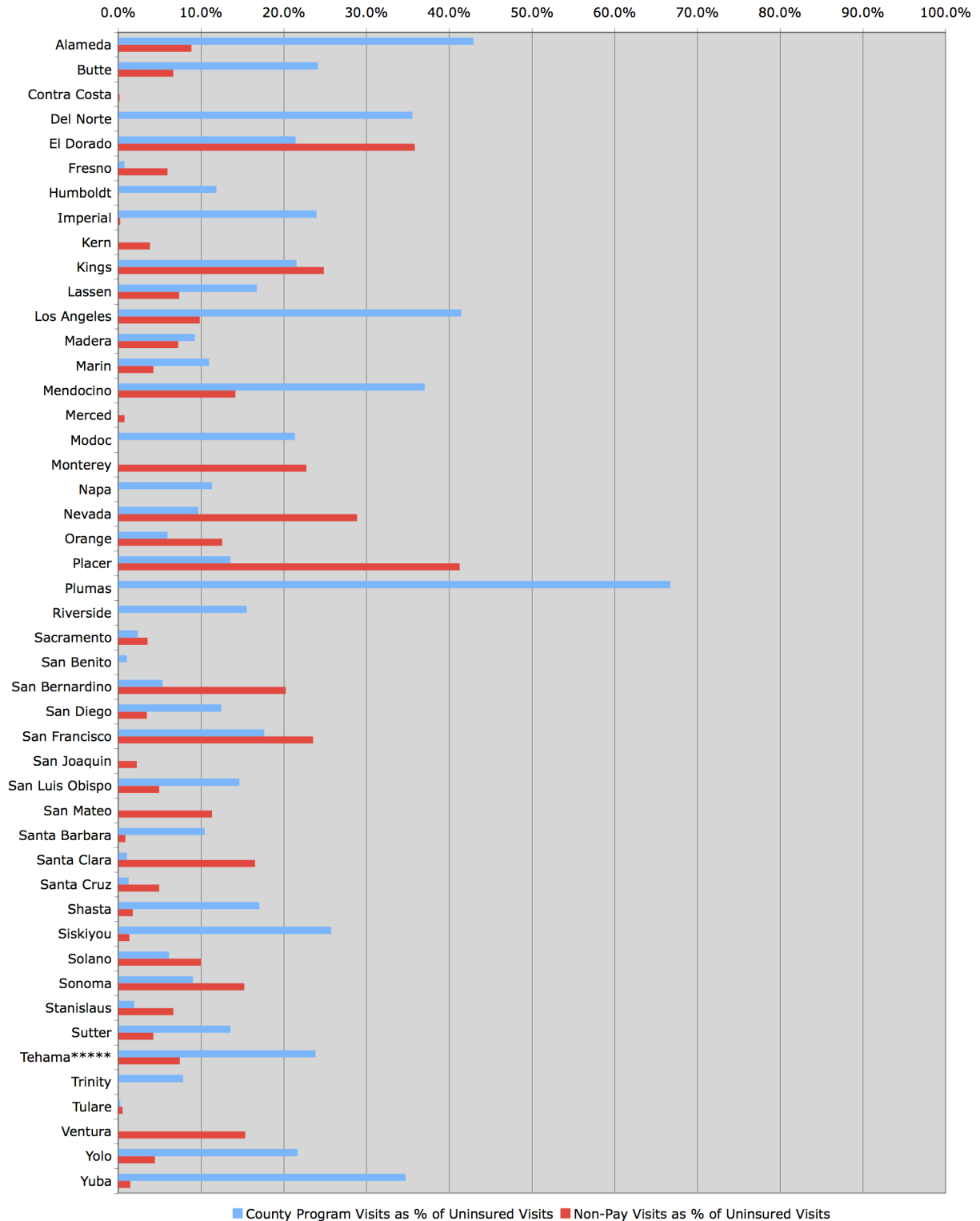
⁷⁰ North Rural Regional Overview of the Uninsured (November, 2007)

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North Rural region in 2005. Earning \$36.7 million in revenues and spending \$36.6 million, clinics had a very small surplus. Patient fees provide the greatest proportion of operating revenues in the clinics from Mendocino County -- 63.9%. The Medi-Cal program accounts over half of the clinics' revenue from their patient fees. The next largest proportion of clinics' patient revenue comes from uninsured patients and programs -- 22.0%. Private sources along with federal and state grants make up the next largest sources of revenue for clinics in this county.

Figure 7: County and No-Pay Visits as a Percent of the Uninsured Visits

Office of Statewide Health Planning and Development, "2005 Primary Care Clinics Annual Utilization Data" at <http://oshpd.ca.gov/HQAD/Clinics/clinicsutil.htm>



North Central Region⁷¹

In the North Central Region community clinics earned \$119.0 million in operating revenues with expenses totaling \$118.0 million. Accounting for 43.2% of their patient fees, Medi-Cal is the greatest source of patient revenues. Several programs generate revenues for the uninsured patients including self-payment (21.5%), county programs (14.3%), Family PACT (44.9%), and CHDP. Programs such as EAPC and Breast Cancer also contribute to the revenues for clinics' uninsured patients. In this region clinics in El Dorado County had the lowest revenue and expenses while clinics in Sacramento County had the highest.

In 2005 clinics in El Dorado County earned \$5.7 million in operating costs however they ran a deficit of \$1.1 million as the total expenses were \$6.8 million. In El Dorado clinics, patient fees are the largest revenue source with 70.7%; the next largest sources are state and federal grants and contracts. The largest proportion of patient revenue comes from Medi-Cal at 43.9%. Private insurance comprises a significant proportion of patient fees at 26.0%. Uninsured patients and programs amount to 12.1% of clinics' patient revenues.

Clinics in Sacramento County earned \$30.1 million and ran a deficit of \$0.9 million in 2005. Their top three sources of revenue are patient fees, federal grants, and donations. Patient fees provide 85.4% of the total funding. The largest proportion of patient's fees is from Medi-Cal patients at 42.5% while uninsured patients make up 31.9%.

Central Coast Region⁷²

The clinics in the Central Coast region earned \$112.1 million in revenues and their expenses totaled \$109.5 million. As in the other regions, patient fees account for the largest proportion of the revenues, accounting for two thirds of the total funding with Medi-Cal contributing the majority at 53.3%. For the patients who are uninsured the revenue comes from self-payment (18.6%), EAPC (19.6%), CHDP, counties (4.4%), Family PACT (50.5%), and Breast Cancer. Clinic funding partnerships with counties appear very weak in the Central Coast. In this region clinics in San Benito County had the lowest revenue and expenses while clinics in Santa Barbara County had the highest.

Clinics in San Benito County earned almost \$3.0 million in operating revenues in 2005 and ran a surplus of \$0.2 million. Patient fees in San Benito are the largest source of revenue for the clinics at 68.7% of revenues, followed by state grants and contracts. In the clinics from this county, uninsured patients make up the majority of patient visits and likewise account for over half of the patient fees at 59.0%. The next largest proportion is Medi-Cal with 17.1% of patient fees.

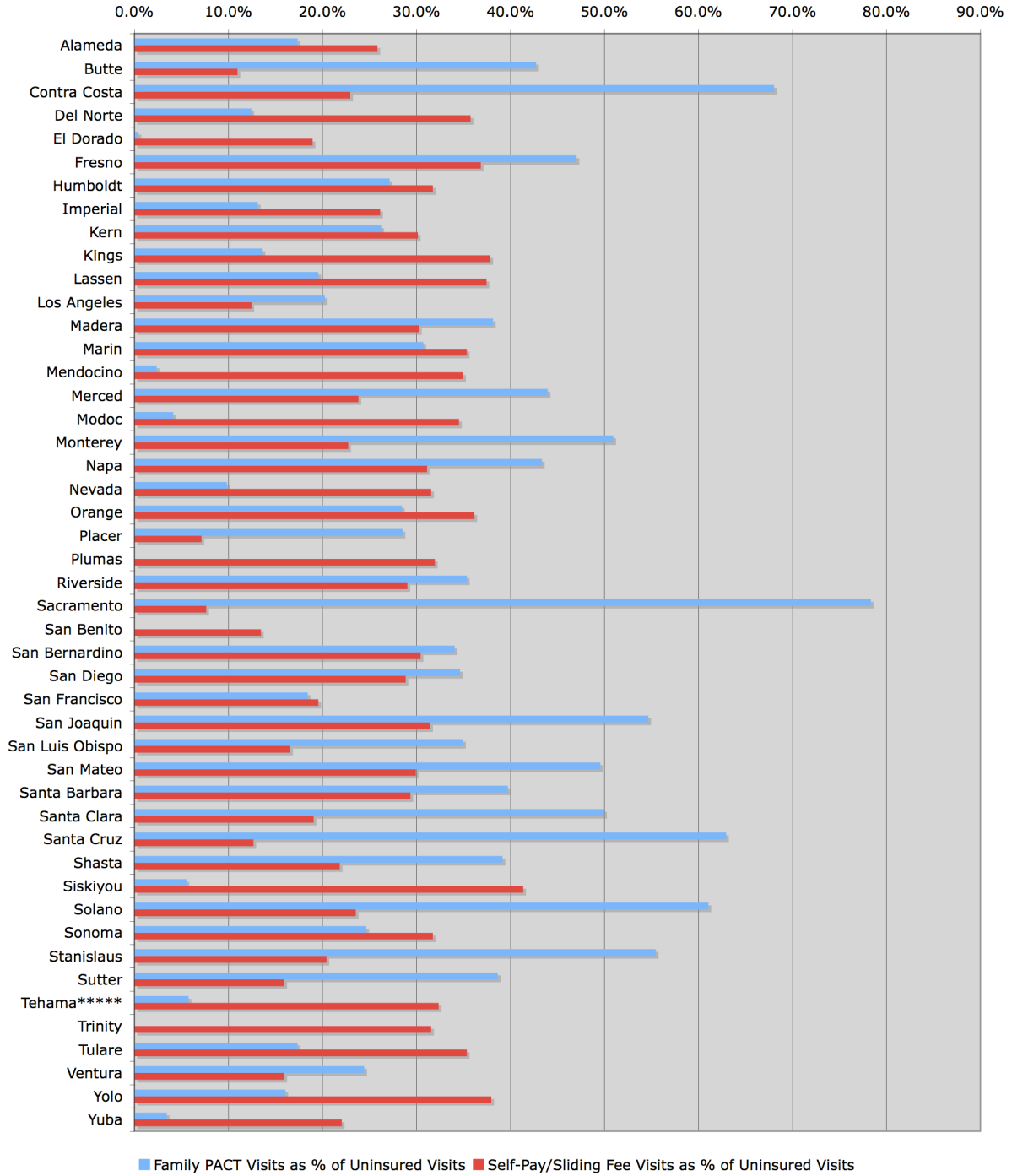
In 2005 clinics in Santa Barbara County ran a surplus of around \$0.9 million after earning \$31.6 million in operating revenues. Over half of the total funding for the free and community clinics is from patient fees. Federal and state grants and donations are the next largest sources of clinic revenue. Programs for the uninsured and Medi-Cal contribute equal percentages of patient fees at 45.0%.

⁷¹ North Central Regional Overview of the Uninsured (November, 2007)

⁷² Central Coast Regional Overviews of the Uninsured (December, 2007)

Figure 8: Family PACT and Self-Pay/Sliding Scale Fee Visits for Uninsured

Source: Office of Statewide Health Planning and Development, "2005 Primary Care Clinics Annual Utilization Data" at <http://oshpd.ca.gov/HQAD/Clinics/clinicsutil.htm>



Section 3: Hospitals

In fiscal year 2005, California's 334 hospitals provided 16.4 million inpatient days, 40.7 million outpatient visits, and 7.6 million emergency department visits.⁷³ Their net patient revenues were \$47.1 billion and operating expenses were \$46.8 billion, leaving a narrow operating margin of \$0.3 billion. DSH (Disproportionate Share Hospital) funds are not counted as patient revenues, and they do widen hospitals' operating margins by \$2 billion.

Care for the uninsured in California hospitals appears in two guises in the OSHPD data: as an uncompensated care expense (bad debt and charity care to the uninsured) and as revenue from the county for care to the county indigent. Care for the uninsured from both sources totals about 6.6% of hospital expenses. It is roughly evenly split between county reimbursed care to the hospital and bad debt and charity care (also known as uncompensated care and not to be confused with Medi-Cal uncompensated care), but the respective shares are highly variable from county to county. *See Figure 11 for county comparisons.* In private non-profit hospitals, the uncompensated care to the uninsured may be one aspect of the hospitals' community benefit obligations.

In some communities, non-profit clinics and private hospitals work collaboratively in delivering care to the uninsured. Likewise, some private and public hospitals cooperate in caring for the uninsured. Hospitals sometimes help to fund community clinics for the uninsured, others have helped start and fund local coverage initiatives for the uninsured.

Funding Sources for Hospitals' Care to the Uninsured

- Private hospitals: county payments, small portion of State Prop 99 through the county, private DSH like and private DSH like supplement
- County hospitals: county payments, small portion of State Prop 99, Local Certified Public Expenditure, Public DSH and Safety Net Care Pool
- University of California hospitals: county payments, small portion of State Prop 99, Certified Public Expenditure, Public DSH and Safety Net Care Pool

County reimbursed care⁷⁴

Hospitals report earning over \$1.4 billion in net patient revenues from county reimbursed care to the uninsured. Roughly 3% of all hospital inpatient days, 5% of hospital outpatient visits, and 11% of hospital emergency room visits are paid by the counties; this is highly variable between counties. Hospitals report being paid by counties for 428,447 inpatient days, 1,991,581 hospital outpatient visits and 441,708 emergency room visits (87 days, 406 hospital outpatient and 90 emergency room visits per 1000 uninsured).⁷⁵ *For inter county comparisons of county funded*

⁷³ Overview of the Uninsured: California 2007; Office of Statewide Health Planning and Development, "Selected Hospital Annual Financial Data: FY 2004-2005," at www.oshpd.ca.gov/HQAD/Hospital/financial/hospAF.html

⁷⁴ Overview of the Uninsured: California 2007; Office of Statewide Health Planning and Development, "Selected Hospital Annual Financial Data: FY 2004-2005," at www.oshpd.ca.gov/HQAD/Hospital/financial/hospAF.html The OSHPD reports by hospitals on their payments from the counties differ and in many cases quite drastically from the MICRS and CMSP from the counties on what they pay the hospitals. We have no basis for determining which set of data is more accurate. In Figures 10, 11 and 12 computations we used the hospital OSHPD reports. (Check computations) (check LA, Lassen and Monterey for inaccuracies).

⁷⁵ Overview of the Uninsured: California 2007

inpatient days and outpatient visits for the uninsured, see Figures 9 and 10.

Why do hospitals have bad debt and charity care then, what don't counties pay for? *See Figure 11 for inter county comparisons of county reimbursements and hospitals' bad debt and charity.* In provider counties, while the county funds its own public hospitals, private hospitals are not typically reimbursed by the county for their care to the county indigent though some private hospitals do qualify for federal and state payments through private DSH. In payor, hybrid and CMSP counties by contrast, hospitals are not typically reimbursed by the counties for their care to several groups of the uninsured indigent: parents and children, county residents with incomes above the county's medically indigent eligibility level and county residents without legal permanent residence status (a green card).

Bad debt and charity care⁷⁶

Hospitals report providing more than \$1.7 billion in costs of charity care and bad debt to the indigent uninsured. Reported hospital bad debt and charity care as a percent of revenues varies from a high of 6.9% in Plumas County to a low of 1.3% in Napa County.

Offsets

In large counties there is typically a dominant private facility or public system that provides the bulk of services for the uninsured. For example in the large counties of Sacramento, Orange, and San Diego, the University of California has taken over the responsibility, the facility, and financing from the former county hospital. In the counties of Merced and Fresno a non-profit community hospital now operates where the county hospital once was -- taking on its roles and financing. These private facilities may work out supplemental financial agreements with the county.

Private hospitals that serve disproportionately large percentages of Medi-Cal are also likely to receive private DSH and DSH supplements to help pay for their larger than average shares of uncompensated care. The state and the federal government pay in equal measure for private DSH and DSH supplements.

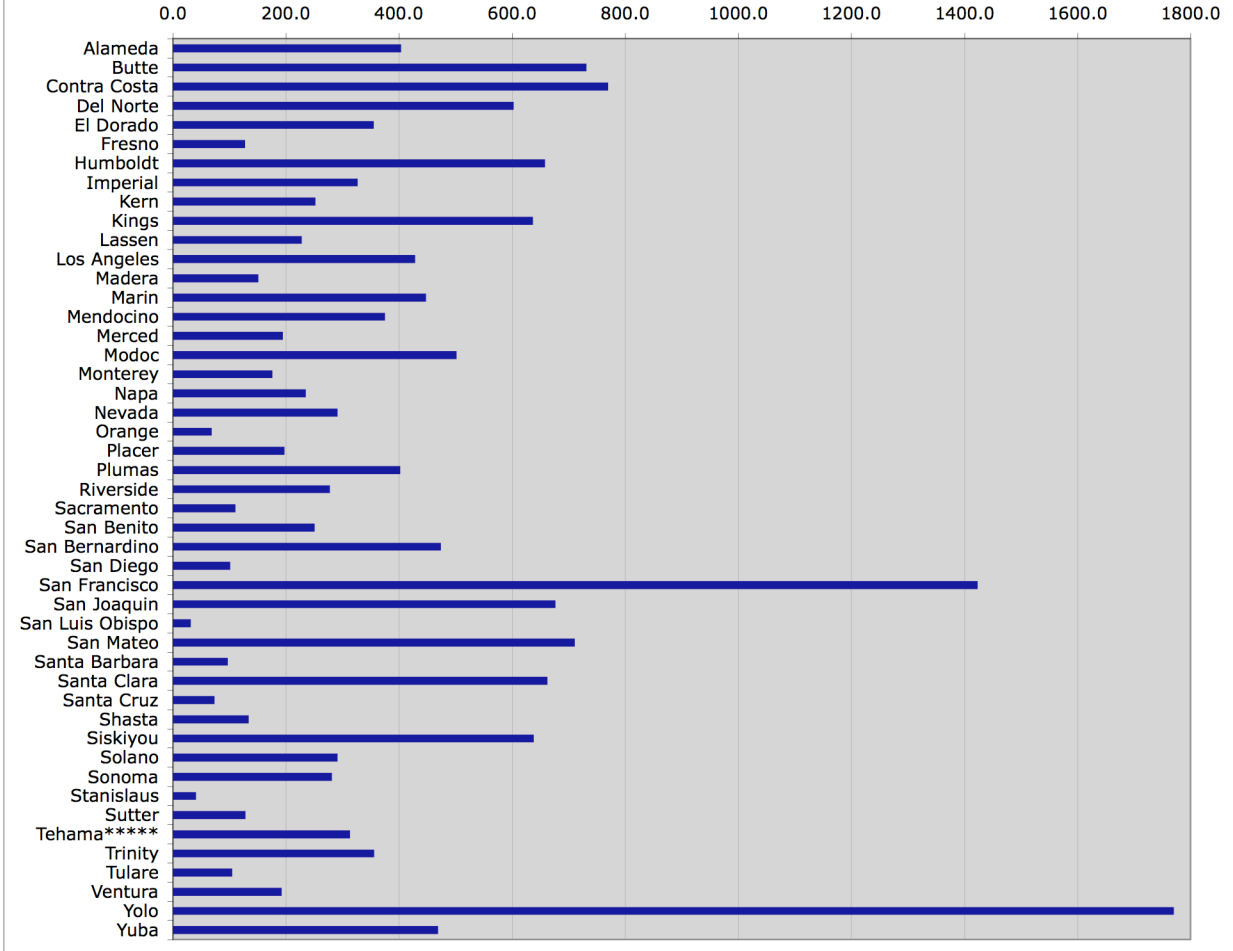
In large counties with public hospitals, county expenditures serve as the state match for Medi-Cal DSH, Safety Net Care Pool and Medi-Cal inpatient rates through a mechanism known Certified Public Expenditures (CPE). CPE is a public hospital's cost of care to Medi-Cal and uninsured patients and a county's spending on indigent adults. This match secures the federal Medicaid DSH and Safety Net Care Pool funding for care to the uninsured. Safety Net Care Pool funding can be spent on care to the uninsured in and out of hospital settings so that for example it could be used to help pay for care in community clinics; however it cannot be used to pay for care to the undocumented uninsured.

The CMSP program in small counties reimburses hospitals for county indigent adults the same way the Medi-Cal program does for families and the disabled. Very few hospitals in these small rural counties qualify for or receive federal DSH and SNCP funds or the private DSH and DSH supplements.

⁷⁶ Ibid.

**Figure 9: County Reimbursed Uninsured Outpatient Visits
(Per 1000 Uninsured)**

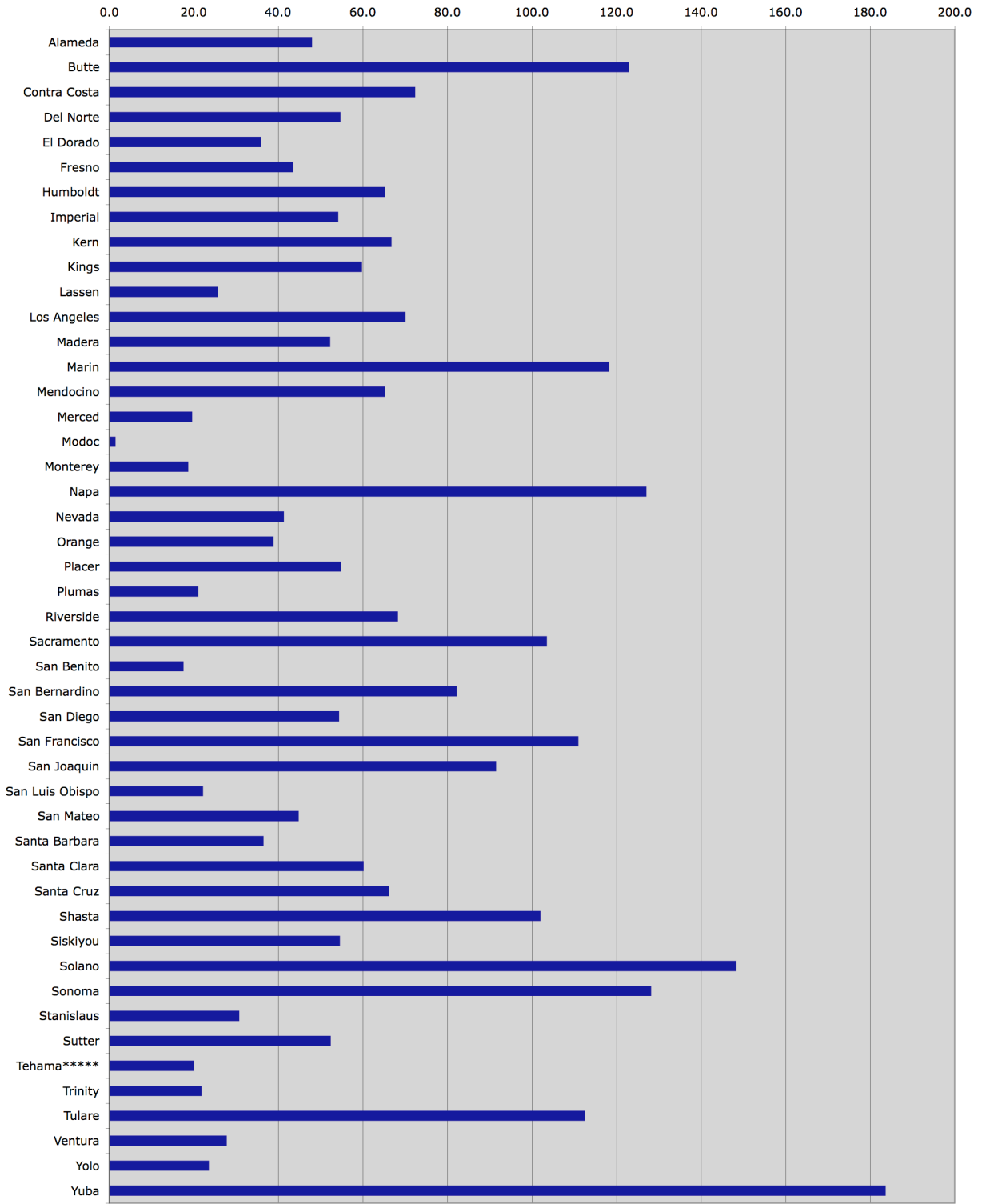
Source: *California Hospitals: A 48 County Comparison, Hospitals in 48 California counties, including statewide numbers (January 2007) at www.itup.org*



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Figure 10: County Reimbursed Uninsured Inpatient Days (Per 1000 Uninsured)

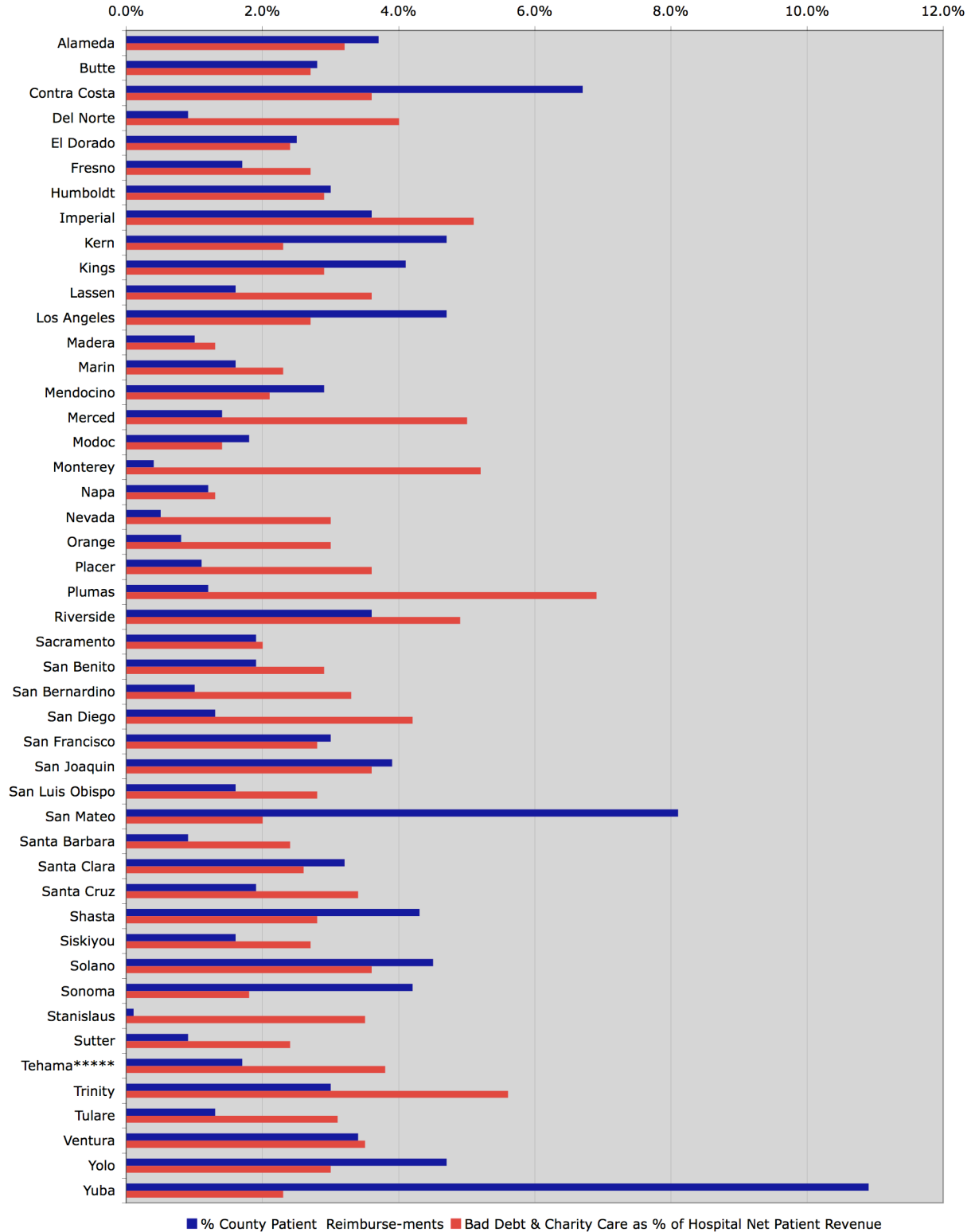
Source: California Hospitals: A 48 County Comparison, Hospitals in 48 California counties, including statewide numbers (January 2007) at www.itup.org



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Figure 11: Hospitals Bad Debt & Charity Care and County Reimbursement

Source: California Hospitals: A 48 County Comparison, Hospitals in 48 California counties, including statewide numbers (January 2007) at www.itup.org



Hospital Reimbursements For Care To The Uninsured From The Federal And State Governments

Bad debt and charity care to the uninsured and underpayments through Medi-Cal are both characterized as uncompensated care in hospitals, which the federal DSH program can and does reimburse for eligible hospitals. According to the most recent OSHPD data, California hospitals have about \$1.7 billion in bad debt and charity care costs and about \$2 billion in Medi-Cal underpayments.⁷⁷

Private DSH-like funding is distributed based on a set formula to private hospitals with high shares of uninsured and Medicaid patients. Public DSH funding by contrast is based on the public facility's actual cost of care. There are two DSH caps that limit the amount of hospitals' DSH funding. The first caps the total federal DSH funding a state can receive. The second caps the amount any given facility can receive; this second cap assures that any facility cannot receive more than its cost of care. Private hospitals receive \$477 million in DSH-like payments and \$292 million in DSH-like supplements.⁷⁸ Public hospitals receive \$1 billion in net DSH payments and \$580 million in Safety Net Care Pool payments, in addition public hospitals are paid for their actual costs of care for Medi-Cal patients.⁷⁹ In California, the state pays for the state match for DSH in private hospitals while counties put up the match for DSH in public hospitals. Putting all these together, the net loss on California hospital care to the uninsured and uncompensated care might be \$1.3 billion (\$3.7 billion minus \$2.4 billion).

⁷⁷ A Summary of Health Care Financing for Low Income Californians 1998-2008 (August 2008)

⁷⁸ Ibid.

⁷⁹ Ibid.

Section 4: Local Managed Care

Medi-Cal managed care programs are located in large counties, where managed care is mandatory for families and children. Smaller counties have an option to operate mandatory managed care programs (County Organized Health Systems), but only a few have voluntarily chosen to do so.

Local Medi-Cal managed care entities are the focal coordinating point for the safety net in many local pilot programs to cover the uninsured. There are three structures in which the programs are organized. First is a County Organized Health System (COHS), which is a single managed care entity for all of those enrolled in Medi-Cal. Second, is a competitive managed care plan between a private commercial health plan and the counties’ local initiative; these are known as Two Plan Counties. The third is Geographic Managed Care (GMC), which is competitive managed care among several private commercial health plans.

Table 11: Managed Care Systems for Medi-Cal Patients by County

County Organized Health Systems (COHS)	Monterey, Napa, Orange, Santa Barbara, San Luis Obispo, San Mateo, Santa Cruz, Solano, Yolo
Two Plan Counties with Public Managed Care (LI or Local Initiative)	Alameda, Contra Costa, Kern, Los Angeles, Riverside, San Bernardino, San Joaquin, Santa Clara, San Francisco
Two plan Counties without Public Managed Care	Fresno, Stanislaus, Tulare
Geographic managed care	Sacramento, San Diego
Fee for service	El Dorado, Del Norte, Glenn, Humboldt, Imperial, Lake, Merced, Madera, Marin, Mendocino, Modoc Nevada, Placer, Siskiyou, Sonoma, Sutter, Tehama, Trinity, Ventura, Yuba

Disabled adults in Medi-Cal and critically ill children in the CCS program are exempt from mandatory enrollment in capitated managed care, except in the counties with a County Organized Health System. For the most part, counties do not use managed care entities to organize the delivery of care for their indigent populations; however San Francisco, San Mateo and Contra Costa are leading exceptions.

Several states including Oregon, Arizona, New York and Massachusetts have federal §1115 waivers and consolidate their Medi-Cal and indigent adult populations in Medicaid managed care. During the course of our regional workgroup discussions, several counties and regions have expressed an interest in merging their Medi-Cal and county indigent programs and delivering managed care to the entire low-income population.

Expansion of Medi-Cal and Healthy Families managed care models was one of the cornerstones of the recent California reform discussions. Some drawbacks to merging the Medi-Cal and uninsured patients into a single managed care system include the inadequate funding for indigent care and the concerns of safety net providers about competing for patients with private sector plans and providers.

There are multiple county initiated pilot programs for the uninsured; typically they use the county managed care plan as the base or infrastructure to organize the safety net delivery systems.⁸⁰ Many counties have established local managed care programs for uninsured providers of home care services (In Home Supportive Services or IHSS) to the disabled and elderly. These pilots are now typically self-supporting with a combination of county, state and federal matches plus a modest subscriber premium. A number of counties have developed local Healthy Kids programs for uninsured children not otherwise eligible for Medi-Cal and Healthy Families; these do not as yet have a self-sustaining source of funding and to date rely on a patchwork quilt of First 5, philanthropic and local health plan donations.

Table 12: Local Pilot Programs for the Uninsured that Used the Infrastructure of County Managed Care Delivery Systems⁸¹

Provider Counties	<i>Yes:</i> Alameda, Contra Costa, Los Angeles, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara <i>No:</i> Kern, Ventura ⁸² and Monterey
Payor Counties	<i>Private:</i> San Diego (FOCUS)
Hybrid Counties	<i>Private:</i> Sacramento (SacAdvantage)
CMSP Counties	<i>Public:</i> Solano (Partnership Health Plan)

Not all local health plans are equally successful in their competition with commercial plans for enrollment Medi-Cal and Healthy Families subscribers. Local plans’ competitiveness depends on the degree of collaboration between safety net providers and the safety net health plan, the level of patient satisfaction with the local safety net providers and safety net plan, and the marketing and enrollment skills of the safety net providers and local plans vis-a-vis the private sector.

In markets with a COHS, the local plan is assured 100% of the mandatory Medi-Cal enrollees. In counties with a Two Plan model and a publicly operated Local Initiative (LI), the LI is guaranteed a baseline enrollment of 60% of the market. In Geographic Managed Care counties there is no local safety net plan and no guaranteed minimum enrollment. We included San Diego County in our comparison due to the nature of its local non-profit safety net plan. In the Healthy Families market, subscribers have a \$3 monthly discount if they choose the local safety net plan. In Table 13, we compare the competitiveness of local managed care plans in Medi-Cal and Healthy Families markets.

Safety net providers have important Medi-Cal rate protections such as DSH and FQHC reimbursement that result in stronger incentives for them to compete for Medi-Cal enrollees than for Healthy Families subscribers. Safety net plan competitiveness (or not) in both these markets has important immediate financial consequences for their local safety net providers. It should also serve as an important guide to local safety nets in assessing their potential success in differing competitive models of health reform. Healthy Families is more likely to be the model of

⁸⁰ Mannanal, Directory of Local Efforts to Expand Health Care Access for the Uninsured (January 2007) at www.itup.org/reports

⁸¹ Ibid.

⁸² Kern and Ventura both have local coverage expansion grants that could build partnerships with local community clinics and small employers.

future California health reforms than is Medi-Cal, and many local safety nets will need to improve their competitiveness in this reform model.

Few local managed care plans are ready to participate and compete with large commercial carriers in the individual and small employer markets, as they lack agent broker networks and underwriting skills and experience in these markets.

Many safety net providers in regions and counties that are not yet subject to mandatory Medi-Cal managed care believe that managed care is not viable for either Medi-Cal or uninsured patients due to their small populations, rural provider networks, large financial risks and perceived perils to local safety nets through competition. As a result they lack the locally operated managed care infrastructure for successful pilots or major reform efforts. They too are going to need to participate and learn to thrive in a managed care environment in the future.

Table 13: Local Safety Net Plans: Success in Public Competitive Managed Care Markets⁸³

County	% Medi-Cal Enrollment in Mandatory Local Health Plan	% Healthy Families Enrollment in Local Health Plan
Alameda	72.2%	47.5%
Contra Costa	79.3%	32.3%
Kern	79.0%	45.4%
Los Angeles	60.7%	12.4%
Monterey*	100%	6.8%
Napa*	100%	n/a
Orange*	100%	44.4%
Riverside	75.7%	31.1%
San Bernardino	70.6%	33.7%
San Diego**	41.0%	35.2%
San Francisco	70.0%	52.5%
San Joaquin	67.6%	48.4%
San Luis Obispo*	100%	n/a
San Mateo*	100%	52.5%
Santa Barbara*	100%	21.6%
Santa Clara	67.2%	54.0%
Santa Cruz*	100%	19.9%
Solano*	100%	n/a
Yolo*	100%	n/a

*County Organized Health Systems have 100% of Medi-Cal market share

**Safety Net Health Plan in a Geographic Managed Care County

⁸³ Managed Risk Medical Insurance Board. Healthy Families Program, Current Enrollment Distribution by County and by Health Plan (January 3, 2006) at <http://www.mrmib.ca.gov/MRMIB/HFP/HFPPReports/html> and California Department of Health Care Services, Medical Care Statistics Section, Medi-Cal Beneficiary Profiles by County 2005 Medi-Cal pivot tables at <http://www.dhc.ca.gov/mcss/RequestedData/Beneficiary%20files.html>

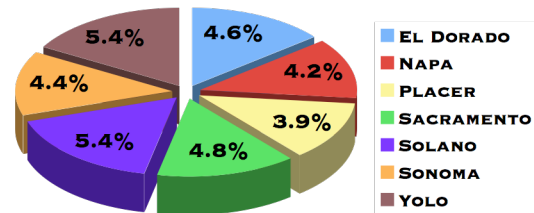
Section 5: Economy & Demographics

Economy: Unemployment

In California, the August 2008 statewide unemployment rate is 7.7%, as compared to 5.4% in 2005.⁸⁴ Of the state’s residents 14.2% live on incomes below the federal poverty line.⁸⁵

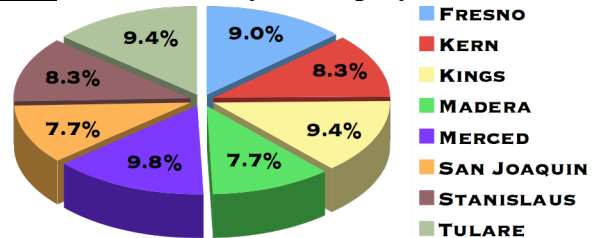
Within the North Central region, the region with the lowest unemployment rate, Placer had the lowest rate at 3.9%.⁸⁶ Yolo and Solano Counties had the highest unemployment rates -- 5.7%.

Figure 12: North Central Unemployment Rates



The Central Valley region had the highest unemployment rate – 8.6%. Within the Central Valley, Madera and San Joaquin had the lowest unemployment rates at 7.7%, while Merced had the highest rate at 9.8%.

Figure 13: Central Valley Unemployment Rates



*Demographics: Poverty*⁸⁷

California is one of the most ethnically and economically diverse states in the nation, and its population grew by 6.7% between 2000 and 2005. Within the state, 14.2% of the residents are living on incomes below the FPL and 18.8% are living on incomes between 100% and 200% of FPL. Overall 33.1% of California residents live on incomes below 200% FPL.

⁸⁴ United States Department of Labor, Bureau of Labor Statistics, Regional and State Employment and Unemployment (August 2008) at www.bls.gov

⁸⁵ U.S. Census Bureau, “PCT141.Ratio of Income in 1999 to Poverty Level,” Census 2000 Summary File (SF 4) – Sample Data at <http://factfinder.census.gov>
Poverty data was obtained from the U.S. Census Bureau’s “Ratio of Income in 1999 to Poverty Level” whereas reports prior to 2003 relied on the California Department of Finance’s 2000 figures. Any difference between these two sources should be minimal.

⁸⁶ State of California Employment Development Department, Labor Market Information Division “Industry Employment and Labor Force – by Annual Average (1990-2006); March 2005 Benchmark (Not Seasonally Adjusted),” (July 24, 2006) at www.labormarketinfo.edd.ca.gov
Unemployment and industry information were obtained from the State of California’s Employment Development Department in March 2007. There were no changes from prior reports’ methodologies.

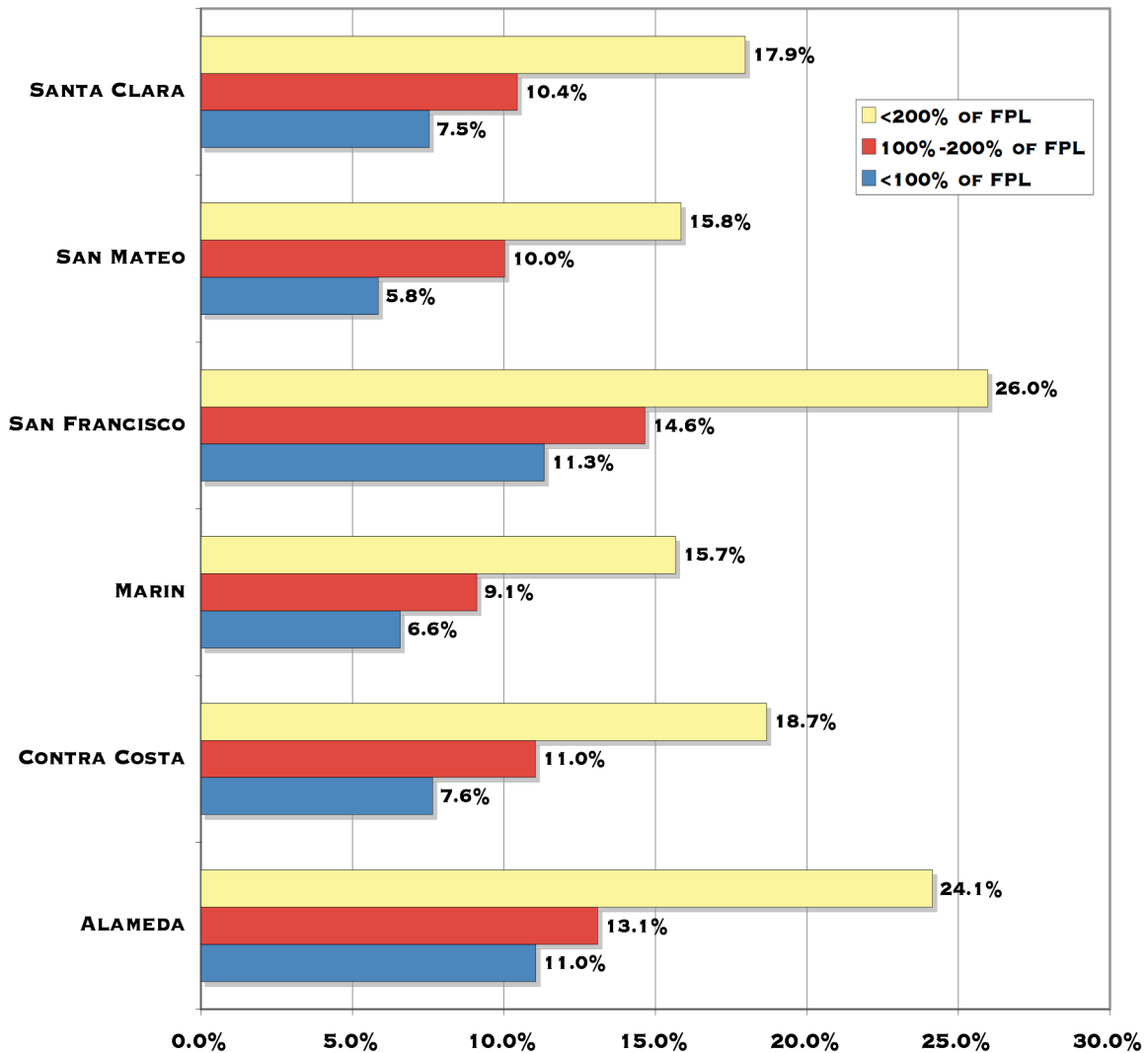
⁸⁷ US Census Bureau, County Population by Age, Sex, Race and Hispanic Origin, April 1, 2000 through July 1, 2005 at <http://www.census.gov/popest/counites/asrh/CC-EST2005-alldata.html> and U.S. Census Bureau, “PCT141.Ratio of Income in 1999 to Poverty Level,” Census 2000 Summary File (SF 4) – Sample Data at <http://factfinder.census.gov>

The Bay Area region has the state’s lowest percentage of residents in poverty at 8.7%, while the highest poverty rate at 20.5% is in the Central Valley region. *For charts regarding demographic information for California by region refer to the appendix.*

In the Bay Area region, 8.9% of residents live on incomes below the 100% federal poverty level. In this region there are 11.8% of residents living on incomes between the 100% and 200% FPL and 20.7% living on incomes below the 200%.

San Mateo County has the lowest percentage of residents living on incomes below 100% of FPL and between 100% and 200% of FPL. Marin County has the lowest percentage of residents on incomes living below the 200% FPL. San Francisco County has the highest percent of people living on incomes below all three federal poverty level.

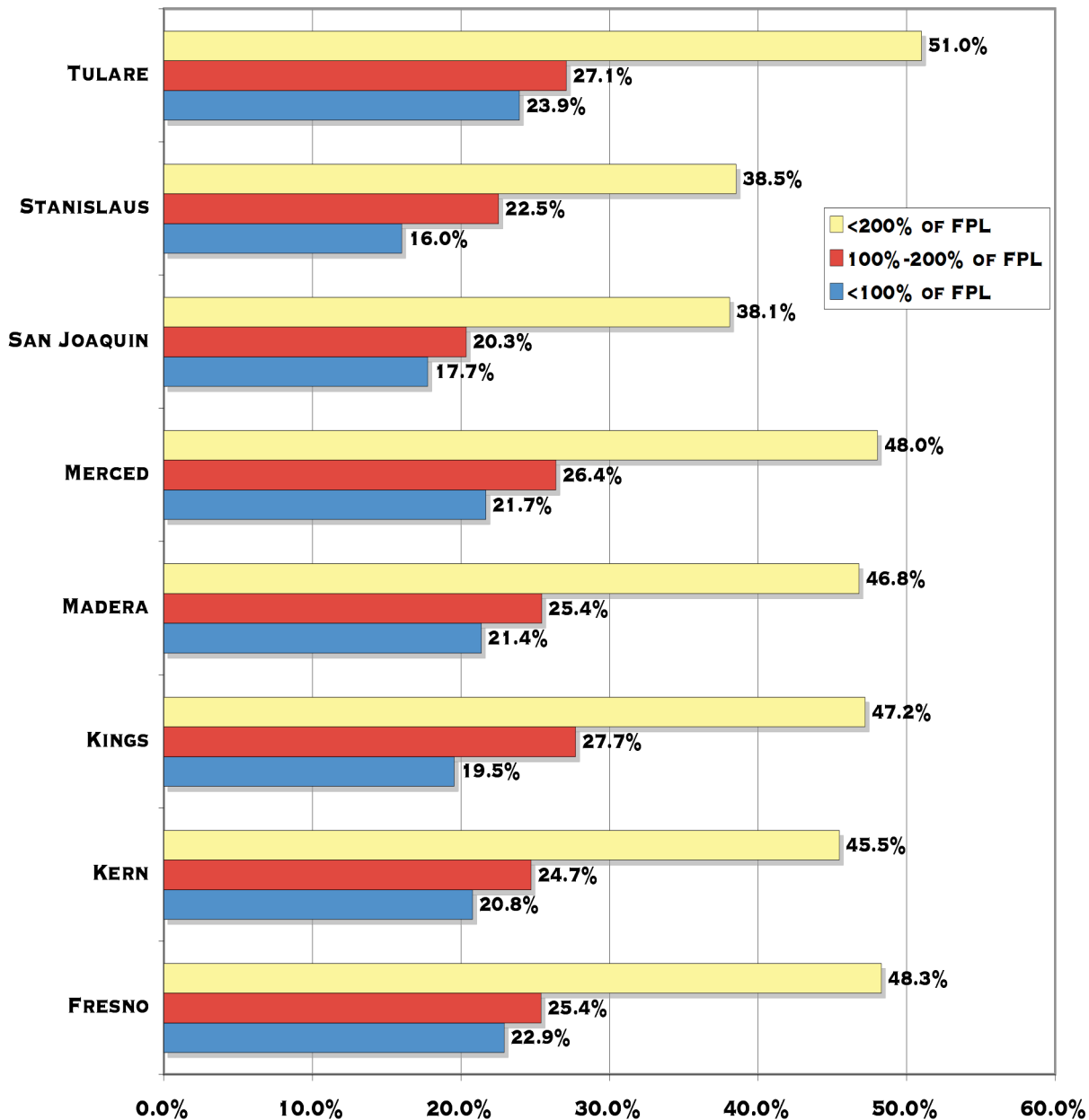
Figure 14: Bay Area Federal Poverty Levels⁸⁸



⁸⁸ U.S. Census Bureau, “PCT141.Ratio of Income in 1999 to Poverty Level,” Census 2000 Summary File (SF 4) – Sample Data at <http://factfinder.census.gov>

The Central Valley region has the highest percentage of residents living on incomes below 100% of the FPL at 20.5%. There are 24.3% of the region's residents that live on incomes between 100% and 200%. 44.8% that live on incomes below 200% of FPL. In this region Stanislaus County has the lowest number of residents living on incomes below all three federal poverty levels. In the Central Valley region, Tulare County has the highest percent of residents living on incomes below the 100% FPL and also below the 200% FPL, while Kings County has the highest percent of residents living on incomes between the 100%-200% FPL.

Figure 15: Central Valley Federal Poverty Levels⁸⁹



⁸⁹ Ibid.

California's regional uninsured rates vary quite widely from a low of 14.2% in the North Central Region to a high of 23.0% of individuals under the age of 65 uninsured in the North Rural Region.

Table 14: Uninsured Rates by Region⁹⁰

Region	Percentage of uninsured persons under age 65
Bay Area	14.9%
Central Coast	20.1%
Central Valley	22.6%
North Central	14.2%
North Rural	23.0%
Southern California	22.3%
California	20.2%

⁹⁰ UCLA Center for Health Policy Research "2005 California Health Interview Survey" at www.chis.ucla.edu

Section 6: Health Care Reform & ITUP Recommendations⁹¹

Health care reform not only has to improve the quality of care that is provided, but it also has to broaden the population that is covered and slow rising prices in premiums and medical costs. It will also need to address existing inequities in funding and infrastructure of delivery systems between counties and regions. More money spent on health care and higher prices do not necessarily ensure better quality care. Currently, the United States has poorer health outcomes for our dollars spent compared to every other industrialized country.⁹² Rising health costs not only effect those receiving care and paying more out of pocket, but also the economy as a whole, digging into workers wages and impairing the global competitiveness of American businesses.

ITUP's recommendations for health care reform take into account the realities of the populations in various areas. First, reform should seek to cover every uninsured individual, including all workers, those that are disabled, self-employed, unemployed, homeless, and early retirees. For undocumented adults working in the state, California should cover emergency care. Reform can be financed through shared responsibility with federal Medicaid matching funds, with financing from the uninsured individuals and the uninsured employer, and with a phased redirection of funds being spent on care to the uninsured to pay for coverage of the uninsured.

As for benefits, the private commercial plans that are more affordable tend to have high deductibles with high out of pocket costs, while more comprehensive benefits through private insurers can cost 20% to 60% of low-income individuals and families' annual incomes; these private models are not appropriate for the low and moderate income uninsured. Public plans may be more appropriate, provided federal and state matching funds can be secured; these plans have benefit packages with modest cost sharing and appropriate access to preventative services for the age and gender of enrollees.

Reform should not be tilted to public or private coverage, or to advocates' preferences or antipathies for the HMO or fee for service models, but should guarantee a choice of public or private insurance for all California residents and a mandate that they enroll in one of the options available. Safety net providers that have developed patient loyalty will fare well in a competitive environment; they have geographic, linguistic and cultural advantages, and most should have pricing advantages over their private competitors as well. State subsidies should be limited to the least costly plans, offering the basic package of services. Individuals who prefer and choose more costly plans should pay the incremental cost of their choice of those more costly options.

Existing safety net funds should follow patients as they enroll in coverage, and residual funds

There are about 4.9 million uninsured Californians at any given point in time. Most are young low incomes workers and their families:

- 80% Workers or Family Members
- 60% Under Age 30
- 60% Low & Moderate Income (below 200% FPL)

⁹¹ ITUP, Safety Nets and Coverage Expansion: Recommendations (July 2007) and Lucien Wulsin, Discussion of Reform Opportunities (February, 2007) at www.itup.org/reports.html#universalcoverage

⁹² ITUP, International Health Effectiveness Comparison: How Does the US Stack Up (April 29, 2008) and Adam Dougherty, International Health System Comparisons (ITUP, July 2008) at www.itup.org/reports.html#fresh

should be used for those not yet enrolled. There is no basis for giving windfalls to counties, clinics, hospitals or the federal government. Silo based funding and programs and the fragmented delivery system it produces need to end and be consolidated in the over-all financial package.

Safety net providers and plans should be assured the opportunity to participate in both public and private coverage; however they need to collaborate much better and form networks that deliver quality care for those with chronic illnesses. The safety net should not be guaranteed perpetual exclusivity as the only place the uninsured can receive their care; patient choice and competition strengthens rather than weakens good delivery systems, and poor quality delivery systems typically do not improve without the incentives of choice and competition. A choice of plans and providers should be transitioned rather quickly with benchmarks for expanding patient choice. Local safety nets have the added advantages of sharing governance and delivery networks with public health and mental health. Public health should be treated and maintained as a separate entity but must be re-integrated with the performance of the health system. Mental health systems need to be re-integrated with medical care systems as these systems overlap in their care of patients with complex multi-disciplinary conditions. The system should be interactive so that successful investments and interventions that for example reduce uncontrolled diabetes or result in reductions in obesity or teen pregnancies are rewarded.

How do you pay for this? First, every individual should contribute towards the cost of his or her coverage (whether through taxes, fees or sliding fee scale premiums), and it should include “Healthy Incentives” adjustments to encourage individual behavioral health changes. Second, all employers should contribute based on a minimum affordable percent of wages and salaries; there should be incentives to reward those employers with proven, effective approaches to promote a healthier and more productive workforce. California needs to expand its Medi-Cal program to make it more effective in maximizing federal funds and should seek federal waivers to secure a federal match on current county and state spending for the uninsured. Lastly, California needs to increase taxes on smoking and alcohol and other behaviors that contribute to poor population health. Expanding the sales tax to services while lowering the sales tax on goods ought to be part of the menu of revenue options for discussion.

The cost containment aspect of health reform is vital as the costs spent on medical services continue to grow higher while workers’ wages do not. Rising costs cannot be controlled without re-orienting pay and performance incentives and giving good and reliable information on cost and quality to patients. Employers and consumers need better comparative information on quality, effectiveness, and prices in order to allow for more informed choices. Providers need reimbursement reforms with better and consistent incentives to improve quality and patient outcomes and deliver more cost effective care. Health plans need to have flexibility and be accountable to redesign the delivery and compensation systems so that costs are reduced and quality improved.

Self employed individual and employer-based coverage have pre-tax purchasing advantages to make it more affordable; however it is now structured to subsidize primarily those employees in higher income tax brackets. This subsidy should be turned upside down so the largest tax subsidies go to those who can least afford their coverage. This will require federal legislation and is not something a state can tackle on its own. Employers should be encouraged to restructure premiums based on a percent of the wages to assure employee affordability.

Pooled purchasing for employers, employees and individuals must be made more convenient and available but not mandatory, so employers and individuals can make informed and cost effective choices of plan and coverage. Underwriting rules of guaranteed issue and renewal should apply to all sizes of employers, all employees and all individuals.

Affordability is the biggest challenge to solve for family coverage since premiums for a full family are triple the premiums for single individuals and families do not have three times as much income. This can be solved by coordinating family coverage for lower wage working families with federal matching funds. A severe affordability challenge also applies to some older individuals whose premiums can be three times as high as the costs for twenty year olds. Refundable tax credits for those whose premiums exceed a certain portion of their income could resolve this issue.

Children's coverage is the least costly and should be implemented first with new funding. To ensure that children are continually covered, the existing state and federal programs will need to be consolidated and coordinated with private coverage.

Short of over-all health reform, what can be done? At the local levels, primary care clinics need to become better integrated into the county financed networks of care for the uninsured.⁹³ Hospitals, doctors and clinics are caring for many of the uninsured but in a fragmented and typically episodic fashion; they need to overcome the perverse incentives of silo funding and begin to effectively collaborate both in over-all delivery and planning, in their patient referrals and information sharing.⁹⁴ Local stakeholders should conduct a careful review of local financing and delivery networks for counties, clinics and hospitals, there is some overlap, inefficiency and opportunity for improving care even without new state or federal funding. Future funding opportunities need to be pursued by local health collaboratives where local unmet needs are the greatest and the potential for progress on local system reform is highest.⁹⁵

The state of California and its 58 counties and local stakeholders need to pursue the broadest-reaching Medicaid Section 1115 waiver possible to cover the Medically Indigent Adults in Medi-Cal managed care and increase federal funds for their care and coverage.⁹⁶ We need to decide what concessions might be acceptable to receive this large infusion of federal funds, which could double federal financing for this population.

⁹³ Alameda, Santa Clara, Los Angeles and San Diego have developed model working relationships between their free and community clinics and their county health systems. ITUP has recently begun to update its ten year old reports "Clinics, Counties and the Uninsured" to assess local progress in clinic county collaboration over the past decade.

⁹⁴ Contra Costa, San Francisco and San Mateo are counties with the greatest progress in using local managed care organizations to coordinate safety net care for their uninsured. See Mannanal, Directory of Local Efforts to Expand Health Care Access for the Uninsured (January 2007) at www.itup.org/reports and Jay Espejo, Overview and Update of California's Section 1115 Waiver Coverage Expansion Initiatives (October 2008) at www.itup.org

⁹⁵ Orange, San Francisco, and San Mateo have all conducted such reviews recently and taken follow-up action to develop exemplary local reform efforts. Ibid.

⁹⁶ See Harbage, A Roadmap to Coverage: Implementing a Childless Adult Medi-Cal Waiver in California (March 2008) at <http://www.blueshieldcafoundation.org> and Wulsin, Safety Nets and Coverage Expansion: ITUP Recommendations (July 2007) at <http://www.itup.org/reports.html#wavier>

Appendix

California Figures:

Figure A1: California Regional Unemployment Rate 2004⁹⁷

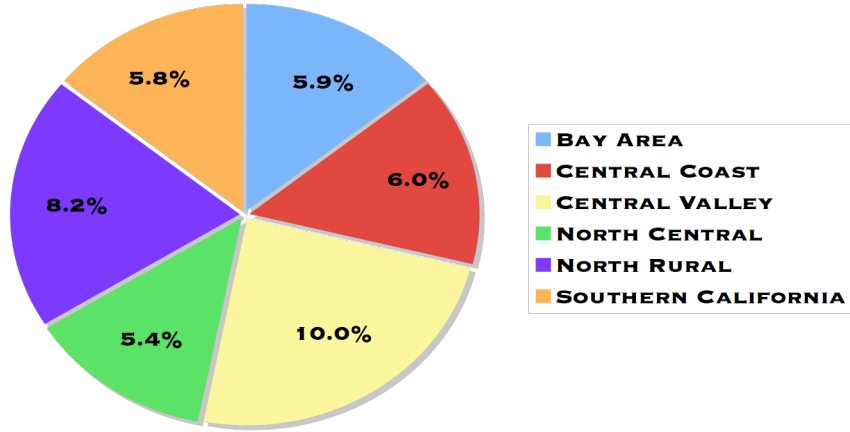
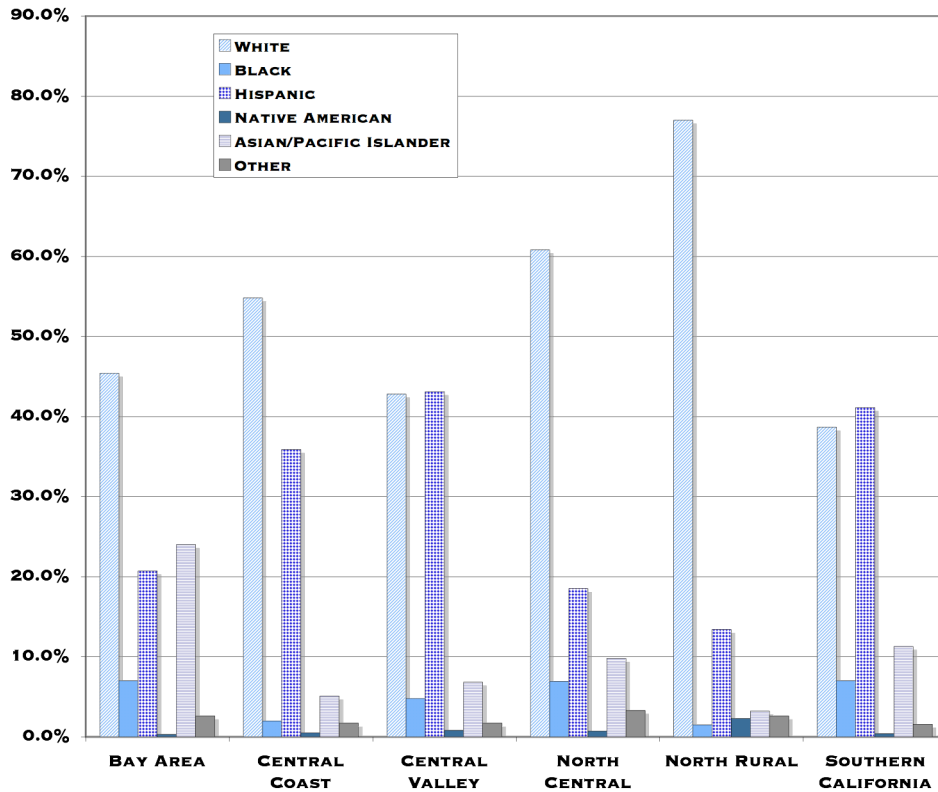


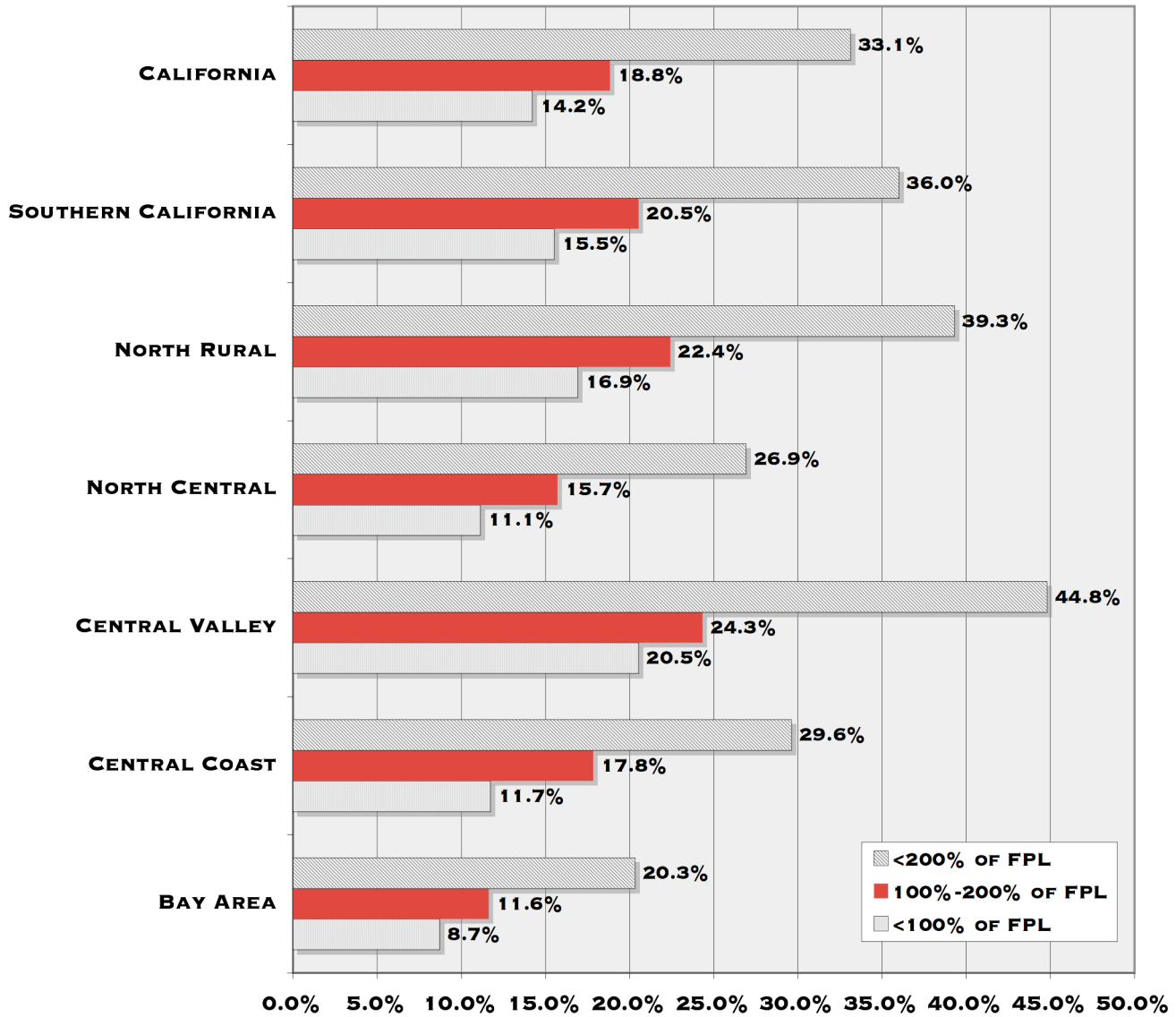
Figure A2: California Regional Populations by Ethnicity (2004)⁹⁸



⁹⁷ State of California Employment Development Department, Labor Market Information Division “Industry Employment and Labor Force by Annual Average (1990-2005) at <http://www.labormarketinfo.edd.ca.gov/cgi/databrowsing/?PageID+4&SubID=166>

⁹⁸ U.S. Census Bureau, “County Population by Age, Sex, Race, and Hispanic Origin: April 1, 2000 through July 1, 2005” at <http://www.census.gov>

Figure A3: California Regions by Poverty Level (2004)⁹⁹



⁹⁹ U.S. Census Bureau, "PCT141.Ratio of Income in 1999 to Poverty Level," Census 2000 Summary File (SF 4) – Sample Data at <http://factfinder.census.gov>