California’s Uninsured & the Future of Open Door Providers

A Call for Investment in Our Communities’ Health
California’s Uninsured
& the Future of Open Door Providers

A Call for Investment in Our Communities’ Health

April 1999
“If our health care system is left entirely unprotected from market forces, it will evolve into something that divides rather than unites us.”

Dan Beauchamp, Ph.D.
School of Public Health
State University of New York at Albany
# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>List of Figures and Tables</td>
<td>iv</td>
</tr>
<tr>
<td>Executive Summary</td>
<td>1</td>
</tr>
<tr>
<td>Introduction</td>
<td>3</td>
</tr>
<tr>
<td><strong>SECTION I (Odd Pages):</strong></td>
<td></td>
</tr>
<tr>
<td>California’s Growing Uninsured Population</td>
<td>5</td>
</tr>
<tr>
<td>Intense Market Competition</td>
<td>7</td>
</tr>
<tr>
<td>Impact of Medi-Cal Managed Care</td>
<td>15</td>
</tr>
<tr>
<td>Unstable Financing Structure</td>
<td>19</td>
</tr>
<tr>
<td><strong>SECTION II (Even Pages):</strong></td>
<td></td>
</tr>
<tr>
<td>California’s Open Door Providers: A Welcome Distinction</td>
<td>6</td>
</tr>
<tr>
<td>Comprehensive Systems of Care</td>
<td>8</td>
</tr>
<tr>
<td>Primary Care and Preventive Services</td>
<td>10</td>
</tr>
<tr>
<td>Caring for Uninsured &amp; Vulnerable Populations</td>
<td>12</td>
</tr>
<tr>
<td>Centers of Excellence</td>
<td>14</td>
</tr>
<tr>
<td>A Vital Teaching Role</td>
<td>16</td>
</tr>
<tr>
<td>Preparing for the New Millenium</td>
<td>18</td>
</tr>
<tr>
<td>Changing with the Times</td>
<td>22</td>
</tr>
<tr>
<td>Controlling Costs</td>
<td>24</td>
</tr>
<tr>
<td>Quality Comes First</td>
<td>26</td>
</tr>
<tr>
<td>Conclusion</td>
<td>27</td>
</tr>
<tr>
<td>Endnotes</td>
<td>29</td>
</tr>
<tr>
<td>Appendix: CAPH Members</td>
<td>32</td>
</tr>
</tbody>
</table>
List of Figures and Tables

FIGURES

Figure 1a: Health Insurance Coverage of Californians, Ages 0-62 ................................................................. 5
Figure 1b: Post-Incremental Reform: Two-thirds Still Uninsured ........................................................................ 5
Figure 2: Patient Mix at Core Open Door Providers by Race .............................................................................. 8
Figure 3: Percent Change of Indigent and Uninsured Discharges at Core Open Door Providers and All Others .......... 11
Figure 4: Average Payor Mix at Core Open Door Providers ..................................................................................... 13
Figure 5: Medi-Cal Deliveries at Core Open Door Providers, 1993 and 1997 ........................................................ 17
Figure 6: Federal Medi-Cal DSH Funding ............................................................................................................... 21
Figure 7: Proposition 99 Appropriations for the California Healthcare for Indigents Program (CHIP) .................... 23

TABLES

Table 1: Expenses Attributable to Serving the Uninsured at Core Open Door Providers and All Other Hospitals ....... 9
Table 2: Indigent and Uninsured Discharges at Core Open Door Providers and All Others ..................................... 11
Table 3: Hospital-based Outpatient Services to Indigent and Uninsured Patients at Core Open Door Providers ........ 11
Table 4: Concentration of the Uninsured at Core Open Door Providers ................................................................. 13
Executive Summary

California revels in its reputation for being on the cutting edge—of entrepreneurship and high technology, of ethnic diversity and multiculturalism and of social and political trends that later sweep across the nation. In health care, too, California leads the way—in biotechnology, world-class research and medical centers, state-of-the-art medical treatments and the managed care revolution.

Unfortunately, California also holds the distinction as a leader in indicators that bode ill for our communities’ health: one of the lowest rates of employer-sponsored health insurance coverage, one of the fastest growing income gaps between rich and poor families, one of the lowest rates of Medi-Cal reimbursement and one of the highest rates of people without health insurance in the country. These and other major pressures are converging to challenge the health system in a profound and alarming way.

Mounting Pressures

Managed care now dominates the health care marketplace in California, which has one of the highest rates of market penetration and health delivery system reorganization in the country. While managed care has done much to address the issue of cost, it has neglected other critical areas of health care as a whole.

In particular, the survival of the state’s open door providers—providers which by mission and mandate serve the health care needs of all individuals in their communities, regardless of insurance status or ability to pay—is threatened by managed care and this intensely competitive health care marketplace.

Health policy researchers have identified four key pressures that are straining the ability of open door providers and our entire health care infrastructure to fulfill essential public goals, including providing access to care for the uninsured, maintaining critical community services, such as trauma care, and teaching the next generation of physicians.

1. The uninsured population is continuing to grow, even with a booming economy. The number of uninsured persons in California is rising at a rate of 50,000 per month. Currently, an estimated seven million people statewide are uninsured, despite the fact that the vast majority work at least part time. Despite their work status, three-fourths (75%) of the uninsured are in families with incomes below 200 percent of poverty. Most efforts to address the problem of the uninsured focus narrowly on expanding health insurance coverage to individuals through such programs as the new children’s health insurance program, Healthy Families. However, even assuming the successful adoption and full implementation of the most ambitious expansion proposals, nearly five million Californians would still be uninsured.

2. Market competition remains fierce. Both national and California data point to an intensely competitive marketplace that is straining open door providers. As financial pressures from managed care limit the ability of hospitals and physicians to provide care to the uninsured, open door providers are treating an increasing number and proportion of uninsured and medically indigent patients. A small group of 30 core open door providers—comprising only 6 percent of all hospitals statewide—provided nearly 40 percent of all inpatient care to these populations in 1998. Moreover, the total number of discharges for this patient population grew a dramatic 11 percent at open door providers in just five years. During the same period of time, overall discharges at these hospitals decreased by nearly 15 percent. In 1996 core open door providers expended more than $1.3 billion on hospital care to the uninsured—nearly 30 percent of their combined total operating expenses. Because only 15 percent of their payor mix are commercially insured patients, open door providers are severely limited in their ability to cross-subsidize.

3. Medi-Cal managed care has resulted in a diversion of key resources. Historically, open door providers have relied on Medi-Cal...
revenues to help cover the cost of providing care to the uninsured populations. With the advent of Medi-Cal managed care, private hospitals and physicians began to actively court Medicaid patients. The result has been a shift of Medi-Cal patients—and the revenues that follow them—away from open door providers.

4. Financing mechanisms are increasingly unstable. Open door providers rely on a patchwork of federal, state, and local funding to deliver a range of public goods that benefit the entire community, including health care to the uninsured. This funding structure is inherently unpredictable and, in many cases, the revenue sources that comprise it are in sharp decline. The Medi-Cal Disproportionate Share Hospital Payment program, for example, which has sustained open door providers during much of the 1990s, will experience a federally mandated 20 percent decrease by the year 2002. Similarly, the state’s tobacco tax, which was created by Proposition 99 in 1988 and funds health care to the uninsured, has plummeted in recent years as tobacco use decreases. The deteriorating financing structure, coupled with the managed-care squeeze, makes California’s open door providers among the most vulnerable in the country.

Open Door Providers: Increasing Cost-effectiveness

Like all other providers that operate in today’s intensely competitive marketplace, open door providers have responded by implementing cost-efficiencies, reengineering their systems and expanding their outpatient capacity. Such strategies are a critically important component of preserving the long-term viability of these essential providers. For example, Los Angeles County’s Department of Health Services is in the midst of a five-year restructuring project, with the goal of becoming more patient-based and oriented toward managed care. One of the innovations is the establishment of dozens of public-private partnerships with community clinics. In the Central Valley, the San Joaquin County Health Care Services joined other community providers to establish Community Health Partners, an integrated services network designed to meet the increasing challenges of expanding access to quality health care in the era of managed care. Similarly, in the Silicon Valley, the Santa Clara Valley Health and Hospital system undertook a comprehensive reengineering project to improve overall quality of care and patient satisfaction and to streamline operations.

Policy Recommendations

Although the future of open door providers is dependent on making their systems as cost-effective as possible, such efforts alone will not guarantee the survival of these essential providers. A renewed commitment by government to support open door providers is fundamental. The continued rise in the number of uninsured and growing marketplace pressures are not problems that open door providers or local government can solve on their own. State and national leaders must pick up where the market leaves off.

A new competition-era health care policy is needed that recognizes the role of open door providers in fulfilling certain social responsibilities and invests in their future. Just as our public schools provide the foundation for our children’s learning, California’s open door providers constitute the infrastructure for our people’s good health.

A Balanced Approach

California’s uninsured crisis and the limits of incremental reform call for a more balanced approach to health care reform. Policymakers should:

- Identify specific areas of health insurance coverage and health care services where the market has failed or is failing.
- Pursue opportunities to incrementally expand publicly sponsored insurance programs (e.g., Medi-Cal, Healthy Families) and, where appropriate and financially feasible, establish mechanisms to make employer-based and private insurance more affordable and available.
- Direct targeted support to health care systems that ensure access to basic medical services for low-income and uninsured populations and that maintain essential (if unprofitable) health services that benefit the entire community.
introduction

Providing access to quality health care services for all Americans has been one of the greatest challenges of our society. For most of this century, policymakers have proposed various plans for national health insurance, all of which have failed. In the meantime, programs and policies have been stitched together to support a number of public goals, including ensuring access to health care for the poor and uninsured, training health professionals and providing essential community services.

A core group of health care providers has assumed a major responsibility for these public goods. These “open door providers”—so-called because no one is denied access to the full scope of health care services they offer—are today at a crossroads. Far beyond the emergency care that hospitals are required by law to provide, open door providers embrace a mission and mandate to serve the health care needs of all individuals in their communities, regardless of insurance status or ability to pay. While these health care systems have managed to fulfill a commitment to serve their communities, growing instability in the current financing structure and intensified market pressures pose a threat to the continued viability of these important institutions.

California’s increasing number of uninsured individuals further complicates this equation. Since the rejection of President Clinton’s proposal for universal health care coverage in the early 1990s, the development of health care policy at both the state and federal levels has been—and will likely continue to be—incremental in nature. Yet, as modest expansions of health insurance coverage are enacted, open door providers will continue to provide the bulk of care to low-income uninsured populations.

A recent report published by the Washington, D.C.-based Urban Institute identified four key factors creating the uncertain future now facing open door providers throughout the country:

- The growing number of uninsured
- Intense marketplace competition
- Medicaid managed care
- An unstable financing structure

These researchers found that providers like open door providers appear to be capable of averting collapse so long as these factors are not all acting at the same time. Unfortunately, the future forecast for health care in California indicates not only that these factors will exist simultaneously, but that each will also be on an order of magnitude far surpassing its present level. In fact, open door providers in California were ranked among the most vulnerable in the country.

Of particular concern is the deteriorating financing structure that supports open door providers. For nearly two decades, California’s open door providers have been supported by an unstable patchwork of funding mechanisms that has helped to keep them solvent and accessible to the public. But this patchwork is fraying. The major explicit funding sources—including the Medi-Cal Disproportionate Share Hospital payment program and Proposition 99 (tobacco tax) funding—are diminishing, while the implicit sources, such as cross-subsidies from paying patients, are being rendered ineffective by the competitive marketplace and the impact of managed care.

Many researchers and public policymakers now recognize that direct and targeted support for open door providers is necessary to ensure continued access to care for the uninsured.
providers may be the most cost-effective and appropriate solution to ensuring that the growing millions of uninsured Americans retain access to health care services. In fact, President Clinton’s fiscal year 2000 budget includes a proposal to provide $1 billion over the next five years for just this purpose. Unless such steps are taken to address the precarious financing structure that currently maintains open door providers, access to health care services will be jeopardized for millions of Californians.

**About the Report**

This report describes the important role open door providers play in keeping California healthy and in giving all residents—including uninsured and vulnerable populations as well as the general public—the opportunity to enjoy healthy, productive lives. Against this backdrop, we offer a look—through national research and independent analysis—at the key emerging factors that shape the current health care marketplace and the challenges they present to these essential community providers. Finally, we conclude with recommendations for a competition-era health care policy that will preserve access to health care for all Californians now and in the future.

**A Note About the Data**

For purposes of reporting data in this report, we concentrate exclusively on the most easily identifiable subset of open door providers: those which have both a mission and a legal mandate (under §17000 of California’s Welfare and Institutions Code) to care for low-income uninsured populations. We recognize, however, that certain other key hospitals (including children’s hospitals, among others) and community clinics also provide extraordinary levels of care to the uninsured or otherwise play a critical role in ensuring the health and well being of their communities and may be considered open door providers. For the sake of clarity, we refer to the former group as “core open door providers.”

**HOW TO READ THIS REPORT**

The report consists of two separate, though complementary, sections running side-by-side the entire length of the document. Section I, which describes the marketplace and its challenges for open door providers, runs along the odd pages of the document (right side of a spread). Section II, which focuses on the role of open door providers and offers a series of “profiles” on some of the specific efforts open door providers have undertaken, runs along the even pages of the document (left side of a spread). Readers may follow the sections either simultaneously or sequentially. This introduction, as well as the conclusion, tie the two sections together for a complete picture of open door providers and the challenges they face.
California’s Growing Uninsured Population

The number of uninsured persons in California is rising at a rate of 50,000 per month. Despite California’s strong economy in recent years, the latest data reveal that seven million people statewide are uninsured (Figure 1a). Ethnic and racial minorities, especially Latinos, have lower rates of job-based insurance coverage and higher rates of uninsurance. California’s low- and moderate-income residents are also more likely to be uninsured. Nearly half of California’s non-citizen residents are uninsured.

The vast majority of uninsured Californians—8 out of 10—work at least part time, and nearly half work full time, year-round. Despite their work status, three-fourths (75%) of the uninsured are in families below 200 percent of poverty (less than $26,700 for a family of three in 1997), an income level that makes health insurance premiums a difficult financial burden. Indeed, most uninsured Californians report that their main reason for not having insurance is that coverage is simply unaffordable. Although the number of Californians covered by job-based health insurance increased in 1997, declines in Medi-Cal coverage and the private purchase of health insurance more than offset these gains.

Consequences of a lack of coverage

The health consequences of a lack of insurance are well known. Uninsured individuals and families are much less likely to have regular contact with the health care system than those who have insurance coverage. One study found that about 18.5 percent of California’s children live in low-income families where parents are “not confident” that they could get their child needed medical care. Researchers at the University of California, Berkeley found that uninsured adults in California had significantly lower rates of receiving recommended preventive care than the insured. For example, only 34 percent of uninsured California women 50 years and older received recommended mammograms in the last two years compared to 85 percent of insured women over 50. Because their primary health care needs are not being

Figure 1a. Health Insurance Coverage of Californians, Ages 0-64

![Figure 1a. Health Insurance Coverage of Californians, Ages 0-64](image)


Figure 1b. Post-Incremental Reform: Two-thirds Still Uninsured

Even under the most expansive and optimistic projections for covering the uninsured under existing programs, nearly five million Californians will remain uninsured.

![Figure 1b. Post-Incremental Reform: Two-thirds Still Uninsured](image)

Remaining Uninsured: 4,857,000

Number of people insured under proposals to streamline/expand Medi-Cal & Healthy Families: 2,143,000

Source: UCLA Center for Health Policy Research, March 1999
CALIFORNIA’S OPEN DOOR PROVIDERS: A WELCOME DISTINCTION

Open door providers represent an essential part of our communities’ resources. Without them, we wouldn’t have the peace of mind that comes with knowing that life-saving trauma systems are in place; that our children are immunized; that the restaurants we dine in are safe; or that if we lose health insurance coverage we will still have a place to go for care.

California’s open door providers are the hospitals, clinics and health care systems that share a mission and mandate to serve the health care needs of all Californians, regardless of their ability to pay. Theirs is a promise to keep their doors open to every member of the community—whether young or old, rich or poor, well or sick, insured or uninsured. In many communities, this promise has been a tradition for more than a century.

The public health care systems that serve as open door providers form the core of the state’s health care infrastructure, just as public schools and public roads constitute the foundation of our education and transportation systems. When any part of this vital health care infrastructure is neglected or weakened, the repercussions are felt throughout our communities, in both the public and private sectors. When a public hospital emergency room closes because of a lack of funding, the private sector experiences increased pressure to meet the demand for services, a situation that can ultimately result in limited access to care, especially for low-income and uninsured populations.

Open door providers are committed to ensuring the availability of high quality, cost-effective and culturally appropriate health care provided in a welcoming, supportive and respectful environment. They offer the full spectrum of essential community health services, from emergency medical services and prevention-oriented primary care services for the whole family, to highly specialized medical treatments and long-term care. In 16 California counties, the open door providers are publicly owned and operated at the local level. In other counties, local government has partnered with the private sector or the local University of California medical centers to fulfill this important role.

“We need to enable our public hospitals, and our community and university health centers, to provide basic, affordable care for the millions of working families who don’t have any insurance.”

President Clinton
1999 State of the Union Address

ODP FACT FILE:
Core open door providers account for more than 60 percent of all burn care, psychiatric emergency care and Level I trauma centers in California.
met, uninsured individuals are also more likely than their insured counterparts to be hospitalized for complications resulting from common preventable medical conditions, like asthma or diabetes.

**The limits of incremental reform**
In recent years, most efforts to address the problem of the uninsured have narrowly focused on expanding health insurance coverage for the individual. Although these piecemeal changes are important first steps, they do not adequately address the problem. California’s Healthy Families program promises to cover as many as 328,000 low-income children when fully implemented. But according to projections by the program’s administrators, fewer than half that many (138,000) will be enrolled by the program’s one-year anniversary. Another 788,000 children are currently eligible for, but not enrolled in, the Medi-Cal program. All other state-sponsored health insurance programs combined (i.e., AIM, HIPC, MRMIP) cover only about 170,000 Californians. Even assuming the successful adoption and full implementation of pending proposals to expand eligibility in the Medi-Cal and Healthy Families programs for children and their parents up to 300 percent of poverty, the number of uninsured Californians would still be nearly five million (Figure 1b).

**Intense Market Competition**

California has one of the most competitive health care market places in the country. In fact, when compared to other states, California is often characterized as a state with one of the most advanced stages of market development. One measure of such development is the degree of managed care market penetration. Approximately 70 percent of non-elderly insured Californians are covered by a managed care plan. Nearly 50 percent are enrolled in an HMO, including more than 10 percent of whom are enrolled in a Medi-Cal managed care plan.

Further contributing to the competitive environment is the continuing consolidation of market power by a few large health plans and provider delivery systems. Very few private hospitals remain unaffiliated with some larger chain—such as Catholic Healthcare West, Sutter Health, Tenet Healthcare Corp., or Columbia/HCA Healthcare Corp.—and only four HMOs now dominate the managed care market. Such consolidations, as well as conversions of not-for-profit health care systems and HMOs to for-profit status, are driven by the need to reduce costs and maintain market share among paying patients.

A fiercely competitive marketplace affects open door providers in two ways. First, it makes it more difficult for these health systems to attract private-pay patients and, increasingly, Medi-Cal patients. Price competition puts open door providers at a severe disadvantage in obtaining managed care contracts because managed care organizations are reluctant to recognize the added costs associated with the public service mission—teaching, care to the uninsured, and maintaining unprofitable, but essential, community services.

Second, competitive pressures limit the private sector’s ability to cost-shift, resulting in a loss of charitable capacity. Simply put, providing a significant amount of uncompensated care is a competitive disadvantage. Joyce Mann of the Rand Corporation and her colleagues found a direct correlation: “The greater the degree of HMO penetration, the lower the provision of uncompensated care relative to the hospital’s size, with the effect being stronger in the most competitive markets.”

Similarly, a recent study found that physicians tend to provide less charity care as their practices become more dominated by managed care business. Physicians who derive 85 percent or more of their total practice income from managed care provided about half as much charity care as those with no managed care business.

**The cost of health care for the uninsured**
In 1996, the 30 hospitals that comprise the core of California’s open door providers provided over $1.3 billion of hospital care to the medically indigent (generally defined as individuals with incomes at 100 percent of poverty and below) and uninsured populations. Such care constitutes a significant percentage of these hospitals’ total operating expenses—29 percent. In contrast, all other hospitals in the state combined—477 statewide—provided about $1.4 billion in care to medically
Most open door providers are comprised of comprehensive health care systems offering a broad array of programs that include ambulatory care services, hospital care, public health services, home health care, emergency medical services, substance abuse treatment services and mental health services. The structure ensures patients access to a lifetime continuum of services across the health care spectrum. More importantly, the close relationships that are established through these coordinated systems of care make it easier for patients to gain access to the entire range of services they need. For example, a patient receiving care at an open door primary care clinic may require special care for a drug problem or psychiatric disorder. Because of the close ties open-door providers have to other segments of the local health care system, they can help patients more easily navigate the system and ensure good continuity of care. Likewise, many open door providers are the locus for a variety of important public health efforts—like breast cancer early detection programs, HIV/AIDS prevention and child health and disability programs. This close linkage enables a smooth transition from population-based public health services to medical treatment that is tailored to meet the needs of the individual.

The health care needs of California's diverse communities are often a function of the complex economic, social and cultural factors that shape each community differently. As such, cookie-cutter approaches to delivering health care, especially to vulnerable populations, simply don’t work. Because most open door providers are locally owned and operated, they are uniquely well suited to develop creative and effective approaches that fit the special health care needs of the people they serve. Working in partnership with schools, government agencies, community groups and community-based organizations, open door providers are continually inventing new and different ways to improve the health and well being of their communities.

California’s core open door providers serve a patient population that reflects the Golden State’s diversity (Figure 2).

![Figure 2. Patient Mix at Core Open Door Providers by Race](source: OSHPD hospital discharge data for 1996)
indigent and uninsured patient populations, which represents about 5.8 percent of their total operating expenses (Table 1). Thus, while core open door providers account for only six percent of hospitals statewide (and ten percent of the beds), they provide nearly half of all care to indigent and uninsured populations in the state.

Not all care to the uninsured is unreimbursed, however. In many private hospitals in California, care to the uninsured actually results in net revenues—not losses—which may be the result of an ability on the part of a significant subset of the uninsured to pay for their own care out of pocket.27 Elective cosmetic surgery, for example, is generally not covered by insurance. In hospitals that did experience shortfalls from care provided to patients without a third-party payor, those shortfalls totaled $332 million out of $1.4 billion in total expenses.28

Data from Alameda and Los Angeles counties exemplify the uncompensated-care disparity between public and private hospitals. In these counties, according to a study by the Urban Institute, the majority of all uncompensated care was concentrated in core open door providers—the highest percentage of the 16 sites surveyed nationwide.29

Growing burden on open door providers
It is undisputed that care to the uninsured has increased dramatically in open door providers and that uncompensated care is becoming more concentrated in these hospitals, especially public teaching hospitals. In fact, just 66 public hospitals nationwide account for nearly one-quarter of the total uncompensated care costs provided by all hospitals in the U.S., according to the National Association of Public Hospitals and Health Systems.30

Numerous published studies report that, on average, public hospitals provide more than twice as much uncompensated care as private hospitals.31 In addition, the level of uncompensated care provided by major public teaching hospitals nationwide increased by more than one-third between 1989 and 1994, while private hospitals, including private teaching hospitals, reduced their percentage of uncompensated care.32

In California, the gap between the level of care to the uninsured provided by open door providers and other hospitals is clearly growing. The number of dis-

---

**Table 1. Expenses Attributable to Serving the Uninsured at Core Open Door Providers and All Other Hospitals**

<table>
<thead>
<tr>
<th></th>
<th>Core ODPs</th>
<th>All Others</th>
<th>Core ODP Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of hospitals</td>
<td>30</td>
<td>477</td>
<td>5.9%</td>
</tr>
<tr>
<td>Expenses attributable to serving the uninsured</td>
<td>$1.3 billion</td>
<td>$1.4 billion</td>
<td>48%</td>
</tr>
<tr>
<td>Total operating expenses</td>
<td>$4.6 billion</td>
<td>$24.3 billion</td>
<td>15.9%</td>
</tr>
<tr>
<td>Percent of total operating expenses attributable to serving the uninsured</td>
<td>29.0%</td>
<td>5.9%</td>
<td>n/a</td>
</tr>
</tbody>
</table>

Source: OSHPD hospital and financial data for 1997

“Mergers among hospitals and conversions of nonprofit hospitals to for-profit status, especially amid a system-wide drive toward cost efficiency, raise questions about continued commitments to community-based uncompensated care.”

*Stephen Zuckerman, Ph.D. et al.*

*Urban Institute*
Primary Care and Preventive Services

Over the past several years, the health care industry has witnessed a dramatic change in the way health care services are delivered. This change is characterized by a shift away from costly, hospital-based services to more affordable, prevention-oriented primary care services delivered in an outpatient setting. In other words, the focus today is on keeping people healthy and out of the hospital.

Although the need for hospital care cannot always be avoided, advances in medical technology have enhanced the ability of medical providers to treat illness and prevent disease in conveniently located, community-based outpatient settings. Open door providers offer patients a wide range of primary care and specialty services available on an outpatient basis.

When it comes to ensuring good health, an ounce of prevention truly is worth a pound of cure. By some estimates, prevention efforts could curb the nation’s $1 trillion spending on health care by one-third. For example, studies show that every $1 spent on prenatal care saves $3 in future costs for preventable health problems in babies. But the value of primary and preventive care is measured in both financial and human terms. Medical cost-savings do not begin to approach the tremendous savings gained by averting the physical and emotional suffering wrought by disease, disability and illness.

In line with this heightened emphasis on primary and preventive care, public health care systems have steadily increased their capacity for delivering outpatient services. Most are expanding existing health centers or building new ones, contracting with community-based organizations for additional health care services or joining with partners in the private sector to augment their delivery networks. Many also operate school-based or mobile health clinics designed to bring needed medical services to community residents in remote areas.

Open Door Profile #1: Emphasizing Prevention-oriented Primary Care

In 1996, Los Angeles County’s Department of Health Services (DHS) began a five-year restructuring project, with the goal of becoming more outpatient-based and oriented toward managed care. In exchange for federal funding, the department committed to increase access to primary care services by 50 percent and significantly decrease inpatient care and inappropriate use of emergency services. One of the innovative ways in which the department has begun to fulfill this commitment is through the establishment of dozens of public-private partnerships. These partnership arrangements include 1) the privatization of once-public health centers, 2) private agencies co-locating with DHS staff at health centers, and 3) arranging for low-income uninsured patients to receive care at a private partner’s facility.

This business strategy has expanded the public health system’s relationship with other providers in the county who also have a long history of serving the poor and uninsured population. Referral centers established at each of the county’s open door hospitals link private primary care partners to the diagnostic, specialty and inpatient services available at DHS facilities throughout Los Angeles. Each referral center has a full-time staff dedicated to managing requests, eliminating duplication of patient intake and screening, and reducing entry into the system through emergency room visits. Based on client data, the public-private partnerships are successfully targeting low-income individuals between the ages of 15 and 44 years who lack alternative health insurance coverage.

Although the need for hospital care cannot always be avoided, advances in medical technology have enhanced the ability of medical providers to treat illness and prevent disease in conveniently located, community-based outpatient settings. Open door providers offer patients a wide range of primary care and specialty services available on an outpatient basis.

When it comes to ensuring good health, an ounce of prevention truly is worth a pound of cure. By some estimates, prevention efforts could curb the nation’s $1 trillion spending on health care by one-third. For example, studies show that every $1 spent on prenatal care saves $3 in future costs for preventable health problems in babies. But the value of primary and preventive care is measured in both financial and human terms. Medical cost-savings do not begin to approach the tremendous savings gained by averting the physical and emotional suffering wrought by disease, disability and illness.

In line with this heightened emphasis on primary and preventive care, public health care systems have steadily increased their capacity for delivering outpatient services. Most are expanding existing health centers or building new ones, contracting with community-based organizations for additional health care services or joining with partners in the private sector to augment their delivery networks. Many also operate school-based or mobile health clinics designed to bring needed medical services to community residents in remote areas.
charges for indigent and uninsured Californians at core open door providers rose by 11 percent between 1993 and 1998, while private hospitals statewide experienced a 16 percent decrease in hospital discharges for these populations (Table 2 and Figure 3). In 1998, 30 open door providers alone reported almost 95,000 discharges for the indigent and uninsured—nearly 40 percent of all inpatient care to these populations statewide.33

Similarly, open door providers are experiencing dramatic increases in their volume of outpatient services to the uninsured. Table 3 illustrates that between 1993 and 1998, the number of hospital-based outpatient visits for the uninsured increased at core open door providers by more that 20 percent and accounts for more than one-third of all their visits. This does not include the nearly three million additional outpatient visits to community-based clinics operated by open door providers or their affiliates and partners, a similar proportion of which are made by uninsured patients.

**Open door providers increase access for the uninsured**

Overall access to health care for the uninsured is enhanced by the presence of an open door provider. Specifically, the total amount of uncompensated care provided in a community tends to be greater in communities with a public hospital than in those without, indicating that core open door providers ensure a critical access point for the uninsured that is absent in areas without such providers.34, 35 This is particularly true with regard to specialty care. One recent study found that insurance status is a major determinant of where patients who are in need of certain types of specialty care—AIDS, high-risk infant care and major trauma care—receive their care. Uninsured patients are disproportionately treated in open door providers, particularly major public teaching hospitals.36

In California, state data show that more care is provided overall to low-income populations in counties with a county hospital than in comparable counties without one.37,38 Moreover, patients treated in open door providers appear to have comparatively greater severity of illness and longer average lengths of stay than their counterparts treated in the private sector. By definition, this means that open door providers incur much greater costs caring for these more vulnerable patients. Again, this appears particu-

<table>
<thead>
<tr>
<th>Year</th>
<th>Core ODPs</th>
<th>All Others</th>
<th>Core ODP Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993</td>
<td>84,447</td>
<td>177,947</td>
<td>32.2%</td>
</tr>
<tr>
<td>1998</td>
<td>94,030</td>
<td>149,514</td>
<td>38.6%</td>
</tr>
<tr>
<td>Percent Change</td>
<td>11.35%</td>
<td>-15.98%</td>
<td>n/a</td>
</tr>
</tbody>
</table>

Table 2. Indigent and Uninsured Discharges at Core Open Door Providers and All Others

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Uninsured/Indigent Visits</th>
<th>Total Visits</th>
<th>Percent Uninsured/Indigent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993</td>
<td>2,058,271</td>
<td>5,512,383</td>
<td>37.34%</td>
</tr>
<tr>
<td>1998</td>
<td>2,501,080</td>
<td>7,090,092</td>
<td>35.28%</td>
</tr>
<tr>
<td>Percent Change</td>
<td>21.51%</td>
<td>28.62%</td>
<td>n/a</td>
</tr>
</tbody>
</table>

Table 3. Hospital-based Outpatient Services to Indigent and Uninsured Patients at Core Open Door Providers

Source: OSHPD hospital financial quarterly data for 1993 and 1998

Figure 3. Percent Change of Indigent and Uninsured Discharges at Core Open Door Providers and All Others, 1993 to 1998

Source: OSHPD hospital financial quarterly data for 1993 and 1998
CARING FOR UNINSURED & VULNERABLE POPULATIONS

Open door providers share a long-standing commitment of reaching out to individuals who are most vulnerable to health problems and their consequences. Their multicultural and multilingual health professionals are specially trained to meet the unique needs of vulnerable populations and are experienced in treating patients whose medical needs may be complicated by psychosocial or socioeconomic factors. In short, open-door providers are the experts in delivering the best, most comprehensive and culturally appropriate care to individuals whose health care needs are complex and varied.

Studies show that vulnerable populations—including the poor, the uninsured, the homeless and the mentally ill—are more likely to lack a routine source for health care. As a result, they tend to delay seeking needed health care until they are very sick. This lack of continuity leads to greater reliance on the sporadic treatment provided through the emergency room. Treating vulnerable populations only in emergencies is often more costly than preventive care—for a patient, for providers and for the overall economy. By placing greater emphasis on primary and preventive services designed to enhance the health and well-being of all Californians, open door providers lead the way in delivering high-quality, cost-effective health care that keeps the focus on what’s best for patients.

For the most part, open door providers operate ambulatory care clinics where patients may “walk in” or make an appointment for care. Many also offer urgent care and extended evening and weekend hours for greater convenience. This is especially important for the uninsured, as walk-in hours at hospitals and health centers provide necessary access to patients unable to secure regular appointments during normal business hours.

Open Door Profile #2: Helping Patients with Special Needs

Several studies have found that a large number of emergency department (ED) visits are accounted for by a relatively small group of patients. These high users—many of whom use the ED as their primary source of medical care—often have significant medical disorders as well as psychological, social and economic problems. Besides serious medical, psychiatric and cognitive problems like depression and substance abuse, these patients are homeless, unemployed, uninsured and suffer significant “life stressors” like profound alienation, isolation and the threat of physical assault.

To address this problem, San Francisco General Hospital conducted a pilot study to determine whether intensive case management services could meet the complex needs of these high users while decreasing utilization and costs. The program results are remarkable: homelessness decreased by 44 percent, substance use decreased by 38 percent, inpatient hospitalizations decreased by 30 percent, and ED visits among these high users decreased by 21 percent. In addition, 32 percent of patients were successfully linked to other support programs. This successful program has served hundreds of high-user patients and is now being expanded.
larly true for certain types of specialty care. For example, the 30 hospitals that make up the core open door providers deliver fully 28 percent of the care for “complex AIDS” cases in California. Similarly, 18 of the core open door providers who participate in the California Children’s Services program (CCS) provide nearly one-third of all inpatient Medi-Cal services to children who are diagnosed with a chronic or serious acute medical condition under CCS.39

Shrinking ability to cross-subsidize care to the uninsured

As care to the uninsured becomes more concentrated in open door providers, the uninsured also represent a greater proportion of the patient mix at these hospitals—further limiting the ability of open door providers to utilize cost-shifting mechanisms to help subsidize this care. Whereas in 1992 an average of 22 percent of all discharges at California’s core open door providers involved indigent and uninsured patients, by 1998, this proportion grew to nearly 29 percent of all discharges (Table 4).40

At the same time, open door providers have few options to pay for this care and must rely predominantly on public revenues and subsidies. Core open door providers receive on average only about 31 percent of their operating budgets from Medicare and privately insured patients. The remaining service—70 percent—is to low-income Medi-Cal and the uninsured patients (Figure 4). Total margins, which account for hospital revenues from all sources, including such things as grants and parking, are another important indicator of the fiscal vise created by the competitive marketplace. OSHPD reports that, for 1996, county hospitals, on average, experienced slightly negative total operating margins.41 Although recent reports indicate that total hospital margins have tightened during 1999, the hospital industry averaged a positive four percent margin in 1996, with investor-owned facilities reporting the highest margins, at 7.7 percent.42

In contrast, private hospitals are able to employ a broader range of cost-shifting methods to cover shortfalls resulting from treating Medi-Cal patients as well as unreimbursed care to the uninsured. Direct payments (e.g., Medicare and Medi-Cal Disproportionate Share Hospital (DSH) payments, grants and private philanthropy) and indirect payment methods (e.g., cost-shifting to commercially insured and Medicare

<table>
<thead>
<tr>
<th></th>
<th>Total Uninsured/ Indigent Discharges</th>
<th>Total Discharges</th>
<th>Percent Uninsured/ Indigent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993</td>
<td>84,447</td>
<td>384,577</td>
<td>21.96%</td>
</tr>
<tr>
<td>1998</td>
<td>94,030</td>
<td>327,512</td>
<td>28.71%</td>
</tr>
<tr>
<td>Percent Change</td>
<td>11.35%</td>
<td>-14.8%</td>
<td>n/a</td>
</tr>
</tbody>
</table>

Source: OSHPD hospital quarterly financial data for 1993 and 1998

Seventy percent (70%) of expenses at core open door providers are attributable to serving low-income populations (i.e., Medi-Cal and uninsured).
Although their primary mission centers on meeting the health care needs of vulnerable, low-income and uninsured populations, open door health systems provide a comprehensive array of inpatient, outpatient and public health services that ensure access to essential health care services for the whole community. It is often the case that open door providers offer services that are simply unavailable elsewhere in the county.

In addition to the typical menu of hospital services—including emergency room, labor and delivery, and acute medical/surgical services—open door providers offer many highly specialized services that most private health care institutions find economically unattractive, such as:

- Neonatal intensive care units
- Trauma care
- Burn care
- Hazardous material exposure treatment
- Rehabilitation services
- Acute psychiatric care
- AIDS clinics

Many of these “public goods” require major up-front investments in fixed assets that are relatively underused. For example, the cost of keeping a trauma unit in place and operational stays constant, no matter how many people receive treatment there. In many regions of the state, these tertiary services are available only through open door providers, which means they are an essential community resource that benefits everyone, regardless of income or insurance status. Open door providers are also on the front lines of response in the event of a major disaster, such as an earthquake, when large numbers of community residents are likely to be affected. In addition, open door providers are frequently the sole providers of health care for cases of an extremely sensitive nature—such as rape or sexual abuse—that might require involvement by the criminal justice system. Open door provider staffs have the expertise needed to testify in legal proceedings and are specially trained to deal with the special emotional and physical needs of traumatized patients.
patients and, for not-for-profit hospitals, the value associated with tax-exempt status) are used to cover their uncompensated care costs and maintain positive operating margins.

For example, a recent Urban Institute study reported that one Los Angeles private hospital which serves a significant number of Medi-Cal patients had an operating margin of negative 1.5 percent, exclusive of Medi-Cal DSH payments. After accounting for Medi-Cal DSH payments, however, that hospital’s operating margin was a positive 12 to 15 percent. It is important to note that this same hospital’s charity fraction as calculated under the state’s DSH formula was only 3.3 percent. Clearly, while Medi-Cal DSH payments helped the hospital make up shortfalls resulting from low Medi-Cal payment rates, they did not provide any additional incentive to serve the uninsured.

Impact of Medi-Cal Managed Care

Beginning in the mid-1990s, California embarked upon the largest expansion of Medicaid managed care in the country. Today, nearly 2.5 million Medi-Cal beneficiaries are enrolled in a managed care program. Nineteen of the state’s largest counties participate in a mandatory managed care program, utilizing one of three primary modes—Two-Plan Model, County Organized Health System, and Geographic Managed Care.

Nationwide, numerous studies point to the negative impact Medicaid managed care is having on providers that serve the poor. Historically, open door providers have used Medicaid revenues, especially DSH revenues, to help cover the cost of providing care to the uninsured populations, as well as to Medicaid beneficiaries. With the advent of Medicaid managed care and as overall competition increases, private hospitals are actively courting Medicaid patients, especially when they also receive DSH payments. The result is a shift of Medicaid patients and DSH payments to the private sector, without a concomitant shift in care to the uninsured.

Published assessments of Medicaid managed care programs in Oregon and Tennessee identified a serious unintended consequence: because of the precarious financial status of open door providers following the implementation of managed care, the uninsured may actually be worse off than before. A recent study by the Center for Health System Change confirms this finding. The study found that uninsured persons were about 75 percent more likely to lack a usual source of care in states with high Medicaid managed care penetration than uninsured persons in low Medicaid managed care states.

Open door providers losing Medi-Cal marketshare

The trends in California are similar. Under the expansion of Medi-Cal managed care, open door providers are losing their marketshare of Medi-Cal patients. As increasing numbers of Medi-Cal beneficiaries are being treated by the private sector, essential revenues once used to subsidize care for the uninsured have shifted to the private sector. Researchers at the Urban Institute report that competition for Medicaid patients across the country

“As managed care plans squeeze out the surpluses from care of those with private insurance, access to free or subsidized care is increasingly at risk. The consequences of being uninsured are even bleaker than in the past.”

Karen Davis, Ph.D.
President
The Commonwealth Fund
A VITAL TEACHING ROLE

California’s open door providers operate programs for training physicians, nurses and a cadre of allied health professionals such as pharmacists, midwives, physician assistants, laboratory and x-ray technologists, physical, occupational and speech therapists, dietitians, podiatrists and others. The open-door providers run by the University of California—the UC Medical Centers at Davis, Irvine and San Diego—operate residency programs that alone train nearly 2,000 physicians each year.

Medical professionals training in the ethnically diverse world of open door providers gain experience with a wide variety of sociocultural and socioeconomic factors that influence patient disease patterns, treatment regimens and the provider-patient relationship. Such exposure is especially valuable in a state like California, where more than half the population will be non-white by the turn of the century. Open door providers’ unique configuration as part of a larger health care system supports training in a range of both hospital- and community-based settings. Moreover, the volume and diversity of the low-income and uninsured populations treated in teaching facilities are critical to ensuring the state-of-the-art academic and research programs needed to train the workforce of the new millennium.

Most open-door providers offer training programs in the high-demand specialty of family practice, the medical specialty that provides continuing and comprehensive health care for the individual and family. The growing demand for family practitioners may be traced to the rise of managed care and the general trend in health care toward concentrating on prevention-oriented primary care services. San Bernardino County’s public hospital is home to California’s largest—and the nation’s second largest—family practice residency program. Since its establishment thirty years ago, the family practice training program at Ventura County Medical Center has graduated the most family practice physicians of any program in the country.

Not only do these major teaching centers play a vital role in maintaining outstanding training programs for California’s future generation of physicians, they also serve as a major source of health care to vulnerable populations that face limited access to health care services as well as for the entire community. Kern Medical Center, for instance, offers the only 24-hour physician coverage of any hospital in the county through its graduate medical education programs. Moreover, many residents will stay to practice medicine in the community where they complete their training, helping to ensure a steady supply of providers in those geographic regions. For example, more than half of the medical residents enrolled in the training programs at University Medical Center in Fresno remain in the area to practice medicine locally.

Open Door Profile #4: Creating a Vision Together

The city of North Richmond, located in West Contra Costa County, is one of the poorest communities in the state, characterized by poverty, persistent unemployment, violence, toxic exposures, HIV/AIDS, TB, low birth weight, substance abuse and chronic disease. In 1993, a toxic release from a local refinery resulted in over 20,000 West County residents seeking medical treatment. As a result of this incident, Contra Costa Health Services, working in partnership with the community, secured funding to construct a new health center—named the Center for Health. The Center, which opened in 1999, is designed to offer basic family practice medical care for all ages including preventive dental care, health education, and coordination of care for all special needs, prevention and treatment TB and HIV/AIDS, and youth programs that open avenues to health careers. Services and activities also include environmental health and worker health education through an interactive community education center.
tends to focus on newly eligible pregnant women and children but not on the disabled or children with special health care needs.” Figures in California bear out this trend. From 1993 to 1997, the number of Medi-Cal deliveries at open door providers decreased by 39 percent (Figure 5). This loss of Medi-Cal patients further limits the ability of open door providers to cross-subsidize care for the uninsured.

A particularly dramatic example of this phenomenon can be found in Orange County. The University of California at Irvine (UCI)—the major open door provider in Orange County providing highly specialized care as well as care to the uninsured—experienced a severe drop in Medi-Cal inpatient days following implementation of CalOPTIMA, the Medi-Cal managed care program in Orange County. Between March 1996 and 1998, UCI saw a 52 percent decline in Medi-Cal managed care enrollees.

At least two other reports from late 1997—one by the Health Access Foundation and one by the Institute for Health Policy Studies—further document the loss of Medi-Cal market share by open door providers as a consequence of managed care.

**Inadequate protection measures**

California’s Medi-Cal managed care programs include a number of protections which have attempted to mitigate the potential negative effects of managed care, such as the establishment of local public health plans, called Local Initiatives, requirements to contract with safety net providers and favorable auto-assignment policies. Regrettably, these provisions have proven insufficient. For example, contracting requirements do not guarantee that open door providers will enroll members or receive referrals.

This is particularly true with respect to the Commercial Plan in Two-Plan Model counties. Although most open door providers have contracts with both the Local Initiative and the Commercial Plan, Commercial Plan members utilize open door providers, in both absolute and percentage terms, to a far lesser degree than do members of the local health plan.

Medicaid managed care may also exacerbate risk selection, the process by which health plans or providers seek to enroll healthy, low-cost patients. As noted above, commercial health plans and private providers are aggressively seeking the healthier Medi-Cal beneficiaries. At the same time, sicker and poorer patients who have a relationship with an open door provider will often choose to remain or be automatically assigned to that provider and its contracting plan. For example, in Oregon’s Medicaid managed care program—one of the earliest and most comprehensive in the country—the safety-net provider-based HMO, Care Oregon, is experiencing intense adverse selection. It enrolls a disproportionate share of HIV/AIDS patients as well as non-English speaking members, who need translation and other support services. The capitation payments are inadequate to adjust for this phenomenon.
PREPARING FOR THE NEW MILLENNIUM

In the past few years, California’s open door providers have experienced a renaissance. Many public facilities have undergone major renovation or replacement to ensure the continued availability of state-of-the-art, seismically safe facilities designed with the needs of patients foremost in mind. These modern facilities combine the most up-to-date medical technology for patient care with the flexibility to accommodate future changes in technology. As such, they are valued community resources that will benefit the communities they serve now and for decades to come.

With the opening of several new facilities around California, open door providers today rank among the most modern, efficient and seismically safe hospitals anywhere in the state. In addition to breathing new life into a long-ignored public health care delivery infrastructure, these improved facilities provide an opportunity for public facilities to deliver high-quality health care in a more efficient and cost-effective manner. Moreover, state law requires acute care facilities in California to evaluate their buildings and prepare plans for achieving seismic safety standards by 2001. The law sets a deadline of Jan. 1, 2008, for these hospitals to either meet the updated standards or be decommissioned as inpatient facilities. Although the end result of this legislation is an anticipated 29 percent fewer hospital beds statewide, all of the newer open door hospitals are built to meet these stricter standards.

Open Door Profile #5: Anatomy of a World-Class Hospital

Health care executives from New York to Japan have traveled to the new Arrowhead Regional Medical Center to see what many consider to be the most advanced medical equipment available in hospitals today. Here’s a sampling of some of the high-tech highlights:

- Picture Archiving and Communication System (PACS) is a filmless radiology system that uses computerizes images for all X-rays and MRIs and makes them available at online workstations throughout the hospital. Arrowhead is one of only a few hospitals worldwide and the first in the nation to use all-digital imaging.

- Medaes Critical Care Gas Columns—conveniently located next to every trauma and intensive care unit bed—are equipped with medical gases, electrical outlets, nurse call buttons, telephone, data and patient monitoring devices. The moveable column facilitates patient care by making essential medical equipment readily accessible to physicians and nurses.

- The pharmacy in the outpatient care center uses a unique automated prescription-filling device called an Optifill that allows pharmacists more time to counsel patients. Medications are dispensed from cassettes into bottles, which are then labeled and sent down a conveyor belt to a pharmacist who checks the prescription.

- Remote diagnostic networking using portable monitors gives doctors up-to-the-minute information on the brain and heart activity of their patients any time of the day or night. Results can be viewed from the doctor’s office or home computer.

- Space Labs Fetal Monitors can measure and record heart activity for even the smallest baby, allowing the physician/nurse team to better monitor every baby’s well-being during the labor and delivery process.

In the heart of Silicon Valley, the new Santa Clara Valley Medical Center stands as a testament to the long tradition of service and dedication to the health of the whole community. Former White House Chief of Staff Leon
Healthy Families Program
California recently implemented Healthy Families, the state’s version of the federal Children’s Health Insurance Program. This program offers health insurance coverage for children in families with incomes up to 200 percent of the poverty line who do not qualify for Medi-Cal. This expansion in health coverage—the largest since Medicaid and Medicare in the mid-1960s—targets the healthiest and easiest to insure population. Yet, this program leaves millions of Californians uninsured and reliant on open door providers for their health care needs.

Although still too early to tell, this new health care expansion for children is expected to follow the same pattern as the Medi-Cal managed care program. With multiple commercial plans participating in each county, open door providers do not expect to enroll significant numbers of patients. Consequently, revenues from this program will not likely assist the state’s core health care infrastructure.

Unstable Financing Structure
California’s core open door providers currently rely on a tenuous and unpredictable patchwork of funding—based primarily on Medi-Cal revenues and state and local subsidies—to carry out their mission and mandate to serve the health care needs of all residents, regardless of insurance status or ability to pay. Unfortunately, over much of the last two decades, these programs have not kept pace with the rising cost of, and demand for, health care services. Indeed, during this same period of time, California’s population has increased by 40 percent, the cost of medical care has skyrocketed, and the state suffered a severe and prolonged recession creating more poverty and uninsured families.

Moreover, the incentives associated with these funding programs, which were created before the advent of managed care, are in conflict with today’s competitive health care environment, which emphasizes primary and preventive care delivered in outpatient settings. Most of the financing streams that support health care to the low-income uninsured are inpatient-driven. This conflict imposes a significant barrier to the ability of open door providers to restructure their health care systems into primary care-focused systems consistent with the principles of managed care and cost-effectiveness. Los Angeles County sought and won approval of a federal 1115 waiver from the federal government in order to transform its health care system. Central to the success of this restructuring effort is changing the financing mechanisms, and the waiver provides, for the first time, federal financial support for indigent care provided in the outpatient setting.58

Funding Sources
Six main financing mechanisms exist to support health care services to California’s uninsured: Medi-Cal, Medi-Cal supplemental payments (such as DSH), state tobacco tax (Proposition 99) appropriations, Medicare Graduate Medical Education (GME) payments, realignment funds, and county general funds. This limited pool of federal, state and local funding is uncertain from one year to the next and is steadily declining.

Medi-Cal Reimbursement. California has a long history of keeping Medi-Cal provider rates low. The state ranks 46th nationwide in total Medi-Cal expenditures per beneficiary. In 1995, the state spent on average 39 percent less per Medi-Cal enrollee ($1,959) compared to the country as a whole ($3,202).59 These low spending rates have compelled Medi-Cal providers to be among the most cost-efficient in the nation. Still, the state’s failure to keep pace with health care inflation means that Medi-Cal providers must rely on additional funding sources to cover shortfalls. In particular, Medi-Cal outpatient rates have remained generally stagnant for most of the last 14 years and now reimburse providers, at most, at about 43 percent of actual costs. Poor reimbursement is an impediment to open door providers undertaking greater expansions of outpatient services—services that could enhance patients’ access to prevention-oriented primary care services and ensure a more cost-effective
Panetta praised the new Natividad Medical Center in Monterey County as a living example of the commandment to “love thy neighbor as you would love thy self,” an acknowledgment of the mission common to all open-door providers.

More than half of all counties in California with public health care systems have already completed major capital projects to replace or revitalize inpatient and outpatient facilities, including Contra Costa, Los Angeles, Monterey, Riverside, Sacramento, San Bernardino, San Mateo, San Joaquin and Santa Clara counties, among others. Key legislation sponsored by the California Association of Public Hospitals and Health Systems in the late 1980s made it possible for these and other key providers to finance major capital projects. The Construction/Renovation Reimbursement Program (CRRP), more commonly referred to as SB 1732, reimburses selected hospitals for a portion of debt service payments for qualifying capital projects. Additional capital projects using these and other funds, including facility replacements in Alameda, Fresno and Los Angeles counties, are currently in the works.

Open Door Profile #6: Reaching Out to Underserved Communities

The Eastmont Wellness Center, part of the Alameda County Medical Center network, is a showcase for a relatively new concept in the delivery of health care in California. Located in the middle of an urban shopping mall, the Wellness Center blends health care with a wide variety of community-based service providers and retail outlets to offer community residents a pleasant, conveniently located site for “one-stop shopping.” The Wellness Center provides community residents—many of whom are medically underserved—the traditional scope of primary care services, including pediatrics and women’s health, as well as health education programs that focus on keeping people healthy through effective health prevention and promotion activities.

What distinguishes this health center from others is its strategic co-location under a single roof with other vital community services: a Head Start facility for children, a public library, a transportation hub, a pharmacy and an activity center for seniors. The placement of health services in a neighborhood mall allows residents to integrate proactive and preventive health care into their daily routines. Patients and visitors waiting for medical appointments can shop, run errands, have a meal, or simply relax in bright, attractive surroundings.

In addition to rebuilding inpatient facilities, open door providers have made major expansions in ambulatory care. Many health centers have been renovated to improve operational efficiency and maximize capacity. Other brand new facilities have recently opened or are under construction. These revitalized facilities offer patients and their families access to a full array of primary, specialty and ancillary health care services provided in a safe, comfortable and welcoming environment. Ambulatory care upgrades are an essential ingredient to improve the aesthetic appeal of the health centers and thus better attract paying patients, including Medi-Cal patients enrolled in managed care who now have a wider selection of providers from which to choose.

ODP FACT FILE:
The new Arrowhead Regional Medical Center in the Inland Empire is designed to withstand an earthquake up to 8.3 in magnitude and remain fully functional.
and clinically appropriate entrance to the spectrum of available health care services.

Moreover, those counties that operate Federally Qualified Health Centers—known as FQHCs—will see their reimbursement severely decline over the next four years. Recognizing the vital role played by community health centers in providing access and primary care to medically underserved communities, Congress created the FQHC designation, which enables health centers to receive cost-based reimbursement under Medicaid. In 1997, the federal Balanced Budget Act put into place a phase-out of the federal mandate for cost-based reimbursement of clinics beginning in the year 2000. Effective October 1, 2003, the requirement is totally repealed.

Similarly, the basic Medi-Cal inpatient rates have risen only minimally, if at all, during the last decade, even though health care inflation, new technologies, and quality and seismic standards and requirements continue to increase the cost of hospital care.

Medi-Cal Supplemental Payments. To address low Medi-Cal base rates, the State has created three programs over the last decade—the SB 855, SB 1255, and Graduate Medical Education programs—to provide supplemental Medi-Cal payments to targeted groups of hospitals. All of these programs are financed with intergovernmental transfers from local government, the University of California, and, to a much smaller degree, hospital districts.

The SB 855 Medi-Cal disproportionate share hospital payment program (DSH) was created in 1991 to generate new federal funding for hospitals that treat the greatest numbers of Medi-Cal and uninsured low-income patients. Since then, the number of hospitals eligible for DSH funding has mushroomed, thus diminishing the payments to many hospitals, especially to those public open door providers that provide the intergovernmental transfers that fund the program. The DSH program is slated for a 20 percent reduction in federal funds by the year 2002 as mandated by the Balanced Budget Act—from $1.1 billion in 1998 to $880 million (Figure 6). This once primary source of funding for the uninsured threatens to dissipate precipitously. Under the best scenario, core open door providers will lose as much as $110 million in 2002.

The California Medical Assistance Commission (CMAC) administers the SB 1255 and the new Graduate Medical Education programs as part of the Selective Provider Contracting Program. On a confidential basis, CMAC sets hospital rates and determines the level of SB 1255 and GME funding through a negotiated process with participating hospitals. These programs are voluntary and are designed to recognize the added value of and higher costs associated with the mission of open door providers, including trauma care, teaching and serving a higher concentration of seriously ill patients. However, these programs—subject to annual

“In the absence of universal coverage, safety net hospitals will require additional direct support from either the federal government through a restructured DSH program or directly from state and local governments to be able to continue to provide care for the uninsured.”

John F. Holahan, Ph.D. Urban Institute

Figure 6. Federal Medi-Cal DSH Funding (Core open door providers receive approximately one-half of these funds.)
CHANGING WITH THE TIMES

With the rise of managed care in our state, where nearly half of all Californians are enrolled in health maintenance organizations, great emphasis has been placed on controlling health care costs without compromising quality. California’s open door providers are changing the way they do business in order to survive—and thrive—in today’s increasingly competitive health care marketplace. In many instances, open door providers have adopted strategies from the private sector in order to carry out their public missions more efficiently and effectively. These changes have been especially important in light of the state’s transition to Medi-Cal managed care, during which time open door providers have seen a drop in the number of Medi-Cal patients they serve.

Service consolidations to eliminate duplication and improve resource utilization have helped streamline systems and services as well as reduce expenses. Systems reengineering, employee retraining, expanded outpatient capacity and enhanced customer relations are just some of the recipes for change public hospitals have adopted. Customer service is also a top priority for all open door providers. Most systems have assigned teams of employees to evaluate different patient service issues and implement broad-based action plans to increase patient satisfaction and enhance community relations.

Open Door Profile #7: Engineering a Better System

When the Santa Clara Valley Health and Hospital System faced a budget shortfall in 1995, administrators initiated a reengineering project affecting both the hospital and outpatient clinics. Although the primary objective of the project was to cut expenses, many felt that the process could be used to improve overall quality of care and patient satisfaction. On the premise that substantial savings could be achieved by streamlining processes and redesigning workflow, several hundred employees were engaged in the reengineering process.

As part of the restructuring, employees experienced dramatic changes in job descriptions, worksites and roles. To minimize layoffs, overall downsizing of the staff was achieved primarily through attrition and retraining. While many positions were eliminated, and the employees in those positions were laid off, many other positions were created, with hiring preference given to laid-off employees. The result? In addition to realizing $18 million in cost-savings without compromising quality, perhaps one of the best measures of Santa Clara’s success is the dramatic three-fold increase in the number of provider groups who now contract with the hospital. The health system’s reengineering effort is now in the process of implementing a comprehensive customer service program designed to increase patient satisfaction and enhance employee and community relations.
negotiations and the vagaries of the state budget—lack predictability and stability needed to ensure open door providers long-term viability.

**Tobacco Tax (Proposition 99).** When Proposition 99 was enacted in 1988, it increased the tax on cigarettes and devoted those revenues to a variety of health purposes, including indigent health services. The County Health Indigent Program (CHIP), which counties administer, received more than $336 million in fiscal year 1989-90. Open door providers throughout the state received a significant portion of those funds. As smoking rates in the state have declined, however, fewer dollars are available to fund these programs. In state fiscal year 1998-99, the CHIP account decreased to $146 million—an overall 57 percent drop. With the implementation of Proposition 10, which will increase the tax on cigarettes by 50 cents in order to create the California Children and Families First Trust Fund for early childhood development programs, the Proposition 99 CHIP account is projected to drop significantly again in this budget year (Figure 7).61

**Medicare Graduate Medical Education (GME) payments.** Together, 30 core open door providers train about half of the state’s medical residents. Some hospitals are major teaching hospitals with hundreds of residents. Others operate only one or two residency programs.

Federal funding of medical education costs is accomplished through two add-ons—for direct and indirect medical education costs—to a hospital’s Medicare payments. Although most open door providers treat a small proportion of Medicare beneficiaries, Medicare GME financing is a significant funding source for these hospitals. This method of supporting medical education has come under fire in recent years. In particular, indirect medical education payments will be reduced by $5.6 billion nationwide between 1998 and 2002. Moreover, there are proposals in Congress to completely separate GME funding from Medicare and subject it to the annual budgeting process. This would inevitably make GME funding more vulnerable as it would compete with a variety of national pressures, priorities and needs.

**Realignment.** Created in 1991, realignment is the major state-funded program that supports health care for the medically indigent—generally those uninsured with incomes below 100 percent of the federal poverty line who are not eligible for Medi-Cal. It replaced a series of programs, including AB 8 and the Medically Indigent Services Program, which had been perennially underfunded since the early 1980s. To be clear, neither realignment nor any of its predecessor programs was intended to subsidize health care for all of California’s uninsured, which is a larger societal responsibility.

Funded by a portion of states sales tax and vehicle license fees, realignment funds were originally intended to ensure a steady source of revenue to counties to fund health care to the low-income uninsured as well as public health services independent of annual state budget negotiations. Because of the recession in the early and mid-1990s,
CONTROLLING COSTS

Because most open door providers are public entities, they are sometimes criticized as being more costly and less efficient than their private-sector counterparts. According to a 1997 study published in the *New England Journal of Medicine*, however, administrative costs in public hospitals were found to be nearly 25 percent lower than at for-profit hospitals. Specifically, the study found that private for-profit acute care hospitals had higher adjusted administrative costs per discharge ($2,289) than did private not-for-profit ($1,889) or public ($1,432) hospitals. This finding suggests that where public institutions do experience higher overall costs, the costs are more likely attributable to costlier patient needs than to bureaucratic inefficiencies.

At the same time, many of the special services furnished by open door providers to ensure greater access to care for the uninsured and other vulnerable populations—such as extended clinic hours—make controlling costs more difficult. According to a United Hospital Fund/New York University survey, facilities that respond to the needs of the uninsured by providing more flexible hours may also encounter greater management and cost challenges.

A clinic with a high number of walk-ins, for example, may have more difficulty increasing productivity, maintaining provider continuity and managing clinics efficiently.

Open Door Profiles # 8: Fulfilling the Mission Through Creative Partnerships

In 1988, when health officials in Riverside County began to explore options for replacing the county's outmoded inpatient facility, they knew they would have to come up with a creative financing structure. The traditional approach to financing such a project—issuing bonds that would be repaid from general fund monies—was not feasible given the county's economic situation at that time. In response, the county devised an alternative revenue mechanism that tapped into three unique sources: local redevelopment funding, commercial development of the existing hospital site, and lease development of a new site.

More than a decade later, the strategic plan they set into play has come to fruition. The new Riverside County Regional Medical Center (RCRMC), which opened in 1998, is situated on a 100+-acre stretch of county-owned land in the city of Moreno Valley. Hospital replacement costs were partially offset by funding from the city's redevelopment agency. To help generate future revenues for the county and support the expansion of a fully integrated health care "campus" for community residents, the county has entered into lease agreements for the private development of additional health care facilities on 40 acres of available land. In June 1998, the first of these public-private partnerships—a 20,000 square foot private dialysis center—opened on the campus. A second project, scheduled for completion in 1999, will establish a skilled nursing facility, an adult day care center, a child care center, and an assisted living program that will include 48 apartment units. The project is expected to generate annual lease revenues to the county of $200,000. The county also expects to receive lease revenues from the former site of the county's hospital and from a company that plans to lease land to construct a private medical office building.
however, the realignment revenues never realized their projected levels. In fact, in the 1991-92 fiscal year, the first year of realignment, the actual indigent health portion was 11 percent less than the amount that was originally expected. The anticipated 1991-92 levels were not reached for three more years, until 1994-95.  

Moreover, the gap has persisted. Taking into account all realignment revenues—those both directly and indirectly related to patient care—as well as Proposition 99 funding and county subsidies, public open door providers have experienced significant shortfalls associated with caring for the medically indigent population ranging from more than $200 million to $400 million during the last two fiscal years for which there is complete data (1995-96 and 1996-97).

Compounding this deficiency, the number of uninsured grew dramatically over the last decade—from 4.5 million uninsured in 1987 to 7 million today. Not only has realignment not kept pace with its original intent—to partially subsidize counties for providing health care to the medically indigent—but the demands on core open door providers have heightened as a result of the increase in California’s overall population, especially among the low-income uninsured.

Underscoring the unreliable and unpredictable nature of this funding source is a new state law that reduces vehicle license fees (VLF). Although the state has made assurances to backfill lost VLF revenues using general fund dollars, this change has reinstated a degree of vulnerability into the program. Maintenance of realignment funding is essential if county open door providers are to serve the medically indigent and provide public health services for all residents. Under this state mandate, which has been in place for about 100 years, counties are required to be the “providers of last resort” to all who cannot afford health care.

**County general funds.** Counties use local tax dollars from their general fund to subsidize health care for the indigent. Some spending is required in order to receive the state matching funds, but many counties appropriate additional discretionary funds to cover the costs of serving the uninsured. However, seven years of property tax shifts have severely constrained the ability of local governments to adequately fund health care services to the uninsured. Beginning in 1992-93, when the state suffered deep budget deficits as a result of the recession, the state shifted property taxes from counties and other local governments in order to increase funding for schools. This shift grew to reach about $3.8 billion in the current budget year. Although there have been measures enacted to mitigate the impacts, such as trial court funding relief and Proposition 172 for public safety services, these efforts have not provided full relief nor did they restore flexibility and discretion to the counties.
QUALITY COMES FIRST

Although open door providers have undergone a number of significant changes in recent years, one ingredient has remained constant—the commitment to provide high quality care. Open door providers consistently receive high marks from groups that monitor health facilities for performance and quality. The Joint Commission on Accreditation of Healthcare Organizations, the nation’s predominant standards-setting and accrediting body in health care, accredits every one of California’s core open door providers. U.S. News and World Report also consistently ranks open door providers among “America’s Best Hospitals,” in such areas as rehabilitation, AIDS care and orthopedics.

As with most organizations, the driving force behind California’s open door providers is the collection of dedicated employees who work there. The multicultural and multilingual providers, staff and volunteers mirror the diversity of the patient populations they serve. From award-winning physicians to top-notch nurses, the health care providers at these leading institutions rate among the best in the nation. And like the organizations they work for, the staffs at open door providers share a commitment to serve all individuals and families with respect, compassion and sensitivity.

Open Door Profile #9: Building a brighter future

The North Fair Oaks section of Redwood City is the poorest area in San Mateo County, and has been chosen by the county’s Health Services Agency for targeted health outreach. When San Mateo County Health Center completed its new AIDS clinic, nine modular buildings became surplus space. The Hoover School Children and Youth Health Facility Project is a collaboration of seven agencies established to relocate the 6,000 square foot modular buildings and bring together and provide space for three distinct programs designed to meet the needs of this low-income community: The Redwood City Youth Health Center, the Hoover School Family Resource Center and a new Hoover School Pediatric Health Clinic.

In less than a year, the collaboration raised over $150,000 to relocate and reconfigure the modular buildings to allow for the expansion of much-needed services within this underserved community. This collaboration ensures that students at the Hoover School will receive a quality education at the same time they and their families have access to health services, family support services, counseling, adult education classes and recreation services.

ODP FACT FILE:

In 1997, Natividad Medical Center received “accreditation with commendation,” a distinction enjoyed by only 10 percent of hospitals nationally.
Marketplace economics have played a crucial role in curbing the runaway health care costs that began to spiral out of control in the 1980s. At the same time, the market-driven economy creates new challenges for those segments of the health care system that are not responsive to market forces. Like other public goods that benefit the community at large—public education or public libraries—health care public goods are not commodities that can be easily bought and sold. While such services may be highly valued in the abstract, they are often very costly and usually unprofitable. Real markets, which favor low costs and high efficiency, offer few economic incentives to addressing the needs of communities. This is particularly true in the case of low-income communities with limited purchasing power.

Despite the success of market economics and managed care in controlling health care costs, it has failed in two equally important areas: providing care to the uninsured and ensuring access to essential services for the whole community. The reality of today’s highly competitive health care environment is that health plans do not compete to cover low-income uninsured persons, and health providers do not compete to deliver money-losing services like trauma or burn care. Quite simply, it is not profitable to do so. That’s why California’s open door providers are so unique—and important.

Firmly committed to fulfilling their public missions, open door providers work hard to meet the health care needs of their communities within the tight fiscal constraints of our modern health care economy. Time and time again, they have risen to the challenge of doing more with less and have proven themselves to be invaluable partners in protecting and promoting the health and well being of all Californians. Unfortunately, they are now at a turning point created by a combination of mounting pressures: the growing uninsured population, intense competition, Medi-Cal managed care and diminishing support from the programs that were established to fund them.

Beginning in the late 1980s, public policy has tended to favor programs that offer health insurance coverage to targeted groups of individuals, such as children or between-jobs workers, over ones that provide direct support for health care systems that deliver public goods and serve poor communities. Incremental health reforms, such as proposals to expand health coverage under the Medi-Cal and Healthy Families programs, offer one approach to insuring a portion of the seven

---

**Policy Recommendations: A Balanced Approach**

California’s uninsured crisis and the limits of incremental reform call for a more balanced approach to health care reform. Policymakers should:

- Identify specific areas of health insurance coverage and health care services where the market has failed or is failing.
- Pursue opportunities to incrementally expand publicly sponsored insurance programs (e.g., Medi-Cal, Healthy Families) and, where appropriate and financially feasible, establish mechanisms to make employer-based and private insurance more affordable and available.
- Direct targeted support to health care systems that ensure access to basic medical services for low-income and uninsured populations and that maintain essential (if unprofitable) health services that benefit the entire community.
million Californians who currently lack coverage. Yet the magnitude of the crisis we now face virtually guarantees that anything short of universal coverage will still leave millions without coverage.

It is time to restore balance in our health care policy. What is needed is a new competition-era policy that preserves and enhances access to health care for all Californians. Marketplace solutions have their place in health care today, but government ultimately has the responsibility to pick up where the market leaves off.

Government leaders must renew their commitment to open door providers. Just as our public schools provide the foundation for our children’s learning, California’s open door providers constitute the infrastructure for our people’s good health. As competition becomes more intense and the uninsured population continues to grow, it is only through restored balance in our health care policy that all Californians will have the sense of security that comes with knowing that the doors to good health remain open in their communities.

“The worsening of the lot of the uninsured under market competition, if it occurs and is not offset by government, would not be an example of market failure. Rather, it would be an example of serious ‘government failure,’ an example of political failure and perhaps of moral failure. Markets would be doing what they do best. It would be government that would be failing to do what it should do.”

Mark V. Pauly
Wharton School
University of Pennsylvania
Endnotes

1 Federal law requires that all hospitals with an emergency room accept and stabilize any and all patients who present at their facilities. However, many hospitals transfer uninsured patients to open door providers after stabilization. For example, in FY 1996-97 five open door hospitals in Los Angeles County accepted transfers of indigent patients from other hospitals that resulted in nearly 30,000 days of inpatient care.


7 Schaufller and Brown.


12 Schaufller and Brown.


19 Schaufller and Brown.

20 Bovbjerg and Marsteller.

21 Altman and Guterman.


24 The term “core open door providers” refers to the following 30 providers, which have both a mission and a legal mandate (either directly or via contract with county government) to fulfill the county’s obligation under §17000 of the Welfare and Institutions code to care for low-income uninsured populations: Alameda County Medical Center, Contra Costa Regional Medical Center, Crystal Springs Rehabilitation Hospital, Harbor/UCLA Medical Center, High Desert Hospital, Kern Medical Center, King/Drew Medical Center, Laguna Honda Hospital and Rehabilitation Center, LAC+USC Medical Center, Sutter Merced Medical Center, Natividad Medical Center, Olive View Medical Center, Rancho Los Amigos Medical Center, Riverside County Regional Medical Center, San Bernardino County Medical Center (now Arrowhead Regional Medical Center), San Francisco General Hospital, San Joaquin General Hospital, San Luis Obispo General Hospital, San Mateo County General Hospital (now San Mateo County Health Center), Santa Clara Valley Medical Center, Stanislaus Medical Center (closed in November 1997), Sutter Santa Rosa Medical Center, Trinity General Hospital, Tuolumne General Hospital, University of California Davis Medical Center, University of California Irvine Medical Center, University of California San Diego Medical Center, University Medical Center, Ventura County Medical Center. “All others” refers to all hospitals—
excluding core open door providers, state-owned hospitals, alcohol and drug rehabilitation hospitals, large skilled-nursing-emphasis hospitals, and prepaid health plan hospitals—filing a financial report with the Office of Statewide Health Planning and Development (hereafter cited as OSHPD). Unless otherwise noted, all California data are based on financial, utilization and discharge reports submitted to OSHPD with analysis conducted by the California Association of Public Hospitals and Health Systems (hereafter cited as CAPH).

25 OSHPD, 1997. The uninsured patient population includes patients in County Indigent Programs (CIP) and all patients not sponsored by any form of third-party health care coverage (Medicare, Medi-Cal or any third-party payor). This includes patients who are designated as self pay and uninsured patients who are not the responsibility of the county.

26 Ibid.

27 Ibid.

28 Ibid.

29 Norton and Lipson.


31 Mann et al.


33 OSHPD, 1998.


38 California Department of Health Services. Emergency Department Use by County Indigents, Sacramento: The Department, December 1996.

39 Medi-Cal Program Month of Payment data for year ending June 1997.


41 OSHPD, 1996.

42 Ibid.


44 The charity fraction is a component of the Low Income Utilization Rate, which is used to calculate eligibility and payments under the Medi-Cal DSH payment program. The method for computing the charity fraction is set forth in California’s Medi-Cal State Plan and is based on the ratio of a hospital’s gross revenue related to charity care to its total gross revenue.

45 The Two-Plan Model, which offers beneficiaries the option of enrolling in a locally developed health plan (known as a local initiative) or a commercial plan, operates in Alameda, Contra Costa, Fresno, Los Angeles, Riverside, San Bernardino, San Joaquin, San Francisco, Santa Clara, Stanislaus and Tulare Counties; the County Organized Health System, which utilizes a single public agency to administer Medi-Cal for all beneficiaries, operates in Orange, San Mateo, Santa Barbara, Santa Cruz and Solano/Napa Counties; the Geographic Managed Care model involves multiple health plans and operates in Sacramento and San Diego Counties.


49 Holahan.


52 Center for Studying Health System Change. “Managed Care Cost Pressures Threaten Access for the Uninsured.”


54 Norton and Lipson, 9.


Bodenheimer.


Zuckerman et al.

CAPH. “Medi-Cal Disproportionate Share.”


OSHPD, 1996 and 1997. Analysis assumes for purposes of discussion that all realignment funds and county appropriations are expended solely on care to the medically indigent. Actual expenditures may be less, if additional funds are spent on public health, mental health, etc.

Appendix

CAPH Members

ALAMEDA COUNTY
Alameda County Health Care Services
Alameda County Medical Center

CONTRA COSTA COUNTY
Contra Costa Health Services
Contra Costa Regional Medical Center

FRESNO COUNTY
University Medical Center

KERN COUNTY
Kern Medical Center

LOS ANGELES COUNTY
Los Angeles County Department of Health Services
Harbor/UCLA Medical Center
High Desert Hospital
King/Drew Medical Center
Olive View Medical Center
Rancho Los Amigos Medical Center
LAC+USC Medical Center

MARIN COUNTY
Health & Human Services of Marin County

MONTEREY COUNTY
Natividad Medical Center

ORANGE COUNTY
University of California Irvine Medical Center

RIVERSIDE COUNTY
Riverside County Health Services Agency
Riverside County Regional Medical Center

SACRAMENTO COUNTY
University of California Davis Medical Center

SAN BERNARDINO COUNTY
San Bernardino County Medical Center

SAN DIEGO COUNTY
University of California San Diego Medical Center

SAN FRANCISCO COUNTY
San Francisco Department of Public Health/
Community Health Network of San Francisco
San Francisco General Hospital
Laguna Honda Hospital and Rehabilitation Center

SAN JOAQUIN COUNTY
San Joaquin County Health Services
San Joaquin General Hospital

SAN LUIS OBISPO COUNTY
San Luis Obispo County Health Agency
San Luis Obispo General Hospital

SAN MATEO COUNTY
San Mateo County Health Services Agency
San Mateo County Health Center
Crystal Springs Rehabilitation Center

SANTA CLARA COUNTY
Santa Clara Valley Health & Hospital System
Santa Clara Valley Medical Center

VENTURA COUNTY
Ventura County Health Care Agency
Ventura County Medical Center

Key
- Hospitals/Medical Centers
- Health Systems