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June 30, 2016

Sent by Electronic Mail wendi.horwitz@doj.ca.gov and FedEx

Wendi A. Horwitz
Deputy Attorney General
State of California Department of Justice
300 South Spring Street, Suite 1702
Los Angeles, California 90013

Dear Ms. Horwitz:

This letter serves as a request by Doctors Medical Center of Modesto, Inc., doing business as Emanuel Medical Center ("EMC" or the "Hospital"), pursuant to California Code of Regulations, title 11 ("Regulations"), section 999.5, subdivision (h), to modify Condition VII set forth in the "Conditions to the Proposed Sale of Emanuel Medical Center and Approval of the Asset Purchase Agreement by and between Emanuel Medical Center, Inc. and Doctors Medical Center of Modesto, Inc." issued by your office on January 10, 2014 (the "Attorney General Consent Letter"). Pursuant to Regulations section 999.5, subdivision (h)(2), a "request for an amendment shall include a description of each proposed amendment, a description of the change in circumstance requiring each such amendment, a description of how such amendment is consistent with the Attorney General's consent or conditional consent to the transaction, and a description of the efforts of the entity making the request to avoid the need for amendment." We address such requirements in this letter below.

I. Summary

In connection with EMC's acquisition of Emanuel Medical Center in 2014, your office approved the transaction subject to the conditions described in your letter to Emanuel Medical Center's counsel on January 10, 2014. Condition VII requires that the Hospital provide charity care of at least $3,212,054 annually (which amount is prorated for any partial years, and which amount has an annual CPI adjustment) for six fiscal years following the closing of the transaction. That dollar amount was determined using the 5-year average of the Hospital's cost of charity care for fiscal years 2008 through 2012. In your letter to the Hospital dated May 5, 2016, you indicated that the Hospital had a charity care deficiency for the August 2014 to December 2014 time period (EMC's initial period of ownership of the Hospital) of $1,344,576. As described below in this letter, the implementation of The Patient Protection and Affordable Care Act has resulted in a dramatic increase in the Hospital's Charity care patients who have become eligible for Medi-Cal or other coverage. Despite the Hospital's good faith efforts to comply with Condition VII, and by virtue of the intended, but unknown consequences of The Patient Protection and Affordable Care Act, the Hospital has experienced a corresponding, dramatic reduction in the number of patients who qualify as Charity care patients, resulting in a decline of the need for Charity care in our community, and the Hospital being unable to provide Charity care anywhere near the amount required by Condition VII.

As a result, we are submitting this request that Condition VII be modified to (a) in our preferred methodology, credit the Hospital for the costs associated with the Hospital serving an increased number of Medi-Cal patients who would have previously qualified as Charity care patients prior to the implementation of The Patient Protection and Affordable Care Act or (b) in an alternative methodology, take into account the cost of the Hospital serving indigent care patients based upon OSHPD-reported data for all of the Charity and Indigent payer groups (that is, Medi-Cal, Managed Medi-Cal, County Indigent and Charity Other), to reflect the fact that patients who previously qualified as Charity care patients have shifted to another payer category in connection with the implementation of The Patient Protection and Affordable Care Act. The details of our modification request are set forth below in this letter.

II. Transaction Background

As you know, EMC acquired substantially all of the assets comprising the Hospital pursuant to an Asset Purchase Agreement dated as of February 20, 2013, as amended, by and between Emanuel Medical Center, Inc., a California nonprofit religious corporation and Doctors Medical Center of Modesto, Inc., a California corporation (the "APA"). The transaction contemplated by the APA was consummated by the parties thereto on July 31, 2014, effective as of August 1, 2014.

Condition VII of the Attorney General Consent Letter ("Condition VII") requires, for six fiscal years from the closing date of the APA (that is, until July 31, 2020), that EMC provide an annual amount of Charity Care (as defined in the Attorney General Consent Letter) at the Hospital equal to or greater than $3,212,054 (defined in Condition VII, as the "Minimum Charity Care Amount"). For this purpose, "charity care" means the amount of charity care costs (not charges) incurred by EMC in connection with the operation and provision of services at the Hospital. The definition and methodology for calculating "charity care" and the methodology for calculating "costs" shall be the same as that used by the California Office of Statewide Health Planning and Development ("OSHPD") for annual hospital reporting purposes. EMC's obligation is prorated on a daily basis if the closing date of the APA occurs on a date other than the first day of EMC's fiscal year.

For the period from August 1, 2014 through December 31, 2014 (the "2014 Period"), the prorated Minimum Charity Care Amount pursuant to the above formula was $1,346,422. In your letter to the Hospital dated May 5, 2016 (the "May 5th Letter"), you indicated that the Hospital had a deficiency in the Minimum Charity Care Amount for the 2014 Period of $1,344,576 based upon EMC's Hospital Summary Individual Disclosure Report submitted to OSHPD. For the reasons set forth below in this letter, EMC believes that it had complied in good faith with Condition VII for the 2014 Period, insofar as the Hospital has continued to care for all patients in its community irrespective of their having insurance coverage, and the Hospital has partnered with policymakers to ensure that more patients have access to quality healthcare in the Central Valley, as well as access to insurance coverage for previously uninsured patients.

III. Changes in the Healthcare Marketplace

As you know, most hospitals and the communities that they serve have been positively impacted by The Patient Protection and Affordable Care Act ("ACA"). At its core, ACA was intended to drive a massive and dynamic series of healthcare reforms, including enhanced quality and a better healthcare delivery system. Broader coverage via Medicaid and state/federal exchanges would, over time, facilitate improved access to quality medical care (including primary care and a medical home) and concurrent improvements in the overall health for tens of millions of previously uninsured people. As a result, the hospital industry fully supported ACA based upon these fundamentals and long-term improvements in healthcare delivery and population health. Moreover, hospitals also supported over $300 billion in future reductions across a range of programmatic and payment system changes, including with respect to hospital readmissions, hospital-acquired conditions and payments based upon performance for outcomes and quality measures. With California opting fully for Medi-Cal expansion, ACA's broad scope and effect is more evident here (as compared to other states which did not opt for Medicaid expansion) and while some trends may have been anticipated, the degree to which those trends would impact hospitals and other stakeholders was unknown at the time of the closing of the transaction contemplated by the APA (the "Closing").

Through programs like Medi-Cal expansion and Covered California, more people have access to quality healthcare than ever before. California's Central Valley hospitals have experienced significant expansion in coverage and dramatic decreases in the level of Charity care provided. Enclosed with this letter are a report dated September 10, 2015 from Insure The Uninsured Project (the "ITUP Report"), and an Excel spreadsheet prepared by ITUP, which illustrate that, in the Central Valley, Other-Indigent inpatient patient days have decreased from 26,819 in 2013 to 11,921 in 2014 (that is a 14,898 day reduction (or 55.6% reduction) from 2013 to 2014), along with County-Indigent inpatient patient days decreasing from 58,912 in 2013 to 36,826 in 2014 (that is a 22,086 day reduction (or 37.5% reduction) from 2013 to 2014). At the same time, in the Central Valley there has been a corresponding increase in the number of overall Medicaid inpatient patient days (both fee for service (FFS) and Managed Care) from 761,992 in 2013 to 865,095 in 2014 (that is a 103,103 day increase (or 13.5% increase) from 2013 to 2014. This data is illustrated in the following table, which also shows similar trends in the number of outpatient visits:

Central Valley Inpatient Days (ITUP Report)	2013 Days	% of Total	2014 Days	% of Total	Variance Days	Var %
Medi-Cal	761,992	34.1%	865,095	36.3%	103,103	13.5%
Medi-Cal FFS	541,313	24.2%	591,983	24.8%	50,670	9.4%
Medi-Cal MC	220,679	9.9%	273,112	11.4%	52,433	23.8%
Other Indigent	26,819	1.2%	11,921	0.5%	-14,898	-55.6%
County Indigent	58,912	2.6%	36,826	1.5%	-22,086	-37.5%

Central Valley Outpatient Visits (ITUP Report)	2013 Days	% of Total	2014 Days	% of Total	Variance Days	Var %
Medi-Cal	1,827,710	35.2%	2,487,956	42.2%	660,246	36.1%
Medi-Cal FFS	578,400	11.2%	753,649	12.8%	175,249	30.3%
Medi-Cal MC	1,249,310	24.1%	1,734,307	29.4%	484,997	38.8%
Other Indigent	82,816	1.6%	60,929	1.0%	-21,887	-26.4%
County Indigent	175,727	3.4%	112,045	1.9%	-63,682	-36.2%

As further evidence of the intended, but unknown consequences of the implementation of the ACA (and why the Hospital's Charity care figures have so dramatically decreased for the 2014 Period), page 16 of the ITUP Report illustrates that there has been a 185% increase in Medi-Cal managed care membership in Stanislaus County, increasing from 98,020 members in September 2013 to 278,947 members in May 2015. A closer look at various hospitals in the Central Valley reveals dramatic shifts; some having Charity care declines of more than 85% in 2014 (per OSHPD reports; in particular, please see our table below). In certain instances, that decrease has further accelerated into 2015 as more patients have become educated about the opportunities afforded by the ACA. For instance, consistent with the goals of the ACA, the Hospital, through our Path to Health campaigns over the last couple of years, has played an active role in educating the public about such opportunities afforded by the ACA, enrolling patients in available coverage, and working with community organizations. In fact, the Hospital has five full-time-equivalent eligibility counselors who assist patients in determining what type of program the patients may be eligible for, including ensuring that those patients who can be enrolled in Medi-Cal are enrolled in Medi-Cal. Below is a table containing examples (based upon available OSHPD data) from hospitals in our service area, along with selected other hospitals in the Central Valley, demonstrating the dramatic shift from Charity care to Medi-Cal, along with, in certain instances, the accelerated effect of such shift into 2015:

	Charity - Other per OSHPD						
Charges for Patients Charity Care Adjustments	2011	2012	2013	2014	2015	2014 vs. Avg Pre-ACA 3 Yrs	2015 vs. Avg Pre-ACA 3 Yrs
Emanuel Medical Center Pre-Tenet*	$36,923,017	$40,361,399	$58,296,099	$17,986,053			
Emanuel Medical Center Post-Tenet**				$12,414	$1,492,342		
Lodi Memorial Hospital***	$27,692,550	$28,075,801	$24,836,705	$3,800,165		-85.9%	
San Joaquin General (June FY)***	$55,018,385	$103,764,717	$116,165,141	$70,142,102	$19,154,298	-23.5%	-79.1%
Doctors Hospital of Manteca	$3,131,955	$3,695,753	$2,973,653	$1,015,272		-68.9%	
Memorial Medical Center of Modesto	$61,386,690	$64,366,666	$75,569,313	$28,887,578		-57.0%	
Doctors Medical Center of Modesto	$104,169,706	$114,148,539	$118,096,087	$76,634,232		-31.7%	
Mercy Merced Medical Center (June FY)	$12,962,406	$26,974,083	$30,798,091	$22,086,843	$20,362,326	-6.3%	-13.6%

*Note: Figures in the year where most of months in fiscal year are (i.e. FY end Jan 2012 is in 2011 column). Further, 2014 only includes 6 months.

**Note: 2014 is for 5 months

***Note: Included other area hospitals to illustrate impact in Central Valley and also due to Kaiser hospitals in the service area not having comparable data available on OSHPD

	Contractual Adjustments						
Medi-Cal (Traditional and Managed)	2011	2012	2013	2014	2015	2014 vs. Avg Pre-ACA 3 Yrs	2015 vs. Avg Pre-ACA 3 Yrs
Emanuel Medical Center Pre-Tenet*	$196,610,187	$210,307,258	$294,474,294	$182,117,595			
Emanuel Medical Center Post-Tenet**				$166,171,239	$276,893,181		
Lodi Memorial Hospital	$189,894,460	$186,343,111	$230,495,515	$295,913,117		46.3%	
San Joaquin General (June FY)	$238,378,067	$236,833,059	$168,215,784	$408,976,167	$450,548,849	90.7%	110.1%
Doctors Hospital of Manteca	$80,055,925	$90,894,027	$106,486,645	$160,158,108		73.2%	
Memorial Medical Center of Modesto	$301,244,280	$277,545,438	$274,709,021	$407,508,208		43.2%	
Doctors Medical Center of Modesto	$887,027,985	$979,636,895	$1,118,652,087	$1,535,286,773		54.3%	
Mercy Merced Medical Center (June FY)	$215,974,337	$213,630,240	$237,240,774	$305,135,410	$299,889,487	37.3%	34.9%

All data reported using OSHPD reports and 2015 figures are for hospitals who have reported to OSHPD (June FY)

IV. Emanuel Medical Center's Situation

At Emanuel Medical Center, we have experienced the same dramatic shift in Charity care and Medi-Cal: that is, a large decline in our Charity care, with a corresponding increase in our Medi-Cal population. As the data in the below table on page 6 shows, comparing the period of August through December 2013 (the "2013 Base Period") to the corresponding period of August through December 2014 (the latter of which is EMC's initial period of ownership of the Hospital, and which is referred to herein as the 2014 Period), the Hospital experienced a decrease in the level of Charity charges of $24,911,221 and a corresponding increase in charges for Medi-Cal patients of $54,401,592. We recognize that this is a drastic reduction in Charity charges for the 2014 Period, but this is attributable to a correspondingly drastic increase in Medi-Cal coverage for our patient population. In order to be able to specifically assess and quantify the direct effect that Medi-Cal expansion has had upon the reduction in Charity care provided at the Hospital, the Hospital evaluated the patient files of all 530 new patients who were screened by the Hospital's Medi-Cal enrollment specialists for the 2014 Period. We determined that, had the ACA not gone into effect, 450 of such 530 new patients (84.9%) would have been classified as patients for whom Charity care would have been provided for the 2014 Period. This tectonic shift in how patients are classified, resulting from the intended, but unknown consequences of the implementation of the ACA, has made it impossible for the Hospital to deliver the same amount of Charity care as currently defined by Condition VII. Nevertheless, the Hospital continues to care for all patients that choose the Hospital for their healthcare needs – it is just that they are being classified differently.

Further, since the Closing, the Hospital has continued to have in place the same charity care policy that was in place at the Hospital immediately prior to the Closing. Since the Closing, the Hospital has continued to devote resources towards ensuring that the community served by the Hospital is aware of the Hospital's charity care policy. This has included having the Hospital's five full-time-equivalent eligibility counselors (as described above) assist patients in determining whether they are eligible for charity care, and making available on the Hospital's website information concerning its charity care policy.

V. Requested Amendment to Condition VII

Proposed Methodology #1:

In the spirit of our continued commitment to serving all patients, including low-income and Indigent, the uninsured and the underinsured, and recognizing the dramatic impact that Medi-Cal expansion has had in accordance with the ACA as described above in this letter, we are requesting that the Hospital's compliance with Condition VII for the 2014 Period, and all future fiscal years after the 2014 Period, be determined in accordance with the following methodology ("Proposed Methodology #1"):

This methodology takes into account the increase in the cost of care related to the increased Medi-Cal population and adds the cost of care related to Charity patients. The table on the following page is a comparison showing Medi-Cal charges between the 2013 Base Period and the 2014 Period (we experienced a $54,401,592 Medi-Cal charge increase between those two time periods). Then each fiscal year's charges is multiplied by the applicable cost to charge ratio per the OSHPD reports in their respective years to calculate the cost of care for each of those fiscal years. The increase in the cost of care for Medi-Cal patients was $6,896,732 between these two time periods.

As stated above, 84.9% of the 530 new patient accounts reviewed for Medi-Cal eligibility during the 2014 Period would have qualified as Charity care prior to the implementation of ACA. We then multiply the increase in the cost of care for Medi-Cal patients of $6,896,732 by 84.9%, which yields an equivalent cost of Charity care of $5,855,716.

Adding in the cost of Charity care from accounts that qualified for Charity care during the 2014 Period of $1,846, the total cost of Charity care would be $5,857,562 for the 2014 Period.

Method 1	Aug-Dec 2013	Aug-Dec 2014	Var
Charity Charges	$24,923,635	$12,414	($24,911,221)
Medi-Cal Charges	$76,405,722	$52,782,791	($23,622,931)
Managed Medi-Cal Charges	$56,125,925	$134,150,448	$78,024,523
Total Medi-Cal Charges (A)	$132,531,647	$186,933,239	$54,401,592
Cost/Charge Ratio per OSHPD (B)	15.77%	14.87%	
Cost of Care of Medi-Cal Patients (A x B)	$20,900,241	$27,796,973	$6,896,732

Back-Tested 530 Accounts of Potentially Eligible Medi-Cal Accounts From 2014 and Here are the Findings:		
Percentage of Accounts That Qualified for Charity pre ACA	84.9%	
Percentage of Accounts That Didn't Qualify for Charity pre ACA	15.1%	
Cost of Charity Care Based on 84.9% of Accounts Above ($6,896,732 x 84.9%)		$5,855,716
Cost to Charity Care From Charity Amount on OSHPD ($12,414 x 14.87%)	$12,414	$1,846
Total Cost of Charity Care		$5,857,562

Additional Info For Future Years:

	Jan-Dec 2014	Jan-Dec 2015	Var
Medi-Cal Charges	$171,918,283	$119,952,665	($51,965,618)
Managed Medi-Cal Charges	$280,524,570	$433,449,756	$152,925,186
Total Medi-Cal Charges	$452,442,853	$553,402,421	$100,959,568

Stated another way, had ACA not been implemented, the Hospital would have shown a total of $5,857,562 in total cost of Charity care for the 2014 Period, which figure is higher than the prorated Minimum Charity Care Amount of $1,346,422 for the 2014 Period. This is attributable primarily to the 84.9% of the screened accounts that would have otherwise been eligible for Charity care. For calendar years 2015 and later, we would perform the same calculation to back-test accounts to identify what percentage of screened accounts would have qualified as Charity care prior to the implementation of ACA, and apply the results of those findings against the cost of care for Medi-Cal patients during the applicable year (as compared to calendar year 2013) in the same manner reflected in the above table. The resulting cost of Charity care based upon such calculation, plus the cost of treating Charity care patients (per OSHPD data) in the applicable calendar year, would be the Hospital's total cost of Charity care for purposes of determining whether the Hospital has complied with the Minimum Charity Care Amount for the applicable calendar year.

Proposed Methodology #2:

While Proposed Methodology #1 is our preferred methodology, the following methodology ("Proposed Methodology #2") is another approach that would be acceptable to EMC for addressing the issues raised in this letter. In the MDS report dated May 20, 2013 in which MDS provided its recommendations to your office regarding the transaction described in the APA (the "MDS Report"), MDS determined the Minimum Charity Care Amount contained in Condition VII by calculating the 5-year average of the Hospital's cost of charity care for fiscal years 2008 through 2012. Insofar as a significant number of patients who would otherwise have been classified as charity care patients pre-ACA are now covered by Medi-Cal, we are proposing in Proposed Methodology #2 that the Minimum Charity Care Amount in Condition VII that would be applicable for the 2014 Period and all future fiscal years would be calculated differently, based upon OSHPD-reported data for all of the Charity and Indigent payer groups compared to historical averages. The below table shows a 4-year historical average of all of the Indigent payer contractual adjustments for the Hospital per OSHPD reports between fiscal year ending 2010 and fiscal year ending 2013. The average cost of care for this time period for these Indigent payers, using the OSHPD-calculated cost to charge ratio for the Hospital for each applicable fiscal year, is $36,889,261. Accordingly, we are proposing that Condition VII would be modified under this Proposed Methodology #2 so that going-forward, for the Charity and Indigent payer groups described in the below table, the Hospital's minimum cost of care for such payer groups on an annual basis would be $36,889,261. Such amount would be increased each year with the same CPI adjustment that is currently set forth in Condition VII. Under this methodology, the pro-rated amount for the 2014 Period would be $15,463,170.

Method 2

	Contractual Adjustments						
Year	Medi-Cal Trad	Managed Medi-Cal	County Indigent	Charity Other	Total Indigent	Cost/Charge Ratio	Cost of Indigent Care
FY 2010	$126,171,984	$32,538,507	$838,514	$13,061,838	$172,610,843	17.58%	$30,344,986
FY 2011	$102,794,282	$63,363,587	$442,725	$23,586,663	$190,187,257	19.14%	$36,401,841
FY 2012	$128,922,291	$67,687,896	$179,406	$36,923,017	$233,712,610	16.10%	$37,627,730
FY 2013	$120,745,124	$89,562,134	$100,728	$40,361,399	$250,769,385	17.22%	$43,182,488
4-Year Avg	$119,658,420	$63,288,031	$390,343	$28,483,229	$211,820,024		$36,889,261
					Pro-rated for 5 Months ------>		$15,463,170
5 Months 2014	$41,062,430	$125,108,809	$0	$12,414	$166,183,653	14.87%	$24,711,509

Based on this Proposed Methodology #2, the Hospital has delivered $24,711,509 for the cost of care related to Charity and other Indigent payers for the 2014 Period. This measure effectively allows for shifts between low-income categories (that is, between Charity care and Medi-Cal), which is what the Hospital, along with other hospitals in the Hospital's service area, are experiencing as a result of the implementation of ACA.

This letter is consistent with Regulations section 999.5, subdivision (h)(1), which states that an entity may request approval of any amendment of the terms and conditions of any agreement or transaction for which the Attorney General has given conditional consent, based solely on "a change in circumstances that could not have reasonably been foreseen at the time of the Attorney General's action."

The terms of Condition VII set forth that the ACA may cause a reduction in future needs of charity care and that any such reduction will be considered "unforeseen" for purposes of Regulations section 999.5, subdivision (h). Consistent therewith, MDS stated in the MDS Report that it could not foresee the impact that the ACA would have on EMC as it pertains to charity care.

Specifically, on page 38 of the MDS report, MDS stated that "while these [ACA-related] initiatives may result in more individuals with health insurance, it is unknown if this will result in less charity care and bad debt, especially in a service area like Hospital's where a high percentage of the population is medically indigent." Likewise, EMC was not in a position to be able to foresee, or to control, the changes that the implementation of ACA would have upon Charity care and our Medi-Cal population.

Thank you for your consideration of the request set forth in this letter. We are committed to ensuring that each person in the Central Valley community has access to quality healthcare and we take pride in our continuing to care for all types of patients regardless of their ability to pay. We believe that the above methodologies set forth in this letter are consistent with the principles contained in the Attorney General Consent Letter and appropriately take into account how the ACA has dramatically changed the landscape of how healthcare is delivered to our patients.

If you need additional information, please contact me at (209) 664-5090, or at sue.micheletti@tenethealth.com.

Sincerely,

Susan C. Micheletti
Chief Executive Officer
Emanuel Medical Center

Enclosures

ITUP

INSURE THE UNINSURED
PROJECT

Delivery Systems and Financing Care for the Remaining Uninsured in Fresno, Imperial, Merced, Stanislaus and Tulare Counties

Prepared by:
Marina Acosta, Janet Perkins, and Lucien Wulsin

September 10, 2015

Funded by a Generous Grant from The California Endowment

Table of Contents

Part I: INTRODUCTION

This paper provides an overview of the transitions that have taken place and the opportunities available throughout the health care system and insurance coverage landscape in California's Central Valley, specifically Fresno, Merced, Stanislaus and Tulare. The paper also includes findings on Imperial County whose community demographics and health care access issues have many parallels with those in the Central Valley. The information presented is based on interviews with various stakeholders who care for the newly insured and remaining uninsured in these regions.

County Demographic Overview

All five counties studied for this report share basic geographic characteristics. First, the Central Valley and Imperial County have economies significantly driven by agro-industry. Thanks to extensive irrigation systems, there are year-round growing seasons. This industry is highly dependent on low-wage, highly skilled immigrant workers. Imperial County's demography has one significant difference from the Central Valley in that it lies on the U.S., Mexico border.

Employment Status

Agro-business is one of the larger employers in these counties, but other areas of employment are also robust. In Fresno, the County's main employers industries, are government, trade, transportation and utilities, education and health services, and farm and agriculture.[1] Merced lists its major employers as the government (county and municipal) followed by agricultural-related industries.[2] Stanislaus employment is mostly through the trade, transportation and utilities industry as well as education and health services, and health care and social assistance. Farming accounts for many jobs in Stanislaus as well.[3] Farm and government are the biggest industries in Tulare.[4] Finally, Imperial County lists the government services sector as its largest employer and agro-industry has the next highest employment.[5]

Unemployment

The counties have significantly high unemployment rates. The unemployment rate as of April 2015 for the five counties studied, ranged from approximately 9 percent to 21 percent (Table I). The higher figures are likely due to the seasonal nature of employment associated with the region's agro-business.[6] All five counties exceeded the seasonably adjusted unemployment rates for California (6.2%) and the U.S. (5.3%).

Population Income Characteristics

A disproportionate number of people living in these rural counties survive on very modest

[1] State of California. Employment Development Department. (Jun 2015). Local area profiles, Employment by industry (Not seasonally adjusted). Retrieved from http://www.labormarketinfo.edd.ca.gov/data/industries.html
[2] Ibid.
[3] Ibid.
[4] Ibid.
[5] Ibid.
[6] State of California, Employment Development Department. Apr 2015. Report 400 C, Monthly labor force data for counties, June 2015, preliminary, not seasonally adjusted. Retrieved from http://www.calmis.ca.gov/file/lfmonth/countyur-400c.pdf

financial resources. Between 2009 and 2013 approximately 50 percent of each county's population had incomes at, or below, 200 percent of the Federal Poverty Level (FPL), except for Stanislaus (44%) (Table II). Two hundred percent FPL is about $2000 a month for a single person in 2015.[7] Fifty-percent of the population living at or below 200 percent FPL is much higher than California's proportion, which is only 36 percent.

TABLE I: Unemployment Rate 2015[8,9]

Report Area	Labor Force	Employed	Unemployed	Unemployment Rate
FRESNO	450,300	407,800	42,600	9.5%
IMPERIAL	79,200	62,500	16,700	21.1%
MERCED	116,300	104,100	12,200	10.5%
STANISLAUS	242,300	219,700	22,600	9.3%
TULARE	200,600	178,600	22,000	11.0%
California	19,056,900	17,878,400	1,178,500	6.2%
United States	157,037,000	148,739,000	8,299,000	5.3%

TABLE II: Poverty - Population Below 200% FPL[10]

Report Area	Total Population	Population with Income at or Below 200% FPL	% Population with Income at or Below 200% FPL
FRESNO	922,739	461,832	50.1%
IMPERIAL	164,573	85,069	51.7%
MERCED	253,641	134,711	53.1%
STANISLAUS	512,206	224,389	43.8%
TULARE	440,509	237,803	54.0%
California	36,913,404	13,254,517	35.9%
United States	303,692,076	103,964,437	34.2%

[7] Medicaid. (2015). 2015 Poverty guidelines. Retrieved from http://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/downloads/2015-federal-poverty-level-charts.pdf
[8] State of California, Employment Development Department. Apr 2015. Report 400 C, Monthly labor force data for counties, June 2015, preliminary, not seasonally adjusted. Retrieved from http://www.calmis.ca.gov/file/lfmonth/countyur-400c.pdf
[9] U.S. Bureau of Labor Statistics. Jun 2015. Series report.
[10] U.S. Census Bureau. American fact finder. Poverty status in the past 12 months, 2009-2013 American Community Survey 5-year estimates. Retrieved from http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_13_5YR_S1701&prodType=table

Health Profile of County Residents

The residents in the Central Valley and Imperial regions have poor health profiles. For example, only 18 percent of adults in California report being in poor to fair health (Table III). However, the rates of poor health in the Central Valley and Imperial were much higher: Fresno, 23.4%; Imperial, 29.0%; Merced, 23.0%; Stanislaus, 22.3% and Tulare, 24.8%.

TABLE III: Percent of Adults Reporting Poor Health

Report Area	18 and over Population[11]	Age-Adjusted %[12]	Estimated Adult Population with Poor/Fair Health[13]
FRESNO	652,943	23.4%	152,789
IMPERIAL	123,430	29.0%	35,795
MERCED	175,095	23.0%	40,272
STANISLAUS	367,295	22.3%	81,907
TULARE	298,055	24.8%	73,918
California	27,958,916	18.4%	5,144,440

There is a high prevalence of chronic disease in the five counties. The percentage of adults that are clinically obese (29%) is significantly higher than the statewide figure (22%) (Figure I).[14] The data also indicates that while the numbers of obese adults are falling state and nationwide, there is actually an increase beginning in 2011 in the five counties.

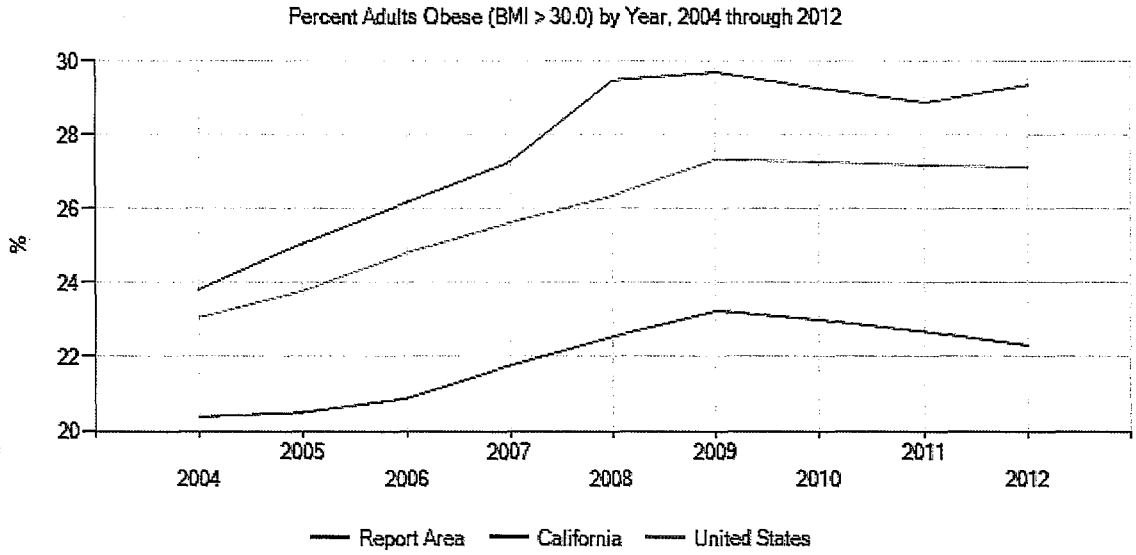
[11] U.S. Census Bureau. (2011). American fact finder. Annual estimates of the resident population for selected age groups by sex: April 1,2012 to July 1, 2011 Population estimates. Retrieved from http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP_2011_PEPAGESEX&prodType=table

[12] Centers for Disease Control and Prevention, Public Health Surveillance and Informatics Program Office. Behavioral Risk Factor Surveillance System, Fair or poor health: adults (percent). Retrieved from http://www.healthindicators.gov/Indicators/Fair-or-poor-health-adults-percent_5/Profile/Download

[13] Extrapolated adult population with poor/fair health in each region was calculated by multiplying the adult (18 over) population with age-adjusted percent reporting fair or poor health.

[14] Clinically obese is defined as a body mass index that exceeds 30.

FIGURE I: Percent of Obese Adults[15]



Access to Care and Insurance Coverage Prior to ACA

Prior to the implementation of the Patient Protection and Affordable Care Act (ACA) many of the residents in these counties were without access to health care. For example, data collected from the Behavioral Risk Factor Survey (BRFSS) between 2011 and 2012 indicated that at least one out of every four adults in each of the five counties studied reported not having a person they dub as their medical provider (Table IV).[16] Additionally, all five counties had higher percentages on this indicator than the national figure (22%) with Imperial the highest at 45 percent and Fresno the lowest at 25 percent.

[15] Centers for Disease Control and Prevention. (2012). National Center for Chronic Disease Prevention and Health Promotion, Obesity. Retrieved from http://assessment.communitycommons.org/CHNA/report?page=6&id=603
[16] BRFSS includes this question in its survey to identify areas where increasing access might demonstrate measurable differences in reducing the incidence of preventable health issues and emergency department visits.

TABLE IV: Adults Without A Regular Doctor[17]

Report Area	Survey Population (Adults 18+)	# of Adults without a Person they think of as their Health Provider	% of Adults without a Person they think of as their Health Provider
FRESNO	690,843	173,073	25.1%
IMPERIAL	132,314	59,499	45.0%
MERCED	181,471	60,628	33.4%
STANISLAUS	410,720	118,579	28.9%
TULARE	385,288	128,986	33.5%
California	*28,234,219*	*7,660,782*	*27.1%*
United States	*236,884,668*	*52,290,932*	*22.1%*

The counties differ on the amount of employment-based health insurance offered. Imperial (34%), Fresno (34%) and Tulare (28%) have the highest amounts of employers not offering health benefits in the 2011-12 year (Table V). Merced (20%) and Stanislaus (21%) have rates that are similar to California (19%) on employment health benefits.

TABLE V: Employment Health Benefits Acceptance and Eligibility[18]

Report Area	Accepted health benefits	Eligible for benefits, but did not accept	Not eligible for benefits offered by employer	Employer didn't offer health benefits
FRESNO	50.1%	8.0%	8.4%	33.5%
IMPERIAL	54.7%	7.8%	3.3%	34.2%
MERCED	56.3%	9.3%	14.8%	19.6%
STANISLAUS	63.1%	9.8%	5.7%	21.4%
TULARE	47.3%	15.6%	8.8%	28.3%
California	59.9%	11.9%	8.9%	19.3%

The uninsured population also experienced no regular access to health care before the ACA. The 2011-2012 California Health Interview Survey (CHIS) data indicated that prior to the ACA, between 42 and 55 percent of uninsured respondents reported that they had no usual source of care in the five counties studied (Table VI). Of those with a source of care, between 23 and 44 percent indicated that clinics were their usual source of health care. Seventeen to 31 percent of the uninsured responded they received care from a doctor or some type of health management organization (HMO).

[17] Centers for Disease Control and Prevention. (2012). Behavioral Risk Factor Surveillance System. Retrieved from http://assessment.communitycommons.org/CHNA/report?page=4&id=504
[18] California Health Interview Survey. (2012). Filters used: Geographic area: Fresno, Imperial, Merced, Stanislaus, Tulare, California; Topic: Employer health benefits acceptance/eligibility.

TABLE VI: Regular Source of Care for the Uninsured[19]

Report Area	Doctor's Office/ HMO/Kaiser		Clinics/Hospital		ER/Urgent Care		Some other place/No one place		No usual source of care	
	# Adults	%	# Adults	%	# Adults	%	# Adults	%	# Adults	%
FRESNO	19,000	19.4%	31,000	31.7%	7,000	7.4%	-	-	7,000	41.6%
IMPERIAL	6,000	31.0%	5,000	23.3%	-	-	-	-	9,000	45.3%
MERCED	5,000	16.5%	9,000	28.1%	-	-	-	-	17,000	55.1%
STANISLAUS	9,000	18.1%	13,000	26.2%	2,000	3.6%	-	-	2,000	51.4%
TULARE	17,000	23.8%	17,000	44.4%	-	-	-	-	32,000	45.3%
California	714,000	17.8%	1,212,000	30.3%	83,000	2.1%	66,000	1.6%	1,927,000	48.2%

Note: Number of adult respondents rounded to nearest 1,000.

Health Care Delivery System and Finances Prior to ACA

The following table (Table VII) quantifies the number of hospitals and primary care clinics (federally qualified health center (FQHCs,) look-alikes, county health clinics and others) that makeup much of the health care safety-net in the five counties. The number of hospitals designated as Disproportionate Share Hospitals (DSH) is provided in the table, as well as the number of district hospitals.[20,21] Additionally, the number of Health Professional Shortage Areas (HPSA) is provided.[22] These providers deliver the majority of health services utilized by low-income uninsured individuals and families.

[19] California Health Interview Survey. (2012). Filters used: Geographic area: Fresno, Imperial, Merced, Stanislaus, Tulare specified; Topic: Access & Utilization, Usual Source of Care, Type of usual source of care; Limit population: Age in years (18-64) and Any time during past year without insurance (under 65, had no insurance the entire past year).

[20] Disproportionate Share Hospitals (DSH) receive additional state and federal funds to help offset the costs of delivering care to low income uninsured individuals.

[21] District hospitals are public facilities that are locally controlled and supported by local property taxes. They can also qualify to receive federal matching payments for their local Certified Public Expenditures for their Medi-Cal and uninsured patients.

[22] Health Professional Shortage Areas (HPSAs) are designated by HRSA as having shortages of primary care, dental care, or mental health providers and may be geographic (a county or service area), population (e.g., low income or Medicaid eligible) or facilities (e.g., federally qualified health centers, or state or federal prisons).

TABLE VII: Safety-Net System Overview

Report Area	Population[23]	Total # of Hospitals[24]	# of DSH[25]	# of District Hospitals[26]	Total # of Clinics[27]	# of PC HPSA Clinics[28]
FRESNO	965,974	6	3	1	38	2
IMPERIAL	179,091	2	2	1	8	2
MERCED	266,353	2	2	0	16	3
STANISLAUS	531,997	5	2	0	16	1
TULARE	458,198	3	3	3	18	3

Clinical Services Provided

The following tables present aggregate clinic and hospital utilization and revenue data in the Central Valley (Fresno, Kern, Kings, Madera, Merced, San Joaquin, Stanislaus and Tulare) and Imperial County from the Office of Statewide Health Planning and Development (OSHPD). In general, Medi-Cal patients and the uninsured are seen the most by clinics.

More than half of the patients on clinic rosters are Medi-Cal patients. According to OSHPD clinical data for 2013, in the Central Valley region approximately 54 percent of all clinic patient visits were provided to Medi-Cal enrolled patients, accounting for 66 percent of the total patient revenue collected by the clinics (Table VIII and IX). Medi-Cal patients seen in Imperial County FQHC clinics made up approximately 53 percent of visits. This accounted for 66 percent of revenues collected by the clinics (Table X).

The next highest portion of clinic visits was from uninsured patients. Visits from uninsured patients made up nearly 30 percent of all visits at clinics in the Central Valley and 25 percent of all visits in Imperial County (Table VIII and X). In the Central Valley, revenue collected from uninsured patients was about 20 percent of total patient revenues (Table IX). In Imperial, where nearly 25 percent of all visits were provided to uninsured patients, the revenue generated totaled only about 17 percent of collections from patients (Table X). Self-pay (8.9%) and Family PACT funds (7.3%) were the primary sources of payment for the Central Valley clinics' uninsured (Table IX). County funds including the now discontinued Medically Indigent Services Program (MISP) (8.2%) accounted for a much larger share of Imperial clinics uninsured revenues followed by funds from the Child Health and Disability Prevention program (3.5%) (Table X).

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[23] U.S. Census Bureau. (2014). Annual estimates of the residents population: April 1, 2010 to July 1, 2014, 2014 population estimates. Retrieved from http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP_2014_PEPANNRES&src=pt

[24] State of California, OSHPD. (2013). Hospital annual financial data. Retrieved from http://www.oshpd.ca.gov/HID/Products/Hospitals/AnnFinanData/CmplteDataSet/index.asp

[25] State of California, OSHPD. (2010). Disproportionate share hospitals. Retrieved from http://gis.oshpd.ca.gov/atlas/topics/dsh

[26] State of California, OSHPD. (2013). Hospital annual financials. Retrieved from http://www.oshpd.ca.gov/HID/Products/Hospitals/AnnFinanData/CmplteDataSet/index.asp

[27] State of California, OSHPD. (2013). Primary care and specialty clinics annual utilization data. Retrieved from http://www.oshpd.ca.gov/hid/Products/Hospitals/Utilization/PC_SC_Utilization.html

[28] U.S. Department of Health and Human Services. (2015). HPSA find. Retrieved from http://datawarehouse.hrsa.gov/tools/analyzers/hpsafind.aspx

Patients with private insurance are not a large source of revenue for either region. The revenue generated through reimbursements from private insurance patients generated less than 10 percent of total patient revenue in the Central Valley (7.0%) and Imperial (2.3%) (Table IX and X).

Clinics with full FQHC status generate a significant amount of operating revenue from their federal §330 grant and other federal grants. In 2013, this funding contributed more than $60 million or 18.4 percent of the operating revenue for all FQHCs in the Central Valley.[29] For FQHCs in Imperial, federal §330 grants totaled $3.4 million and constituted 19 percent of their operating revenue.[30]

There is a scheduled reduction in federal §330 grants in 2017, which was postponed from a 2015 start date.

TABLE VIII: Central Valley Clinics Patient Visits by Insurance - 2013[31]

	FQHC		NON-FQHC		FQHC LOOK ALIKE		ALL CLINICS	
	Total	%	Total	%	Total	%	Total	%
Medicare	167,461	7.1%	35,622	10.2%	8,074	4.8%	211,157	7.4%
Medicare FFS	*154,939*	6.6%	*31,027*	8.9%	*8,074*	4.8%	*194,040*	6.8%
Medicare MC	*12,522*	0.5%	*4,595*	1.3%	*0*	0.0%	*17,117*	0.6%
Medi-Cal	1,311,416	55.8%	98,013	28.1%	124,836	73.8%	1,534,265	53.5%
Healthy Families	15,554	0.7%	391	0.1%	249	0.1%	16,194	0.6%
Private	178,803	7.6%	60,726	17.4%	5,366	3.2%	244,895	8.5%
Other Coverage	6,544	0.3%	3,748	1.1%	5,806	3.4%	16,098	0.6%
Uninsured	671,501	28.6%	150,893	43.2%	24,722	14.6%	847,116	29.5%
County/MISP	*16,346*	0.7%	*2,011*	0.6%	*0*	0.0%	*18,357*	0.6%
Self-Pay	*481,930*	20.5%	*9,893*	2.8%	*11,714*	6.9%	*503,537*	17.5%
Breast Cancer	*21,703*	0.9%	*1,105*	0.3%	*86*	0.1%	*22,894*	0.8%
Child Health and Disability Prevention	*51,244*	2.2%	*911*	0.3%	*8,807*	5.2%	*60,962*	2.1%
Family PACT	*80,042*	3.4%	*115,878*	33.2%	*3,577*	2.1%	*199,497*	7.0%
TOTAL	2,351,279	100.0%	349,393	100.0%	169,053	100.0%	2,869,725	100.0%

[29] State of California, OSHPD. (2013). Primary care and specialty clinics annual utilization data. Retrieved from http://www.oshpd.ca.gov/hid/Products/Hospitals/Utilization/PC_SC_Utilization.html
[30] State of California, OSHPD. (2013). Primary care and specialty clinics annual utilization data. Retrieved from http://www.oshpd.ca.gov/hid/Products/Hospitals/Utilization/PC_SC_Utilization.html
[31] State of California, OSHPD. (2013). Primary care and specialty clinics annual utilization data. Retrieved from http://www.oshpd.ca.gov/hid/Products/Hospitals/Utilization/PC_SC_Utilization.html

TABLE IX: Central Valley Clinic Patient Revenue - 2013[32]

	FQHC		NON-FQHC		FQHC LOOK ALIKE		ALL CLINICS	
	Total	%	Total	%	Total	%	Total	%
Medicare	$17,839,523	7.2%	$3,965,746	10.7%	$781,231	3.6%	$22,586,500	7.3%
Medicare FFS	*$17,003,642*	*6.8%*	*$3,425,892*	*9.2%*	*$781,231*	*3.6%*	*$21,210,765*	*6.9%*
Medicare MC	*$835,881*	*0.3%*	*$539,854*	*1.5%*	-	-	*$1,375,735*	*0.4%*
Medi-Cal	$171,251,311	68.9%	$10,756,932	29.0%	$19,099,997	87.5%	$201,108,240	65.4%
Healthy Families	$746,090	0.3%	$24,790	0.1%	$37,796	0.2%	$808,676	0.3%
Private	$15,383,717	6.2%	$5,635,435	15.2%	$438,522	2.0%	$21,457,674	7.0%
Other Coverage	$295,665	0.1%	$208,653	0.6%	$484,598	2.2%	$988,916	0.3%
Uninsured	$42,981,126	17.3%	$16,488,100	44.5%	$984,553	4.5%	$60,453,779	19.7%
County/MISP	*2,332,999*	*0.9%*	*212,402*	*0.6%*	-	-	*$2,545,401*	*0.7%*
Self-Pay	*$25,911,264*	*10.4%*	*$847,006*	*2.3%*	*$473,538*	*2.2%*	*$27,231,808*	*8.9%*
Breast Cancer	*$897,987*	*0.4%*	*$81,804*	*0.2%*	*$8,889*	*0.0%*	*$988,680*	*0.3%*
Child Health and Disability Prevention	*$5,383,951*	*2.2%*	*$70,227*	*0.2%*	*$148,670*	*0.7%*	*$5,602,848*	*1.8%*
Family PACT	*$6,834,044*	*2.8%*	*$15,254,853*	*41.1%*	*$353,456*	*1.6%*	*$22,442,353*	*7.3%*
TOTAL	$248,49,432	100.0%	$37,079,656	100.0%	21,826,697	100.0%	$307,403,785	100.0%

TABLE X: Imperial County Clinic - 2013[33]

	Patient Visits by Insurance		Patient Revenue	
	Total	%	Total	%
Medicare	20,903	14.9%	$1,745,783	13.1%
Medicare FFS	*20,903*	*14.9%*	*$1,745,783*	*13.1%*
Medicare MC	*0*	*0.0%*	-	*0.0%*
Medi-Cal	74,828	53.3%	$8,814,834	66.2%
Healthy Families	*1,093*	0.8%	$134,107	1.0%
Private	*8,641*	6.2%	$308,077	2.3%
Other Coverage	*0*	0.0%	-	0.0%
Uninsured	*34,881*	24.9%	$2,311,949	17.4%
County/MISP	*10,739*	*7.7%*	*$1,091,494*	*8.2%*
Self-Pay	*11,859*	*8.4%*	*$339,041*	*2.5%*
Breast Cancer	*1,630*	*1.2%*	*$47,029*	*0.4%*
Child Health and Disability Prevention	*3,935*	*2.8%*	*$461,846*	*3.5%*
Family PACT	*6,718*	*4.8%*	*$372,539*	*2.8%*
TOTAL	140,346	100.0%	$13,314,750	100.0%

[32] State of California, OSHPD. (2013). Primary care and specialty clinics annual utilization data. Retrieved from http://www.oshpd.ca.gov/hid/Products/Hospitals/Utilization/PC_SC_Utilization.html
[33] State of California, OSHPD. (2013). Primary care and specialty clinics annual utilization data. Retrieved from http://www.oshpd.ca.gov/hid/Products/Hospitals/Utilization/PC_SC_Utilization.html

Hospital Services Provided

In terms of hospital utilization by payer, OSPHD data shows Medi-Cal patients as the largest patient groups in both inpatient and outpatient days (Table XI and XII). Hospital days utilized by Medi-Cal patients in the Central Valley comprised more than one-third of inpatient (34.1%) and outpatient (35.2%) total visits and days (Table XI). Imperial hospitals had similar rates of inpatient visits (35.7%) and outpatient days (38.1%) (Table XII).

Medicare and private insurance patients make up the remaining majority of payer types in the Central Valley and Imperial hospitals, after Medi-Cal.

It is important to note that these hospitals utilize various "indigent" funds (county, plus other indigent funds) to cover the uninsured. In the Central Valley indigent funding accounted for about 3.8 percent of inpatient days and 5 percent for outpatient days.[34] Among hospitals in Imperial, total indigent fund payments made up 3.4 percent of inpatient days and about 6 percent of outpatient days. With the State's redirection of a share of the counties' realignment funds, which paid for hospital care to the uninsured through MISP and CMSP, hospitals now rely more on Medi-Cal expansion to fund the newly insured and a combination of DSH funds and Emergency Medi-Cal to pay for the care provided to the remaining uninsured

By design, DSH funding is a program that provides additional Medicaid funds to hospitals that serve a large number of Medicaid and uninsured patients. The reductions in federal Medicaid DSH that were scheduled to begin in 2017, have now been pushed back to 2018. Medicaid DSH hospitals in the Central Valley received more than $258 million in DSH payments in 2013 and DSH hospitals in Imperial received nearly $6.5 million (Table XIII).

Hospitals' charity care and uncompensated care amounts ("bad debt/charity care") are very informative about the populations a hospital serves. A recent article in Health Affairs showed that higher amounts of charity care spent by hospitals is associated with caring for more uninsured, Medicaid and minority patients.[35] The study also showed hospitals with higher amounts of bad debt were associated with more uninsured patients and a greater number of patients living below poverty level.[36] The 2013 OSHPD data showed hospitals uncompensated expenses ("bad debt/charity care") totaled nearly $355 million, while in Imperial these expenses totaled $14 million (Table XIII). This high amounts can thus be attributed to the high rates of uninsured, Medicaid, minority, and patients living below poverty level in these areas.

There is also a Medicare DSH program that pays hospitals with a disproportionate share of Medicare and Medicaid patients. The Medicare DSH reductions have already begun.

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[34] Total indigent percentages calculated by adding "county indigent" + "other indigent" from hospital utilization by payer date in Tables XI and XII.
[35] Valdovinos, E., Le, S., & Hsia, R. Y. (2015). In California, not-for-profit hospitals spent more operating expenses on charity care than for-profit hospitals spent. *Health Affairs, 34*(8), 1296-1303. Retrieved from http://content.healthaffairs.org/content/34/8/1296.full.pdf+html?sid=121f875f-a1eb-4662-9168-65955fa6f60d
[36] Ibid.

TABLE XI: Central Valley Hospital Utilization by Payer - 2013[37]

	Inpatient		Outpatient	
	Days	% of Total Days	Days	% of Total Days
Medicare	621,987	27.8%	1,310,850	25.3%
Medicare FFS	*514,103*	*23.0%*	*1,134,373*	*21.9%*
Medicare MC	*107,884*	*4.8%*	*176,477*	*3.4%*
Medi-Cal	761,992	34.1%	1,827,710	35.2%
County Indigent	58,912	2.6%	175,727	3.4%
Private	305,161	13.6%	1,274,728	24.6%
Other Indigent	26,819	1.2%	82,816	1.6%
Other	462,217	20.7%	513,787	9.9%
TOTAL	2,237,088	100.0%	5,185,618	100.0%

Note: May not up to 100% due to rounding.

TABLE XII: Imperial County Hospital Utilization by Payer - 2013[38]

	Inpatient		Outpatient	
	Days	% of Total Days	Visits	% of Total Days
Medicare	4,296	36.0%	82,172	28.2%
Medicare FFS	*3,958*	*33.2%*	*77,111*	*26.4%*
Medicare MC	*338*	*2.8%*	*5,061*	*1.7%*
Medi-Cal	4,260	35.7%	111,265	38.1%
County Indigent	396	3.3%	15,416	5.3%
Private	2,262	19.0%	67,824	23.2%
Other Indigent	6	0.1%	1,724	0.6%
Other	706	5.9%	706	0.2%
TOTAL	11,926	100.0%	291,864	100.0%

Note: May not add up to 100% due to rounding.

[37] State of California, OSHPD. (2013). Hospital annual financials. Retrieved from http://www.oshpd.ca.gov/HID/Products/Hospitals/AnnFinanData/CmplteDataSet/index.asp
[38] Ibid.

TABLE XIII: Hospital Income- 2013[39]

	Central Valley	Imperial County
Gross Patient Revenue	$30,180,218,380	$1,008,915,144
Net Patient Revenue	$7,420,859,490	$209,333,545
Other Operating Revenue	$173,402,565	$2,441,485
Total Operating Expenses	$7,526,062,841	$216,447,315
Non-Operating Revenue	$451,732,552	$10,394,983
Non-Operating Expenses	$45,741,253	$4,882,673
DSH (SB 855)	$(258,481,672)	$(6,456,281)
Bad Debt/Charity Care	$1,442,450,727	$67,553,507
Bad Debt/Charity Care Adj	$354,676,829	$14,016,258
Net Income	$469,349,161	$840,025
Net Income as a % of Total Oper. Expenses	6.2%	0.4%

[39] State of California, OSHPD. (2013). Hospital annual financials. Retrieved from http://www.oshpd.ca.gov/HID/Products/Hospitals/AnnFinanData/CmplteDataSet/index.asp

Part II: INSURANCE COVERAGE RATES CHANGES AFTER the IMPLEMENTATION OF THE AFFORDABLE CARE ACT

Pre Affordable Care Act

Prior to the implementation of the Affordable Care Act, the American Community Survey (ACS) estimated that more than 6.6 million California residents were uninsured (Table VI). This constituted nearly 18 percent of all Californians. CHIS 2011-12 data corroborates this number, indicating the number of non-elderly Californians who reported having been uninsured for all or part of the past year was 21 percent.[40] Half of these uninsured individuals were full-time working families.[41] Of the five counties studied, approximately 20 percent of residents were uninsured in 2013 according to the ACS (Table XIV).

TABLE XIV: Insurance Status for Counties[42]

Report Area	Total population (with/known insurance status)	Population with any insurance	% Insured Population	Total Medicaid Insured Population	% Medicaid Population	Total Uninsured Population	% Uninsured Population
FRESNO	927,913	746,473	85.1%	290,765	*39.0%*	181,440	*19.6%*
IMPERIAL	164,921	129,824	82.2%	54,796	*42.2%*	35,097	*21.3%*
MERCED	255,713	206,645	80.4%	83,186	*40.3%*	49,068	*19.2%*
STANISLAUS	514,872	423,034	78.7%	132,645	*31.4%*	91,838	*17.8%*
TULARE	442,333	347,361	80.8%	139,712	*31.6%*	94,972	*21.5%*
California	37,130,876	30,529,357	82.2%	7,146,678	*23.4%*	6,601,519	*17.8%*
U.S.	306,448,495	260,878,830	78.5%	52,714,286	*20.2%*	45,569,665	*14.9%*

Post Affordable Care Act: Medi-Cal

California's decision to expand Medicaid resulted in many more families and individuals receiving health insurance. The expansion led to an additional 2 million covered by the State's Medicaid program, Medi-Cal after the first open enrollment.[43] Today, total Medi-Cal enrollments numbers are upward of 12 million, up from 9 million before the expansion.[44] There was a 56 percent increase in Medi-Cal enrollment between January 2013 to April 2015, with Healthy Families enrollees transitioning to Medi-Cal managed care during this time period.[45,46]

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[40] Charles, Jacobs et al. (2014). The state of health insurance in California. UCLA Center for Health Policy Research. Retrieved from http://healthpolicy.ucla.edu/publications/Documents/PDF/2014/shicreport-dec2014.pdf
[41] Ibid.
[42] U.S. Census Bureau. American fact finder. ACS demographic and housing estimates, 2009-2013 American Community Survey 5-year estimates. Retrieved from http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_13_5YR_S2701&prodType=table
[43] Covered California. (Apr 2014). Covered California enrollment statistics. Retrieved from http://news.coveredca.com/2014/04/covered-californias-historic-first-open.html
[44] State of California, Department of Health Care Services – Research and Analytical Studies Section, "Medi-Cal Statistical Brief, Medi-Cal Eligibles 24-Month Trend at May 2015 – Advance Counts," Jun 2015. Retrieved from http://www.dhcs.ca.gov/dataandstats/statistics/Documents/Enrollment_May2015_final.pdf
[45] State of California, Department of Health Care Services – Research and Analytical Studies Section, "Medi-Cal Statistical Brief, Medi-Cal Monthly Eligibles Trend Report for January 2014 " Jan 2014. Retrieved from

A recent longitudinal survey from Kaiser Family Foundation stated that 68 percent of those uninsured in California before the implementation of the ACA are now insured.[47]

Table XV highlights the tremendous gains in the number of Medi-Cal enrollees from pre-ACA to the present in the five counties. Between September 2013 and May 2015, the number of Medi-Cal managed care enrollees doubled in Stanislaus (185%). Fresno (38%), Merced (45%) and Tulare (33%) also had high enrollment increases during this time. All together, an additional 429,920 individuals were enrolled in Medi-Cal managed care since September 2013 in the five counties. All studied counties mounted expansive enrollment efforts in order to achieve these enrollment increases.

TABLE XV: Medi-Cal Enrollment 9/13 and 5/15[48,49]

Report Area	Enrolled in Medi-Cal managed care 9/13	Enrolled in Medi-Cal managed care 5/15	Difference	% Change
FRESNO	255,540	352,377	96,837	38%
IMPERIAL	-	68,847	-	-
MERCED	83,864	121,979	38,115	45%
STANISLAUS	98,020	278,947	180,927	185%
TULARE	137,980	183,174	45,194	33%
California	5,923,257	9,552,752	3,629,495	61%

One major source of Medi-Cal managed care enrollment was due to the well-coordinated efforts by the five counties in transitioning enrollees in the MISP and Low Income Health Program (LIHP) into Medi-Cal (Table XVI). Stanislaus (98%) and Tulare (94%) had the highest transition rates of their LIHP members enrolled in Medi-Cal. In Merced, 1,300 MISP participants transitioned to Medi-Cal out of a total of 1,600 participants. Most of Fresno's MISP participants were also transitioned, between 68 and 74 percent. Many of those not transitioned were undocumented individuals that were not eligible for Medi-Cal coverage. Imperial County LIHP enrollees transitioned to Medi-Cal under the CMSP, which includes several small rural counties.

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http://www.dhcs.ca.gov/dataandstats/statistics/Documents/RASB_Issue_Brief_Medi-Cal_Eligibles_Trend_Report_for_January_2014%20(Feb%202014).pdf

[46] State of California, Department of Health Care Services – Research and Analytical Studies Section, "Medi-Cal Statistical Brief, Medi-Cal Certified Eligibles Statewide Pivot as of May 2015 " May 2015. Retrieved from http://www.dhcs.ca.gov/dataandstats/statistics/Pages/Medi-Cal-Certified-EligiblesRecentTrends.aspx

[47] Kaiser Family Foundation. (Jul 2015). New survey finds 68 percent of previously uninsured adult Californians gained coverage since the ACA's implementation. Retrieved from http://kff.org/health-reform/press-release/new-survey-finds-68-percent-of-previously-uninsured-adult-californians-gained-coverage-since-the-acas-implementation/

[48] State of California. (Oct 2013). Department of Health care Services. Medi-Cal Managed Care Enrollment Reports – September 2013. Retrieved from http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Enrollment_Reports/MMCDEnrollRptSep2013.pdf

[49] State of California. (Jun 2015). Department of Health care Services. Medi-Cal Managed Care Enrollment Reports – May 2015. Retrieved from http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Enrollment_Reports/MMCEnrollRptMay2015.pdf

TABLE XVI: Enrollees Transitioned from MISP/LIHP to Medi-Cal[50,51,52]

Report Area	MISP/LIHP Enrollment	Transitioned to Medi-Cal	% Enrolled in Medi-Cal
FRESNO	19,000	13,000 - 14, 000	68% - 74%
IMPERIAL	-	-	-
MERCED	1,600	1,300	81%
STANISLAUS	9,000	8,800	98%
TULARE	3,699	3,484	94%

Post Affordable Care Act: Covered California

The implementation of the ACA and its establishment of the state-based health exchange, Covered California, resulted in many individuals and families with health care coverage. During the first open enrollment Covered California enrolled 1.4 million people.[53] During the second open enrollment an additional 500,000 signed up for coverage with Covered California.[54] The Central Valley and Imperial counties have had success in enrolling individuals and families in Covered California. Over the past two open enrollment periods more than 88,000 individuals have enrolled in Covered California in the five counties (Table XVII).

TABLE XVII: Enrollment in Covered California by County[55]

Report Area	First Open Enrollment		Second Open Enrollment	
	Number Enrolled	% of State Total after 1st Enrollment	Number Enrolled	% of State Total after 2nd Enrollment
FRESNO	23,164	1.7%	8,475	1.7%
IMPERIAL	4,401	0.3%	2,441	0.5%
MERCED	8,403	0.6%	2,931	0.6%
STANISLAUS	18,504	1.3%	6,052	1.2%
TULARE	9,832	0.7%	4,018	0.8%
California	1,395,929	100%	495,073	100%

Note: Data include individuals who finished their applications and selected plans though February 22, 2015.

[50] Interviews with county departments of public health provided the number of enrollees transitioned from MISP to Medi-Cal for Merced, Stanislaus and Tulare.
[51] The County of Fresno. (Aug 2014). Board briefing report, Update regarding the Medically Indigent Services Program and Community Medical Centers Agreement. Retrieved from http://www.co.fresno.ca.us/WorkArea//DownloadAsset.aspx?id=60019
[52] UCLA Center for Health. (Dec 2013). Low income health program performance dashboard. Retrieved from http://healthpolicy.ucla.edu/programs/health-economics/projects/coverage-initiative/Documents/Dashboard_Tulare.pdf
[53] Covered California. (Apr 2014). Covered California enrollment statistics. Retrieved from http://news.coveredca.com/2014/04/covered-californias-historic-first-open.html
[54] Covered California. (2015). 2015 Regional open enrollment data. Retrieved from http://hbex.coveredca.com/data-research/library/OE2-regional-tables.pdf
[55] California Health Benefits Exchange. (2015). 2015 Regional open enrollment data. Retrieved from http://hbex.coveredca.com/data-research/library/OE2-regional-tables.pdf

Part III: COMPOSITE SUMMARY OF STAKEHOLDER INTERVIEWS

This section is a composite of more than 20 interviews with stakeholders from Fresno, Imperial, Merced, Stanislaus and Tulare. The categories of stakeholders varied by location. The study's goal was to interview representatives from the Departments of Public Health, behavioral health services, community clinics, local hospitals, Medi-Cal health plans, and others involved in caring for the newly insured and remaining uninsured populations to get detailed information of their successes and challenges before and after the implementation of the ACA.

Highlights from Stakeholder Interviews

Stakeholders provided insight into several key factors about the transitions that took place after the implementation of the ACA. Major themes identified included:

- *Significant reductions in the number of uninsured individuals following implementation of the ACA.*
- *Characteristics of the remaining uninsured are described below:*
    - *Half are undocumented residents.*
    - *Perhaps, as much as 50 percent would meet the qualifications, both in terms of income and residency, for either Medi-Cal or Covered California tax credits.*
    - *In most of the counties they are long-term residents who speak either Spanish or, in some counties, a Southeast Asian language as their primary language.*
    - *Many have developed a renewed distrust of government due to recent efforts to stem illegal immigration.*
- *FQHCs provide much of the region's care for the newly insured and remaining uninsured residents. Due to this influx of insured clients, clinics are adding new facilities and would like to broaden the scope of services offered at sites.*
- *Despite significant increases in the number of insured residents, some emergency departments in the region are still experiencing high levels of emergency room usage for ambulatory care sensitive conditions.*
- *Rural health clinics serve as an important source of specialty care for the newly insured and remaining uninsured, but they are also a source of competition for primary care services offered by FQHCs.*
- *In the majority of communities, behavioral health services are provided to low-income residents by a mix of community clinics that provide care for those with sub-acute behavioral health conditions and county behavioral health agencies that provide care for acute behavioral health conditions.*
- *Strong collaborations among the safety-net providers in each of the five counties demonstrated solid problem solving to find better ways to care for the most vulnerable populations.*

A. Overview of County's Health Care System, the Newly Insured and the Remaining Uninsured

Merced and Stanislaus Counties

Health Care System

FQHCs provide much of the primary care for Merced and Stanislaus' newly insured Medi-Cal beneficiaries as well as their remaining uninsured. FQHCs Golden Valley Health Centers (GVHC) and Livingston Community Health Services serve residents in both Merced and Stanislaus. Castle Family Health Centers, an FQHC look-alike, cares mostly for Merced residents. Stanislaus county-operated clinics provide primary and some specialty care for their local uninsured residents.

GVHC is working with Mercy, Sutter and Doctors Medical Center (DMC) hospitals for formal transfer and admitting arrangements, as well as agreements to deliver discounted hospital services for GVHC's uninsured patients. GVHC also has arrangements with Valley Children's Hospital to treat GVHC children.

Mercy Medical Center, a hospital in Merced, operates an ambulatory care clinic staffed by UC Davis (UCD) residents. If patients treated in the emergency room (ER) do not have a medical home the UCD residents will care for them. Patients with medical homes are discharged back to their primary care providers.

Emergency Department Utilization

Despite significant increases in the number of newly insured that could be taking advantage of primary care services, emergency departments in the region are still experiencing high levels of ER use for ambulatory care sensitive conditions (ACSC). In some cases ER utilization is increasing; one estimate of this trend is as much as a 42 percent increase with no corresponding increase in hospitalizations or acuity of presenting conditions. Merced is also experiencing an increase in ambulance transports.

The over-loaded primary care system in these counties as well as affordability issues may be the reasons for such high ER utilization. Stakeholders stated there are delays in scheduling for primary care visits and limited availability of evening and weekend appointments. As an immediate solution to high ER utilization, Mercy emergency department (ED) has increased staff from Friday evening through Monday to meet the demand for weekend services. Issues of affordability have also come up during the Merced Building Health Communities Project with the uninsured community informing partners about their difficulty paying the required $30 to $40 cost for clinic visits.

Behavioral Health Services

Access to behavioral health services is growing in Merced. First, GVHC has hired and placed behavioral health specialists in the clinic. This is a significant step towards a more integrated/whole health care model as patients can be immediately linked to behavioral health services. Additionally, Merced Behavioral Health Agency is growing in several respects including, 1) expanding regional psychiatric bed capacity, 2) placing psychiatric nurses at

hospitals in Merced and Livingston, and 3) establishing a mobile crisis team. Increasing the number of regional psychiatric beds will allow patients with serious mental illness requiring institutional care to be treated regionally instead of being transferred to Bay Area facilities. Care coordination will likely improve with on-site psychiatric nurses and the newly deployed mobile crisis unit. Lastly, Mercy Hospital, in partnership with the Central California Alliance for Health (The Alliance), has established a halfway recovery house for homeless individuals following hospital discharge. The facility's goal is to reduce the number of re-admits among this population.

Newly Insured Population

According to stakeholders, approximately 45 percent of all Merced residents are now enrolled in Medi-Cal. An astoundingly high percentage (81%) of MISP participants were successfully transitioned in Medi-Cal. Stakeholders in these counties noted a significant decrease in the number of uninsured clients in the clinic system, with a high of 25 percent uninsured clients, pre-ACA, down to approximately nine percent following ACA implementation. Castle Family Health Center, in Merced, noted that only about three percent of the Center's current patients remain uninsured. Additionally, Merced's Department of Mental Health has seen an increase of 800 newly insured patients after ACA implementation.

Health Plan of San Joaquin (HPSJ) stakeholders noted that its number of subscribers has grown by 110,000 from February 2014 to today due to the community-wide collaborative effort to enroll all ACA eligibles. HPSJ also stated that in Stanislaus there is sufficient primary care capacity and the local clinics are mature infrastructures well versed in the delivery of managed care services. However, there is a big need to educate the newly insured on how to use covered services appropriately to avoid unnecessary ER usage. Specialty care access was less of a problem in Stanislaus due to the County's specialty clinic and HPSJ's two-county (Stanislaus and San Joaquin) regional specialty care network. HPSJ did note gaps in orthopedics and dermatology specialty care access. One solution for dermatology has been a telederm program in which the primary care physicians takes pictures of a patient's dermatology problem and then sends it to a specialist in the Bay for an initial consult. This saves patients time and money from having to make the long trip to the Bay or Sacramento.

Remaining Uninsured

According to The California Endowment's, Building Healthy Communities, as many as 24,000 Merced residents are undocumented, of which 54 percent are uninsured. In order to enroll more of the remaining uninsured, HPSJ noted that they are engaging with small-businesses through local business chambers of commerce for a more targeted outreach approach.

Fresno and Tulare Counties

Health Care System

Clinica Sierra Vista in Fresno and Family Health Care Network (FHCN) in Tulare are FQHCs that provide comprehensive health services through extensively integrated models of care. Both operate on extended hours; some of FHCN's clinics operate seven days a week, are open until 9:00pm at most sites and provide care on a walk-in basis. Both clinic systems provide some specialty care, including obstetrics (OB) and pediatrics, and some of the physicians on staff have

admitting privileges at local hospitals.

Fresno County's Clinica Sierra Vista offers additional specialty care including behavioral health services, podiatry and diabetes management. They recently opened their first school-based health center in the fall of 2014. Services are provided to children up to age 19 and behavioral health services are available on site.

Tulare County's FHCN has an expansive physician network and offers an array of services. OBs and adult medicine physicians from FHCN serve at least one day a week as hospitalists. In order to attract specialists at their clinics, FHCN handles specialists' billing services and provides them with free office space. FHCN OBs handle all aspects of OB care for their patients including inpatient and outpatient services. FHCN has also developing a partnership with Sierra View District Hospital to provide additional specialty care services for FHCN's Medi-Cal and uninsured patients. Lastly, FHCN is in the process of building a durable medical equipment (DME) service as low-income county residents have little access to these resources.

Most of FHCN's patients are Spanish-speaking farmworkers, though they also serve individuals from the Laotian population and Hmong and Oaxacan Indian communities. Of FHCN's 127,000 total clients, 94,000 have incomes below 100 percent FPL and an additional 19,000 clients have incomes between 100 and 200 percent FPL.

Tulare County Health and Human Services Agency operates a county clinic network consisting of three clinics that are FQHC look-alikes. They mostly serve the Medi-Cal and uninsured populations. The undocumented are seen on a sliding fee scale. Their biggest challenge is securing specialty care access for their patients. FHCN tries to fill in this access gap by providing OB support and dental services for Tulare County clinic patients. To further improve care coordination between hospitals and the clinics, the county employs hospitalists to manage discharge planning for all patients.

Community Regional Medical Center and Children's Hospital Central California are the only hospitals in Fresno that accept Medi-Cal patients. UC San Francisco (UCSF) Faculty Practice physicians provide specialty care at Community Regional. Community Regional is the primary specialty care provider for five counties. Community Regional employs a transition clinic to care for uninsured and newly Medi-Cal insured patients after they are discharged from the ER. Many patients after discharge find difficulties seeing a primary care physician within the seven to ten days that are so important to prevent avoidable readmissions. To address this, the transition clinic was setup. A specialty/primary care partnership with Valley Health team, an FQHC, is also being developed at Community Regional. This partnership process should be finalized in the spring.

As seen in other counties, local hospitals are building rural health clinics (RHC). The RHCs compete with FQHCs for Medi-Cal patients, but do not treat the uninsured.

There is need for a greater primary care workforce. Due to the fact that more clinics are being built, there will be even greater competition for the limited number of federally subsidized loans and available scholarships.

Emergency Department Utilization

A representative from Health Net stated that Medi-Cal utilization of the local ERs was high, but there have not been recent increases in ER utilization since the ACA in either Fresno or Tulare. A Community Regional Medical Center representative reported that 36% of the patients seen in the ER should not be using the ED for their specific health care issue, however due to shortages, individuals are unable to make appointments with their primary care provider. Although the level of ER utilization has not increased, unlike Merced and Stanislaus Counties, there is a need for urgent care access, more timely primary care appointments, longer hours and better patient education to reduce inappropriate ER use.

Behavioral Health Services

There are limited behavioral health resources in the region due to an insufficient workforce and an increased demand for behavioral health services due to the recent Medi-Cal expansion. The workforce problem is an ongoing issue as recruitment of behavioral health specialists is especially challenging in rural regions. Primary care clinics in Tulare and Fresno provide significant levels of the behavioral health services to their clients, but care coordination is lacking between all parties to meet the behavioral health needs of the newly insured and uninsured. Fresno County behavioral health services are becoming better integrated as the County employs social workers and funds a psychiatrist for the local clinics. Tulare County clinics stated one of their biggest challenges is care coordination and behavioral health integration.

Newly Insured Population

The Fresno Department of Public Health, Fresno Healthy Communities Access Partners (FHCAP) and many other Fresno health care providers all came together to enroll a large proportion of Fresno's uninsured in Medi-Cal and Covered California. FHCAP has had much success in signing up uninsured individuals. Large portions (30%) of FHCAP's Medi-Cal enrollees are Permanently Residing in the United States under the Color of Law (PRUCOL) and Deferred Action for Childhood Arrivals (DACA) residents.[56]

Fresno's Clinica Sierra Vista noted that the percentage of uninsured clients they serve has declined from 35 percent prior to the ACA, to 21 percent. Of this 21 percent, Clinica Sierra Vista estimates that about half would qualify for Medi-Cal or Covered California tax credits. The remaining half is likely those that are undocumented.

Before the ACA Community Regional had 18-19,000 individuals enrolled in medically indigent programs. They assumed 80% would go to Medi-Cal and the remaining 20% would be cared for through hospital charity and debt. Local stakeholders reported that many of the remaining 20% uninsured were determined eligible under PRUCOL for full-scope Medi-Cal.

Although much of Fresno's realignment funds going back to the State, the County does offer financial hardship waivers. These waivers offer county coverage to modest income residents who missed Covered California open enrollment deadlines. The program does not have any participants at this time.

[56] PRUCOL enables long-term residents, who are known to the U.S. Citizenship and Immigration Services and have applied for, or received DACA status, are able to receive full scope Medi-Cal benefits.

In Tulare, current estimates indicate that as much as 45 percent of Tulare's population is now enrolled in Medi-Cal. The County's Department of Public Health teamed up with local FQHCs to enroll 41,000 Medi-Cal eligibles, increasing total Medi-Cal enrollment from 165,000 to 206,000. FHCN reported that their uninsured rate fell from 35 percent of their patient population, prior to the ACA, to 22 percent.

Remaining Uninsured

FHCAP noted that the remaining uninsured are long-term residents of the County who work in the agriculture business. They are largely Spanish speaking and undocumented. Tough immigration efforts have nearly eliminated the flow of new undocumented residents to Fresno. FHCAP staff has also noticed a marked increase in the populations' distrust of government. Statistics published by the Migration Policy Institute estimate 11,000 undocumented residents Fresno County could immediately qualify for DACA and an additional 8,000 can qualify based on education and age requirements.[57] Approximately 50,000 parents of U.S. citizens could qualify for a comparable adult program, Deferred Action for Parents of Americans (DAPA).[58] However due to the growing distrust of government, obtaining DAPA, DACA and lawful permanent resident statistics is difficult at best.

Imperial County

Health Care System

Imperial's only FQHC, Clinicas de Salud del Pueblo (Clinicas) provides primary and specialty care for the County's Medi-Cal and uninsured populations. Clinicas offers primary care until 10pm on most nights and operates an after hour center that is open until 10pm and will soon expand closing hours to midnight. They recently took over a local OB practice that was due to close. Clinicas' OBs and pediatricians have admitting privileges at local hospitals (El Centro Regional Medical Center and Pioneer Memorial Hospital) and serve as hospitalists. Specialists see Medi-Cal patients at the Clinicas clinic, but do not treat these patients in their private practices. Clinicas is excited about its collaboration with UCSD and Connecting Care in which UC San Diego (UCSD) doctors using telemedicine treatment technology will deliver specialty services to patients.

The majority of Clinicas' patients are now enrolled in Medi-Cal managed care. Approximately 85 percent of Clinicas' clients are Hispanic.

El Centro Regional Medical Center (ECRMC) is a 161-bed hospital serving Imperial Valley. It also operates two RHCs, one in El Centro and the other in Calexico, that serve the region's Medi-Cal patients. The El Centro RHC recently absorbed the Imperial Valley Women's Clinic, increasing its women's services. Calexico RHC is increasing provider capacity by adding more exam rooms. ECRMC is tightly aligned with Clinicas and provides Clinicas patients with specialty and inpatient care. ECRMC is aligned with UCSD Medical Center and Medical School.

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[57] Migration Policy Institute. (2013). Deferred Action for Childhood Arrivals (DACA) profile: Fresno County, CA. Retrieved from http://www.migrationpolicy.org/content/fresno-county-ca

[58] Migration Policy Institute. (2013). Unauthorized immigrant populations by county and region, top state and county destinations, 2009-13. http://www.migrationpolicy.org/programs/data-hub/charts/unauthorized-immigrant-populations-country-and-region-top-state-and-county

UCSD is providing management and human resources support to improve hospital efficiency. UCSD will also send residents for rotations at the hospital. ECRMC uses San Diego's Health Insurance Exchange (HIE) to connect with local clinics and San Diego area hospitals.

Pioneer Memorial Hospital, in the city of Brawley, also treats Imperial County patients. Pioneer Memorial Hospital is opening an RHC in Brawley, and also has an RHC in Calexico

Emergency Department Utilization

ECRMC sees 50,000 patients a year in its ER, a number that is on par with ER use in much larger metropolitan cities. Due to the fact that ECRMC saw so many ER visits before the ACA, there has not been an additional increase in the already high number of visits. The ER's 12 beds are frequently full and patients are stationed in the hallways. A contributing factor to the overflow of patients in the ER is that there are not enough practicing physicians in the community. As a result, there is an insufficient supply of primary care and specialty care providers. ECRMC also noted nurse retention challenges resulting in a low supply of experienced nurses. Increased capacity for primary care providers would help to relieve ER overcrowding. Partnerships with UCSD, San Diego State University and San Diego hospitals may be the best way for Imperial to meet the serious provider shortages.

Behavioral Health Services

Imperial County's Behavioral Health Services (BHS) provides the majority of behavioral health care to low-income Imperial residents. In partnership with Clinicas, they have put in place an approach that is unique among the five counties interviewed for this study; they have become the primary provider of all behavioral health services for the County's Medi-Cal and uninsured populations. BHS contracts with all the Medi-Cal insurers and provides behavioral health services to most of the local hospitals' and Clinicas patients. This unique set-up came out of necessity due to increasingly unmet needs in the community. BHS is also part of a collaborative with ECRMC to establish a psychiatric resident rotation.

Interviewees, including BHS and ECRMC, stated that there is a dire need for more psychiatric beds. The county mental health facility is frequently full to capacity. ECRMC is working with Alvarado Medical Center in San Diego to increase the number of psychiatric beds, and to provide additional behavioral health resources in the community.

Newly Insured

Prior to the ACA, 11 percent of Clinicas clients were uninsured, but by the end of 2014, this percentage decreased to four. ECRMC reports that uninsured self-pay patients have declined by 10% as a result of the ACA. An estimated 40 percent of the newly insured come to Clinicas when the wait time to see their private primary care physicians is too long. In general, many of Clinicas' clients shuttle back and forth between the ER and the clinic for their care. Newly insured patients would benefit from focused education on the benefits of preventive care and the effective use of primary care in the health care system.

Remaining Uninsured

The Remaining Uninsured Project of the San Diego Council of Community Clinics estimates that

as many as 33,000 uninsured individuals reside in Imperial County. Of these, approximately one third are estimated to be undocumented residents.

Clinicas reports that its remaining uninsured are undocumented, along with children who are eligible for either Medi-Cal or Covered California but are not enrolled as their parents fear deportation. Some of Clinicas uninsured patients regularly go across the border into Calexico for cheaper specialty care.

BHS estimates that on average, about 15 percent of the children and 25 percent of the adults they serve are uninsured. The rest of their patients are primarily insured by Medi-Cal.

B. Perceived Barriers for the Safety-Net's Ability to Serve the Remaining Uninsured

Counties in the Central Valley and Imperial share many of the same challenges in meeting the health care needs of their low-income recently insured and uninsured populations.

Overall, the Counties struggle with the following:

- *Provider shortage/recruitment*
- *Poor utilization of primary care services*
- *Lack of specialists/specialists closed to new Medi-Cal patients*
- *Covered California premium costs and copays*
- *Timely enrollment status information*
- *Undocumented residents' distrust in government and delays in seeking care*
- *Traditional views on serving the undocumented and the financial risk*
- *Lack of service integration*
- *Inpatient behavioral health service deficits*
- *Data sharing needs*

Additional details of these barriers can be found in the subsequent section, below.

Provider shortage/recruitment

A consistent theme from the conversations with stakeholders was the shortage of primary and specialty care physicians willing to work in these rural regions. One health center in Merced has been trying for two years to hire physicians. Additionally, FQHCs and county departments are not able to compete with the large health systems like Kaiser, Sutter and Dignity who can offer higher salaries and a better work/life balance for their physicians. To add further cause for concern, many of the health centers are worried about their ability to meet increased primary care demands should there be a large increase in new Medi-Cal enrollees under PRUCOL (DACA and DAPA individuals) as most clinics are already working at maximum capacity.

Poor utilization of primary care services

Despite the declining rates of uninsured residents in all five counties, many of the hospitals still report high ER use for ACSC instead of utilizing primary care services. The cited reasons for such high ER usage are: 1) delays in scheduling primary visits, 2) the limited availability of urgent care services and evening and weekend appointments, 3) the lack of community awareness of walk-in clinic hours, and 4) the knowledge gap of the newly insured in not knowing how to use their insurance to access primary care services.

To address these issues primary care providers in some communities have extended hours and weekend appointment availability. There was general agreement among interviewees that education efforts are needed to improve patients' effective use of the health care system. These two courses of action may help to curb ER utilization rates.

Interviewees agreed in order for ER utilization trends to change, local officials should be better informed on the cost-effectiveness of maintaining community-based medical homes. Currently,

hospital EDs are seen as a 'fail safe' source of primary care for all. However, more resources directed towards preventative and primary care access could reduce ER financial burdens, which are incurred by all residents in the community.

Lack of specialists/specialists closed to new Medi-Cal patients

All five counties reported significant struggles in accessing specialty care, particularly for Medi-Cal and the uninsured populations. Multiple counties reported that specialists are not willing or able to see new Medi-Cal enrollees. Residents have to travel to the Bay Area, Los Angeles, San Diego and Sacramento to access specialty care. This is a major hardship for low-income working families that have severely limited transportation budgets.

The Counties are pursuing various options to increase specialty care access. For example, many of the health centers interviewed are pursuing expansions of their FQHC status to include specialty care. However, approval from the federal Bureau of Primary Health Care is slow and can take a couple of years for approval. One innovative approach by a Fresno FQHC is to offer free office space and billing services to attract specialists to practice in their centers. Local hospitals are also utilizing RHCs to provide scarce specialty care to the newly insured. Specialists receive higher reimbursement rates caring for Medi-Cal patients in RHCs rather than treating them in their private practice. Telemedicine is considered a promising development to be used for some specialty services.

Issues of specialty care are not limited to Medi-Cal or uninsured patients. Some private specialists stated it is difficult to treat patients enrolled in Covered California's bronze plans because patients are unable to cover large co-pays and deductibles.

Covered California premium costs and copays

Among all five counties, 50 percent of the remaining uninsured likely qualify for either Medi-Cal or Covered California with tax assistance. Various interviewees stated that too many low-income residents who qualify for tax credits are not enrolling in Covered California because they are unable to afford premiums and copays.

Timely enrollment status information

There are issues with the enrollment process in these counties. First, there are significant delays in beneficiaries receiving notification from the county of successful Medi-Cal enrollment. Enrollment specialists are also not provided processing status updates or enrollment outcome data from the County. For example, FHCAP staff expressed frustration with not knowing which applications were successfully enrolled and which needed follow-up. If an individual was enrolled, it was then unclear if they had selected a primary care physician. FHCAP staff is able to provide insurance education, guidance on choosing a primary care physician and re-enrollment assistance, but none of this information is relayed due to the lack of data sharing and communication between county offices and enrollment organizations. A similar experience was noted with individuals enrolled in Covered California. Unfortunately, Medi-Cal beneficiaries also lose coverage because they never receive re-enrollment notifications that require paperwork to be completed, and are subsequently left without health insurance.

Undocumented residents' distrust in government and delays in seeking care

The President's reinforcement of U.S. borders has triggered a renewed distrust of government among undocumented residents. Undocumented residents and mixed-status families may seek care from the community clinics they know, but stakeholders state some are now waiting until they are far sicker to seek care. In addition, the anxiety associated with enrolling in government programs was mentioned as a significant impediment to enrolling mixed-status working families in immigrant communities.

Traditional roles and views on serving the undocumented

For hospital EDs and most clinics, the undocumented are simply patients. Hospitals are bound by Emergency Medical Treatment and Labor Act (EMTALA) to provide medical care for anyone who enters their ER regardless of immigration status. Most clinics in these regions are dedicated to a deep-rooted mission of treating everyone regardless of immigration status, as well.

Despite these safety-net mechanisms in place, providing more robust medical care for undocumented residents is politically and financially challenging for elected leaders in these counties. This results in a near silence on the topic of paying for health care for undocumented residents, even though they are the backbone of the region's agricultural workforce.

Lack of service integration

In most of the communities studied providers collaborate across service silos. Even so, each county shared at least one area where provider coordination and service integration is significantly lacking. The two most frequent challenges noted were: 1) hospital/clinic coordination, particularly on care for uninsured patients, and 2) behavioral health services/clinic coordination. California's three separate silos for substance abuse disorders, mental illness and physical health, need to be combined so that the whole person can be treated effectively. Alignment of behavioral and physical health is a key component of the §1115 waiver with a proposal that encourages co-location of these services and "gain sharing" among the plans and providers.

Notable exceptions to such collaborative barriers include: Mercy Medical Center's collaboration with Merced's Mental Health Department; and Clinicas and Imperial County's BHS effective partnerships.

Inpatient behavioral health services

Inpatient care for behavioral health services was noted as a challenge throughout the region. In Merced and Imperial Counties it is nearly impossible to find inpatient placements for anyone who is not court-mandated to receive such care. Mercy Medical Center, in Merced, has treated approximately 300 new Medi-Cal enrolled patients with acute behavioral health conditions but has no dedicated behavioral health inpatient beds in which to place them. As a result, inpatient capacity for physical health needs is significantly impacted. In Merced, children with acute behavioral health conditions have to go the Bay Area or Los Angeles for inpatient treatment, as there is nothing local – a severe hardship for the child, and the entire family.

To at least partially address the County's inpatient needs, Merced's Mental Health Department will be opening an adult mental health impatient facility. It will be 16 beds, in order to comply

with Medi-Cal reimbursement rules concerning bed capacity. The contractor operating this new facility has a record of successfully operating small behavioral health facilities. Unfortunately there are no plans at this time to open a behavioral health facility for children and adolescents. Also, ECRMC in Imperial is working with Alvarado Medical Center in San Diego to increase the number of psychiatric beds to meet local needs.

Data Sharing Needs

Stakeholders expressed a need for a greater spectrum of data from managed care organizations. Data from managed care plans would help public health planners and safety-net providers pinpoint geographically and by treatment category where unmet needs exist and where collaborative interventions focused on ER diversion, or curbing high diabetes and hypertension rates, might improve health outcomes.

C. Collaborations and Financing Strategies

Throughout the Central Valley and Imperial County physician shortages, limited access to specialty care, and the challenges of providing costly uncompensated care have led providers to form creative collaborations. In most of the five counties studied, communitywide health provider consortiums have been established. Often initiated by county health agencies, these collaborative efforts are bringing community health centers, hospitals, behavioral health, managed care plans and others to jointly address health systems issues.

County funds for indigent specialty care

This year, with State approval, the Fresno Board of Supervisors reallocated unspent State highway funds to a $5.5 million fund that covers specialty care and medications for uninsured Fresno residents. Managed by a third party administrator, Avantex, the fund pays for specialty care provided by Community Regional Medical Center and its UCSF faculty practice. While none of the funds can be utilized for primary care, the fund does provide the uninsured with (even harder to access) specialty care and prescriptions. Implementation of the new fund has been slow.

The new fund partially offsets the now defunct $21 million MISP, in which the County previously contracted with the Community Regional Medical Center to care for the uninsured. MISP was created with realignment funds, but when realignment funds were re-appropriated back to the State the program was cut.

Blue Shield grant for health services integration

With the impetus of their Blue Shield grant, a broad-spectrum of Merced health providers has formed a collaborative to develop strategies for health care integration. Led by the Merced Department of Public Health, the collaborative brings together Merced's Department of Mental Health, hospitals, and FQHCs to provide opportunities for improved care coordination. The collaborative has created whole-health tools including a universal screening form for all their partners.

In an effort to bolster collaboration, Merced's Department of Mental Health also meets monthly with The Alliance's mental health administrator, Beacon Health Strategies. They focus on ways to improve and expand mental health service capacity.

Central California Alliance for Health's recruitment assistance

Many of the Medi-Cal health plans view investing in safety-net capacity building as a critical component for ensuring access to quality health care services for its members, especially with the influx of the newly insured. For example, in the Central Valley, The Alliance is trying to increase provider capacity by collaboratively working with community clinics to help recruit primary, specialty and behavioral health providers. Specifically, they have approved $116 million in grant funds for provider incentives. Sixty percent of the fund will go to recruitment of primary care providers and 30 percent to recruitment of behavioral health care providers. The final 10 percent will be used to find innovative strategies that will target and curb medical services utilized by high users.

Better collaboration among different providers

Some cross-sector, inter-provider collaborations are successfully working in parts of the Central Valley and Imperial. In Tulare, FHCN is working collaboratively with Tulare County's Health and Human Services Agency (HHSA) and Sierra View District Hospital to provide comprehensive care for their clients. FHCN and Tulare County's HHSA work together in providing primary care. Tulare County's HHSA also provides some specialty care. FHCN and Sierra View collaborate on specialty care for FHCN's clients and fills the specialty care gaps of Tulare County's HHSA.

In Imperial, BHS works with Clinicas and hospitals to ensure patients, regardless of ability to pay, receive needed behavioral health treatment. In Stanislaus, a collaborative among the Stanislaus County Health Services Agency, Doctors Medical Center hospital and UC Davis salvaged a much-needed medical residency program for the county. Also, the Health Plan of San Joaquin is supporting medical school scholarships for students expected to return to practice in Stanislaus.

In Merced, Imperial and Tulare safety-net systems are benefiting from countywide consortiums. In Merced, the Department of Public Health supports three individual workgroups: ACA Implementation, clinic/hospital/managed care organizations/behavioral health services coordination and, behavioral health services/primary care integration. The workgroups helped bring a Blue Shield Foundation-funded service integration strategy grant to the County.

Part IV – RECOMMENDATIONS

This section, part IV, presents recommendations from stakeholders to improve the care provided by the safety net in the Central Valley and Imperial County. As the number of insured residents continues to increase providers must work to provide accessible, comprehensive, quality health care to these individuals.

Patient Education

Many of the newly insured are unfamiliar with the world of health insurance. It is the responsibility of all health care provider agencies, but especially health plans, to help with this education process. New enrollees especially need help in navigating how, when and at what entry points should be used to properly access health care services. In one example, Fresno clinics are utilizing FHCAP to provide recently insured patients with education on insurance, health system utilization and support for reenrollment. Also, many of the health plans interviewed are doing their due diligence to get in contact with recent enrollees to discuss their new benefits and get them established with their preferred primary care physician.

Real-time view of appointment availability and countywide education to reduce ED use

There is a great need for more effective clinic and ED coordination for the newly insured and remaining uninsured. One of the strategies mentioned to partially address elective ED utilization is to train all call-takers on the different entry points (i.e. clinic, urgent care, ED, etc.) to better assist callers to the best point of entry for their specific condition. Another solution is to have call-takers better informed about appointment availability throughout the system and to better inform patients of clinic walk-in hours.

Single countywide behavioral health plan

A strategy to increase care coordination between physical and behavioral health is to establish a behavioral health entity that coordinates the care for the spectrum of behavioral health illnesses, ranging from mild/moderate to acute diagnoses. One example of this is in Imperial. BHS, a behavioral health provider, is contracted to provide both acute and sub-acute behavioral health care services for the majority of low-income county residents. Managed care plans, hospitals and clinics coordinate with BHS for the full spectrum of physiological and psychiatric benefits for their patients.

Creating new behavioral health beds

There is a real need for psychiatric beds in the Counties to properly treat individuals with severe behavioral health symptoms. To at least partially address these inpatient care needs, Merced's Mental Health Department, together with its community partners, is opening a 16-bed regional adult mental health inpatient facility. A contractor with a record of successfully operating small facilities will operate the new facility. Similarly, ECRMC in Imperial is working with San Diego's Alvarado Medical Center to increase the number local behavioral health beds in Imperial. County health departments and their partners in both the physical and behavioral health sectors must come together to pool efforts and resources to add more inpatient beds.

Incentivize physician recruitment

A major barrier reiterated by each of the counties was the difficulty in filling provider vacancies in these rural communities. Physicians are wooed by larger health systems that offer larger salaries and less on-call responsibilities. As previously mentioned, in order to change this dynamic and attract more physicians to their safety-net providers, the managed care plan, The Alliance, is moving ahead with a new initiative that will provide grants to assist clinics in building capacity. The provider capacity grants may be used toward loan forgiveness, and/or to pay for relocation fees. Similarly, HSJP offers scholarships to medical school students who intend to come back to practice in the San Joaquin/Stanislaus region. Other managed health care plans may find it promising to invest in similar strategies. The upcoming §1115 waiver may also be an opportunity to include physician incentives to increase the workforce in these regions in general.

In the short-term, using more nurse practitioners and physician assistants could increase workforce capacity. However, they have different supervisorial oversight issues that can act as barriers. If these issues were changed, nurse practitioners and physician assistants could be utilized more effectively. Similarly medical residents that did not 'match' have a lot of knowledge and could be utilized effectively in clinics.

This workforce capacity is key to ensuring the newly insured Medi-Cal beneficiaries have access to care with their new insurance status.

More opportunities for residency programs at FQHCs

More teaching opportunities at FQHCs have the potential to significantly expand access to both primary and specialty care. Stanislaus, Imperial and other counties have demonstrated that providing additional residency slots in rural areas can aid in provider recruitment and retention, as physicians who practice in an area are more likely to establish roots in these areas.

Working with the local universities (UCD, UCSD, UCSF and A.T. Still University) has been a way to increase provider capacity. Teaching health centers could be very valuable, but the current reimbursement structure is an issue. Providers only get reimbursed if they are face-to-face with patients. Thus, they cannot be compensated for their teaching time. It can be a heavy financial burden for a clinic to reduce the number of visits for faculty time/instruction. The limits in FQHCs can be very restricting in this way.

Pipeline programs for provider capacity

Provider incentives are a good start, but it is not enough and cannot be the only solution. There is a need to convince providers that the Central Valley and Imperial County are great communities, and a place to stay and practice. Thinking needs to go beyond hospitals and residency programs. There needs to be more PRIME program slots, and, potentially, a local medical school at Merced. To truly develop the workforce in a sustainable manner more resources are needed to develop a local pipeline beginning at younger grades. Merced has pipeline schools, the Junior Medical Academy and the Medical Academy. There is support from various organizations including UCD, UCSF and The California Endowment. There needs to be work with the school districts and educational institutions. More local, creative financing is needed for these types of projects. The Centers for Medicare and Medicaid Services may need to be convinced that an investment in pipeline programs can lead students to coming to back to their communities to practice in health care related fields.

More employers offering health insurance

Virtually all undocumented residents are employed and/or are family members of an employed individual. Employment-based health care coverage is a logical building block for health coverage, particularly due to the federal restrictions on Medi-Cal coverage for the undocumented. The ACA does not require employers to offer health coverage to workers, but will impose penalties on larger employers (100 or more workers) if they do not offer coverage starting in 2015. In 2016, this mandate applies to mid-sized employers (50 or more workers). There are exemptions for employees working less than 30 hours and for individuals employed less than 90 consecutive days. The employer mandate applies to the employee and their dependent children, but not to spouses.

In several of the counties studied, growers and other large agro-related businesses are already providing some coverage or access to health care services for farm and manufacturing workers. Some of these companies include: Foster Farms, Nisei Growers, Western Growers and Gallo Winery and Cheese manufacturing. Health plans are also working with employers to get more individuals covered. HPSJ is leveraging its close relationship with small businesses to enroll more of the uninsured. Specifically, they are working with various chambers of commerce, ethnic and others, to increase their outreach efforts with not only employers, but also with their employees to discuss expansion opportunities. This outreach work is especially important as funds are slowly curbed by the State for outreach efforts.

As more companies may be motivated to offer health care benefits to their employees to avoid penalties, more undocumented workers, and their families, will be properly insured for their health care needs.

Telemedicine

Telemedicine represents a potential new tool for increasing primary care services in rural areas and increasing access to scarce specialty care. For example, there is a pilot demonstration by HPSJ, in which dermatologists in the Bay Area consult via telemedicine linkages with clinics based in Stanislaus or San Joaquin. In Imperial, Clinicas is excited about a new telemedicine endeavor with UCSD and Connecting Care that will deliver specialty care to clinic patients. However, telemedicine is not a panacea for all provider shortage issues; in Imperial, BHS reported that as a mechanism for bringing behavioral health specialty services to Imperial's low-income residents telemedicine was not entirely successful.

Expand Medi-Cal coverage to the undocumented

Respondents believed the best way to care for the undocumented is enrollment in Medi-Cal managed care. However, there are no expectations that local governments are able, or willing, to fund health care coverage for local undocumented residents. County-sponsored health care coverage for the undocumented would result in a piecemeal patchwork solution on a county-by-county basis.

There was general consensus on a statewide solution, such as Senate Bill 4, authored by Senator Lara. The bill would expand Medi-Cal to undocumented eligible children and adults. At this time, the Governor and the state legislature have expanded Medi-Cal to undocumented children. After 15 years of persistent advocacy efforts, this is a positive step forward for many providers and, especially, for the hard working undocumented families residing in the State.

Abbreviations

ACA - Patient Protection and Affordable Care Act

ACS – America Community Survey

ACSC - Ambulatory Care Sensitive Conditions

BHS – Imperial County Behavioral Health Services

BRFSS – Behavioral Risk Factor Surveillance Survey

CMSP – California Medical Service Program

CHIS – California Health Interview Survey

Clinicas – Clinicas de Salud del Pueblo

DACA – Deferred Action for Childhood Arrivals

DAPA – Deferred Action for Parents of Americans

DSH – Disproportionate Share Hospitals

ECRMC - El Centro Regional Medical Center

ED – Emergency Department

EMTALA - Emergency Medical Treatment and Labor Act

ER – Emergency Room

FFS – Fee For Service

FHCN – Family Health Care Network

FPL – Federal Poverty Level

FQHC – Federally Qualified Health Center

FHCAP – Fresno Healthy Communities Access Partners

GVHC – Golden Valley Health Centers

HHSA – Tulare County's Health and Human Services Agency

HMO – Health Maintenance Organization

HPSA – Health Professional Shortage Areas

HPSJ – Health Plan San Joaquin

LIHP – Low Income Health Program

MC – Managed Care

MCO – Managed Care Organization

MISP – Medically Indigent Services Program

OB - Obstetrics

OSHPD – Office of Statewide Health Planning and Development

PRUCOL – Permanently Residing in the United States under Color of Law

RHC – Rural Health Center

The Alliance – Central California Alliance for Health

UCD - UC Davis

UCSD - UC San Diego

UCSF – UC San Francisco

List of Interviewed Stakeholders

Organization	Name	Title
Central Valley		
Building Healthy Communities	• Sarah Reyes	• Regional Program Manager
Diringer and Associates	• Joel Diringer	• Principal
Health Net	• Eloisa Estrada	• Provider Relations Manager
Central Valley Health Network	• Cathy Frey	• Chief Executive Officer
Fresno		
Clinica Sierra Vista	• Steve Schilling • Bill Phelps	• Chief Executive Officer • Chief of Programming
Community Regional Medical Center	• Robyn Gonzales	• Associate Administrator, Ancillary Services
Fresno Department of Public Health	• David Pomaville	• Director, Administration
Fresno Healthy Communities Access Partners	• Norma Forbes	• Chief Executive Officer
Imperial		
Clinicas de Salud del Pueblo	• Yvonne Bell	• Chief Executive Officer
El Centro Regional Medical Center	• Cathy Kennerson	• Chief Strategic Development Officer
Imperial County Behavioral Health Services	• Michael Horn • Andrea Kuhlen	• Director • Program Lead
Merced		
Castle Family Health Centers	• Edward Lujano	• Chief Executive Officer
Central CA Alliance for Health	• Alan McKay • Jennifer Mockus	• Chief Executive Officer • Regional Operations Director
Livingston Community Health	• Leslie McGowan	• Chief Executive Officer
Mercy Medical Center	• Philip Brown	• Director Emergency Services
Merced Department of Public Health	• Kathleen Grassi	• Director
Merced Organizing Project	• Crisantema Gallardo	• Community Organizer
Stanislaus		
Golden Valley Health Centers	• Tony Weber	• Chief Executive Officer
Health Plan of San Joaquin	• David Hurst	• Vice President of External Affairs
Health Services Agency	• Mary Ann Lee	• Managing Director
Tulare		
Tulare County Health & Human Services Agency	• Jason Britt	• Director
Family Healthcare Network	• Kerry Hydash	• President and Chief Executive Officer

Appendix A
Partnerships with Academic Medical Centers

In all five counties, partnerships with Academic Medical Centers (AMCs) has enabled medical and allied health residents to gain invaluable clinical experience while also filling in access gaps for many of California's underserved. Described below are several examples of successful collaborations between various teaching institutions and clinics and/or hospitals that can be used as examples for other clinics looking to develop such partnerships.

California Universities

In Fresno, UC San Francisco (UCSF) is an important partner to health providers in the region. UCSF faculty and residents provide much needed specialty care to Medi-Cal and uninsured patients at Community Regional Medical Center. UCSF also works with the clinics, the County, and local managed care organizations to recruit and retain residents to work in Fresno.

In Tulare, Family Health Care Network (FHCN) provides Kaweah Delta Health Care District medical residents with extensive obstetrics (OB) and chronic illness treatment training. Kaweah medical residents are able to acquire most of their rotation hours in OB and chronic illness training due to FHCN's large patient population needing these types of care.

UC Davis (UCD) has collaborative relationships in both Merced and Stanislaus counties. In Merced, UCD medical residents help staff the hospital's ambulatory care center that cares for recently discharged emergency department (ED) patients who lack a medical home. UCD is also affiliated with the Valley Consortium for Medical Education (VCME), a nonprofit organization in Stanislaus, which operates a residency program. The partners affiliated with VCME, including Doctors Medical Center, Memorial Medical Center and Stanislaus County Health Services Agency utilize community-based teaching models. The residency program is critical to maintaining Stanislaus' medical workforce as 30 to 50 percent of these residents remain in Stanislaus to practice following graduation.[59]

Finally, a couple of San Diego universities and Northern Arizona University (NAU) have partnered with neighboring health providers in Imperial County. UC San Diego is teaming with El Centro Regional Medical Center to place psychiatric residents at the hospital, while San Diego State University and NAU are working with Imperial Behavioral Health Services (BHS) to provide clinical rotations for Masters in Social Work students.

Beyond State Borders

Federally qualified health centers (FQHCs) in Tulare and Imperial have benefited from partnerships that cross state borders. Arizona-based medical and behavioral health students fill community practice residency slots at these FQHCs. For example, Arizona's A.T. Still University osteopathic doctors, physician assistants and dentists students have the opportunity to do clinical residencies at FHCN in Tulare, while Marriage and Family Therapy practicums for NAU students are administered at Imperial's BHS clinics.

International Residency

One stakeholder noted that the J1 visa program, offered by the Federal Bureau of Primary Health Care, provides some assistance in hiring health providers. The program places international medical residents in clinics. Imperial BHS was successful in securing psychiatrists from the visa program.

[59] The county-run residency program closed in 2010. VCME was subsequently created to continue residency medical education.

Appendix B
Changing Health Care Landscapes

County Health Departments

County health departments are responsible for providing health care for medically indigent adults (MIAs). The Affordable Care Acts' (ACA) Medicaid and Covered California expansions have diminished the number of MIAs, and thus diminished the amount of services required of the counties, as bound by the Welfare and Institution Code §17,000.[60] However, in counties such as Fresno, Imperial, Merced, Stanislaus and Tulare there are high numbers of undocumented residents that are ineligible to partake in these coverage expansion options. Therefore, investment of county funds by local governments for MIAs' health care services is still an important factor in maintaining the health of Central Valley and Imperial residents.

The counties studied had differing arrangements in caring for the MIAs before the ACA, which were subsequently altered after the implementation of the ACA. For example, Fresno and Merced subcontracted with a local community hospital to provide medically necessary care for MIAs, but contracts were canceled after the start of the ACA. Similarly, in Tulare and Stanislaus, the Counties reimbursed local community hospitals for care provided to MIAs, but reimbursements have since been suspended.

In the Central Valley and Imperial, the undocumented laborers are a key reagent to the agricultural businesses in these regions. In the absence of health care coverage and timely access to primary care, these workers must seek costly emergency services in hospital ERs. These stays usually result in uncompensated care, which is a financial burden for the hospital. Although emergency Medi-Cal is available to the undocumented, it only covers genuine emergencies, prenatal care and deliveries. Additionally, none of the four Central Valley counties and Imperial operates county hospitals, which could potentially fill in gaps of care for the remaining uninsured.

Although funding for MIA programs by counties has been significantly reduced, it is still in the best interest of these counties to find resources to properly care for the individuals that are so vital to their local economies. Acute/ER care is much more expensive than if individuals are able to access and receive preventative and primary care services. Counties would be helping themselves financially if they cared for people in the earlier stages of illness rather than at the latter stages.

There are county funds available to cover the remaining uninsured. Despite the State's reduction in health realignment funds, the county still receives some funds from this source, as well as a county match and tobacco litigation settlement funds. All of these funds could be used to cover primary care services and other health care for the uninsured. For example, Tulare and Stanislaus operate local county clinics that provide primary care and limited specialty care for the uninsured and California Medical Service Program (CMSP) counties, including Imperial, Kings and Madera, are now covering limited primary care and pharmaceutical services for uninsured county residents.

[60] The Welfare and Institution Code §17,000 states that the county must provide support for the medically indigent population that cannot support themselves otherwise.

Counties will also have some relief in bearing all the costs of care for the undocumented as the Governor and Legislature have agreed to provide full scope Medi-Cal for the approximately 170,000 undocumented children in California.

Creative approaches to address the finance issue in caring for the uninsured are also highly sought after. For example, in Fresno, there was a one-time appropriation of $5.5 million to pay for specialty care provided by physicians at a local hospital. The allocation comes from unspent highway funds. Flexibility of funds from other sources to help cover health care services may be one answer to these difficult financing issues.

Local Hospitals

With much of the Medi-Cal population now enrolled in managed care, hospitals' partnerships and alignments with local managed care organizations (MCOs) and community clinics are critical to their long-term survival. One reason is performance measures are being used to evaluate the health outcomes of a hospital's patient population and payments are increasingly being tied to these outcomes. Hence, hospitals' follow-up and coordination with clinics, along with MCO assistance, is crucial to hospitals performing well.

While not all Central Valley hospitals and their physicians participate in Medi-Cal or Covered California, they will increasingly need to do so as nearly half of the consumer base is enrolled in these coverage options. In 2013, nearly a third (34.1%) of Central Valley hospital discharges and over 35% of their outpatient visits were paid for by Medi-Cal.[61] The numbers were similar for Imperial County (35.7% hospital discharges and 38.1% outpatient visit). Medi-Cal managed care is thus the hospitals' largest payer in the Central Valley and Imperial. These percentages will likely increase dramatically in 2014 data when ACA expansions occurred.

From stakeholder interviews, some but not all Central Valley and Imperial County hospitals are well aligned with their local clinics. The clinics are providing vital services in urgent care, specialty care, referrals, admissions, care coordination and post-discharge care. This is in addition to clinics' roles as the bulwarks of traditional primary care services in their communities. Clinic physicians are on staff as hospitalists in local hospitals in Imperial and Tulare counties and clinics are offering specialty care that is otherwise in short supply. The partnering hospitals are assuring access to specialists for clinics' Medi-Cal and uninsured patients alike.

The proposed §1115 waiver and the Medicaid managed care expansions offer an important opportunity to improve clinic/hospital alignment with the assistance of local Medi-Cal MCOs. Under the proposed waiver, district hospitals will be eligible to provide a match for enhanced delivery system reform incentive payment (DSRIP) funds to improve the quality, efficiency and effectiveness of their facilities so that they are more effective participants in managed care. DSRIP proposed in the waiver is focused on improving hospitals' ambulatory care.

Managed Care Organizations

The MCOs are increasingly motivated to improve patient quality and outcomes because this could allow them to reduce their costs. Local MCOs are now responsible for providing coverage

[61] State of California, OSHPD. (2013). Hospital annual financials. Retrieved from http://www.oshpd.ca.gov/HID/Products/Hospitals/AnnFinanData/CmplteDataSet/index.asp

and care to larger portions of the population including the once MIAs, seniors and persons with disabilities and, mothers and children, their traditional subscriber populations. Due to the fact that such high percentages of local residents are now enrolled in Medi-Cal MCOs, these health plans have huge leverage and opportunities to improve local delivery systems. However, in the Central Valley there are barriers to this vision. MCOs are hampered by the dearth of local physicians and by the practical difficulty in aligning local practitioners' incentives. In addition, each county in this study has a separate set of MCOs (Table I).

Table I: Medi-Cal Managed Care Enrollment Numbers – May 2015[62]

Report Area	Plan Name, Enrollment # and, % of Enrollment	
FRESNO	Cal Viva 253,332 (72%)	Anthem Blue Cross 99,045 (28%)
IMPERIAL	CA Health and Wellness 52,472 (76%)	Molina Healthcare 16,375 (24%)
MERCED	Central California Alliance for Health 121,979 (100%)	
STANISLAUS	Health Plan of San Joaquin 202,708 (73%)	Health Net 76,239 (27%)
TULARE	Health Net 97,504 (53%)	Anthem Bluoss 85,670 (47%)

Note: Cal Viva is administered by Health Net

The latest aggregate HEDIS scores, released on June 16, 2015, posted by the Medi-Cal managed care performance dashboard indicate that Health Plan of San Joaquin, Health Net in Stanislaus and Central California Alliance had top regional HEDIS scores; whereas Cal Viva in Kings and Anthem Blue Cross in Kings and Fresno had lower HEDIS scores. These lower scores warrant greater investment in outcome improvements.[63]

Overall, the lower HEDIS rankings among Central Valley plans, as compared to Bay Area and Orange County plans, may be due to the lower incomes and poorer health status of the Central Valley residents. The State's §1115 waiver proposal therefore, may present an important opportunity to attract new federal investments into underserved communities. Improving health plans' partnerships with local public health agencies may be particularly timely; better coordinating behavioral and physical health to share savings, will be key to success in the waiver. Lastly, it may be that with a region-wide plan in the Central Valley could provide a more coherent strategy to improve subscribers' health in these counties.

[62] California Department of Health Care Services. (May 2015). Medi-Cal Managed Care Enrollment Report. Retrieved from http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Enrollment_Reports/MMCEnrollRptMay2015.pdf

[63] Department of Health Care Services. (Jun 2015). Medi-Cal managed care performance dashboard, June 16, 2015 release. Retrieved from http://www.dhcs.ca.gov/services/Pages/MngdCarePerformDashboard.aspx

Central Valley

INPATIENT

2013 Inpatient Days by Hospital Type by Payer

	Central Valley	
	Days	% of Total
Medicare	621,987	27.8%
Medicare FFS	514,103	23.0%
Medicare MC	107,884	4.8%
Medi-Cal	761,992	34.1%
Medi-Cal FFS	541,313	24.2%
Medi-Cal MC	220,679	9.9%
County Indigent	58,912	2.6%
Private	305,161	13.6%
Private FFS	85,279	3.8%
Private MC	219,882	9.8%
Other Indigent	26,819	1.2%
Other	462,217	20.7%
TOTAL	2,237,088	100.0%

2014 Inpatient Days by Hospital Type by Payer

	Central Valley	
	Days	% of Total
Medicare	667,515	28.0%
Medicare FFS	546,615	22.9%
Medicare MC	120,900	5.1%
Medi-Cal	865,095	36.3%
Medi-Cal FFS	591,983	24.8%
Medi-Cal MC	273,112	11.4%
County Indigent	36,826	1.5%
Private	317,368	13.3%
Private FFS	80,387	3.4%
Private MC	236,981	9.9%
Other Indigent	11,921	0.5%
Other	487,480	20.4%
TOTAL	2,386,205	100.0%

Percent Change Inpatient Days by Hospital Type by Payer

	Central Valley
	Days
Medicare	7.3%
Medicare FFS	6.3%
Medicare MC	12.1%
Medi-Cal	13.5%
Medi-Cal FFS	9.4%
Medi-Cal MC	23.8%
County Indigent	-37.5%
Private	4.0%
Private FFS	-5.7%
Private MC	7.8%
Other Indigent	-55.6%
Other	5.5%
TOTAL	6.7%

2013 Inpatient Days by Hospital Type by Type of Care

	Central Valley	
	Days	% of Total
Acute care	1,304,464	58.3%
Psychiatric care	112,013	5.0%
Chemical dependency care	517	0.0%
Rehabilitation care	56,688	2.5%
Long-term care	754,068	33.7%
Residential & other daily serv	9,338	0.4%
TOTAL	2,237,088	100.0%

2014 Inpatient Days by Hospital Type by Type of Care

	Central Valley	
	Days	% of Total
Acute care	1,376,097	57.7%
Psychiatric care	110,405	4.6%
Chemical dependency care	359	0.0%
Rehabilitation care	58,222	2.4%
Long-term care	829,892	34.8%
Residential & other daily serv	11,230	0.5%
TOTAL	2,386,205	100.0%

Percent Change Inpatient Days by Hospital Type by Type of Care

	Central Valley
	Days
Acute care	5.5%
Psychiatric care	-1.4%
Chemical dependency care	-30.6%
Rehabilitation care	2.7%
Long-term care	10.1%
Residential & other daily serv	20.3%
TOTAL	6.7%

2013 Inpatient Discharges by Hospital Type by Payer

	Central Valley	
	Days	%
Medicare	108,467	34.1%
Medicare FFS	86,149	27.1%
Medicare MC	22,318	7.0%
Medi-Cal	107,431	33.8%
Medi-Cal FFS	51,568	16.2%
Medi-Cal MC	55,863	17.5%
County Indigent	11,024	3.5%
Private	78,322	24.6%
Private FFS	18,994	6.0%
Private MC	59,328	18.6%
Other Indigent	5,891	1.9%
Other	7,176	2.3%
TOTAL	318,311	100.0%

2014 Inpatient Discharges by Hospital Type by Payer

	Central Valley	
	Days	% of Total
Medicare	115,757	34.0%
Medicare FFS	91,984	27.0%
Medicare MC	23,773	7.0%
Medi-Cal	128,630	37.8%
Medi-Cal FFS	60,442	17.8%
Medi-Cal MC	68,188	20.0%
County Indigent	5,927	1.7%
Private	80,789	23.7%
Private FFS	16,683	4.9%
Private MC	64,106	18.8%
Other Indigent	2,754	0.8%
Other	6,652	2.0%
TOTAL	340,509	100.0%

Percent Change Inpatient Discharges by Hospital Type by Payer

	Central Valley
	Days
Medicare	6.7%
Medicare FFS	6.8%
Medicare MC	6.5%
Medi-Cal	19.7%
Medi-Cal FFS	17.2%
Medi-Cal MC	22.1%
County Indigent	-46.2%
Private	3.1%
Private FFS	-12.2%
Private MC	8.1%
Other Indigent	-53.3%
Other	-7.3%
TOTAL	7.0%

2013 Inpatient Discharges by Hospital Type by Type of Care

	Central Valley	
	Days	% of Total
Acute care	293,858	92.3%
Psychiatric care	16,929	5.3%
Chemical dependency care	125	0.0%
Rehabilitation care	4,803	1.5%
Long-term care	2,585	0.8%
Residential & other daily serv	11	0.0%
TOTAL	318,311	100.0%

2014 Inpatient Discharges by Hospital Type by Type of Care

	Central Valley	
	Days	% of Total
Acute care	315,167	92.6%
Psychiatric care	16,653	4.9%
Chemical dependency care	79	0.0%
Rehabilitation care	4,883	1.4%
Long-term care	3,681	1.1%
Residential & other daily serv	46	0.0%
TOTAL	340,509	100.0%

Percet Change Inpatient Discharges by Hospital Type by Type of Care

	Central Valley
	Days
Acute care	7.3%
Psychiatric care	-1.6%
Chemical dependency care	-36.8%
Rehabilitation care	1.7%
Long-term care	42.4%
Residential & other daily serv	318.2%
TOTAL	7.0%

2013 Average Length of Stay by Hospital Type by Payer

	Central Valley
Medicare	5.7
Medicare FFS	6.0
Medicare MC	4.8
Medi-Cal	7.1
Medi-Cal FFS	10.5
Medi-Cal MC	4.0
County Indigent	5.3
Private	3.9
Private FFS	4.5
Private MC	3.7
Other Indigent	4.6
Other	64.4
TOTAL	7.0

2014 Average Length of Stay by Hospital Type by Payer

	Central Valley
Medicare	5.8
Medicare FFS	5.9
Medicare MC	5.1
Medi-Cal	6.7
Medi-Cal FFS	9.8
Medi-Cal MC	4.0
County Indigent	6.2
Private	3.9
Private FFS	4.8
Private MC	3.7
Other Indigent	4.3
Other	73.3
TOTAL	7.0

Percent Change Average Length of Stay by Hospital Type by Payer

	Central Valley
Medicare	1.8%
Medicare FFS	-1.7%
Medicare MC	6.3%
Medi-Cal	-5.6%
Medi-Cal FFS	-6.7%
Medi-Cal MC	0.0%
County Indigent	17.0%
Private	0.0%
Private FFS	6.7%
Private MC	0.0%
Other Indigent	-6.5%
Other	13.8%
TOTAL	0.0%

OUTPATIENT

2013 Outpatient Visits by Hospital Type by Payer

	Central Valley	
	Days	% of Total
Medicare	1,310,850	25.3%
Medicare FFS	1,134,373	21.9%
Medicare MC	176,477	3.4%
Medi-Cal	1,827,710	35.2%
Medi-Cal FFS	578,400	11.2%
Medi-Cal MC	1,249,310	24.1%
County Indigent	175,727	3.4%
Private	1,274,728	24.6%
Private FFS	396,608	7.6%
Private MC	878,120	16.9%
Other Indigent	82,816	1.6%
Other	513,787	9.9%
TOTAL	5,185,618	100.0%

2014 Outpatient Visits by Hospital Type by Payer

	Central Valley	
	Days	% of Total
Medicare	1,420,203	24.1%
Medicare FFS	1,241,050	21.0%
Medicare MC	179,153	3.0%
Medi-Cal	2,487,956	42.2%
Medi-Cal FFS	753,649	12.8%
Medi-Cal MC	1,734,307	29.4%
County Indigent	112,045	1.9%
Private	1,310,805	22.2%
Private FFS	389,310	6.6%
Private MC	921,495	15.6%
Other Indigent	60,929	1.0%
Other	508,547	8.6%
TOTAL	5,900,485	100.0%

Percent Change Outpatient Visits by Hospital Type by Payer

	Central Valley
	Days
Medicare	8.3%
Medicare FFS	9.4%
Medicare MC	1.5%
Medi-Cal	36.1%
Medi-Cal FFS	30.3%
Medi-Cal MC	38.8%
County Indigent	-36.2%
Private	2.8%
Private FFS	-1.8%
Private MC	4.9%
Other Indigent	-26.4%
Other	-1.0%
TOTAL	13.8%

2013 Type of Outpatient Visits by Hospital Type

	Central Valley	
	Days	% of Total
Emergency room visits	1,543,471	30.3%
Clinic visits	1,406,402	27.6%
Home health care visits	470,955	9.2%
Referred outpatient visits	1,671,700	32.8%
TOTAL	5,092,528	100.0%

2014 Type of Outpatient Visits by Hospital Type

	Central Valley	
	Days	% of Total
Emergency room visits	1,759,192	30.5%
Clinic visits	1,816,336	31.5%
Home health care visits	420,897	7.3%
Referred outpatient visits	1,767,481	30.7%
TOTAL	5,763,906	100.0%

Percent Change Type of Outpatient Visits by Hospital Type

	Central Valley
	Days
Emergency room visits	14.0%
Clinic visits	29.1%
Home health care visits	-10.6%
Referred outpatient visits	5.7%
TOTAL	13.2%

FINANCING AND REVENUE

2013 Gross Inpatient Revenue by Hospital Type by Payer

	Central Valley	
	Revenue	% of Total
Medicare	$ 7,879,723,582	41.5%
Medicare FFS	$ 6,276,696,180	33.1%
Medicare MC	$ 1,603,027,402	8.4%
Medi-Cal	$ 5,613,435,844	29.6%
Medi-Cal FFS	$ 2,972,636,491	15.7%
Medi-Cal MC	$ 2,640,799,353	13.9%
County Indigent	$ 517,923,644	2.7%
Private	$ 4,147,277,577	21.9%

2014 Gross Inpatient Revenue by Hospital Type by Payer

	Central Valley	
	Revenue	% of Total
Medicare	$ 8,877,769,555	42.0%
Medicare FFS	$ 6,895,495,000	32.6%
Medicare MC	$ 1,982,274,555	9.4%
Medi-Cal	$ 7,193,914,362	34.0%
Medi-Cal FFS	$ 3,683,922,650	17.4%
Medi-Cal MC	$ 3,509,991,712	16.6%
County Indigent	$ 244,930,783	1.2%
Private	$ 4,355,228,495	20.6%

Percent Change Gross Inpatient Revenue by Hospital Type by Payer

	Central Valley
	Revenue
Medicare	12.7%
Medicare FFS	9.9%
Medicare MC	23.7%
Medi-Cal	28.2%
Medi-Cal FFS	23.9%
Medi-Cal MC	32.9%
County Indigent	-52.7%
Private	5.0%

Central Valley

Private FFS	$ 865,270,667	4.6%
Private MC	$ 3,282,006,910	17.3%
Other Indigent	$ 426,650,188	2.2%
Other	$ 392,502,022	2.1%
TOTAL	$ 18,977,512,857	100.0%

Private FFS	$ 871,621,729	4.1%
Private MC	$ 3,483,606,766	16.5%
Other Indigent	$ 219,585,576	1.0%
Other	$ 268,343,932	1.3%
TOTAL	$ 21,159,772,703	100.0%

Private FFS	0.7%
Private MC	6.1%
Other Indigent	-48.5%
Other	-31.6%
TOTAL	11.5%

2013 Gross Outpatient Revenue by Hospital Type by Payer

	Central Valley	
	Revenue	% of Total
Medicare	$ 3,503,098,155	32.4%
Medicare FFS	$ 2,726,195,474	25.3%
Medicare MC	$ 776,902,681	7.2%
Medi-Cal	$ 2,966,048,857	27.5%
Medi-Cal FFS	$ 844,304,132	7.8%
Medi-Cal MC	$ 2,121,744,725	19.7%
County Indigent	$ 324,539,474	3.0%
Private	$ 3,134,629,362	29.0%
Private FFS	$ 619,391,678	5.7%
Private MC	$ 2,515,237,684	23.3%
Other Indigent	$ 274,113,990	2.5%
Other	$ 593,248,418	5.5%
TOTAL	$ 10,795,678,256	100.0%

2014 Gross Outpatient Revenue by Hospital Type by Payer

	Central Valley	
	Revenue	% of Total
Medicare	$ 4,118,396,046	31.8%
Medicare FFS	$ 3,196,040,607	24.7%
Medicare MC	$ 922,355,439	7.1%
Medi-Cal	$ 4,301,413,819	33.2%
Medi-Cal FFS	$ 1,217,746,017	9.4%
Medi-Cal MC	$ 3,083,667,802	23.8%
County Indigent	$ 194,026,335	1.5%
Private	$ 3,545,979,251	27.4%
Private FFS	$ 782,991,104	6.1%
Private MC	$ 2,762,988,147	21.4%
Other Indigent	$ 204,905,659	1.6%
Other	$ 573,378,092	4.4%
TOTAL	$ 12,938,099,202	100.0%

Percent Change Gross Outpatient Revenue by Hospital Type by Payer

	Central Valley
	Revenue
Medicare	17.6%
Medicare FFS	17.2%
Medicare MC	18.7%
Medi-Cal	45.0%
Medi-Cal FFS	44.2%
Medi-Cal MC	45.3%
County Indigent	-40.2%
Private	13.1%
Private FFS	26.4%
Private MC	9.8%
Other Indigent	-25.2%
Other	-3.3%
TOTAL	19.8%

2013 Net Patient Revenue by Hospital Type by Payer

	Central Valley	
	Revenue	% of Total
Medicare	$ 2,151,605,386	29.7%
Medicare FFS	$ 1,716,744,062	23.7%
Medicare MC	$ 434,861,324	6.0%
Medi-Cal	$ 2,058,023,284	28.4%
Medi-Cal FFS	$ 1,099,133,478	15.1%
Medi-Cal MC	$ 958,889,806	13.2%
County Indigent	$ 91,306,354	1.3%
Private	$ 2,656,021,493	36.6%
Private FFS	$ 454,456,421	6.3%
Private MC	$ 2,201,565,072	30.3%
Other Indigent	$ 31,248,240	0.4%
Other	$ 267,616,151	3.7%
TOTAL	$ 7,255,820,908	100.0%

2014 Net Patient Revenue by Hospital Type by Payer

	Central Valley	
	Revenue	% of Total
Medicare	$ 2,323,638,870	30.2%
Medicare FFS	$ 1,833,691,992	23.8%
Medicare MC	$ 489,946,878	6.4%
Medi-Cal	$ 2,131,033,646	27.7%
Medi-Cal FFS	$ 911,871,312	11.9%
Medi-Cal MC	$ 1,219,162,334	15.8%
County Indigent	$ 80,282,699	1.0%
Private	$ 2,892,740,958	37.6%
Private FFS	$ 353,056,024	4.6%
Private MC	$ 2,539,684,934	33.0%
Other Indigent	$ 18,895,067	0.2%
Other	$ 248,189,455	3.2%
TOTAL	$ 7,694,780,695	100.0%

Percent Change Net Patient Revenue by Hospital Type by Payer

	Central Valley
	Revenue
Medicare	8.0%
Medicare FFS	6.8%
Medicare MC	12.7%
Medi-Cal	3.5%
Medi-Cal FFS	-17.0%
Medi-Cal MC	27.1%
County Indigent	-12.1%
Private	8.9%
Private FFS	-22.3%
Private MC	15.4%
Other Indigent	-39.5%
Other	-7.3%
TOTAL	6.0%

2013 Capitation Revenue by Payer

	Central Valley
Medicare MC	$ 85,061,695
Medi-Cal MC	$ 6,246,716
County Indigent MC	$ -
Private MC	$ 54,057,752

2014 Capitation Revenue by Payer

	Central Valley
Medicare MC	$ 81,846,540
Medi-Cal MC	$ 7,361,582
County Indigent MC	$ -
Private MC	$ 67,064,371

Percent Change Capitation Revenue by Payer

	Central Valley
Medicare MC	-3.8%
Medi-Cal MC	17.8%
County Indigent MC	#DIV/0!
Private MC	24.1%

2013 Income Statement

	Central Valley
Gross Patient Revenue	$ 30,180,218,380
Net Patient Revenue	$ 7,420,859,490
Other Operating Revenue	$ 173,402,565
Total Operating Expenses	$ 7,526,062,841
Non-Operating Revenue	$ 451,732,552
Non-Operating Expenses	$ 45,741,253
DSH (SB 855)	$ 258,481,672
Bad Debt/Charity Care	$ 1,442,450,727
Bad Debt/Charity Care Adj	$ 354,676,829
Net Income	$ 469,349,161
Net Imcome as a % of Total Oper. Expenses	6.2%

2014 Income Statement

	Central Valley
Gross Patient Revenue	$ 34,504,023,438
Net Patient Revenue	$ 7,866,646,352
Other Operating Revenue	$ 206,772,444
Total Operating Expenses	$ 8,050,809,183
Non-Operating Revenue	$ 598,024,776
Non-Operating Expenses	$ 126,955,854
DSH (SB 855)	$ 246,329,198
Bad Debt/Charity Care	$ 1,031,275,615
Bad Debt/Charity Care Adj	$ 235,122,741
Net Income	$ 489,799,577
Net Imcome as a % of Total Oper. Expenses	6.1%

Percent Change Income Statement

	Central Valley
Gross Patient Revenue	14.3%
Net Patient Revenue	6.0%
Other Operating Revenue	19.2%
Total Operating Expenses	7.0%
Non-Operating Revenue	32.4%
Non-Operating Expenses	177.6%
DSH (SB 855)	-4.7%
Bad Debt/Charity Care	-28.5%
Bad Debt/Charity Care Adj	-33.7%
Net Income	4.4%
Net Imcome as a % of Total Oper. Expenses	-2.4%