

California's Health Care Safety Net

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Exploring the basics of health policy in California

California has historically maintained a health care "safety net" of providers and programs serving the health care needs of low-income and uninsured residents.

With implementation of the federal Affordable Care Act (ACA), the character of the health care safety net changed. Fewer low-income Californians are uninsured and more are enrolled in comprehensive coverage through Medi-Cal, California's Medicaid program.

Those who remain uninsured, approximately three million Californians, continue to obtain emergency care and other health services through public health care systems, community clinics and health centers, and private providers who by mission serve low-income populations.

This issue of ESSENTIALS reviews the populations, providers and programs that make-up California's health care safety net.

Overview

ITUP uses the following definitions in this report:

► **Safety-net populations** include those under 300 percent of the federal poverty level (FPL) (\$36,180 per year for an individual, or \$73,800 for a family of four) who are either uninsured or enrolled in public programs such as Medi-Cal.

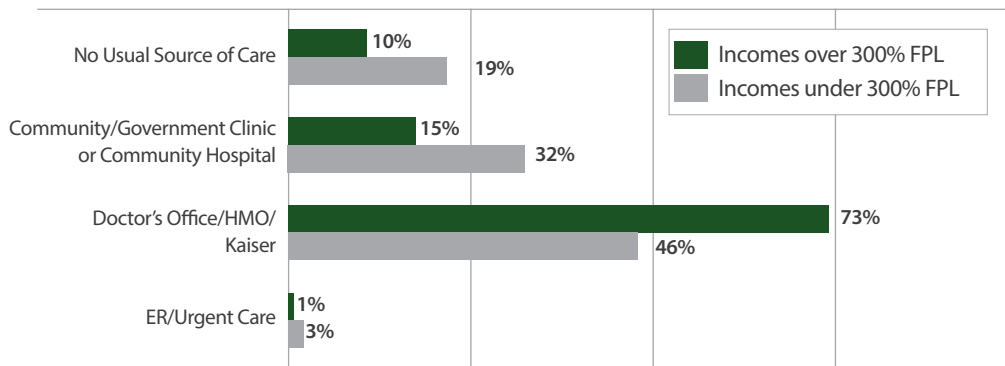
► **Safety-net providers** serve a higher number of Medi-Cal and uninsured patients than other providers. Safety-net providers include public health systems, such as county hospitals, and private, nonprofit hospitals and clinics.

► **Safety-net programs** are public programs serving those under 300 percent FPL, including the uninsured.

Figure 1 shows that 32 percent of low-income Californians access safety-net clinics and hospitals compared to 15 percent of those with higher incomes.

Nearly half of low-income Californians, 46 percent, report they access care through a doctor or HMO. This high proportion is likely because 82 percent of Medi-Cal recipients are in Medi-Cal managed care.

Figure 1. USUAL SOURCE OF CARE



Source: 2016 California Health Interview Survey, October 2017. Chart prepared by Insure the Uninsured Project.

FAST FACTS



10% of Californians under 300 percent of the federal poverty level are uninsured.¹



Californians, or 13.2 million individuals, are covered by Medi-Cal.



Californians access health services from community clinics and health centers.²



of the remaining uninsured receive hospital care through public hospitals and health systems.³

DEFINITIONS

Community Clinics and Health Centers (CCHCs)

are nonprofit providers of outpatient primary and preventive care. CCHCs serve a significant number of Medi-Cal patients and offer free or low-cost services on a sliding fee scale basis.

Federally-qualified health centers (FQHCs)

include CCHCs and publicly operated clinics that meet federal requirements and receive a grant under Section 330 of the federal Public Health Service (PHS) Act to serve uninsured and underserved communities. FQHC Medi-Cal rates are based on a prospective payment system (PPS) methodology, determined using CCHC cost reports.

FQHC Look-Alikes

meet Section 330 PHS Act standards but do not receive 330 grant funding. Look-alike clinics receive PPS reimbursement under Medi-Cal.

Rural Health Clinics (RHCs)

are public or private providers of outpatient services in rural and underserved communities. Federal rules require RHCs to use mid-level practitioners as core providers. RHCs are eligible for Medi-Cal PPS payment rates.

Critical Access Hospitals (CAHs)

are hospitals located in rural areas with no more than 25 beds. CAHs receive cost-based reimbursement from Medicare.

Designated Public Hospitals (DPH)

are health systems operated by a county or county affiliate, or through the University of California. DPHs provide a wide array of services from primary to inpatient care.

District and Municipal Public Hospitals (DMPH)

are facilities locally operated by special districts and administered by a publicly elected Board.

Federal Framework

Federal law influences and supports California's health care safety net by:

- ▶ Setting eligibility and providing federal funding for Medi-Cal and safety-net programs,
- ▶ Defining and setting program standards for different types of safety-net providers, and
- ▶ Requiring public programs, such as Medi-Cal, to include certain safety-net providers and pay specialized rates.

For example, Section 330 of the federal PHS Act (see definitions) requires FQHCs and FQHC look-alikes to, among other things: 1) offer a sliding fee scale to patients below 200 percent FPL, 2) meet service and quality reporting standards, and 3) include a majority of consumers on CCHC governing boards. Federal law requires state Medicaid programs to offer FQHC services and pay PPS reimbursement rates.

Similarly, federal law establishes the Disproportionate Share Hospital (DSH) Program to support safety-net hospitals in serving safety-net populations. The DSH Program requires state Medicaid Programs to make DSH payments to qualifying hospitals that serve large numbers of Medicaid and uninsured individuals, such as DPHs, certain DMPHs, CAHs and nonprofit hospitals. In federal fiscal year 2016, California hospitals received \$1.2 billion in federal DSH funding.

State Framework

California law organizes and preserves the state health care safety net by establishing:

- ▶ The benefits, eligibility and payment rates in the Medi-Cal program as permitted in federal law,
- ▶ The requirement for California's 58 counties to serve as the providers of last resort for low-income and underserved populations with no other source of care,
- ▶ State-level standards for safety-net programs and providers, including funding and payment methodologies, and
- ▶ Incentives to ensure safety-net providers have the opportunity to participate in Medi-Cal, including Medi-Cal managed care.

Safety-Net Providers: CCHCs

Throughout California, CCHCs provide a significant portion of the primary and preventive care for safety-net populations. In 2016, CCHCs cared for approximately 40 percent of low-income Californians under 200 percent FPL.⁴ CCHCs cared for one in six Californians through 1,308 state licensed CCHCs.⁵

State law requires CCHCs to provide services based on patient ability to pay, using a sliding income scale. Nearly 60 percent of CCHC consumers are Medi-Cal recipients, making Medi-Cal the primary revenue source, along with other safety-net program funding, such as Section 330 federal grants that support care for the remaining uninsured.

Figure 2. SAFETY-NET PROVIDER PROFILES

| CCHCs | | DPHs |
|--------------|-----------------------------|---|
| 1,308 | Sites | 21 health systems with over 200 sites |
| 20.8 million | CCHC Encounters** | |
| | Outpatient Visits** | 11.5 million |
| 6.6 million | Consumers/Patients | 2.9 million* |
| 24.4% | Percent Uninsured Patients | 47% of costs attributable to Medi-Cal and uninsured consumers |
| 58.4% | Percent Medi-Cal Recipients | |

Source: Office of Statewide Health Planning and Development (OSHPD), "Primary Care Clinic Annual Utilization Data – 2016 Pivot Profile," November 2017, and OSHPD, "Hospital Annual Financial Data – 2016 Pivot Profile." Chart prepared by Insure the Uninsured Project.

*DPHs do not report the number of patients to the State. ITUP received this information from the California Association of Public Hospitals and Health Systems.

**The data reflects OSHPD definitions for encounters and outpatient visits.

Safety-Net Providers: DPHs

In 1964, California had 66 county-owned and operated hospitals. Today, California has 21 DPHs, which include county-affiliated systems and five University of California (UC) medical centers, accounting for 5 percent of California hospitals.⁶

In California, DPHs serve more than 2.85 million patients annually, providing 11.5 million outpatient visits at more than 200 clinic facilities.⁷ Although DPHs are a small fraction of the hospitals in California, DPHs provide 30 percent of all hospital care to Medi-Cal recipients and 40 percent of all hospital care to the remaining uninsured in the communities they serve.⁸

Public hospitals and health systems provide care regardless of insurance status or ability to pay, and rely on state and federal safety-net programs, including Medi-Cal matching funds, DSH funding, and federal Medicaid waiver funds to cover the costs of care for the uninsured.

Safety-Net Providers: Nonprofit Hospitals

In 2016, the 226 nonprofit hospitals in California provided nine million outpatient Medi-Cal hospital visits, representing nearly 30 percent of all nonprofit outpatient visits.⁹ Nonprofit hospitals derive 25 percent of gross revenue from the Medi-Cal program.¹⁰

County Indigent Care Programs

Since the 1930s, California counties are by law the “providers of last resort” for lawfully present county residents with no other source of care. Counties have wide discretion to define eligibility, benefits and services including providing services to undocumented residents.¹¹

To meet this obligation, counties administer local coverage programs for medically indigent adults (MIAs) and provide services on a sliding fee scale basis. The primary funding sources for county indigent programs are realignment funds (dedicated sales tax and motor vehicle license fees), and county general funds.

County indigent care programs vary widely but are generally one of two types. The 23 largest counties provide, organize, and/or pay for indigent medical care services using a variety of service delivery strategies. Thirty-five smaller, mostly rural counties voluntarily participate in the centrally administered County Medical Services Program. (See [ITUP Fact Sheet](#) on county indigent care programs.)

Since implementation of the ACA Medi-Cal expansion, counties serve significantly fewer individuals in MIA programs. Some counties have adjusted program rules to serve higher income individuals, lengthen the period of eligibility, or include undocumented individuals. (See Figure 3.)

THE DATA

Figure 3. COUNTY MIA PROGRAMS

| Eligibility | | # of Counties |
|-------------|--------------------------------|---------------|
| Income | < 200% FPL | 9 |
| | 200% - 300% | 43 |
| | 300+% | 6 |
| Timeframe* | ≤ 3 months | 4 |
| | 4 – 6 months | 38 |
| | 7 – 12 months | 13 |
| Immigration | Include Undocumented Residents | 11 |

Source: Insure the Uninsured Project, County Medically Indigent Care Programs, October 2017.

*Counties with multiple MIA programs with different timeframes were excluded.



594,427

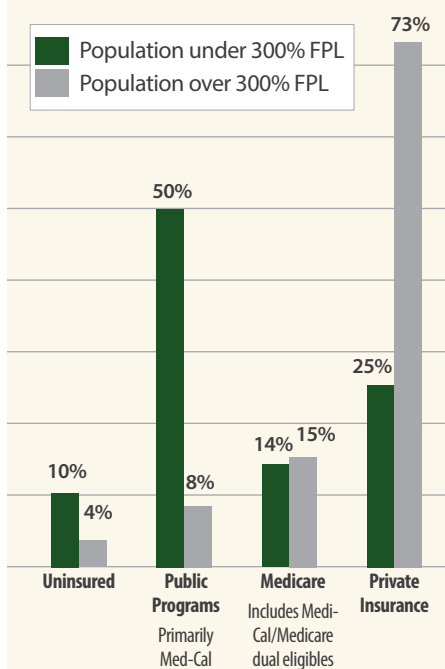
county indigent care program outpatient visits were provided by nonprofit hospitals in 2016.¹²

Figure 4. OTHER SAFETY-NET PROGRAMS IN CALIFORNIA

| Name | Description | Income Eligibility |
|--|--|---|
| Breast and Cervical Cancer Treatment Program (BCCTP) | BCCTP provides cancer treatment and services to eligible low-income individuals diagnosed with breast and/or cervical cancer. | At or below 200% FPL |
| California Children’s Services (CCS) Program | CCS provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children and young adults with CCS-eligible medical conditions, such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, and cancer. | Family income \$40,000 or less, out-of-pocket expense > 20% of income, or Medi-Cal income standards |
| Community-Based Adult Services (CBAS) | CBAS offers services, including professional nursing services, social services, meals, and personal care, to eligible older adults or adults with disabilities to maintain their optimal capacity for self-care. | Medi-Cal income standards |
| Family Planning, Access, Care and Treatment Program (Family PACT) | Family PACT provides comprehensive family planning services to 1.6 million low-income men and women. | At or below 200% FPL |
| Genetically Handicapped Persons Program (GHPP) | GHPP provides different types of health services for adults with certain genetic diseases including hemophilia, cystic fibrosis, Huntington’s disease, phenylketonuria, galactosemia, and Wilson’s disease. | No income limit, but may have an enrollment fee based on income |

THE DATA

Figure 5.
SOURCES OF COVERAGE



Source: 2016 California Health Interview Survey, October 2017. Chart prepared by Insure the Uninsured project.

There are multiple federal, state and local funding streams supporting California's health care safety net. Earlier sections described federal grants for CCHCs, DSH funding for hospitals serving Medi-Cal and uninsured patients, and county indigent care local funds.

Financing Safety-Net Programs

Medi-Cal

Implemented in 1966, Medi-Cal is California's Medicaid program and provides comprehensive health care benefits for low-income Californians including adults, children, pregnant women, infants, seniors, persons with disabilities, children in foster care, and former foster youth up to age 26. Medi-Cal and other public programs provide coverage to half of Californians under 300 percent FPL. (See Figure 5.)

Medi-Cal is financed through a partnership between the state and federal government. In California, the federal government matches 50 percent of eligible state expenditures (known as the match, or federal financial participation) for most Medi-Cal recipients. Under the ACA Medicaid expansion, California receives a higher match (95 percent, declining to 90 percent in 2020 and beyond) for newly eligible childless, nonelderly adults. (See [California Health Care Foundation fact sheet on Medi-Cal](#)).

In addition, California uses state funds to cover populations not eligible for comprehensive Medi-Cal coverage, such as legal permanent residents subject to a five-year waiting period for federal Medicaid eligibility and low-income, undocumented children up to age 19.

Medi-Cal 2020 Federal Waiver

For approximately two decades, California has secured federal Section 1115 Medicaid waivers to gain program flexibility and additional funding to support the state safety net.

The current federal waiver, Medi-Cal 2020, builds on prior waivers to continue state innovations such as the Medi-Cal managed care program, and establishes new programs, including the Whole Person Care Pilots and the Drug Medi-Cal Organized Delivery System improvement initiative.

In addition, Medi-Cal 2020 includes two key programs that provide funding for DPHs and DMPHs to serve safety-net populations including:

- ▶ **Public Hospital Redesign and Incentives in Medi-Cal (PRIME).** PRIME is a pay-for-performance delivery system transformation and alignment program for DPHs and DMPHs.
- ▶ **Global Payment Program (GPP).** GPP streamlines funding sources for the remaining uninsured used by county DPHs, including DSH funding, and establishes a value-based, funding mechanism focused on increasing primary and preventive care services and other high-value services for the uninsured.

The California Story

California officially established a health care safety net in the 1930s, placing primary responsibility on counties to serve those with no other means of support. Because of this historic reliance on counties, today's health care safety net varies significantly region to region, county to county.

Funding for safety-net programs, and the role of counties and safety-net providers, have been dramatically affected year-to-year by economic and fiscal challenges, and the policy and political landscape, at all levels of government. During this time, financing for safety-net populations and programs shifted from the local level to the state level, and at times back again.¹³ For

example, between 1971 and 1982, California operated a state-funded Medi-Cal program for medically indigent adults but returned the program and a portion of funding to the counties in 1982.

Before the ACA, the Medi-Cal program primarily served low-income children, their parents, pregnant women, and seniors and persons with disabilities, while counties primarily served low-income uninsured and undocumented Californians. Medi-Cal is now the primary program used to finance and deliver health care for Californians under 300 percent FPL, relying on 63 percent federal matching funds.^{14, 15}

The diversity of the health care safety net in California remains. Medi-Cal recipients and low-income uninsured Californians may have very different experiences depending on the county they live in. In some communities, a publicly administered system of hospitals and clinics serves as the primary safety-net provider and in other areas, particularly rural communities, CCHCs serve as the main source of primary care for residents at all income levels.

Despite coverage improvements under the ACA, low-income populations have for the most part not changed where they go for health care, underscoring the continued importance of a robust safety net in California.

Key Takeaways

- ▶ Implementation of the ACA dramatically reduced the number of uninsured in California and substantially increased Medi-Cal enrollment. State and an increasing share of federal funding now supports care for safety-net populations, primarily through Medi-Cal, with less of the responsibility being borne by local county and other public providers.
- ▶ Although 90 percent of Californians under 300 percent FPL have health coverage, the need for the safety net remains. Significant percentages of Californians under 300 percent FPL, insured and uninsured, continue to rely on safety-net providers and programs as their usual source of care.
- ▶ Local safety-net providers patch together federal, state, and local funding to ensure access and services for those in need.
- ▶ CCHCs and DPHs continue to serve a high percentage of safety-net populations. Almost three-quarters of CCHC patients are under 200 percent FPL. DPHs account for 5 percent of California hospitals, but provide one third of all hospital care to Medi-Cal recipients and the remaining uninsured. Nonprofit and Critical Access Hospitals are also important safety-net providers, especially in rural California.

Notes

1. UCLA Center for Health Policy Research (UCLA), "[2016 California Health Interview Survey \(CHIS\)](#)," October 2017.
2. Office of Statewide Health Planning and Development (OSHPD), "[Primary Care Clinic Annual Utilization Data – 2016 Pivot Profile](#)," November 2017.
3. OSHPD, "[Hospital Annual Financial Data – 2016 Pivot Profile](#)."
4. According to Kaiser Family Foundation "State Health Facts," in 2016, 12.5 million Californians were under 200 percent FPL. CCHCs served 4.7 million Californians under 200 percent FPL, according to OSHPD data.
5. OSHPD, "Primary Care Clinic."
6. OSHPD, "Hospital Annual Financial Data."
7. OSHPD, "Hospital Annual Financial Data." Hospitals do not report patient numbers to the State. ITUP obtained the data on number of patients from the California Association of Public Hospitals and Health Systems.
8. OSHPD, "Hospital Annual Financial Data."
9. OSHPD, "Hospital Annual Financial Data."
10. OSHPD, "Hospital Annual Financial Data." (Note: This state data excludes UC medical centers as nonprofit hospitals.)
11. California Welfare and Institutions Code Section 17000 establishes the indigent support requirement for counties.
12. OSHPD, "Hospital Annual Financial Data."
13. Deborah R. Kelch, "[Locally Sourced: The Crucial Role of Counties in the Health of Californians](#)," California Health Care Foundation, October 2015.
14. UCLA, 2016 CHIS.
15. California Department of Health Care Services, "[Medi-Cal November 2017 Local Assistance Estimate for Fiscal Years 2017-18 and 2018-19](#)," Fiscal Forecasting Division, December 2017.

Resources

- California Association of Public Hospitals and Health Systems <https://caph.org>
- California Department of Health Care Services www.dhcs.ca.gov
- California Health Benefit Exchange <http://hbex.coveredca.com>
- California Health Care Foundation www.chcf.org
- California's Health Care Safety Net: A Sector in Transition
- California Primary Care Association www.cPCA.org
- County Medical Services Program www.cmspcounties.org
- Office of Statewide Health Planning and Development www.oshpd.ca.gov

About ITUP

Insure the Uninsured Project (ITUP) is a Sacramento-based nonprofit health policy institute that for more than two decades has provided expert analysis and facilitated convenings for California policymakers and decisionmakers focused on health reform.

The mission of ITUP is to promote innovative and workable policy solutions that expand health care access and improve the health of Californians, through policy-focused research and broad-based stakeholder engagement.

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