

**COUNTIES, CLINICS, HOSPITALS,**  
**EMPLOYERS, HEALTH PLANS**  
**AND CALIFORNIA'S UNINSURED:**  
**PERSPECTIVES FROM ITUP'S 2001-2003**  
**REGIONAL WORKGROUPS**

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## **REGIONAL WORKGROUPS**

The California Endowment and the California Wellness Foundation funded ITUP in 2001 for two years to conduct at least six annual regional workgroups on care and coverage for California's uninsured. We proposed regional workgroups to our funders for two reasons: first to extend ITUP's educational activities beyond the urban, coastal core and second to address the very different coverage needs and opportunities that prevail in different parts of the state.

For example, a region such as the Bay Area with vigorous Local Initiatives, an array of safety net providers, strong local financing and experienced health leaders presents very different opportunities to increase coverage of the uninsured than the Northern and Central Valley rural counties with no public safety net, weak local financing, an economy of low wage jobs and small employers and sole source private hospitals and medical staff. We believe county and regional pilots are not only the policy pioneers for subsequent state action, but in the short-term local efforts point state and federal policymakers to the most feasible solutions.

### **Design**

We expected that the very different structures of Medi-Cal managed care and county health systems would be highly influential in the local solutions that are practical for the uninsured. We organized our regional groupings to accommodate these different Medi-Cal managed care and county health structures.

We conducted workgroups in the following regions:

1. Northern Rural
2. North Central
3. Central Coast
4. Central Valley
5. Bay Area
6. Inland Empire
7. Orange and San Diego Counties
8. Los Angeles County

We prepared materials with common information on demographics, participation in and financing of public programs, local delivery systems, and private coverage opportunities for 48 counties. We included a regional overview and charts displaying the differences by county within each region.

Each workgroup shared a common format. They were scheduled for a half-day, with the mornings devoted to a discussion of public coverage and the afternoon to private coverage. We invited a wide range of participants: including business and labor, health plans and brokers, clinics, hospitals and county governments. We concluded each meeting with recommendations. We prepared a summary of the meeting for the participants only and an executive summary for wider distribution.

## **Content**

We sought to focus on, promote and cross-pollinate the work of local stakeholders and pioneers at our workgroups. Participants at each meeting discussed discrete issues relevant to the particular region, including:

- Affordability of and participation in employment-based coverage
- The state budget and state and federal legislation
- Local operational challenges in implementing state public programs
- Challenges and successes of local health initiatives for the uninsured
- Challenges and opportunities in public/private partnerships
- Care and coverage of immigrant communities.

Each regional workgroup was an important venue to discuss information that has never before been assembled and to stimulate collective efforts to develop appropriate local solutions to care for and cover the uninsured. The workgroups help local stakeholders discuss the continued improvement of local models and their spread to other counties. Exemplary models raised in the workgroups included: 1) programs in Solano and Contra Costa Counties to test managed care for medically indigent county patients, 2) programs in Sacramento and San Diego Counties for small businesses' uninsured low wage employees and 3) in-reach and outreach strategies to enroll difficult-to-reach uninsured children.

## **Priorities**

The rich dialogue in the workgroups helped to identify the component parts of effective local efforts and concludes with “next steps” for needed state and local programmatic reforms and priorities. Each regional workgroup identified very different challenges and made different recommendations. For example, in the Central Valley and San Diego/Orange regions, the workgroups noted the limited state and county financial support for care to the uninsured, the importance of private efforts and the need for enhanced federal matching and employer/employee contributions. While in the Northern Rural region, the lack of a strong local managed care delivery system results both in very high use of emergency rooms by public patients and also in very high priced coverage for small employers.

Despite regional variations, many workgroup participants shared two priorities for this year: implementing coverage for Healthy Families parents and testing subsidized coverage for low wage, small business employees.

## **Results**

At the end of each year of the grant, we prepared and distributed two to three page summaries of each county and each regional workgroup and then briefed state officials, foundations and stakeholder groups on the findings and recommendations from that year. These and other workgroup materials are posted on ITUP's website, allowing workgroup results to be disseminated to a broader audience. This past year, attendance doubled at many of the workgroups, and participants are requesting more follow-up.

In this report we seek to present the information, findings and recommendations of the past two years of regional workgroups. See [www.work-and-health.org/workgroup](http://www.work-and-health.org/workgroup) for the studies of 48 counties and recommendations from eight regional workgroups. We believe this is the first time this information has been collected and disseminated and hope that inspires and assists local “do-ers” who are the target audience for our efforts.

## **OVERVIEW OF CALIFORNIA'S HEALTH CARE SYSTEM FOR THE UNINSURED**

### **County Roles, Models and Responsibilities**

In California, counties are responsible for care to indigent uninsured single adults and couples without minor children living at home, while the state is financially responsible for families and the elderly and disabled through MediCal and Healthy Families. For the most part, county indigent health spending is focused on adults age 21-65 with no linkage to the MediCal program. Counties spend over \$1.5 billion on about 1.5 million unduplicated users of the county indigent health system.

#### County Models

There are four different models of county health systems we discuss in this paper: counties with public hospitals (provider counties), counties with private providers (payor counties), counties with a hybrid of county clinics and private hospitals (hybrid counties) and small counties which collaborate in a MediCal like system for indigent adults (small counties). As will be discussed there are wide variations in eligibility, funding and access to services in these very different delivery systems.

#### County Roles

County operated hospitals and clinics are major participants in the state's MediCal and Healthy Families programs. County Local Initiatives organize the delivery systems for MediCal families and Healthy Families children. County Social Services programs determine MediCal eligibility. Counties also coordinate outreach for the Healthy Families program.

#### County Funding

County funding to care for the uninsured comes primarily from the state and federal governments: realignment, Prop 99, and Medicaid Disproportionate Share Hospital (DSH) funding. In order to receive realignment and Prop 99 funds, counties must contribute a county match from their county General Funds. A county's own contributions are referred to as the county match. Some counties contribute significant amounts of county funding in excess of their required match; this is referred to as county overmatch. The county share of the tobacco settlement is part of the county General Fund. Some counties devote these funds to health care for the uninsured; others do not.

#### Provider Counties

In a county with a public hospital, the county health department is funded through realignment (a share of the state sales tax and vehicle license fees), Prop 99 (the cigarette tax) and SB 855 and 1255, the MediCal Disproportionate Share Hospital (DSH) programs. We refer to these counties as provider counties. They treat all the uninsured, including children, individuals without legal permanent residency status and those with incomes above poverty. Many of these counties are heavily dependent on MediCal funding streams and must compete effectively with private providers to remain financially viable.

### Payor Counties

In a county without a county hospital, the county receives and allocates realignment funding and Prop 99 to private providers; DSH funds go from the state directly to the private hospitals. We refer to these counties as payor counties. Some payor counties concentrate their funding for the indigent uninsured in a single private facility, and others spread the funding among all facilities. Payor counties typically limit program eligibility to adults without minor children living at home with incomes below the poverty level. County residents who lack legal permanent residency status are usually ineligible for the county indigent health program in these counties.

### Hybrid Counties

Other counties, such as Sacramento, Tulare and Santa Barbara, operate mixed public/private systems: county operated outpatient clinics and county-reimbursed private hospitals. We refer to these as hybrid counties. DSH funds in these counties go directly to private hospitals.

### Small Counties

Counties with populations of less than 300,000 (small counties) have the option to contract with the state Department of Health Services to administer their systems of care to the indigent. These counties operate a fee for service system of coverage that offers somewhat fewer benefits than MediCal (County Medical Services Program, CMSP). We refer to these counties as small counties or CMSP counties. In most small counties, there is little or no DSH funding for hospitals. Small counties typically limit program eligibility to adults without minor children living at home with incomes below the poverty level. County residents who lack legal permanent residency status are eligible in these counties for emergency benefits only.

### Variability In Funding, Delivery Systems, And Eligibility

County systems are extraordinarily different from each other. Each county makes its own decisions as to how much relative emphasis to place on care for the uninsured as opposed to other county health priorities, on inpatient and emergency services versus primary care and outpatient services and the mix of public and private providers to deliver services.

The following chart describes the funding streams available to fund care for the indigent uninsured in the study counties:

Table 1: County Financing by County Type

	Provider Counties	Payor Counties	Hybrid Counties	CMSP Counties
Realignment	Yes	Yes	Yes	Yes
Prop 99	Yes	Yes	Yes	Yes
Net County DSH	Yes	No	No	No
Net SB 1255	Yes	No	No	No
County Match	Yes	Yes	Yes	Yes
MAA/TCM	Yes	Yes	Yes	Yes
FQHC	Yes	No	Yes	No

The following chart compares county delivery systems:

Table 2: County Delivery System by County Type

	Provider counties	Payor counties	Hybrid counties	CMSP counties
Hospital	Public	Private	Private	Private
Doctors	Public	Private	Public	Private
Clinics	Public and sometimes non profit community clinics	Non profit community clinics	Public and sometimes non profit community clinics	Non profit community clinics

The following chart describes the county eligibility rules for funding care to the uninsured in the study counties:

Table 3: County Eligibility Rules By County Delivery Systems

	Provider counties	Payor counties	Hybrid counties	CMSP counties
Indigent uninsured adults	Yes	Yes	Yes	Yes
Indigent uninsured children	Yes	No	Yes, in county clinics only	No
Residents without legal permanent residency status	Yes	No	Yes, in county clinics only	No, except for emergency care
MediCal and Healthy Families	Yes	No	Yes, in county clinics only	No

### Hospitals

Hospitals in California provide care to the uninsured in two ways: first as county reimbursed care to the county indigent uninsured and second as bad debt and charity care to the uninsured. Hospital care to the uninsured is roughly evenly split between unreimbursed bad debt and charity care and county reimbursed care to county indigents – about 6% of hospital services in toto.

Hospitals report providing over \$1 billion in their costs of charity care and bad debt to the uninsured. Hospitals report receiving over \$1.4 billion in net patient revenues from counties for their care to county indigents. Counties pay for about 3% of all hospital inpatient days, 5% of hospital outpatient visits and 11% of all hospital emergency room visits.

### Hospital Reimbursements For Care To The Uninsured From Counties

Why do hospitals have bad debt and charity care? What don't counties pay for? In provider counties, the county funds public hospitals, but private hospitals are not typically reimbursed by the county for their care to county indigents. In payor and CMSP counties, hospitals are not typically reimbursed for their care to several groups of the uninsured: children, county residents with incomes over poverty and county residents without legal permanent residence status (a green card).

In large counties without a public hospital, one dominant private facility is frequently the major provider of services to the uninsured. In counties such as Orange, Sacramento and San Diego, the University of California took over the physical plant, financing and responsibility for the indigent from the ex-county hospital. In Fresno and Merced a non-profit community hospital took over the role and financing from the closed county hospital. In some large payor counties, the dominant private facility has worked out special supplemental financial arrangements with the county. In small counties, the CMSP program reimburses all hospitals in the same manner as the MediCal program does.

Private hospitals receive small allocations of state Prop 99 funds through the county and SB 855 and SB 1255 (DSH) funds directly from the state. County hospitals, University of California hospitals and district hospitals contribute a match known as local Certified Public Expenditure (CPE) to draw down federal DSH funding through SB 855 and SB 1255. Public hospitals' net DSH funding is their total or gross DSH minus their CPE.

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

DSH reimburses hospitals for their uncompensated care: i.e. their bad debts and charity care to the uninsured and the financial underpayments through MediCal. DSH (SB 855) is distributed based upon a fixed formula to approximately 150 hospitals with high shares of Medicaid and uninsured patients. Information on SB 855 DSH funding is publicly available, and we report it by county and by region. SB 1255 is a negotiated amount between C-MAC (the California Medical Assistance Commission) and 60 or more individual DSH hospitals that maintain a trauma center or full service emergency room. Net 1255 funds are \$800 million statewide. The distribution of SB 1255 funding by county and by region is confidential information and thus was not available to us.

Funding arrangements for hospitals in counties are described in the attached chart.

Table 4: Funding Arrangements for Hospitals by County Delivery System

	Provider counties	Payor counties	Hybrid counties	CMSP counties
Public hospital	Yes	No	No	No
Private hospitals	Yes, but limited to Prop 99 distribution and DSH funds	Yes, but limited to county indigent adults and DSH	Yes, but limited to county indigent adults and DSH	Yes, but limited to county indigent adults

## Managed Care

Large counties are required to have a mandatory managed care program for families. Smaller counties can choose but are not required to implement managed care. Disabled adults in MediCal and the 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 entire MediCal population.

These managed care entities come in three forms: County Organized Health Systems (a single managed care entity for all MediCal enrollees), Two Plan Counties (competitive managed care between the county’s Local Initiative and a private commercial health plan) and Geographic Managed Care (competitive managed care among several private commercial health plans).

Table 5: Managed Care Systems for Public Patients

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

Local managed care entities are the focal organizing point for many of the local pilot programs to cover the uninsured.

Table 6: Local Efforts by County Delivery Systems

Provider counties	Payor counties	Hybrid counties	CMSP counties
Yes in Alameda, Contra Costa, Los Angeles, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara	Private efforts in San Diego	Private efforts in Sacramento	Private efforts in Siskiyou, Public efforts in Solano
No in Kern, Ventura and Monterey			

For the most part, counties do not use managed care entities to organize the delivery of care for their indigent populations; Contra Costa and Solano are the only exceptions. Several counties and regions have expressed an interest in merging their MediCal and county indigent programs and delivering managed care to the entire low-income population. Other regions and counties believe that managed care is not viable due to their small populations, rural provider networks, large financial risks and perceived perils to local safety nets through competition.

Several states including Arizona, Tennessee, New York and Massachusetts have federal §1115 waivers to consolidate MediCal and indigent adult populations in managed care. Some drawbacks to these approaches include the on and off nature of beneficiaries in both programs, the inadequate funding for indigent care and the concerns of safety net providers about the impacts of competition for patients with the private sector.

### Community Clinics

Free and community clinics serve large numbers of uninsured patients (over 50% of their patient visits) and provide over 4.5 million visits to the uninsured. For the most part clinics deliver primary care rather than specialty care services. Some clinics concentrate on families; others serve the same indigent adult patients as the counties do. Some clinics specialize in care to children and others in family planning services. The size and sophistication of the community clinic networks and their relationships to the county indigent system are highly variable among the study counties.

Clinic funding for care to the uninsured comes from:

- Federal government as grants and contracts,
- State government through the Family PACT, EAPC and CHDP programs and other state grants and contracts (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 source.

Some clinics have long standing funding relationships with their counties. Elsewhere, clinics are not reimbursed by the county for their care to county indigents.

Table 7: Funding Arrangements for Community Clinics and County Delivery Systems

Provider counties	Payor counties	Hybrid counties	CMSP counties
Yes in Los Angeles, Alameda and Santa Clara	Yes, except in Fresno, Merced, and Stanislaus	No, except in Santa Barbara	Yes
No in Kern, Riverside, San Bernardino, San Joaquin, San Francisco, Monterey, Ventura and Contra Costa			

## EXECUTIVE SUMMARY OF FINDINGS FROM ITUP'S REGIONAL STUDIES

- Rates of Employment Based Coverage
  - Rates of employment-based coverage vary primarily by poverty, rather than by the price of coverage
  - Price of coverage is highest in Northern Rural region and lowest in Southern California region
  - North Central region had a slightly higher rate of employment-based coverage that could be due to a high proportion of public employment.
  
- Rates of Poverty, Uninsured and Participation in Public Programs
  - Rates of uninsured were highest in Southern California region, while rates of poverty were highest in Central Valley region
  - Rates of MediCal program participation roughly track rates of poverty; Central Coast region had lower than expected rates of MediCal program participation while Central Valley and Bay Area regions had stronger than expected rates of MediCal program participation
  - MediCal participation rates were inversely correlated with uninsured rates, implying that successful MediCal enrollment efforts are linked to reductions in uninsured rates.
  - Healthy Families participation rates did not correlate to poverty rates, MediCal participation rates or rates of uninsured
  - County Health Program participation rates were highest in Bay Area and Southern California regions
  
- Program Participation by Ethnicity
  - Uninsured non Hispanic Whites were lower than expected users of Healthy Families in all regions
  - In Northern Rural region, Hispanics were lower than expected users of MediCal and county health programs
  - In Southern California and Bay Area regions, Asian and Pacific Islanders were lower than expected users of most public programs
  
- Funding and Spending for County Health Programs
  - Funding for county health programs was 1/6 the cost of a well managed commercial HMO and 1/4 the cost of a well managed MediCal HMO
  - Central Coast region had the lowest funding for county health and the lowest spending for inpatient, outpatient and emergency care to the uninsured
  - Bay Area region had the strongest base of funding and spending for care to the uninsured.
  - Northern Rural region had the second highest base of funding, the highest rate of spending on inpatient care and the highest percentage share of county health spending devoted to inpatient services.

- Utilization of Care by the Uninsured
  - Southern California and Central Coast regions had the lowest rates of community clinic visits to the uninsured and Bay Area and Northern Rural regions had the highest rates.
  - Southern California and Central Coast regions had the lowest rates of county funded outpatient visits to the uninsured and Bay Area region had the highest rate.
  - Northern Rural and Bay Area regions had the highest rates of county funded inpatient days and Central Coast region had the lowest rate of county funded inpatient days to the uninsured.
  - Bay Area region had the highest rates of county funded emergency visits and Central Coast region had the lowest rate of county funded emergency visits for the uninsured
  - The largest unmet needs for outpatient services were in the Central Coast and Southern California regions
  
- Community Clinics
  - Fifty-five percent of all community clinic visits were for the uninsured and roughly twelve percent of all clinic visits were not compensated.
  - Southern California community clinics had the highest percentage of uninsured and the lowest share of MediCal visits.
  - Bay Area community clinics reported the greatest funding shortfall for care to the uninsured.
  - Southern California and Northern Rural community clinics had the strongest funding relationships with their counties while Central Valley and Central Coast clinics had the weakest funding from their counties.
  
- Hospitals
  - Hospital care to the uninsured averaged 6% of hospital services of which roughly half was bad debt and charity care and half was reimbursed by the counties.
  - Hospitals in the Southern California region had the highest percent (8%) of hospital care devoted to care for the uninsured and greatest proportion reimbursed by counties.
  - County paid inpatient days were 3% of all days; county paid hospital outpatient visits were 5% of all hospital outpatient visits and county paid emergency room visits were 12% of all emergency room visits.
  - High rates of MediCal emergency room visits were reported in the Central Valley, Central Coast and Northern Rural regions.
  
- Public Managed Care Entities
  - Contra Costa's Local Initiative had the highest MediCal market share and Los Angeles' Local Initiative had the lowest MediCal market share.

- Los Angeles and Monterey’s Community Provider Plans had the lowest Healthy Families market share while Alameda, San Joaquin and Santa Clara’s plans had the highest.
- Los Angeles and Fresno had the best “reported” success in controlling MediCal emergency room use.

## FINDINGS

### Employment-Based Coverage

- Rates of employment-based coverage varied primarily by poverty. In general we found that as poverty rates increased, the rates of employment-based coverage fell. In the Bay Area and North Central regions, employment-based coverage was highest; these are the regions with the lowest rates of poverty. The North Central region had a slightly higher rate of employment-based coverage than might be expected that could be due to a high proportion of employees working for public agencies. In the Central Valley and Northern Rural regions, where poverty was highest, rates of employment-based coverage were low (See Figure 1).

There were some anomalies. In the Central Coast region, employment-based coverage was surprisingly low, despite its high poverty rate. In the Southern California region, there was a very marked difference between the rates of job-based coverage for adults as compared to children, which did not occur in other regions.

- The price of coverage did not affect rates of employment-based coverage. We expected that the price of coverage would strongly influence rates of employment-based coverage. It did not. The Southern California region had the lowest HMO premiums for small employers, yet a low rate of employment-based coverage and the highest rates of uninsured of any of the regions. Premiums for small employers' HMO coverage were substantially higher in the Northern Rural region than in any other region yet the rates of employment-based coverage in the Northern Rural region for adults and children were only slightly different from the Southern California region. (See Tables 1 and 2).
- PacAdvantage HMO premiums are at least 20% higher in the Rural North than any other region. We asked regional workgroup participants and state stakeholders to explain the far higher prices of PacAdvantage coverage in Northern Rural region. They explained that in this region there was a dearth of providers, a provider dislike for HMOs and that the managed competition model simply did not work in one-hospital communities with a shortage of physicians. The least expensive PacAdvantage HMO premiums are offered in Southern California (See Table 2).

## Poverty, the Uninsured and Participation in Public Coverage Programs

We examined rates of poverty, uninsurance and participation in public programs, such as Medi-Cal, Healthy Families and County Health programs. We expected that rates of poverty would correlate to public program participation rates and to rates of uninsured. While Medi-Cal participation rates did generally track poverty, none of the others did. (See Figure 2).

- There is no apparent relationship between poverty and rates of uninsurance. Rates of uninsured were highest in Southern California and Central Coast regions, yet rates of poverty were highest in the Rural North and Central Valley.
- Rates of Medi-Cal program enrollment generally increased with poverty. The region with the smallest percentage of its population below 200% FPL, the Bay Area, has the lowest rate of Medi-Cal enrollment while the poorest region, the Central Valley, has the highest. The Central Coast region, however, had an unusually low rate of Medi-Cal program participation as compared to its average poverty rate. The Bay Area and North Central regions had relatively high Medi-Cal participation rates compared to their low poverty rates. Their high rates of employment-based coverage, combined with comparatively strong Medi-Cal participation account for their low rates of uninsured. The high poverty Central Valley region had high participation in Medi-Cal and a lower than would-be-expected uninsured rate.
- Rates of Medi-Cal enrollment were inversely correlated with rates of uninsured. Counties with poorer than expected Medi-Cal program participation correlated to a higher than expected uninsured rate. This can be observed by comparing the Central Coast region to the North Central and Southern California regions, by comparing Riverside County to San Bernardino County within the Southern California region or by comparing Medi-Cal and uninsured rates for counties in the Rural North. Successful Medi-Cal enrollment efforts link to reductions in uninsured rates.

Regional workgroup participants attribute successful Medi-Cal enrollment efforts to improved cooperation between the County Social Services and Health Departments, frequently mediated by the Board of Supervisors.

- Healthy Families enrollment rates did not correlate to poverty rates, Medi-Cal enrollment rates or rates of uninsured. Healthy Families participation rates are driven by successful on the ground enrollment efforts, rather than by demographics. In general, one or two counties in each region stood out as having the most successful Healthy Families enrollment efforts: Colusa in the Northern Rural region, Riverside in Southern California, Monterey and Ventura on the Central Coast, San Joaquin and Merced in the Central Valley, Santa Clara in the Bay Area and Sonoma in the North Central.

Regional workgroup participants identified a range of factors contributing to successful enrollment. These included in-reach, the adoption of Healthy Kids

programs, community-wide collaboration and provider competition as factors in successful enrollment. Many identified schools while others found little success through school-based enrollment. At least one county, San Diego, identified small business outreach while others reported no success in their efforts to coordinate with small employers.

- County Health program participation (unduplicated users) appeared to vary by type of county. In general, County Health program participation rates were highest in counties with public hospitals and lowest in small rural counties participating in the CMSP program. County Health program participation rates were higher in counties with hybrid systems of public clinics and private hospitals than in payor counties with private hospitals. Participation rates (unduplicated users) in County Health programs were highest in the Southern California region where uninsured rates were highest and in the Bay Area region where uninsured rates were lowest.

Workgroup participants explained that the low reported use of CMSP in rural areas was due to eligible individuals' reluctance to apply for the program, unless facing a large bill for hospital services. Access to eligibility workers is also limited as workers are out-stationed in hospitals and not in community clinics.

County Health program participation rates are a factor of a county's reporting systems and do not necessarily describe access to care and services in that county. In CMSP counties, unduplicated users accounted for approximately 10% of the uninsured. In some public hospital (provider) counties, unduplicated users were 1/3<sup>rd</sup> of the uninsured. In a later section of this report, we describe use of County Health services, which is a truer measure of a county system than its reports of unduplicated users. Use of inpatient hospital services in CMSP counties, for example, is higher than in provider counties.

## Program Participation by Ethnicity

In examining program use by race and ethnicity, we found surprising variations between counties and regions. As each program, county and clinic uses different definitions of ethnicity, these observations are at most a starting point for further inquiry.

- Uninsured non-Hispanic whites were lower than expected users of Healthy Families. Non-Hispanic whites comprise approximately 30% of California's uninsured, but only 15% of children participating in Healthy Families. Workgroup participants informed us that that outreach to these uninsured children was extremely difficult because of the low over-all rates of uninsured among non-Hispanic white children (See Figure 3).
- In the Northern Rural region, Hispanics were lower than expected users of Medi-Cal and county health programs. Hispanics comprise over 30% of the uninsured in the Northern Rural region but only approximately 10% of enrollees in Medi-Cal and the County Health program (CMSP) (See Figure 3a).
- In Southern California and the Bay Area, Asian and Pacific Islanders were lower than expected users of most public programs. Asian Americans comprise over 20% of the uninsured in the Bay Area, but only approximately 10% of Medi-Cal enrollees and County Health program users. Asian Americans comprise over 10% of the uninsured in the Southern California region, but only approximately 5% of Medi-Cal and Healthy Families enrollees and County Health program users (See Figures 3d, 3f).

## Funding and Spending for County Health Programs

### Funding

We reported on state, county and federal funding for County Health programs. We included state realignment, state Prop 99 funds to counties, federal net county DSH and required county match. From these combined sources, counties receive on average \$500 per uninsured resident for the costs of all County Health programs.

Counties may choose to spend their realignment funds on programs such as public health services to all county residents and on county care to the uninsured, but counties must spend their Prop 99 funds on care to the uninsured. Counties report to the state on their spending on the uninsured and their net county spending on public health. We used these county reports, which vary in their accuracy and consistency from county to county.

We excluded some sources of funding such as county overmatch, county tobacco settlement, private hospital DSH and net SB 1255 for public and private hospitals. Our rationale for entirely excluding net SB 1255 (about \$800 million) is that we had no data on its distribution by county or by region as C-MAC considers this information confidential. Our rationale for excluding tobacco settlement is that counties are not required to spend these funds on County Health; though many do, some do not. We excluded county overmatch (some counties do and others do not), as counties are not required to spend these funds on county health. We excluded private DSH as this funding goes directly to private hospitals for their uncompensated care to the uninsured; it is not distributed through county health programs although counties may choose to take this funding into account in their program funding decisions.

- County Health programs are under-funded when compared to costs of providing public or commercial coverage. We compared funding for county health to the cost of coverage for an average adult, using costs for an essential benefits package as computed by Milliman and Robertson for the Blue Shield Foundation of California. Funding for county health was less than 1/6 the cost of coverage through a well-managed commercial HMO with providers reimbursed at commercial rates and 1/4 the cost of coverage through a well-managed HMO with providers reimbursed at Medi-Cal rates (See Figure 4).
- Funding per uninsured county resident is highly variable between regions and counties. Funding per uninsured county resident was lowest in the Central Coast region at roughly \$300 per uninsured county resident and highest in the Bay Area at more than \$1,000 per uninsured county resident. There was wide variation in funding between counties from a low of \$250 or less per uninsured resident in several Central Coast, Central Valley and Southern California counties to a high of more than \$1,800 per uninsured county resident in San Francisco County in the Bay Area (See Figure 5).

Furthermore, in the Southern California, Central Coast and Central Valley regions, those counties with higher funding had twice as much funding per uninsured as those counties with the lowest funding. In the Bay Area, the county with the highest funding had more than three times as much funding per uninsured as the counties with the lowest funding in the same region. In the Northern Rural region, counties with the most funding had nearly 250% more money per uninsured than counties with the lowest funding. Inter-county variations in funding per uninsured existed in the North Central region as well, but the ratios from low to high were less than two to one in that region.

## Spending

Data on county spending is less reliable than the data on county funding for several reasons. First, there are clear reporting omissions in several counties. For example, Riverside County reported its outpatient clinic visits and spending to OSHPD as a community clinic but not to MICRS. The Ventura County report appears to us to contain large reporting errors. Second, in earlier reports we discovered that in several counties, expenses for inpatient care are actually reported as expenses for outpatient care. Third, at the regional workgroups, several participants pointed to errors in their county reports. Despite flaws in the county reports, we found very wide variations in spending on inpatient and outpatient services between the regions.

- Spending for care to the uninsured varied tremendously between regions. The Central Coast region had the lowest spending per uninsured for inpatient, outpatient and emergency care to the uninsured. This is to be expected as the Central Coast region had the lowest funding per uninsured. The Central Valley region had the second lowest spending per uninsured on all categories of service. The Bay Area had the highest spending per uninsured on outpatient services and on emergency services; it also had the most resources and highest funding per uninsured. The Northern Rural region had the highest spending on inpatient services and devoted the highest percentage share (3:1) of its spending to inpatient services (See Table 3).
- The difference in county spending on the uninsured between the highest spending region and the average commercial spending per adult was quite large. We compared county spending per uninsured with private commercial spending on insured adults. Counties are spending less than 1/2 as much for inpatient care and 1/5<sup>th</sup> as much for outpatient services. County spending per uninsured on emergency care was higher in the highest spending region (the Bay Area) than commercial spending per adult on emergency services. In the other regions, county spending per uninsured on emergency care was 1/3<sup>rd</sup> that of commercial coverage. We had no data on small county spending for emergency care.

## Utilization of County and Community Clinic Services by the Uninsured

Utilization rates of county-reimbursed inpatient and outpatient care for the uninsured are significantly lower than utilization rates of care for commercially insured adults. Several regions, however, reported higher rates of county-funded emergency services for the uninsured than for commercially insured patients.

Data on the amounts of county and clinic care are less reliable than the data on county funding. First, there are reporting errors and omissions in several counties, such as Riverside and Ventura. Second, when we compared county MICRS and CMSP reports and hospital OSHPD reports, there were large reporting discrepancies in the data for inpatient days and emergency room visits in many counties. We do not know which data source is more accurate, but in this section of the report we use the county reported CMSP and MICRS data. MICRS reports county-funded inpatient, outpatient and ER services. The outpatient category includes hospital visits, as well as visits to community and county clinics, and private physicians' offices. Despite the uncertain data in the county reports, we found wide variation in use of inpatient and outpatient services between the regions, and between counties in each region.

- Most regions reported low rates of county-funded outpatient visits; the Bay Area and Northern Rural regions reported the highest. All regions other than the Bay Area and Northern rural regions reported between 0.3 and 0.7 county-funded outpatient visits per uninsured. The Bay Area region reported 200-300% higher utilization – 1.5 outpatient visits per uninsured than the other regions. The average commercial patient uses 4 outpatient visits a year. For regions other than the Bay Area and Northern Rural regions, the ratio of county-reimbursed visits per uninsured to visits per privately insured adult was greater than 1:5. This indicates extremely low county-reimbursed access to outpatient care (See Table 4).

It is important to note that community clinic visits that are not reimbursed by the county are not reported to MICRS or CMSP. Community clinics provide significant additional access to primary care, outpatient services for the uninsured, discussed on p. 12.

- Northern Rural and Bay Area regions had the highest rates of county-funded inpatient days and Central Coast and Central Valley regions had the lowest rate. The Northern Rural region reported the highest utilization rate of inpatient days – 148 days per 1,000 county uninsured. The Bay Area and North Central regions also reported inpatient utilization rates above 100 days per 1,000 uninsured. The average commercial plan pays for 236 inpatient days per 1,000 insured adults a year. In these three regions the ratio of county reimbursed bed days to the uninsured to bed days for the privately insured was 1:2 (See Table 4).

In the Southern California region, this ratio was approximately 1:3; in the Central Valley, the ratio was about 1:4 and in the Central Coast region, the ratio was 1:7. As

will be discussed later on p. 15, hospitals also provide uncompensated care to the uninsured in the form of bad debt and charity care in addition to the hospital services reimbursed by counties. This data however, is not included in the MICRS or CMSP reports, but is reflected in the OSHPD reports.

- Bay Area and North Central region had the highest rates of county funded emergency visits and Central Coast and North Central regions had the lowest. The average commercial plan pays for 154 emergency room visits per 1,000 insured adults a year. The Bay Area and North Central regions reported the highest utilization rate of emergency rooms – 237 visits per 1,000 county uninsured in the Bay Area and 260 per 1,000 in the North Central region – a rate 150% as high as the rate for commercially insured adults. The Central Valley and Southern California regions also reported emergency room utilization rates above 100 days per 1,000 uninsured or only slightly lower than the use rates of emergency services for commercially insured adults (See Table 4).

### **Community Clinic Care to the Uninsured**

Some community clinic uninsured visits are reimbursed by some counties – about 18% statewide; however, most are not.

- Southern California and Central Coast regions had the lowest rates of community clinic visits per uninsured and Bay Area region had the highest rate. Community clinics are not equally distributed throughout the state nor do they all provide the same range of services. In several counties with inadequate numbers of community clinics, the use rates of clinics for primary care to the uninsured were as low as 0.3 visits per uninsured; while in other counties the clinic use rates were as high as 4 visits per uninsured. Comparing the regions, Northern Rural and Bay Area clinics had the highest use rate: 2.1 visits per uninsured in the Northern Rural and 1.5 community clinic visits per uninsured in the Bay Area, nearly twice as high as the clinic use rates per uninsured in the Southern California and Central Coast regions (See Table 4).

### **Unmet Need for Outpatient Services**

- The Central Coast and Southern California regions had the largest unmet needs for outpatient services. We calculated unmet need by adding community clinic visits and county reimbursed visits and comparing the total of the two to the utilization of outpatient services for privately insured patients. There is some, but limited, overlap of the two categories since some, but not all, counties reimburse clinics for a portion of their uninsured visits. The uninsured in all regions of the state had significant unmet need for outpatient services. The unmet needs of the uninsured for outpatient services were most acute in the Central Coast and Southern California regions – approximately 2.5 visits annually (See Table 5).

## Community Clinics

Community clinics serve large numbers of uninsured patients (55% of their patient visits) and provide over 4.5 million primary care visits to the uninsured (1 visit per uninsured). Medi-Cal accounts for over 40% of clinic revenues and Medi-Cal FQHC (Federally Qualified Health Center) reimbursement is the most significant single funding source for clinics.

- Fifty-five percent of all community clinic visits were for the uninsured. This is a very high percentage as compared to hospitals where we found about 6% of care is to the uninsured. This is a very high percentage even as compared to most county hospitals and county clinics. Clinics depend on Medi-Cal and uninsured patient revenues in roughly equal amounts for 85% of clinics' patient revenues (See Figure 6).
- Various Sources contribute to clinics' funding for care to uninsured:
  1. Federal government as §330 grants and contracts
  2. State government in the form of the Family PACT, EAPC and CHDP programs and other state grants and contracts (over 1/3 of clinic's uninsured visits).
  3. County governments as reimbursement for their care to county indigent patients and as other grants and contracts (15-20% of clinic visits).
  4. Patients' sliding scale fees (33% of clinic's uninsured visits).
  5. Twelve percent of all clinic visits were uncompensated.(See Figure 6a)
- Community clinics in the Bay Area reported the highest percentage of funding shortfall for their care to the uninsured. We do not have an explanation for why this is so (See Figure 7).
- Rural clinics are more likely to have more diverse payer mixes than their urban counterparts. Rural clinics are more likely to function as sole providers in their communities. They had a larger share of Medicare and privately insured patients than clinics in other regions. In rural areas such as the Northern Rural and Central Valley regions, community clinics had a roughly equal distribution of uninsured and Medi-Cal visits.
- County programs have a small presence in CMSP counties' community clinics. In most rural counties, CMSP paid for about 1/2 of hospital care to the uninsured, but only about 15-20% of clinic visits to the uninsured. Northern Rural workgroup participants explained that CMSP eligible patients were unwilling or unable to travel to the Social Services office and complete the applications to participate in the CMSP program. Many rural counties were financially unable to outstation eligibility workers at the clinic sites to facilitate enrollment.
- Low-income and uninsured residents in rural areas face greater challenges accessing care than their urban counterparts. Central Valley and Northern Rural workgroup

participants explained that few private providers in their communities were willing to provide care to Medi-Cal patients and few dentists were willing to see Healthy Families patients due to low reimbursement; thus the clinics were major providers for both Medi-Cal and uninsured patients. Access to specialty services for clinics' Medi-Cal and CMSP patients often required travel to the Bay Area or Sacramento area.

- Funding for Southern California community clinics is particularly vulnerable. Southern California community clinics had the highest percentage of uninsured visits (nearly 70%) and the lowest share of Medi-Cal visits (24%) of all regions. (See Figure 7). This finding of adverse payer mix was particularly acute in the region's urban areas, where clinics must compete with private physicians, private hospitals and public facilities for Medi-Cal patients. This payer mix means that funding for clinics in these counties is heavily dependent on discretionary annual state and county funding decisions, and these clinics are very vulnerable.

Clinics' patient mixes vary widely by county within each region. For example, within the Southern California region, Medi-Cal revenues amount to 51% of clinics' patient revenues in Imperial County, 35% of clinics' patient revenues in San Diego, but only 19% in neighboring Orange.

- Southern California and Northern rural community clinics had the strongest funding relationships with their counties. County funding accounted for over 35% of clinics' uninsured patient revenues in these regions (See Table 6).

For Northern Rural and Imperial community clinics, CMSP represents a large share of their uninsured revenues in part because CMSP pays well (at FQHC reimbursement rates) for the visits it covers and in part because the clinics have a large number of sliding fee scale and non-paying patients for whom they have little or no revenues.

In Los Angeles County, the community clinics are an integral part of the County's 1115 waiver funding from the federal government to pay for outpatient services to the uninsured. Los Angeles clinics are the most dependent on the county for their funding and are endangered by the county health system's own fiscal instability and dependence on renewal of its 1115 waiver.

San Diego and Orange Counties have no public system and reimburse the clinics for their roles as the outpatient delivery system for the county indigent health system.

Riverside and San Bernardino Counties, however, run their own public clinics and for the most part do not reimburse their non-profit community clinic competition. The Riverside data is skewed as the county clinics report to OSHPD as community clinics.

- Central Valley and Central Coast clinics had the weakest funding from their counties. With the exception of CMSP counties, Central Coast and Central Valley counties reimburse community clinics for virtually none of their uninsured patients' visits. Workgroup participants offered two explanations: 1) counties paid their own public clinics to care for uninsured patients and it was not the counties' responsibility to subsidize their non-profit competitors in these communities and 2) all county funds were committed to community hospitals that had taken over the old county hospitals – a financial local commitment that was politically difficult to change (See Table 6).
- Relationships between community clinics and counties vary in the Bay Area. Community clinics in Contra Costa and San Francisco receive little or no funding from their counties due to clinic-county competition. Community clinics in Santa Clara and Alameda have strong funding and delivery of care relationships with their counties. These relationships extended care to the county indigent, Medi-Cal and Healthy Families programs and enhanced the competitive market positions of the safety net.

**NB** We found that there is inconsistent reporting of county funding by community clinics to OSHPD. Some report their reimbursement from the county as patient revenues from the county and others report these revenues as county/local grants and contracts (clinics' grant and contract revenues are not included in data displayed here but is included in our county-by-county reports).

## Hospitals

Hospitals report their data on care and financing to OSHPD. As we noted earlier there are large discrepancies between the counties' MICRS and CMSP reports on the amounts paid to hospitals and hospitals' OSHPD reports on the amounts received from counties. Neither data source consistently reported higher or lower figures than the other. In this section of the discussion we are using the OSHPD hospital data, not the county reported data.

- Hospital care to the uninsured averaged 6% of all hospital expenses. Approximately half of hospital care to the uninsured was bad debt and charity care and counties reimbursed the other half. County paid inpatient days were 3% of all days; county paid hospital outpatient visits were 5% of all hospital outpatient visits and county paid emergency room visits were 12% of all emergency room visits.

Bad debt and charity care occur when a patient does not pay all or part of the hospital bill. Most but not all bad debt and charity care is for uninsured patients. However, insured patients who do not pay copays and deductibles also contribute to bad debt and charity care. Statewide, hospitals' bad debt and charity care total approximately 3% of hospital expenses (See Figure 8).

County net reimbursements also total 3% of California hospitals' net patient revenues. Hospitals provide care to the uninsured for which they are reimbursed by county indigent health programs. Hospitals also report receiving lump sum operating subsidies from the county to pay for their care to the uninsured. We added hospitals' bad debt and charity care to hospitals' county reimbursements to reach our conclusion that 6% of hospital services are care to the uninsured. There may be some overlap, however, between bad debt and charity care and county subsidies to hospitals.

- Hospitals in Southern California had the highest percent of hospital care devoted to care for the uninsured and greatest proportion reimbursed by counties. In the Southern California region, the total of county reimbursements and bad debt and charity care was over 8% of hospitals' net patient revenue – the highest of any region – which should be expected as this region has the highest percent of its population uninsured. County reimbursed care makes up 4.7% of hospital revenues – also the highest of any region – in large part because of the large public hospital systems in Los Angeles and the Inland Empire (See Figure 8a).

Hospitals in the Central Coast, which had the second highest proportion of its population uninsured, reported the second highest total of county reimbursements and bad debt – 7% of hospitals net revenues. The high rate of county reimbursements was surprising since, as discussed in an earlier section, counties in this region had the least funding and reported to MICRS the least payments for care per uninsured. The high percent of county patient reimbursements appears to be due to the significant

operating subsidies for public hospitals in Ventura and Monterey Counties and the smaller, subsequently closed county hospital in San Luis Obispo.

The Bay Area had the third highest total of county reimbursements and bad debt and charity care – approximately 6.5% of hospitals’ net revenues yet it had the lowest proportion of its population uninsured. The high rates of county reimbursed care was not surprising since this region had the most funding, highest concentration of public hospitals and a high rate of county spending on care to the uninsured. The high percent of bad debt and charity care reported by Bay Area facilities is not readily explicable.

The Northern Rural region, which had a high rate of poverty and a high proportion of its population uninsured, had the lowest total of county reimbursements and bad debt and charity care – 4.8% of hospitals’ net revenues. The low rate of hospital bad debt and charity care was not surprising since counties in this region spent the most on hospital care to the uninsured and bought the highest rates of hospital utilization. The very low reported rate of county reimbursed care (2.3% of net patient revenues) was quite unexpected. It is possible that hospitals in the region reported their CMSP revenues and care as Medi-Cal revenues as the programs are as a practical measure little distinguishable for the hospitals.

- County indigent patients’ hospital utilization patterns varied by type of county. In counties with a public hospital, we observed a ladder effect; that the percentage of county paid hospital outpatient visits were twice the rate of county paid hospital inpatient days; the percentage of county paid emergency room visits in turn were twice the rate of county paid hospital days. In counties without a county hospital, the percentages of inpatient, outpatient and emergency services paid by the county were exactly the same (See Figures 9 and 10).
- Hospital utilization patterns were different for Medi-Cal and county indigent patients. Statewide, the pattern for Medi-Cal hospital care was a U shape; high rates for inpatient stays and emergency room visits, lower for hospital outpatient services. Statewide, the pattern for county indigents was a ladder, low for inpatient days, nearly twice as high for outpatient visits and twice that figure for emergency room visits (See Figure 10).

Workgroup participants explained that it was difficult to persuade patients to apply for Medi-Cal, but the high cost of inpatient services served as a strong incentive for patients and hospitals to complete the often complex application process. Northern Rural workgroup participants explained that it was equally hard to persuade eligible adults to apply for CMSP with the county. Bay Area workgroup participants explained that county hospitals write off indigent patients’ bad debts due to failure to apply for programs such as Medi-Cal as an expense under their medically indigent programs. Workgroups in small counties and public hospital counties agreed that hospital emergency room patients were the most resistant to applying for benefits for which they were eligible.

- High rates of Medi-Cal emergency room visits were reported in the Central Valley, Central Coast and Northern Rural regions. In many of these communities Medi-Cal patients accounted for 50-60% of emergency room visits while accounting for 15-25% of county residents (See Figure 11). Some high utilization rates of MediCal emergency services (such as Santa Cruz and Solano) were due to hospital reporting errors. In other rural counties (such as Humboldt), Medi-Cal emergency room utilization rates were not disproportionate to Medi-Cal enrollment.

As an explanation for these utilization rates, workgroup participants pointed to the lack of access to specialty care in these communities. Patients either go to the local hospital emergency room or travel to San Francisco, Reno or Sacramento area hospitals to access specialists. Others pointed to use of local emergency rooms as after hours or as walk in clinics for primary care. Workgroup participants from Humboldt County stated that physicians throughout the community were committed to treating patients in their own offices or in clinics to prevent unnecessary ER use. Workgroup participants from Lassen County contracted for specialty care through the local community clinics.

## Public Managed Care Entities

There are two types of public managed care entities; County Organized Health Systems (COHS) and Local Initiatives. Local Initiatives were created to provide managed care services to Medi-Cal families. Local Initiatives in counties with a two-plan model compete with a commercial health plan. They compete with several commercial health plans for Healthy Families enrollment. COHS plans have no local competitor and provide managed care for the aged and disabled as well as Medi-Cal families. Successful public managed care entities have begun to use their managed care savings to finance pilot programs that cover the uninsured.

- Public Local Initiatives' shares of the Medi-Cal market vary significantly between the regions. Contra Costa Health plan had the highest market share, nearly 75%, while LA Care Health Plan had the lowest market share, 60%. Unlike the other Local Initiatives, LA Care is an umbrella for five competing plans, one of which is a county health plan (See Figure 12).
- Community Provider plans' shares of the Healthy Families market also vary. Among public Local Initiatives, the plans in Alameda, San Joaquin, and Santa Clara counties had the highest Healthy Families market share in their communities – about 60%. Community Provider Plans in Los Angeles and Monterey had the lowest Healthy Families market share (7% and 13%, respectively). The low market share in Monterey correlates to a late entrance into the Healthy Families market. The low Healthy Families market share in Los Angeles correlates to the weak market performance of the County's Medi-Cal managed care plan (See Figure 13).
- Managed Care in Los Angeles and Fresno Counties had the best “reported” success in controlling emergency room use. One of the hallmarks of successful managed care is the shift in the locus of care from the hospital emergency room to clinics and physician offices. We compared emergency room use by Medi-Cal patients with the percent of the County's population on Medi-Cal in two plan counties. In Los Angeles and Fresno, Medi-Cal patients' use of ER services corresponded to their share of the over-all population. Other county managed care plans appeared to be less successful (See Figure 14).
- Is there a correlation between successes in public managed care markets and the adoption of pilot programs to cover the uninsured? We observed no correlation between a Local Initiative's Medi-Cal market share and the county's decision to adopt a local pilot program for the uninsured; however the four Local Initiatives with the highest Healthy Families market share were also the earliest plans to develop local pilots to cover the uninsured. Most early pilots were developed in the Bay Area, which had the strongest base of local funding for county health care. Local Initiatives, which must compete in the market, were the early adopters of local pilots as opposed to COHS programs that lack a commercial competitor. While the early pilots were developed in counties with public safety nets and Local Initiatives, other counties

with public safety nets and Local Initiatives were not early adopters. We believe that local decisions to implement early pilots were driven by a combination of strong local financing, safety net leadership, locally owned managed care and collective confidence among public safety net providers in their ability to compete.

There have been no comparable efforts to develop local pilots for the uninsured by the large statewide commercial plans that have large Healthy Families and Medi-Cal market shares in Central Valley counties. These plans lack the organizational ties to county public health infrastructure and financing and to local safety net leaders. These plans may also be concerned about cannibalizing existing markets for their commercial markets by offering more affordable coverage to the uninsured.

There have been successful efforts to develop pilots by non-profit, local commercial plans that have large Healthy Families and Medi-Cal market shares in San Diego. These plans lack local public financial support and occur in a county with very weak financing of county indigent health care. These plans are connected to local safety net providers that seek added resources to assure their own financial survival by offering more affordable coverage to the uninsured.

One large statewide commercial plan (Kaiser Foundation Health Plan) has initiated a range of pilots to cover the uninsured. Kaiser is a minor participant in public managed care. Its motivations in adopting pilots for the uninsured may be to offer continuity of care and coverage to existing commercial members in changing circumstances and to maintain its non-profit role and status.

## Care to the Uninsured by Region and by County Model

We reviewed the funding and distribution of care for each region by county models of care to the county indigent. In general, counties with public hospitals had the most funding and provided the most care per uninsured. Small CMSP counties had the second strongest funding and paid for the most inpatient hospital care per uninsured. Counties with hybrid systems and payor counties had the least funding and provided the least care per uninsured.

- Northern Rural Region.

This region had high poverty rates and its uninsured rates were average for the state. Counties in the region use the CMSP model of care to the county indigent uninsured. Counties in this region had average funding, paid for the most inpatient days and above average amounts of outpatient visits per uninsured compared to other regions (See Table 7).

Community clinics in this region had a favorable mix of Medi-Cal and uninsured patients, one of the strongest rates of county reimbursement and provided a well above average volume of primary care visits to the uninsured. This region had the lowest unmet need for primary care services to the uninsured after accounting for county reimbursed and community clinic visits.

Hospitals in the region had the lowest percentage burden of bad debt and charity care and extraordinarily high rates of Medi-Cal emergency room visits.

Small employers paid the highest premiums and managed care had the least penetration in this region. The region had one of lowest rates of employment-based coverage.

- Bay Area

This region had low poverty rates and its rates of uninsured were among the lowest for the state. Almost all counties in this region are provider counties. Counties in this region had the highest funding and provided the most services per uninsured. CMSP and provider counties had about the same funding per uninsured. In this region the CMSP county (Marin) paid for more inpatient days and far fewer outpatient services per uninsured than did provider counties (See Table 8).

Community clinics in this region had a slightly below average rate of county reimbursement and provided the highest rate of primary care visits per uninsured. This region had a low unmet need for primary care services, after accounting for county reimbursed and community clinic visits; yet an unusually high rate of county paid emergency room visits.

Hospitals in the region had an average percentage burden of bad debt and charity care.

Small employers paid an average amount for coverage; managed care had strong penetration throughout this region. This region had the highest rates of employment-based coverage.

- North Central Region

This region had low poverty rates and its rates of uninsured were among the lowest for the state. Half the counties are CMSP and half are payor counties. Counties in this region had average funding per uninsured: CMSP counties had about 10% more funding than payor counties. CMSP counties paid for far more inpatient days and fewer outpatient services per uninsured in this region than did payor counties (See Table 9).

Community clinics in this region had a slightly above average rate of county reimbursement and provided a slightly above average volume of primary care visits to the uninsured.

Hospitals in the region had the second lowest percentage burden of bad debt and charity care.

Small employers paid an average amount for coverage; managed care had strong penetration except in the most rural parts of this region. The region had one of the highest rates of employment-based coverage.

- Central Valley Region

This region had the highest poverty, Medi-Cal and Healthy Families participation rates in the state; its rates of uninsured were above average for the state. This region has all four county models of care. Counties in this region had low funding per uninsured: provider counties had far more funding per uninsured than payor or CMSP counties and hybrid counties had much less funding than the other three models. Hybrid counties provided far fewer inpatient days and outpatient days per uninsured. CMSP counties paid for substantially more inpatient days per uninsured than the other three models (See Table 10).

Community clinics in this region reported little or no county reimbursement for their care to the uninsured except in the CMSP counties and yet provided a slightly above average volume of primary care visits to the uninsured. Clinics in this region had a favorable mix of uninsured and Medi-Cal patients.

Hospitals in this region had an average burden of bad debt and charity care and an average amount of county reimbursed care to the uninsured.

Small employers paid an average amount for coverage; managed care had strong penetration except in the most rural parts of this region. The region had one of the lowest rates of employment-based coverage.

- Central Coast Region

This region had below average poverty, Medi-Cal and Healthy Families participation rates, and its rates of uninsured were well above average for the state. This region has three county models of care. Counties in this region had low funding per uninsured. Provider counties had far more funding per uninsured than payor counties and hybrid counties had much less funding than the other two models. Hybrid and provider counties provided far fewer inpatient days and outpatient services per uninsured than the payor counties (See Table 11).

Community clinics in this region received little or no county reimbursement for their care to the uninsured and yet provided a slightly above average volume of primary care visits to the uninsured.

Hospitals in this region had an above average burden of bad debt and charity care. In those counties with public hospitals, the percentages of hospital care to the uninsured reimbursed by the county were higher.

Small employers paid an average amount for coverage in the southern portion of the region; managed care had strong penetration in the southern portion of the region. The region had an average rate of employment-based coverage.

- Southern California

This region had above average poverty, Medi-Cal and Healthy Families participation rates, and its rates of uninsured were the highest in the state. This region has three county models of care. Counties in this region had low funding per uninsured: provider and CMSP counties had far more funding per uninsured than payor counties. Provider counties provided far more inpatient days and outpatient services per uninsured than the payor counties. The CMSP county (Imperial) paid for more inpatient days per 1,000 uninsured than provider counties (See Table 12).

Community clinics in this region had strong county reimbursement for their care to the uninsured and provided an average volume of primary care visits to the uninsured, except in the Inland Empire. Clinics in this region had the most unfavorable mix of uninsured and Medi-Cal patients.

Hospitals in this region had an above average burden of bad debt and charity care and the strongest percentage financial contribution by their counties, except in Orange and San Diego. In those counties with public hospitals, hospital bad debt and charity care rates were lower, and county reimbursed care rates were higher than in the other counties in the region.

Small employers paid the least amount for coverage in the Southern California region; managed care had strong penetration except in the rural portions of the region. The region had a low rate of employment-based coverage for children.

## **DATA SOURCES**

### Demographics

- Demographic information was gathered from the US Census Bureau, California Department of Finance, UCLA Center for Health Policy Research's California Health Interview Survey (CHIS), the Medi-Cal Policy Institute, the Managed Risk Medical Insurance Board (MRMIB), the Medically Indigent Care Reporting System (MICRS) and the County Medical Services Program (CMSP) Governing Board.

### Community Clinic Data (OSHPD Data)

- Community clinic information was gathered from Annual Utilization Report of Primary Care Clinics, 2000 by the Office of Statewide Health Planning and Development.
- To calculate uninsured clinic patients, revenues and visits, we added Medically Indigent Services Program (MISP) patients, CMSP patients, other county program patients, CHDP patients, EAPC patients, other state program patients, self-pay patients and non-pay patients.
- We calculated use ratios per uninsured using the uninsured numbers from the UCLA CHIS data.

### Hospitals (OSHPD Data)

- Hospital information was derived from the Office of Statewide Health Planning and Development's Individual Hospital Financial Data for California, 2001.
- We calculated bad debt and charity care costs by adding the total of bad debt and charity care and multiplying by the cost to charge ratio.
- We calculated use ratios per 1000 uninsured using the uninsured numbers from the UCLA CHIS data.
- County revenue was calculated by adding County Appropriations, Net Patient Revenue for County Indigent Programs and Restricted Donations and Subsidies for Indigent Care.

### CMSP (Small Counties) Data

- This information was gathered from the CMSP Governing Board, 2000 Summary of CMSP Expenditures and Number of Observations Reported by County and Claim Type.

### MISP (Large Counties) Data

- Utilization and spending data were compiled from the Office of County Health Services of the California Department of Health Services, MICRS 1999-2000 data.
- County spending was derived from County Health Services Budget and Actual Data.

- County funding was derived from the Office of County Health Services Allocations for Realignment, Proposition 99 and public Disproportionate Share Hospitals.

#### Health Plans

- Information on health plan premiums for small employers was gathered from PacAdvantage, Blue Cross, Blue Shield, Health Net, PacifiCare and Kaiser Permanente.
- Premiums for individual and family coverage were secured by requesting rate information from Blue Cross, Blue Shield, Health Net, PacifiCare and Kaiser Permanente.
- 2002 premiums are reported.

## **DATA LIMITATIONS**

For each regional workgroup, ITUP prepared data summaries of each county and region's health care delivery system. The reports included the following information: rates of uninsurance and Medi-Cal and Healthy Families enrollment from CHIS, the Medi-Cal Policy Institute and MRMIB, respectively; community clinic and hospital utilization and financial data from OSHPD; county reported data from MICRS and the CMSP Governing Board; funding information from the County of Health Services at DHS; and private insurance premiums from commercial carriers. (For a complete list and description of data sources please see Appendix \_).

ITUP uses the data summaries as a starting point for discussion on improving care and coverage for the uninsured in each of its regional workgroups. However, it is vital to note the limitations of the data and their impact on discussion within and beyond the workgroups. Through our discussions with workgroup participants, we have learned of several inconsistencies and flaws in the various data collection and reporting systems.

### **Office of Statewide Health Planning and Development (OSHPD)**

There are several reliability concerns with the OSHPD data. A primary issue is the insufficient regulation and accountability of clinics and hospitals' reporting. There is no system to verify the accuracy of the information reported or to ensure the data is uniformly reported. Therefore, there is great potential for the same information to be reported differently by each county and individual facility.

For example, the OSHPD community clinic data reports patient counts, rates of utilization and revenues by payer, including Medi-Cal, Medicare, private insurance as well as other public programs that account for the county uninsured, including CMSP or MISP. We learned from our workgroup participants that not all clinics record county uninsured patient information the same way. Some community clinics record uninsured county patients as Medi-Cal patients whereas others list them under the county payer categories. Some clinics report their county revenues as county patient revenues whereas others report them as county grants and contracts.

Similar problems exist in the OSHPD hospital data. Utilization and revenues are reported by payer category including "county indigent". Hospitals, however, vary in their definition and reporting of county indigent patients. A patient, who may be considered "county indigent" in one county, may be reported under "other payer" or bad debt and charity care in another. Such discrepancies often result in underreported care and revenues for uninsured patients.

For example, hospitals in Ventura County reported that county indigent patients accounted for a very low share of hospital inpatient days, 0.2%. This is a surprisingly low percentage for a county with 14% of its residents uninsured and is most likely a reporting error. Most other counties reported county indigent days between 1% and 5% of total days. In some counties we found extremely high rates of Medi-Cal patients' ER use and reports of nearly non-existent ER use by the county indigent. Marin hospitals,

for example, reported that Medi-Cal patients accounted for 97% of all ER visits and the county indigent only accounted for 0.3%. Though Medi-Cal patients' limited access to care is often reflected in elevated ER utilization rates, Marin's figure is a reporting error.

Furthermore, the OSHPD community clinic data reports do not necessarily include all community clinics. In the rural north and Central Valley, meeting attendees reported that some rural health clinics and Indian Health Centers do not report to OSHPD. Unless one is working closely with community clinics, such omissions can be undetected. On the other hand OSHPD community clinic reports in some cases include data from county facilities. We believe San Joaquin, Placer and Riverside Counties report county clinic data to OSHPD as community clinics.

Consistency in report dates is also a concern within each OSHPD source. The reporting cycles for each facility are not necessarily the same. In each report, some facilities report calendar year data while others report data for the fiscal year. Furthermore, facilities' reports do not necessarily represent the most current information. In both the hospital and clinic reports, some facilities' data is one year older than that of others, regardless of whether the data represents a calendar or fiscal year.

Without uniform reporting cycles, some data categories for the same facilities may not represent the same time period. For example, emergency room visits by payer are reported separately than the utilization of inpatient and outpatient services. The ER data is reported in the Annual Utilization report while the other services are recorded in the Annual Financial report. The same hospitals are listed in each report, yet it is very common for one hospital to submit calendar year data for the utilization report and fiscal year data for the financial report, and vice versa. Therefore, reporting dates for ER data is often inconsistent with the remaining hospital services data.

### **OSHPD, County MICRS and CMSP Data**

OSHPD, MICRS and CMSP all report utilization and financial data for care for the county indigent. Hospitals report the services and expenses reimbursed by the county through OSHPD. The county reports the services and payments to hospitals and other providers through MICRS or the CMSP Governing Board, depending on the county. One might expect these two reports to be the identical at least for inpatient days and emergency room visits. However, this is rarely the case. Data discrepancies were found in almost all reporting categories within each county. Neither data source consistently reported higher or lower figures than the other.

Outpatient reporting discrepancies have a ready explanation. For example, it would not be unusual for the MICRS outpatient data to be higher than that reported by OSHPD, as each source defines the service differently. In MICRS reports, "outpatient visits" include hospital outpatient visits as well as visits to private physicians' offices and county and community clinic visits. OSHPD's outpatient data only includes hospital outpatient visits.

There is a possible explanation for minor discrepancies in the inpatient and ER utilization reported by the hospitals and the counties. MICRS and particularly CMSP data would include county payments to hospitals for care to a county indigent patient who received services in another county. Whereas the hospital OSHPD data could reflect payments for county patients from several different counties; this may be particularly applicable for regional medical facilities in Shasta, Sacramento or Fresno. CMSP and MICRS data for inpatient, outpatient and ER services lacks sufficient detail, specifying the number of out-of-county inpatient days and ER visits and outpatient visits outside of hospitals to reconcile the county data with hospitals' OSHPD reports.

However, wide variations exist in the comparison of these two data sources. These discrepancies have no clear explanation. In many counties, OSHPD hospital reports have unexplainably higher or far lower rates of county indigent inpatient and ER care than the MICRS or CMSP data.

### **California Health Interview Survey (CHIS)**

The 2001 California Health Interview Survey (CHIS) measured the rate of the state's uninsured by county and region by using a sample size nearly ten times that used in the Current Population Survey (CPS). The new CHIS data reflects a much more accurate assessment of the uninsured than previous CPS findings. The CHIS data also reports Medi-Cal and Healthy Families enrollment, which often matched the enrollment counts reported by the Medi-Cal Policy Institute and MRMIB for the respective programs.

However, some feel the CHIS results for the uninsured are inaccurate and too low. Workgroup participants argued that the phone-based survey naturally excludes residents who cannot afford telephone service and who are likely to be uninsured. Therefore, rates of uninsurance in very poor, rural and migrant communities may be particularly underreported.

### **Incomplete Data**

Another data limitation is that some information is simply unavailable. For example, there is no reporting source for county outpatient clinic information. County clinic visits are included in the MICRS data for county-reimbursed outpatient visits, but identifying patients, number of encounters and revenue sources by payer category is not possible as it is with the community clinic information reported to OSHPD. Such information would provide a more complete understanding of county and regional delivery systems and care for the uninsured.

Ethnicity and race data of the uninsured is also incomplete. The CHIS survey reports such figures for counties with sufficiently large and diverse populations. For smaller or less diverse counties, only a few racial and ethnic groups can be identified due to the small sample size. In these counties, information for minority groups is often either statistically unstable or unavailable.

It should be noted that the category of "other" race or ethnicity is not uniformly defined in the reports from different programs and by different facilities. Depending on the

source, “other” can mean one or more of the following definitions: not reported by respondent, another race or ethnic group not listed in a survey, or an individual with multiple races or ethnicities.

## **SUMMARY OF FINDINGS AND RECOMMENDATIONS FROM REGIONAL WORKGROUPS**

ITUP's regional workgroups facilitated discussion on improving coverage and care for the uninsured in California. Throughout the series of meetings, several common themes were identified between the various counties and regions. There was strong consensus for improving access to care, enrolling uninsured children in coverage programs, increasing funding for clinics and hospitals who care for the uninsured, improving the affordability of employer-sponsored and other private insurance, and improving data accountability and reliability. However, each county and region faces different challenges and has varied perspectives on solutions. The following summary highlights the shared concerns, distinct local challenges, successful local models and recommendations.

### **Access to Care**

There was widespread concern to improve access to care for both the uninsured and those enrolled in or utilizing public coverage programs. Uncoordinated and limited access to care jeopardizes patients' health, promotes emergency room use and raises costs.

#### **Challenges:**

- **Uninsured Adults.** While there are model programs in counties such as Contra Costa and Santa Clara, many counties have very low participation by the uninsured in county health programs and very poor access to outpatient services. There is low participation by the uninsured in CMSP and very difficult access to specialists in most rural areas. Access for uninsured in MISP counties is often limited as public financing of county health programs varies enormously. Furthermore, "mini programs" that cover specific health care such as breast or prostate cancer promote fragmented patient access, and severe administrative challenges for smaller facilities.
- **Medi-Cal Enrollees.** Low provider reimbursement rates continue to pose barriers to care for Medi-Cal enrollees, as fewer physicians want to accept these patients. Furthermore, in many rural areas, few specialists accept Medi-Cal, resulting in high ER utilization rates.
- **Healthy Families Enrollees.** Unfunded expansion to parents maintains a fragmented system of coverage and access to care for low-income families.

#### **Recommendations:**

##### **Local Policy Recommendations**

- Seek a federal waiver for county-organized health systems for medically indigent adults in interested areas of the state.
- Develop pilot programs that consolidate "mini-health programs" with Medi-Cal, Healthy Families and county health and present results to the state legislature.
- Develop and test a regional single-payer system for public programs (including Medi-Cal, Healthy Families and County Health programs) based on the Healthy Families model; this would help reduce administrative costs and improve access to care.

- Improve physicians' ties with community clinics to promote Medi-Cal patients' access to primary and specialty care and reduce inappropriate ER use, as seen in Humboldt and Lassen Counties.

#### State Policy Recommendations

- Eliminate the asset test for Medi-Cal and CMSP adult eligibility.
- Expand Healthy Families coverage to parents.
- Increase Healthy Families coverage for kids from 250% to 300% of FPL
- Preserve Medi-Cal reimbursement rates for primary and specialty care
- Increase clinics' expanded access to primary care (EAPC) funding
- Increase federal matching rates for Medi-Cal.

#### **Public Program Enrollment**

Many traditional barriers to enrollment remain, and outreach budgets are reduced. Program enrollment by county is highly variable and dependent on successful and unique local enrollment models.

#### **Challenges:**

- Medi-Cal. Medi-Cal continues to suffer from the welfare stigma, which deters many eligibles from enrolling. Cuts in training and outreach budgets impede enrollment efforts. Financial incentives to enroll Medi-Cal eligible ER and outpatient clinic patients are limited. Hospitals are most motivated to enroll Medi-Cal-eligible inpatients. Paperwork requirements produce barriers to enrollment and retention.
- Healthy Families. Retention is reportedly difficult due to monthly premiums in some Inland Empire, Central Coast and Central Valley communities. The relatively poor enrollment of African-Americans and non-Hispanic whites in Healthy Families may be due to inadequate and more difficult outreach. Paperwork requirements still produce barriers to enrollment and retention.
- Healthy Kids. Children eligible for Healthy Kids programs are difficult to locate.

#### **Recommendations:**

##### Local

- Collaboration with multiple entities for outreach has been successful. Partners include: County Health Dept., local Prop 10 Commissions, health plans, community clinics, hospitals, WIC sites, schools, County Social Services Dept., physicians' offices, insurance brokers, private insurers, community-based organizations, etc.
- Maximize enrollment opportunities with language appropriate enrollment assistance at multiple sites, including clinics and hospitals.
- Collaborate with non-healthcare organizations to expand outreach.
- Maintain a consistent, local marketing strategy, with local contacts
- Strengthen in-reach and local training to improve identification and referral of potential Medi-Cal and Healthy Families eligibles.
- Conduct needs assessments to identify barriers to coverage within county/region.
- Implement "Healthy Kids" programs in more counties

### **Model Counties:**

Alameda – Strong collaboration between community and county clinics to identify and enroll eligible children.

Riverside – Outreach leadership and coordination by County health plan

- Certified application assistants follow through to successful enrollment.
- CAAs speak the same language as the enrollees.
- Strong community clinic-based outreach.
- Referrals from WIC clinics.

Santa Clara – Strong collaboration between community and county clinics to identify and enroll eligible children for Medi-Cal, Healthy Families and Healthy Kids.

Sonoma – A community-wide effort. Sonoma has strong enrollment from multiple venues including schools, clinics, community groups, and the County. Social service agencies communicate and collaborate to improve enrollment and retention.

Ventura – A community-wide effort. Various entities in the County are committed to covering the uninsured.

- Dept. of Public Health uses Prop 10 money to fund bi-lingual outreach.
- Ventura County Health Care Plan targets employees and schools.
- Clinicas Del Camino Real and private physicians actively enroll children in Medi-Cal and Healthy Families.
- There are multiple (48) Medi-Cal and Healthy Families enrollment sites in the County.
- Brokers are motivated by the fee they collect with successful enrollment.
- The County’s living-wage ordinance encourages employers to offer coverage to their employees. Employers must either offer benefits or pay a higher wage.

### **Funding for County Health**

Many counties lack sufficient funding to meet the health care needs of their indigent uninsured residents.

#### **Challenges:**

- Clinics. Community clinic revenues for their uninsured patients are far below their cost of care in most counties and regions. County programs on average pay for 15-20% of clinics’ uninsured patients. In Central Valley and Central Coast counties, clinics receive little or no county reimbursement for uninsured indigent patients. In Inland Empire and some Bay Area counties, community clinics and the counties are “competitors”; community clinics receive little or no reimbursement for indigent uninsured patients in these counties.
- Hospitals. Hospitals in poor rural areas receive little to no DSH funding (SB 855 and SB 1255) to offset their uncompensated care to uninsured patients. Hospitals in San Diego and Orange reported very little county reimbursement for their care to uninsured indigents. Private hospitals in Los Angeles County received a much larger percentage of total DSH funding in the county than did private hospitals in other counties with public hospitals, but are not accountable to deliver care to the uninsured.

- County Health Services. There is little or no federal funding for county health services to adults in counties without a public hospital.

### **Recommendations:**

#### Maximize all opportunities for federal/county match

- 1115 waiver for adults
- County-level expansions for Healthy Families parents and children

#### Cost Controls

- Improve incentives for providers to control costs
- Improve preventive care for the uninsured
- Develop and improve 24-hour nurse triage phone systems, primary care and urgent care facilities so patients with true emergencies only use hospital ERs and trauma systems.

#### Raising Revenues

- Increased tax on alcohol
- Tax services and internet sales
- Re-evaluate Prop 13's application to business property.

### **Managed Care**

Many rural counties are skeptical of managed care as their populations and provider resources are insufficient to effectively control costs while providing appropriate care.

### **Challenges:**

- Small Counties. The northern rural region and other small counties report that they do not have a large enough population for plans and providers to spread the risk of managed care.
- Inadequate Resources. The Central Valley workgroup participants report an inadequate base of participating providers for managed care competition to be successful. Private plans are ineffective in managing care for public patients. Managed care has not connected patients with a primary care doctor, and has instead created more administration and poorer access in the Central Valley.
- Lack of Public Interest. Workgroup participants from Ventura and San Luis Obispo Counties report little or no interest in joining COHS (County Organized Health Systems) from adjacent counties.
- Competitive Weaknesses. In regions such as the Central Coast and Los Angeles, county based plans were not as successful competing in the Healthy Families market.
- Mandatory Managed Care for Aged, Blind and Disabled. This population represents 25% of Medi-Cal enrollment but accounts for 75% of expenditures. Some workgroup participants believe that Medi-Cal managed care would improve access to appropriate services for this population. However others maintain that the challenges of delivering quality care to this population in commercial managed care plans are a significant concern. Mandatory managed care for the disabled also poses issues of how safety net facilities will compete successfully and how this would impact their ability to continue to provide care for uninsured users of the County safety net.

### **Private Coverage**

Employer-based coverage has dropped significantly in the past few years due to rising costs. Many working families cannot afford any type of private coverage. However, pilot programs offer coverage to low-income workers and their families in some counties and regions.

#### **Challenges:**

- **Employer-Sponsored Coverage.** This year California experienced double digit premium increases for the third consecutive year. As a result, employers are passing greater fiscal responsibility for insurance on to employees, and both employers and employees are less likely to maintain coverage.
- **Competition.** Competition model of cost control is unsuccessful in regions with one-hospital towns and provider shortages. Competitive managed care has been unsuccessful in several Central Coast counties where local providers have very strong market dominance. The northern rural region has the highest priced small employer coverage in the state due in part to the lack of provider and plan competition.

#### **Recommendations:**

- Test subsidized coverage for low wage small business employees in more counties to determine take-up rates by employers and employees
- Explore HSAs and hospital-only plans as lower cost alternatives to commercial coverage.
- Living-wage ordinances may encourage more employers to offer coverage.
- Any employer mandate must be accompanied by subsidies for low wage workers and small employers.

### **Model Local Coverage Pilots for Adults**

- **SacAdvantage** for the working uninsured (Sacramento County). The County Board of Supervisors earmarked \$2M from tobacco settlement monies for a pilot program. The County also received \$700,000 in federal support. Coverage is provided through PacAdvantage health plans at the PacAdvantage negotiated premiums. Coverage is available to small businesses with 2-50 employees. There are 3 levels of subsidies based on the least expensive PacAdvantage Plan, the “Standard” HMO. Employees choosing more expensive coverage pay the difference.
- **Partnership HealthPlan** for indigent adults (Solano County). This plan covers indigent adults in Solano County’s County Medical Services Program through the Partnership HealthPlan of California (PHC) (a County Organized Health System). The plan has been very successful in enrolling patients with a primary care provider, increasing access to specialists, and reducing use and costs of hospital in-patient services. It has replaced episodic fee-for-service care with managed care for a very poor and seriously ill population.
- **Basic Health Care Program** (Contra Costa County). Coverage offered through the Contra Costa Health Plan for medically indigent residents, under 300% FPL, regardless of immigration status. Enrollees pay a sliding scale fee between \$0 and \$75 for six months, which provides full coverage at the county hospital and county clinics only. The program is funded through general funds and tobacco settlement

money. The program has seen more use of clinics and better ability to manage and coordinate care. These changes produce better health outcomes.

- San Diego County Efforts
  - Sharp Health Plan's FOCUS Pilot Project targeted uninsuring, low wage, small employers and their employees. Philanthropic foundations subsidized on average 50% of the premium; the small employer and low wage employee pay the rest
  - San Diego's Community Health Group assembled a network of providers who are willing to care for the uninsured at the lowest possible price, and markets more affordable coverage to uninsuring small employers as a commercial product.
  - San Diego's Business Health Care Connection strives to increase private and public coverage through better education of employers and employees on their options for coverage.
- IHSS Workers' Coverage (Bay Area, Los Angeles). Programs provide health coverage to IHSS workers who are authorized to work a requisite number of hours per month. Funding is provided by a Medi-Cal match and additional state and local support. Most programs are administered by community provider plans.
- Childcare Workers Program (San Francisco). A pilot that offers medical savings accounts to low-income licensed family childcare workers. The program does not offer coverage, but provides funds to be used to purchase insurance or pay for other health related expenses. An insurance broker assists workers in applying for health insurance.
- Minimum Benefits Plans (Southern California).
  - Primary Value Plan (Los Angeles County and Inland Empire) offers low co-pays, no deductibles, but a \$50,000 annual cap on cost of covered services. The plan provides access to basic services, but less protection for catastrophic costs. Plan is targeted to mid-sized employers with over 50 employees.
  - Millennium Benefits (Los Angeles County) offers individual and family coverage plan that works with low-wage employers to identify and enroll employees. Two coverage options are available, one covering physician and clinic services and a more comprehensive plan that adds hospital care. Maximum annual and lifetime benefits are \$25,000 and \$250,000, respectively.
- Kaiser Permanente's Steps Program (Statewide). The program provides Kaiser coverage at sliding fee scale of premiums that are adjusted as enrollees' incomes or longevity in the program increase.

### **Healthcare Data Reporting**

Through our preparation of the summaries and discussions with workgroup participants, we have learned of several inconsistencies and flaws in the various data collection and reporting systems.

#### **Challenges:**

- Lack of Consistent and Accurate Reporting. There is wide variation in many communities between the financial reports of hospitals to OSHPD and the financial reports of counties to MICRS. There is wide variation in their OSHPD reports among hospitals and clinics.

- Incomplete Data. Most county clinics and some rural clinics do not report data to OSHPD. County clinic data is also not available through MICRS.

**Recommendations:**

- State level regulation of data collecting and reporting
- Local education and training to promote more uniform reporting from healthcare facilities and counties.

## **GLOSSARY OF HEALTH TERMS**

### Child Health and Disability Prevention Program (CHDP)

A state program that pays for preventive health screening examinations for children with family incomes of less than 200% of FPL. The state and counties administer the program.

### County Indigent Patients

Uninsured, impoverished patients. Under §17000 of the California Welfare and Institutions Code, counties are required to provide care for these patients without collecting fees.

### County Match

The level of funding counties is required to contribute to public health care in order to receive federal or state funding.

### County Medical Services Program (CMSP)

A state-funded county program that provides medical/dental care to medically indigent adults (MIAs) aged 21-64 who are of marginal income and who are not eligible for Medi-Cal. In order to qualify for CMSP participation, a county must have a population of less than 300,000. Currently, 34 small, rural counties participate in this program. Small counties have an option of administering the program themselves or contracting with the state for state-level administration (administered jointly by the Office of County Health Services and the CMSP Governing Board).

### County Organized Health System (COHS)

A Medi-Cal managed care model in which the county operates the managed care program. A COHS must be an independent public entity that meets the state requirements for managed care organizations to obtain HMO licensure. However, unlike managed care organizations, a COHS does not need a Knox-Keene license to operate. COHS in California contract with the California Medical Assistance Commission and are paid by capitation.

### Disproportionate Share Hospitals (DSH)

A state program that reimburses hospitals that serve a disproportionately high number low income uninsured and Medi-Cal patients.

### Expanded Access to Primary Care (EAPC)

A state program that reimburses primary care non-profit and community clinics for “expanded” outpatient care to persons with incomes below 200% FPL who do not have third party insurance. Expanded care includes: preventive health care, health education, smoking prevention and health assessments.

### Federal Poverty Level (FPL)

A specific level of annual income issued each year by the federal government, used to determine financial eligibility for public programs such as Medi-Cal and Healthy Families. For example, income eligibility ceilings for Medi-Cal are as follows: 200% FPL for pregnant women and children through age 1, 133% for children age 1-6, 100% for children age 7 to 21, and 100% for parents eligible through the Medi-Cal 1931b program.

### Geographic Managed Care

A competitive Medi-Cal managed care model that allows multiple for-profit and non-profit commercial plans to operate within a designated area. Unlike both the County Organized Health System and the Two-Plan Model, the geographic managed care model does not include a county-developed plan. Enrollment is mandatory for the CalWORKs-linked Medi-Cal population.

### Healthy Families

California’s State Children’s Health Insurance Program (SCHIP); administered by the Managed Risk Medical Insurance Board. It is a public insurance program that provides health coverage to children in families with incomes between 100% and 250% of FPL who do not qualify for Medi-Cal and do not have private insurance. California has a federal waiver to cover parents between 100% and 200% of FPL, though currently unfunded by the state.

### Local Initiatives

“Safety net” health plans organized at the county level, which provide health coverage for families and children in receipt of Medi-Cal. These initiatives are typically created in counties with a public hospital. They compete with commercial plans for Medi-Cal enrollees. Some Local Initiatives have implemented innovative efforts to cover some of the uninsured: such as home care workers, uninsured children, low wage working families and immigrants.

### Medi-Cal

California’s Medicaid Program; a joint program funded by both the state and federal government. It is a public health insurance program that provides board benefits to

low-income families and individuals. Eligibility is based on income (below 100% FPL; with specific variations for pregnant women, young children, the aged and disabled) and categorical qualifications, such as families with children who are receiving CalWORKs, and elderly, blind or disabled individuals who are receiving SSI. Medi-Cal is the major payer of nursing home services.

#### Medically Indigent Services Program (MISP)

A county program that provides medical/dental care to medically indigent adults (MIAs) aged 21-64 who are of marginal income and who are not eligible for Medi-Cal. It is financed by both the state and the county. Participating counties in this program typically have a population of over 300,000 and are required to administer the program themselves.

#### Medicare

The federal health insurance program that finances health services for the elderly (age 65 or above) and the permanently disabled. Eligibility is based on age and contribution (via Medicare tax), regardless of income level.

#### “Other State” Programs

Other State Health Programs include Breast Cancer Health Services, Immunization Assistance, and California Children’s Services.

#### PacAdvantage

A small employer “purchasing pool” in which small businesses join together to leverage their purchasing power to make coverage more affordable and accessible to employers and employees. Also known as HIPC (Health Insurance Plan of California).

#### Proposition 10 (Tobacco Tax to Promote Early Childhood Development)

A \$0.50/pack state tax on tobacco products that provides funding for early childhood developmental services through state and county Prop 10 Commissions.

#### Proposition 99 (Tobacco Tax and Health Protection Act of 1988)

A \$0.25/pack state tax on tobacco products that provides funding for health services in the state.

### Realignment

State funding for county health services from revenues generated by sales tax and vehicle license fees.

### Tobacco Litigation Settlement

Funding for the state and counties from revenues generated by settlement of the tobacco litigation to compensate state and county government for their costs of care to persons afflicted with diseases caused by smoking.

### Two-Plan Model

A dual-plan Medi-Cal managed care model where a county-developed plan competes with a commercial plan. In this system, the California Department of Health Services is contracted with both the county-developed plan (Local Initiative) and the commercial plan to provide services to the Medi-Cal population.

### Uninsured

An individual, who does not have health coverage, including Medi-Cal or other public coverage programs.