

3 Background

3.1 Role of Public Hospitals

California's public health care systems include 15 county-owned and operated health care systems, and six University of California Medical Centers, and serve the counties where more than 80 percent of Californians live. These systems account for just six percent of the state's hospitals, but provide more than 40 percent of hospital care to the state's remaining uninsured.

The collective mission of these health care systems remains the provision of high quality health care to all who need it, regardless of insurance status or ability to pay. Public health care systems provide a comprehensive range of health care services, including primary care, outpatient specialty care, emergency and inpatient services, rehabilitative services, and in some instances long-term care, while at the same time providing core community benefits such as trauma care, burn care, and the training of over half of the new doctors in California.

Public health care in California began more than a century and a half ago, as part of a state-mandated welfare responsibility. In 1933, this responsibility was codified in Section 17000 of the state's Welfare and Institutions Code, which provides that counties have a statutory obligation to "relieve and support" their indigent residents who have no other source of care.

In 1964, just before the historic creation of the Medicare and Medicaid programs, California had 66 county-owned and operated hospitals. In the decades since then, a majority of these facilities have either closed or turned into private hospitals. Three have become University of California medical centers. Today, the remaining county-run systems and UC medical centers form the core of California's health care safety net.

Various efforts have been made over the years, at the state and Federal level, to provide additional support for hospitals that care for a disproportionately large share of low-income patients with little or no ability to pay. For instance, the Federal Medicaid DSH payment adjustment requirement was imposed in 1981 to support hospitals that particularly focused on a disproportionate share of care for low-income populations.

In 2005, California received its first 5-year section 1115 waiver for public hospitals, in which public hospitals began providing the non-Federal share not just for DSH and supplemental payments which they had been doing long before 2005, but for the entirety of their Medi-Cal inpatient fee-for-service rates.

They also provided the non-Federal share for 1115 demonstration programs like the SNCP UCP, and the HCCI, which expanded coverage to low-income residents in 8 public health care system counties.

The 2010 waiver further expanded both the financing role and the unique safety net role of the public health care systems to prepare California for the ACA. These systems engaged in a first-in-the-nation quality improvement effort through the DSRIP, working on hundreds of quality improvement projects to expand access to care and improve health outcomes, with funding available for achieving pre-determined benchmarks.

Counties also actively engaged in a pre-ACA expansion effort, Low Income Health Program (LIHP), which built on the experience of the HCCI from 2005. There, counties offered enrollment and health benefits to uninsured individuals who would eventually become eligible for coverage under the ACA – enrolling over 662,445 people by the end of the waiver in 2013.¹¹ These individuals were then able to transition to Medi-Cal or other coverage in 2014. Counties and public health care systems financed the non-Federal share of the funding for both the DSRIP and LIHP in addition to the non-Federal share they were already providing for programs like DSH.

Since 2014, public health care systems have continued to focus their efforts on enrolling patients in coverage, including through the use of Hospital Presumptive Eligibility, which has provided timely and critical access to Medi-Cal benefits during a time of great program transition and growth due to the ACA.

While in many respects these systems see a need to focus on becoming “providers of choice” in a coverage environment, they also are driven to retain their core mission of providing care to all who need it, regardless of insurance status, including through new programs in the Medi-Cal 2020 waiver such as the GPP described later in this chapter, funded in part by the SNCP UCP.

¹¹ http://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/CA_EligibilityandEnroll_ABx1_1-Quarterly.pdf