

**Crisis in Care:**  
**Coverage for the Medically Indigent in Fresno**  
**County**



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## Acknowledgements

Fresno Healthy Communities Access Partners (HCAP) led this project to comprehensively address the state of the Medically Indigent Services Program (MISP) in Fresno County, California. The goal of the project funded by The California Endowment was to generate a report providing factual information on MISP data, current practices, legal requirements, structure, “best practices” in other counties, and potential funding sources.

Thanks to the HCAP Board for their leadership and courage to tackle this controversial project. HCAP is a six year old nonprofit organization consisting of twelve healthcare and community organizations working together to improve access to healthcare for medically underserved communities in Fresno and the San Joaquin Valley. For more information on HCAP, please visit <http://www.fresnohcap.org>

HCAP teamed up with Joel Diringer, JD, MPH of Diringer & Associates to comprehensively address the requirements of this project. Joel is an accomplished writer, researcher, and neutral convener of all parties. I sincerely appreciate the skillful contribution of Joel to all aspects of this report. Joel can be reached at [www.diringerassociates.com](http://www.diringerassociates.com).

Thanks also to the HCAP Access to Care Task Force. This collaborative task force is dedicated to creating and implementing community-based plans and strategies to improve access to health services for Fresno County’s low income populations. This varied group of representatives from health plans, community advocates, funders, health care providers, policy analysts, and government officials has met consistently for the past two years to develop and recommend steps for this project.

A special acknowledgement to Simon Haeder, Project Manager for HCAP: Simon’s dedication to learning the history and detail of operations of the MISP program exceeded my expectation. Simon generated the majority of the data research for the project, created the graphics and GIS mapping work, and wrote and edited much of the report.

Particular thanks to The California Endowment for funding this project. It is our intent that the dissemination of this report will result in increased awareness and dialogue among Fresno County policy and decision makers to positively impact the MISP system. We also hope it will contribute to the statewide discussion about providing access to high-quality care for all Californians.

*Norma Forbes, Executive Director  
Fresno Healthy Communities Access Partners  
May 2010*

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## EXECUTIVE SUMMARY

California counties are required by state law to provide care for the medically indigent. The exact extent of a county's obligation is unclear and the subject of much debate. There are many approaches that counties take to meet their legal obligations. The approaches often depend on whether the county has its own delivery system (e.g. a county hospital or primary care clinics), the historic availability of local care through the private sector such as community hospitals, community health centers and private doctors, and the county's fiscal capacity.

With the closure of the county hospital in 1996, the indigent care system in Fresno County was contracted by the County of Fresno to the county's largest nonprofit hospital, Community Regional Medical Center (CRMC). While the County worked out an enviable 30-year, fixed-rate contract for care for the estimated 40,000 to 100,000 uninsured indigent adults, patients and providers report difficulty accessing necessary care and inadequate funding. As other counties are matching their local contributions with federal funds and enhancing their indigent care systems to provide for increased access and care coordination, Fresno County is the sole payer of an underfunded and inadequate system for indigent care.

This report examines the current state of care and coverage for the medically indigent in Fresno County and reviews how other counties are meeting their legal obligations for indigent care. The report also makes recommendations for a more streamlined and efficient system that would re-focus its efforts on prevention and management of chronic disease to provide cost-effective care to those who are truly in need. With concerted leadership, Fresno County has the opportunity to transform its indigent care program and draw down matching federal funds.

In its current configuration, Fresno County's medically indigent program is much more of a payment system for episodic care for individuals rather than a health care delivery system that focuses on the health of a defined population. To be efficient and effective in health care, the system must orient more towards prevention and providing health services to keep its enrollees well and manage their chronic conditions, rather than responding on an intermittent basis.

Fresno County contracts with Community Regional Medical Center to provide both the care for the medically indigent and to administer the Medically Indigent Services Program (MISP). Enrollment in MISP has dropped from approximately 20,000 individuals 10 years ago, to just over 10,000 indigent persons last year due to a variety of reasons including barriers to accessing the program, ever-decreasing eligibility limits, and burdensome documentation requirements. Meanwhile, until recently the eligibility limits for MISP had been left unchanged since the 1980s. In February 2010, Fresno County Supervisors adjusted MISP limits upward to just over 100% of federal poverty level (FPL). Yet even today, Fresno County remains among the very

lowest of all California counties. It is also significantly lower than all other counties in the Central Valley, the majority of which closed their county operated hospitals decades ago.

In addition, no coverage is provided outside of the CRMC system of care, although over one-third of “self-pay/free care” visits in the county are provided by United Health Centers and 10% by Clinica Sierra Vista, two federally qualified health centers with clinics located throughout Fresno County.

Several recent key developments in Fresno County may profoundly affect the future of the MISP program. These developments provide an opportunity for transforming the system by moving to a “medical home” and prevention model while drawing down federal funds to match the County’s approximately \$20 million annual contribution to indigent care.

- National health reform will provide coverage for many low-income adults who are U.S. citizens or legal residents.
- Litigation is pending against the county over the MISP eligibility limits. This lawsuit has the potential to dramatically change the MISP program, increase the County’s financial liability, and impact its contract with Community Regional Medical Center.
- A Fresno County community coalition called the Coalition for Patient Care has been holding a series of town hall meetings on access to care for low-income persons and pressuring the County Board of Supervisors to make changes to the MISP.
- Community Regional Medical Center, the contract facility for MISP, has reported uncompensated care losses in excess of \$34 million annually.
- Fresno County has recently joined with Kings County and Madera County in forming a regional Medi-Cal managed care health plan – the Fresno-Kings-Madera Regional Health Authority Commission. The Commission may be an appropriate venue for administering an indigent care system.
- Fresno County is one of the sites for the Kaiser Permanente-funded Specialty Care Initiative which is developing systems for improving access to specialty care for the county’s medically indigent population.
- The State is pursuing a renewal of its Medi-Cal waiver that would expand the ten-county Coverage Initiatives to additional counties to enable them to draw down federal funds to form more comprehensive indigent care systems. Fresno County previously applied for the Coverage Initiative but was unsuccessful in its bid. Fresno County is well situated to pursue these funds if it can develop a community-wide plan to meet the program’s focus of managing chronic care and establishing medical homes for indigent persons.

In order to manage care more effectively, the following recommendations are made. The County should implement:

- a more streamlined and consumer friendly enrollment process utilizing electronic enrollment tools such as One-e-App
- broader program eligibility mirroring other Valley counties of at least 200% of FPL
- longer periods of eligibility to support disease management and reduce administrative costs
- a broader network of primary and specialty providers located throughout the county in partnership with Federally Qualified Health Centers (FQHCs).
- an emphasis on prevention and chronic care management to control costs and improve care
- technology improvements to integrate and enhance the enrollment and care processes
- seeking state and federal funding to enhance the system's long-term viability

Care for the medically indigent in Fresno County will always be a challenge given the high demand for services and the lack of sufficient resources to meet the needs. However, periodic review and revision of the system for caring for Fresno County's most vulnerable population is necessary to ensure that resources are being used efficiently and that adequate services are being provided to the target population.

There are some serious deficiencies in the current system, but there are also some upcoming opportunities to improve the situation. The most prominent of these is the renewal of California's Section 1115 Medicaid Waiver and the expected expansion of the Coverage Initiative (CI). The CI provides the potential to revamp the medically indigent system to focus more on prevention and better meet the needs of the recipients, providers and payers. Talks are currently underway to expand the CI to additional counties including Fresno beginning late 2010. HCAP has been actively involved in the discussions. Over the past three years, the Coverage Initiative has provided \$180 million in annual matching funds to ten California counties to support the delivery of care to low-income populations. Various reports have highlighted the significant achievements of the CI.

The County cannot afford to miss these opportunities; it must proactively seek participation in programs to draw down new federal funding to help improve the health of its residents. The CI is Fresno County's most promising option. It is our intent this document serve as a *call to action* for the health care leaders in Fresno County to improve services for the medically indigent in Fresno County and provide access to high-quality healthcare services for all residents. The work on the Medicaid 1115 Waiver is coming to an end and it is time for the entire community to come together and move forward collaboratively.

# **Crisis in Care:**

## **Coverage for the Medically Indigent in Fresno County**

### **1. Introduction**

With the closure of the county hospital in 1996, the indigent care system in Fresno County was contracted out by the County of Fresno to the county's largest nonprofit hospital Community Regional Medical Center (CRMC). While the county worked out an enviable 30-year, fixed-rate contract for care for the indigent, patients and providers report access issues due to inadequate funding and difficulty in getting necessary care covered.

This report examines the current state of care and coverage for the medically indigent in Fresno County and reviews how other counties are meeting their legal obligations for indigent care. The report also makes recommendations for a more streamlined and efficient system that will provide care to those who are truly in need and re-focus efforts on prevention and management of chronic disease.

### **2. Who are the “medically indigent” in Fresno County?**

Generally the term “medically indigent” refers to those low-income adults who do not have health insurance, are not eligible for Medi-Cal, and cannot afford to pay for care. It is difficult to ascertain the exact number of medically indigent adults in Fresno County since it depends on the definition that is used and there is a lack of quality data on a local level.

We have estimated there are roughly 40,000 medically indigent persons in Fresno County under the federal poverty level.<sup>1</sup> Of course, there are many people above the poverty level who are also uninsured and who cannot afford care, with estimates ranging up to 148,000 uninsured non-elderly adults in Fresno County.<sup>2</sup> In addition, there are approximately 120,000 adult Medi-Cal recipients in Fresno, who have limited access to care, particularly for specialty care services such as dermatology, neurology, and gastroenterology.<sup>3</sup>

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<sup>1</sup> This calculation is based on the percentage of uninsured non-elderly adults at or below the federal poverty level (41.3%) in the San Joaquin Valley, according to the 2007 California Health Interview Survey. Census data from the American Community Survey (2005-2007) estimate that 17.8% of the 533,370 (94,939) non-elderly adults in Fresno County are below the poverty level. According to these estimates there are approximately 39,210 uninsured persons below the poverty level in Fresno County.

<sup>2</sup> The California Health Interview Survey (2007) estimates that the number of uninsured non-elderly Fresno County adults under 200% FPL is between 54,136 and 100,192 persons. For all non-elderly adults, the 2008 Census Bureau's American Community Survey estimates that there are 148,500 uninsured in Fresno County.

<sup>3</sup> Department of Health Care Services, October 2008.



### 3. What are the legal requirements for caring for the medically indigent?

California counties are required by state law to provide care for low income persons without another source of care (Welfare and Institutions Code §17000 et seq.). These persons, generally referred to as “medically indigent adults” (MIAs), are persons without public or private health coverage and who cannot pay for care with their own resources.

Historically, care for MIAs has been a county responsibility. However, from the early 1970s until 1982, MIAs were covered under the state Medi-Cal program. In the “Medi-Cal Reform” of 1982, responsibility for the MIAs was transferred back to the counties with limited state funding to cover the costs. That funding is now only a small fraction of the costs of caring for the MIAs and the counties are responsible for funding through their general funds.<sup>4</sup> The smaller rural counties had the option of joining a state-administered County Medical Services Program (CMSP). Thirty-four counties, with a combined general population of approximately 3 million persons, participate in CMSP. Fresno County administers its own program known as the Medically Indigent Services Program or MISIP.

*Every county and every city and county shall relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons are not supported and relieved by their relatives or friends, by their own means, or by state hospitals or other state or private institutions.*

Welfare and Institutions Code Section 17000.

The exact extent of a county’s obligation is unclear and the subject of much debate. There are many approaches that counties take to meet their legal obligations. The approaches often depend on whether the county has its own delivery system (e.g. a county hospital or primary care clinics), the historic availability of local care through the private sector such as community hospitals, community health centers and private doctors, and the county’s fiscal capacity.

In the face of a vague statute, the courts have been called upon to interpret the parameters of a county’s obligation. In *Hunt v. Superior Court of Sacramento*<sup>5</sup> the California Supreme Court ruled that counties cannot limit Section 17000 health care exclusively to individuals receiving General Assistance and further found that counties must consider a resident’s financial ability to pay the

<sup>4</sup> See generally, D. Kelch, Caring for Medically Indigent Adults in California: A History, California HealthCare Foundation, June 2005.

<sup>5</sup> *Hunt v. Superior Court* (1999) 21 Cal. 4<sup>th</sup> 984.

actual costs of obtaining care. In a recent San Diego case<sup>6</sup>, the Court of Appeal found that the County could not deny health care to working poor persons who cannot afford to pay for it. The court ruled that the County's inflexible \$1,078 per month income limit for indigent health care illegally denied care to persons who might be able to afford to pay for some but not all of their treatment.

Similar litigation is pending in Fresno County where Central California Legal Services, Inc. and the Western Center on Law & Poverty have filed suit challenging the income eligibility limits of the Fresno County Medically Indigent Services Program<sup>7</sup>. The petitioner alleges that denying free care to a person earning over \$509 a month and denying any care to a person earning over \$764 a month without taking into account that person's ability to pay is a violation of Welfare and Institutions Code Section 17000. At the time of the filing, Fresno County's limits had not changed since the 1980s. According to the lawsuit, they are contrary to California case law prohibiting strict income standards with no consideration of an individual's actual ability to pay for the cost of care. No decision has been reached in the case and proceedings were stayed pending a study that the county is undertaking to determine the income levels and costs of medical care in the county. The study found that the subsistence level in Fresno County amounts to \$1,029 a month for a single adult. On February 23, 2010, the County raised income levels to about 114% of FPL. The decision is yet to be implemented and litigation is still ongoing.

#### **4. Where do the medically indigent receive care in Fresno County?**

##### **Outpatient Services**

In Fresno County the major provider groups for low-income persons include community clinics and several private, non-profit hospitals.

Nearly all of those who are eligible for care under MISP receive care at Community Regional Medical Center (CRMC) and its clinics (88%), as directed in the contract between the County and CRMC. Of the 35,650 MISP outpatient and dental visits, 3,370 (9%) were provided at the outlying Mendota and Coalinga clinics. Ten percent of MISP visits were at St. Agnes and 2% were at United Health Centers (Figure 1).

However, for those persons who cannot pay for their care and are not on MISP, their outpatient visits are provided at a much broader network of clinics. The largest provider of outpatient care for self pay/free care is United Health Centers which provides over one third of the care. St. Agnes Medical Center provides 13% and Clinica Sierra Vista (formerly Sequoia Community Health Centers) provides 10% of the care. Central Valley Indian Health, Valley Health Team and Sierra Kings District Hospital each provide 7% of the self pay/free care outpatient

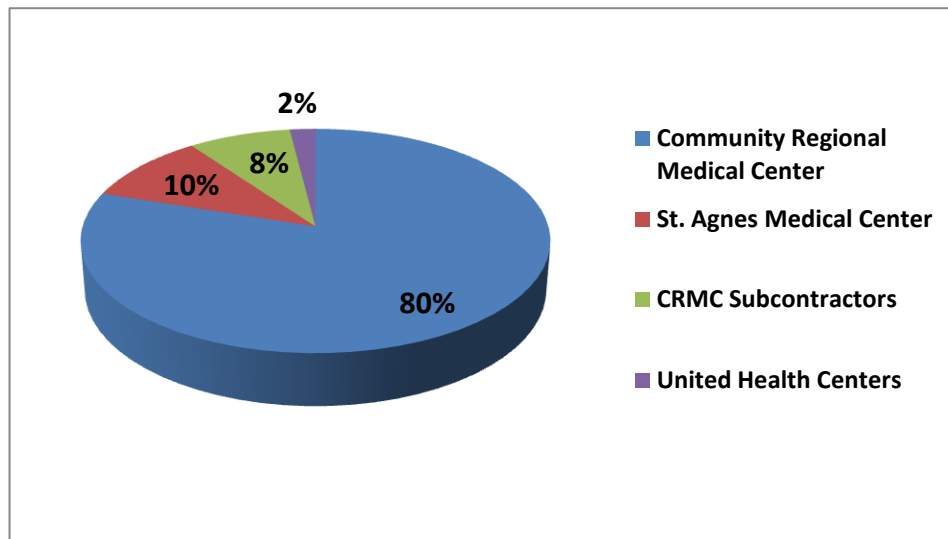
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<sup>6</sup>*Alford v. County of San Diego* (2007) 151 Cal.App. 4<sup>th</sup> 16.

<sup>7</sup>*Piercy v. County of Fresno* (Fresno Sup. Ct No. 08CECG03196)

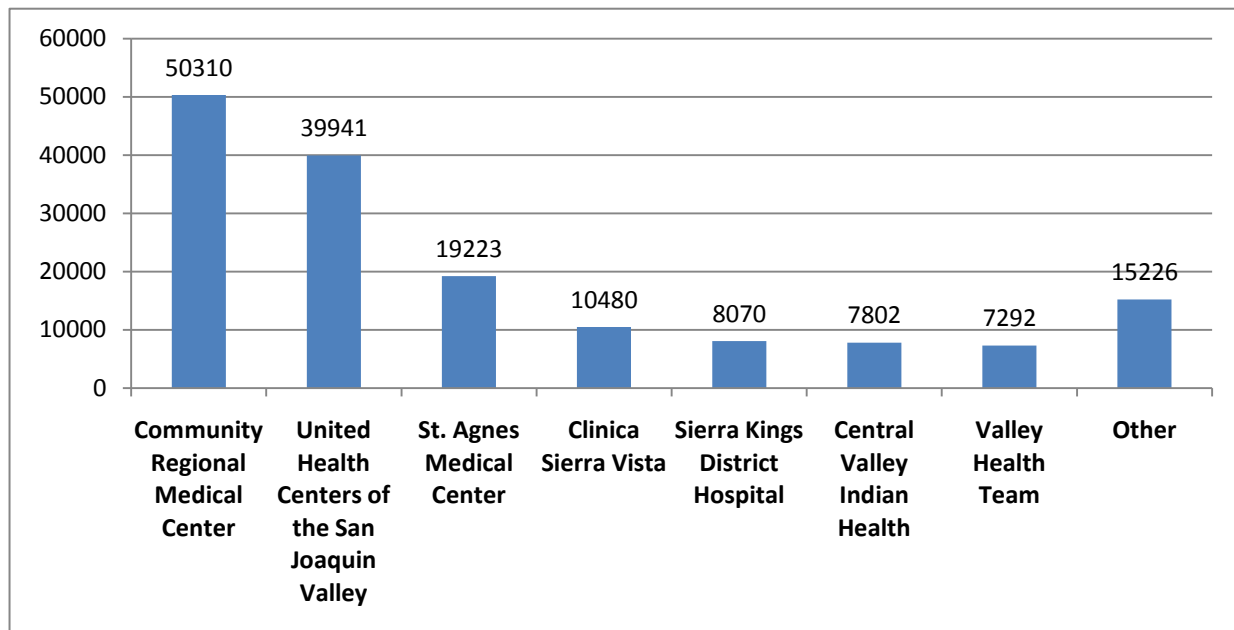
visits. CRMC provides 6% of the self pay/free care outpatient visits (Figure 2). It should be noted that not all self-pay patients are necessarily indigent. Some are patients with the ability to pay cash.

**Figure 1 - MISP Outpatient Visits**



Source: Office of Statewide Planning and Development 2007

**Figure 2 - Self Pay / Free Care Outpatient Visits**



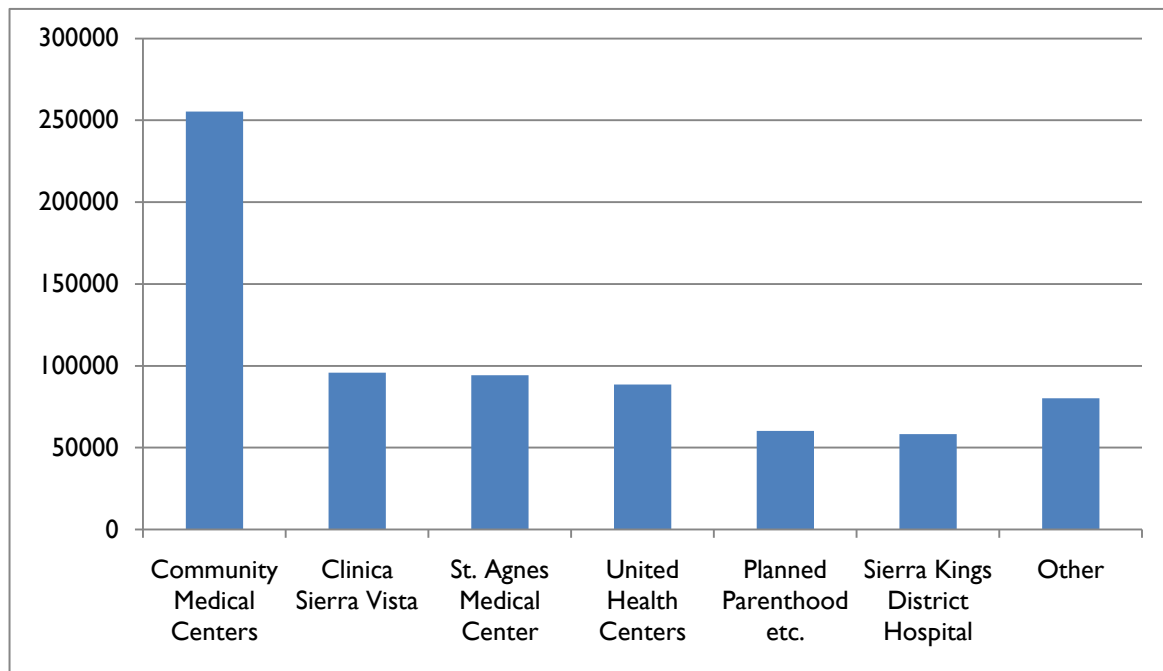
Source: Office of Statewide Health Planning and Development 2007 (Hospitals) & 2008 (Clinics)

Note: Not all "self pay" patients are indigent.

### Medi-Cal/Healthy Families

For those persons who have coverage through Medi-Cal and Healthy Families, outpatient care is provided primarily by CRMC (37%), United Health Centers (13%), St. Agnes (13%), Clinica Sierra Vista (11%) and Sierra Kings District Hospital (9%) (Figure 3). The Medi-Cal and Healthy Families recipients are not “medically indigent” since they have health coverage but they are all low-income residents who also have difficulty in accessing care, particularly specialty care.

**Figure 3 - Medi-Cal, Healthy Families and Other Public Payer Outpatient Visits**



**Source: Office of Statewide Health Planning and Development 2007 (Hospitals) & 2008 (Clinics)**

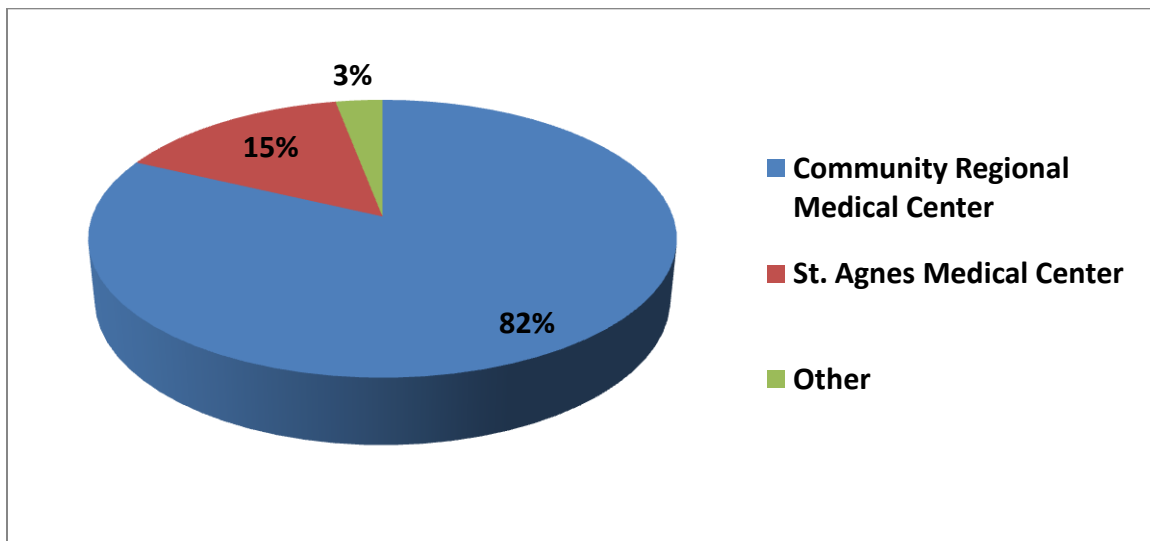
Note: Clinic numbers include Medi-Cal, Healthy Families, CHDP, EAPC, BCCCP, and Family Pact. Hospital numbers include Medi-Cal, Other Indigent Programs, and Other Payers.

### Inpatient Services

Community Regional Medical Center provides all of the inpatient days paid for with County indigent funds – 10,915 days in FY2007/08. “Other” indigent funds also paid for 2,584 patient days – 1,470 (57%) at CRMC, and 1,114 (43%) at St. Agnes. CRMC also provides the overwhelming majority of inpatient days paid for by Medi-Cal (88,227 days or 82% of the county total). St. Agnes had 16,009 Medi-Cal days or approximately 15% of Medi-Cal inpatient days countywide (Figure 4).<sup>8</sup>

<sup>8</sup> Coalinga Regional Medical Center and Kingsburg Medical Hospital are excluded from the above Medi-Cal inpatient calculations since their inpatient days are primarily derived from long term care stays.

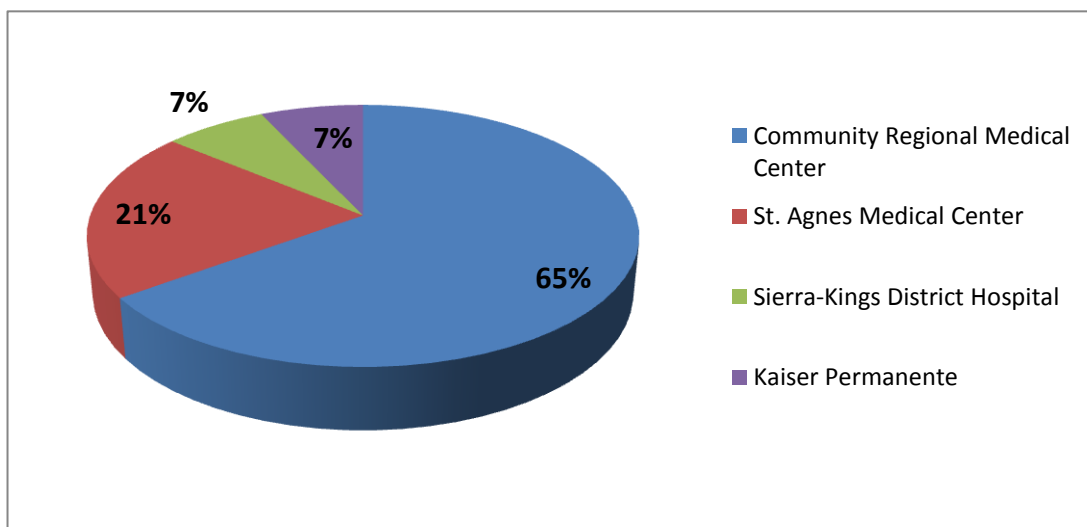
**Figure 4 - Medi-Cal Inpatient Days**



**Source: Office of Statewide Health Planning and Development 2008**

Those persons without insurance or who are self-pay patients are classified as having “other payers”. There were 4,527 hospital days reported paid by “other payers.” These patients were distributed at several hospitals throughout the county (Figure 5).

**Figure 5 - Inpatient Acute Care Days by "Other Payers"**



**Source: Office of Statewide Health Planning and Development 2008**

### Charity Care

All hospitals report their charity care and bad debts to the Office of Statewide Health Planning and Development (OSHPD) according to standard criteria.<sup>9</sup> Certain hospitals, known as disproportionate share hospitals (DSH) that see a high volume of Medi-Cal and indigent patients also receive federal grants. CRMC reported a combined total of \$118 million in charity care and bad debt in 2007 or 82% of the county total. This was offset partially by \$42 million in DSH payments. St. Agnes reported \$21 million in charity care and bad debt. Sierra Kings report \$3 million in charity care and bad debt and received \$2 million in DSH funds (Table I).

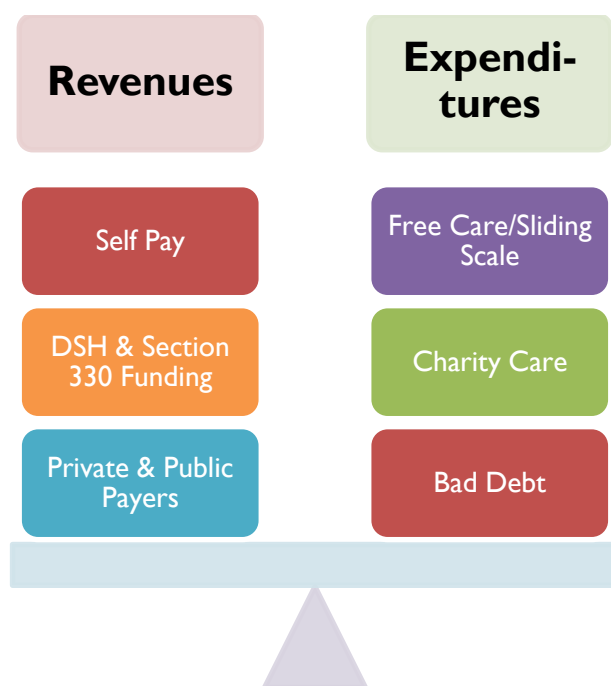
**Table I- Hospital Charity Care, Bad Debt, and DSH payments**

	Charity Care	Bad Debts	DSH Payments	Uncompensated Care/Gross Revenue
<b>Coalinga Regional Medical Center</b>	0	\$830,410	\$56,304	2.38%
<b>Community Medical Center - Clovis</b>	\$3,438,962	\$6,474,972	0	3.00%
<b>Community Regional Medical Center</b>	\$58,552,629	\$49,746,411	\$42,150,920	6.44%
<b>Fresno Heart &amp; Surgical Hospital</b>	0	\$506,279	0	0.31%
<b>Fresno Surgery Center</b>	0	\$206,196	0	0.19%
<b>Kingsburg Medical Center</b>	\$156,493	\$600,895	0	4.90%
<b>Sierra Kings District Hospital</b>	\$606,127	\$2,483,157	\$2,047,780	5.65%
<b>St. Agnes Medical Center</b>	\$13,010,768	\$8,055,113	0	1.70%
<b>Total</b>	\$75,764,979	\$68,903,433	\$44,255,004	4.13%

Source: Office of Statewide Health Planning and Development 2007

<sup>9</sup> Please refer to the Glossary for definitions.

**Figure 6 - Balancing Expenditures and Revenues for Care**



### **5. What is the Fresno County Medically Indigent Services Program?**

To meet its legal requirements established under state law, Fresno County has established the Fresno County Medically Indigent Services Program. Often referred to as MISP or MSP, the program provides coverage for medical costs incurred by very low income residents who are not covered by private insurance or Medi-Cal.

Since the closure of the Fresno County hospital in 1996, the county has contracted with Community Regional Medical Center to provide care for the medically indigent and to administer the Medically Indigent Services Program.

#### **Eligibility criteria**

To be eligible for MISP, a person must be between the ages of 21 and 64 and not eligible for other coverage including Medi-Cal. A person must be a resident of Fresno County. Immigration status is not taken into account. There are also strict limits on income and assets. For income, eligibility is determined by household size. For example, applicants in a one-person household must have a household income of \$509 or less per month (excluding a \$75 per month for work related expenses) in order to receive free medical care. An applicant from a one person household may be eligible for coverage with a “share of cost” if their income does not exceed \$764 per month. If an applicant’s income exceeds the “share of cost” level, they are denied any coverage by MISP. The MISP income eligibility limit for full coverage is approximately 56% of the

federal poverty level, which in 2009 is set at \$903 in monthly income for a single member family (Table 2).

There are also strict limits on the amount of property an MISP applicant may own. Property value cannot exceed \$1,600 for a family of one, with certain exemptions such as one car and the family home. If assets exceed the maximum limit, eligibility is denied. The income and property limits have not been changed since the 1980s.

Undocumented residents – both adults and children – are eligible for MISP according to county regulations.

**Table 2 - Fresno County Income and Property Eligibility Limits**

Household Size	Income Range for Full MISP		Percent of FPL 2009	Income Range for Share of Costs		Maximum Property Limits
	From	To		From	To	
1	0	\$509	56%	\$510	\$764	\$1,600
2	0	\$634	52%	\$635	\$951	\$2,400
3	0	\$784	51%	\$785	\$1176	\$2,550
4	0	\$934	51%	\$935	\$1401	\$2,700
5	0	\$1067	50%	\$1068	\$1601	\$2,850
6	0	\$1200	49%	\$1201	\$1800	\$3,000
7	0	\$1317	48%	\$1318	\$1976	\$3,150
8	0	\$1434	47%	\$1435	\$2151	\$3,300
9	0	\$1540	45%	\$1541	\$2310	\$3,450
10	0	\$1659	45%	\$1660	\$2489	\$3,600

Source: County of Fresno

### Eligibility process

Applications are accepted at designated locations for MISP including offices of the County Department of Social Services, the County health department, and the CRMC clinics.

A face-to-face contact is necessary to complete eligibility. An eligibility appointment will not be made until the applicant already has a medical appointment at one of the clinics or an emergency department visit. Prior to being able to complete a full application, the client is screened for potential eligibility by CMC staff by phone (e.g. meets income/property limits and is not eligible



for Medi-Cal). If found potentially eligible, the client completes a statement of facts; otherwise the client signs a form indicating that they are not apparently eligible.

As part of the review process, it is determined if the client has a share of cost which is calculated as the difference between the net income and the eligibility limits.

Eligibility is for up to three months at a time with renewal application processes required for continued eligibility. Retroactive eligibility for the prior month is available in circumstances such as when the client, through no fault of his or her own, could not complete an application.

Clients have the right to request a hearing on an adverse decision such as a denial or a share of cost determination. Their rights are spelled out on their written notice of denial.

If an applicant is denied MISP coverage, he or she may be eligible for charity care or a sliding fee scale by the provider. All hospitals have comprehensive charity care policies but consumers report that they are not always made aware of these policies or how to apply for them.

### **Covered benefits**

Covered benefits include emergency, medical, and dental services, and specialty services. The medical and dental services include all those included in the Medi-Cal scope of benefits, health education, diabetic treatment, prescription drugs and durable medical equipment, birth control, eye glasses, and dental care. Specialty services that are not provided at Community Regional Medical Center or by the contracted medical group require prior approval for a referral. Transportation assistance is available.

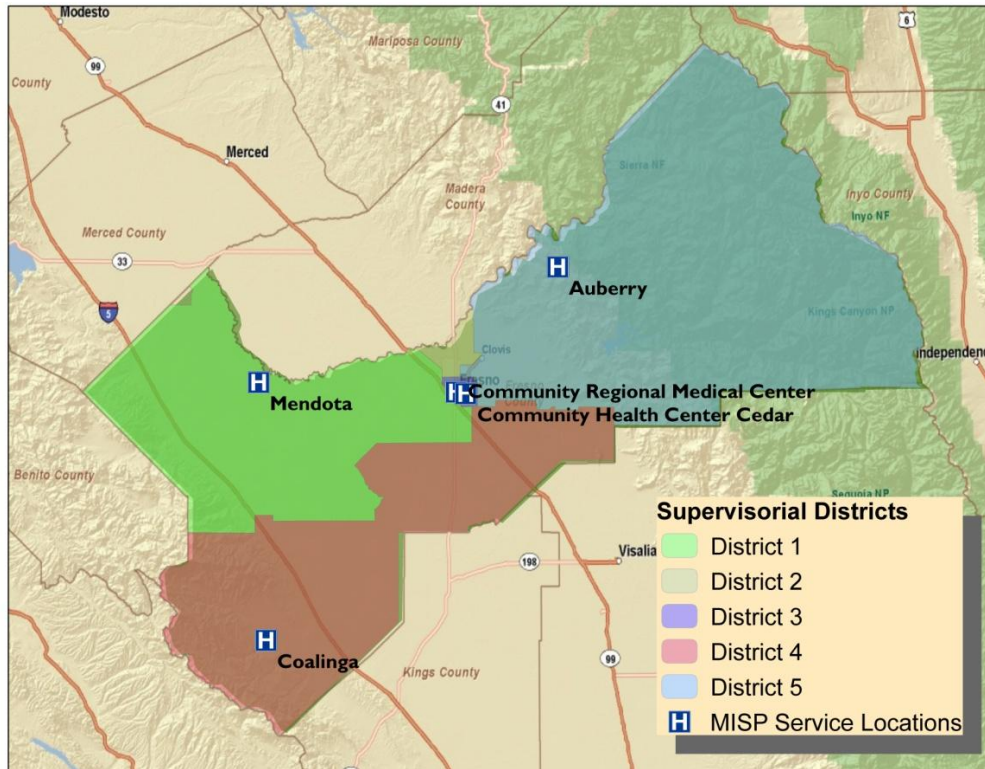
### **Location of services**

Until April 2010, services were provided at clinics operated by Community Regional Medical Center at its main campus and at the former Valley Medical Center site on Cedar Avenue, now referred to as Community Health Center – Cedar. Currently all Fresno clinics have moved or are in the process of moving to the newly constructed Daren Koligian Ambulatory Care Center on the main CRMC campus. In addition, some primary care services are available in Coalinga, Mendota and Auberry (Figure 7). Specialty care may also be provided at other locations upon program approval.

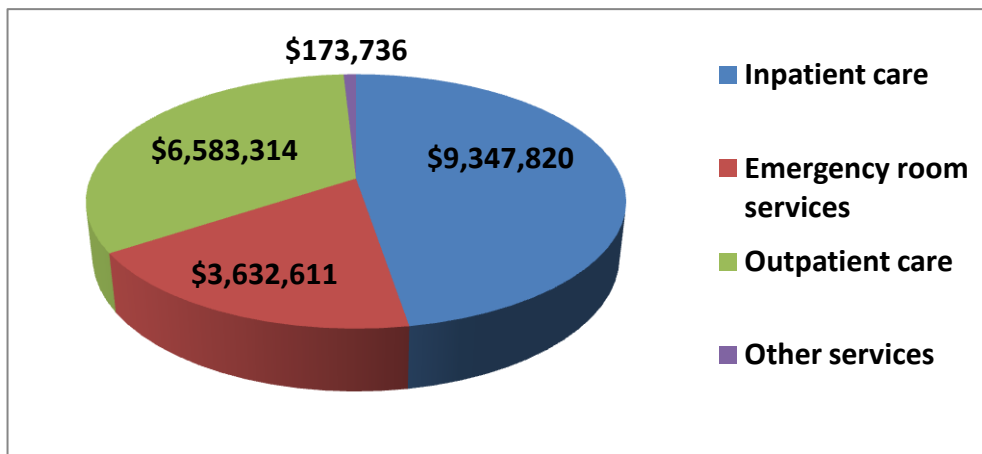
### **Funding**

Fresno County reported spending \$19,737,481 in FY 2007/08 for services provided to 10,361 MISP eligible persons. An additional \$1,437,595 in non-County funds was also spent on MISP patients. Figure 8 shows the categories of indigent care spending, nearly all of which was paid to CRMC.

**Figure 7 - Fresno County MISP Service Locations**



**Figure 8 - County of Fresno Spending on Indigent Care**

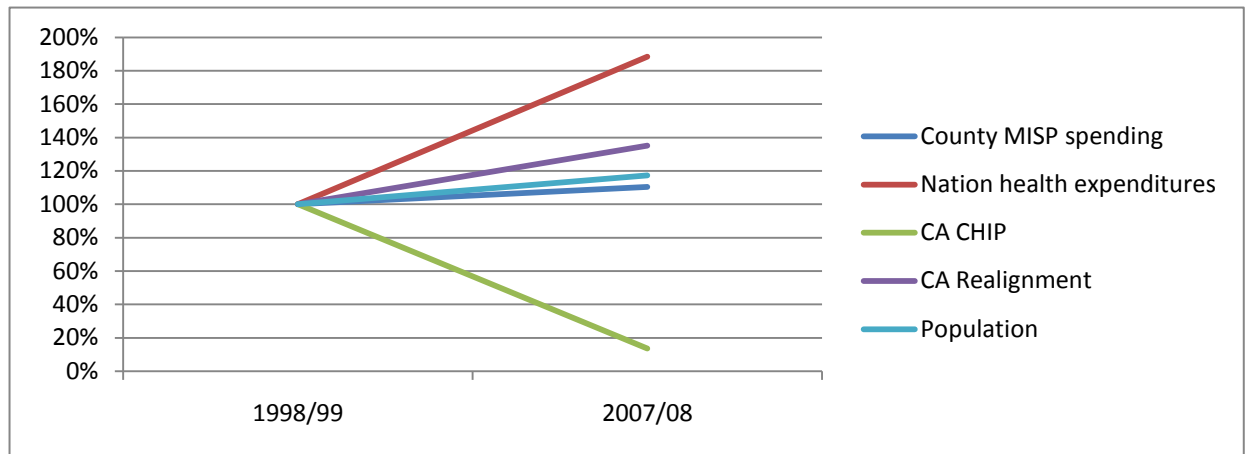


Source: Medically Indigent Care Reporting System (MICRS) 2008

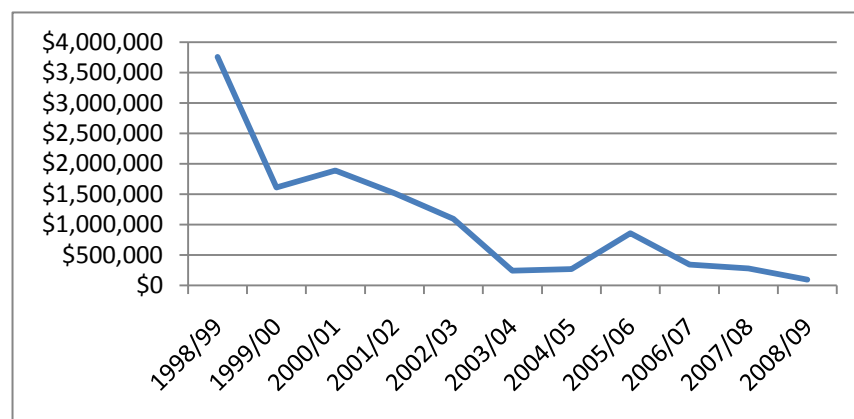
Spending on MISP has remained relatively constant since 1998/1999 when a total of \$19,174,536 was spent. Since that time, the County's population grew by 19% from 777,563 to

928,066<sup>10</sup> and national health expenditures increased by 66% from \$1,353.2 billion in 2000 to \$2,241.2 billion in 2007.<sup>11</sup>

**Figure 9 - Changes in Select Indicators of Population and Health Spending**



**Figure 10 - Fresno County CHIP Allocation**



**Source: California Department of Public Health**

State funding to counties for indigent care has been drastically reduced in recent years. State-wide, funding for the California Healthcare for Indigents Program (CHIP) dropped from \$148.7 million in 1998/1999, to \$20.4 million in 2007/8 (Figure 10). On the other hand, realignment funds, which are derived from a portion of state sales tax and vehicle license fees, increased

<sup>10</sup> <http://www.dof.ca.gov/research/demographic/reports/estimates/e-1/2008-09/>

<sup>11</sup> Medically Indigent Care Reporting System (MICRS) 2008

through 2007/8, but have dropped significantly with the state's economic downturn. Realignment funds are used for many purposes beyond indigent care. Realignment allocations increased from \$1.11 billion in 1997/98 to \$1.57 billion in 2007/8.<sup>12</sup>

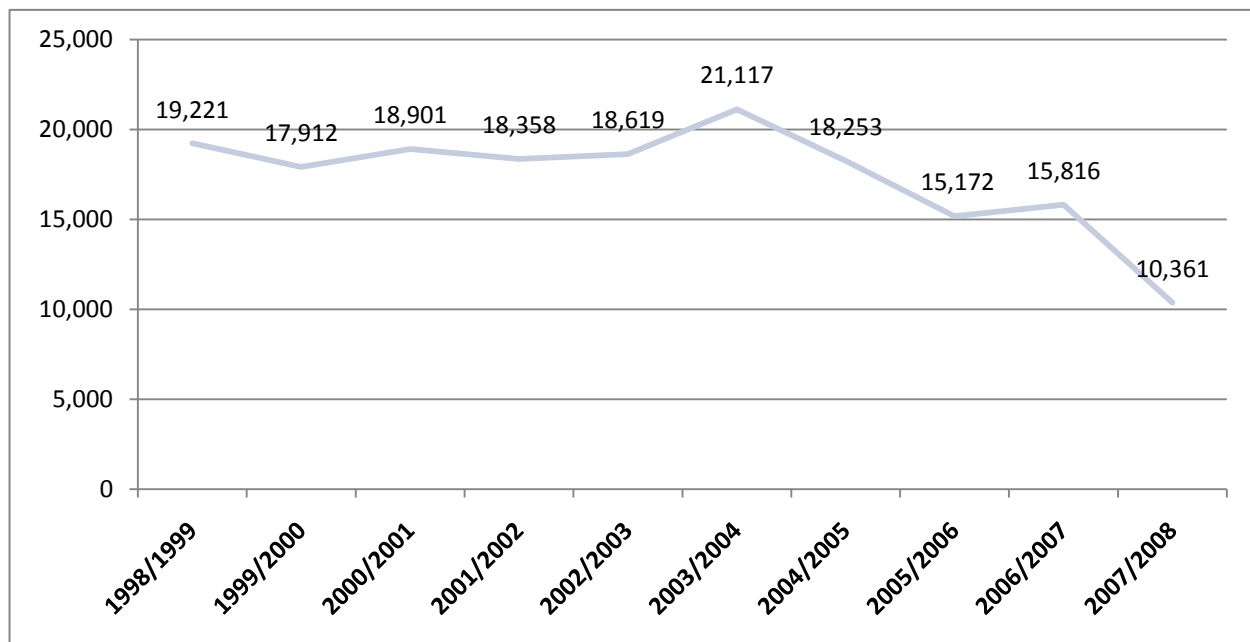
### Who is covered by MISP?

The number of persons covered by MISP in Fiscal Year 2007/2008 was 10,361. This is down from a peak of 21,117 persons in 2003/2004 (Figure 11).

MISP mostly covers single adults with no reported income. In 2007-2008, 92% of MISP patients had a family income below \$500 per month – 75% had no reported income, and 88% were the sole member of their families.

It is unclear why there has been a significant drop in MISP enrollment over the past ten years. CRMC attributes part of the drop to their ability to qualify more MISP patients for Medi-Cal. The drop in enrollment also coincided with the change to “verified enrollment” which required enhanced eligibility documentation in April 2003.

**Figure 11 - Fresno County MISP Enrollment**



Source: Medically Indigent Care Reporting System (MICRS) 2008

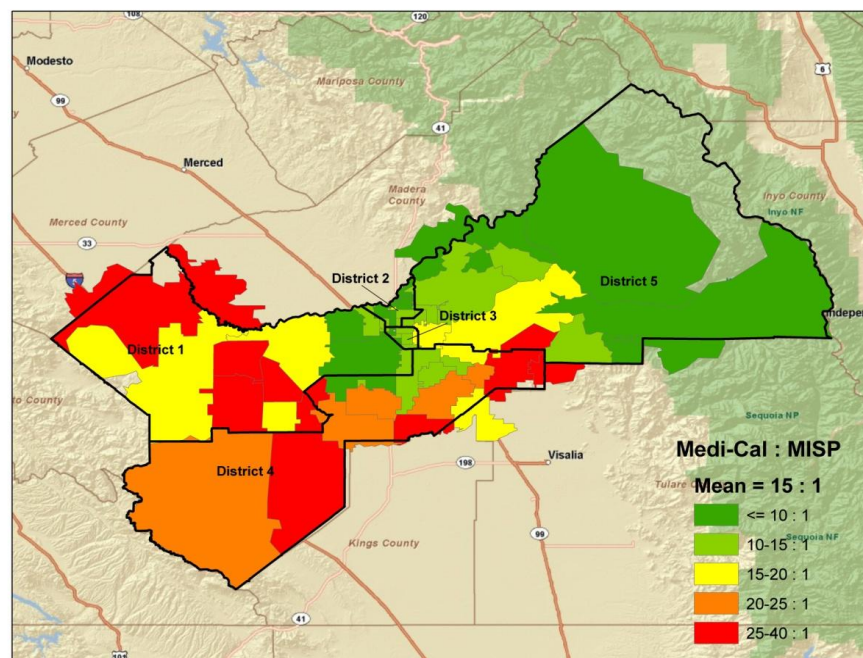
<sup>12</sup> Insure the Uninsured Project, A Summary of Health Care Financing for Low-Income Individuals in California, 1998 to 2008, 2008. Accessed September 14, 2009 from [www.itup.org](http://www.itup.org).

### Where are MISP patients from?

As mentioned above, until April 2010, MISP services were primarily provided at Community Health Centers - Cedar, the former Valley Medical Center in central Fresno with few services available in the rural outlying areas of the county. Currently, all clinic services are being consolidated at a single location on the main Community Regional Medical Center campus. However, many indigent adults receive services at the federally qualified health centers (United Health Centers, Clinica Sierra Vista, and Valley Health Team); they are not reimbursed by MISP.

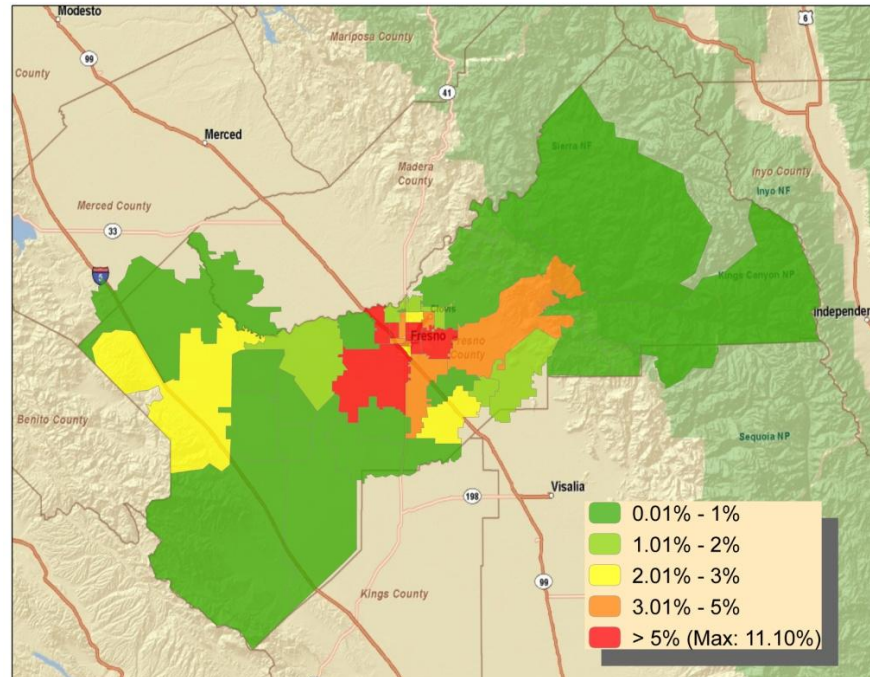
The lack of MISP services outside of Central Fresno is reflected in the geographic maldistribution of MISP patients. The map below (Figure 12) shows the ratio of Medi-Cal to MISP enrollees as they are distributed throughout the county. Since Medi-Cal and MISP are designed to cover similar low income populations, the ratio of Medi-Cal to MISP enrollees (15:1) should be similar throughout the county. However, in the western and southern parts of the county (Supervisory Districts 1 and 4) there are far fewer MISP enrollees than would have been expected if there was a distribution similar to Medi-Cal enrollees. In the more mountainous eastern part of the county (District 5) there are more MISP enrollees than would have been expected, but the number of enrollees is quite small as these areas have small populations. Figure 13 shows the distribution of MISP recipients only.

**Figure 12 - Medi-Cal: MISP Enrollment Ratio, by Zip Code and Supervisor District**



**Source: Medically Indigent Care Reporting System (MICRS) 2008  
and California Department of Health Services**

**Figure 13 - MISP Recipients as Percentage of County Total, by Zip Code**



**Source: Medically Indigent Care Reporting System (MICRS) 2008**

## **6. What are the barriers in accessing care for the medically indigent?**

Over the past several months a coalition of health consumer groups has been holding “town hall” meetings with low income persons to discuss their access to health care and issues with the Fresno medically indigent program. The concerns voiced at these meetings fall into four major categories:

### Eligibility criteria

The income and property limits for eligibility have not changed since the 1980s. The current income limit of \$509 per month for an individual is approximately 56% of the federal poverty level (FPL) of \$903 per month. While persons may be eligible for services with a share of cost up to \$764 per month (85% FPL), there is no eligibility for persons over that limit. This “cliff” means that most low income workers are excluded from eligibility, regardless of medical need or medical costs that have been incurred.

Similarly, the property limits have been static for the same period. An individual with more than \$1,600 in assets (excluding car and home) is ineligible for any coverage, regardless of the extent of medical bills.



### Eligibility process

Attendees at the town hall meetings reported a very confusing and complicated eligibility determination process. They cannot apply for coverage until they actually have an appointment at a clinic, and then they may only apply on certain days. Often it is difficult to get a clinic appointment without MISP coverage.

Another issue is that persons are certified for only a certain period of time (usually three months), after which they need to re-apply. Since waiting times for specialty care appointments are often longer than the eligibility period, a patient's eligibility can lapse prior to the appointment and the patient must re-apply before a follow-up appointment.

While persons are entitled to request a hearing on an adverse decision regarding their application for MISP, this was often difficult due to the lack of a formal denial of benefits. Applicants for MISP are screened for potential eligibility prior to completing a full application. If they are advised that they are not eligible based on the screening, no application is filed and no denial is issued. Thus, an appeal is not possible.

Although there are alternative sources of payment or ways to reduce costs, e.g. hospital charity care policies and sliding fee payments, the low-income persons reported that they were often not told about these alternatives or how to access them.

### Scope of benefits and actual access to care

Although the scope of available benefits under the program guidelines is broad, the reality is that there are an insufficient number of doctors and clinics to provide the services. The waiting times for specialty appointments can be months and clinics are often full.

In addition, access for persons in the non-urban areas is very limited. Getting to appointments is very costly and time consuming given the lack of public transportation. Except for some primary care services in outlying areas, all services are in central Fresno at the CRMC facilities.

### Language and culture

Attendees at the "town hall" gatherings expressed concern over what they believed was a lack of linguistic access and cultural sensitivity. They recounted instances where there were no interpreters for non-English speaking patients and that children were required to translate for their parents at medical appointments. They also said that information about the MISP program and other alternatives was not provided to them in their primary language and in an understandable format.

## **7. How are medically indigent programs operated in other similarly situated counties?**

In order to analyze how other counties are handling their medically indigent programs we reviewed information from similarly situated counties, i.e. those counties without county hospitals

and are not part of the County Medical Services Program (CMSP) which serves small and rural counties<sup>13</sup>. The information provided below was obtained primarily from the California Health-Care Foundation reports on County Programs for the Medically Indigent in California.<sup>14</sup>

The **Merced County** Medical Assistance Program (MAP) serves low-income adults ages 18-64 with all medically necessary services to be received at Mercy Medical Center Merced (MMCM) or one of the two MMCM clinics in Merced. Outside services are available by referral only.

Applications are taken centrally at the MAP office. Coverage ranges from seven days to six months, usually 30-90 days. Patients up to 200% of FPL are eligible and those with incomes between 100% and 200% of FPL have a copayment. A medical need is required for eligibility.

The **Orange County** Medical Services for Indigents Program (MSI) covers low income adults ages 21 to 64. Services are provided at multiple clinics and hospitals throughout the county. Many services require prior authorization.

Applications are taken at the contracted hospitals and clinics with eligibility determination made by the county social services agency. Eligibility is for six months or potentially longer for those with chronic disease. Persons under 200% of FPL are eligible. A current medical need is required before applications are processed.

The **Sacramento County** Medically Indigent Services Program (CMISP) covers low income individuals who receive General Relief or are low-income. Services are provided at County operated clinics located throughout the city of Sacramento and through six contracted hospitals. All non-emergency services require prior authorization.

Applications are taken at the primary care clinics or the CMISP office. There is continuous eligibility for 12 months. Persons under 200% of FPL are eligible for services, sometimes with a share of cost payment. No current medical need is required for eligibility.

The **San Diego County** Medical Services (CMS) program covers low income adults ages 21 to 64 years of age. Services are provided at private clinics and hospitals contracted throughout the county. All services except primary care require prior authorization.

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<sup>13</sup> The County Medical Services Program (CMSP) is composed of 34 rural and small counties that contract for the administration of their MIA programs with Anthem Blue Cross under the oversight of the CMSP Governing Board. Individual counties screen for eligibility for patients who use the Anthem Blue Cross medical networks for their care. CMSP covers indigent adults ages 21-64 with incomes at or below 200% of FPL. No current medical need is required. Undocumented residents only have access to emergency services.

<sup>14</sup> Accessed September 14, 2009 from <http://www.chcf.org/topics/view.cfm?itemID=134110>.



Applications are taken at selective clinics or hospitals. Eligibility is generally for one to six months. Persons under 350% of FPL are eligible for services with higher income persons over 165% of FPL paying a share of cost. A current medical need is required for coverage.

The **San Luis Obispo County** Medical Services Program (CMSP) covers low income individuals ages 21 to 64. Services are provided through contracted community clinics and hospitals throughout the county. All non-emergency services require prior authorization.

Applications are taken at the central CMSP office within seven days of receiving services. Eligibility is determined by County workers for one to three months depending on need. Persons under 250% of FPL are eligible for services with specified co-payments. A current medical need is required for application.

The **Santa Barbara County** Medically Indigent Adult Program (MIA) covers low income adults ages 21 to 64. Services are provided at County operated clinics and private contracted hospitals. Outside services require pre-authorization.

Applications are taken at all County health clinics and social services offices. Eligibility is determined by County workers and lasts for one to four months depending on medical care needs and family finances. Persons under 200% of FPL are eligible for services with some paying a share of cost. A current medical need is required for eligibility.

The **Stanislaus County** Medically Indigent Adult Program (MIA) covers low-income adults ages 21-64 with outpatient services provided at County operated clinics throughout the county and a private hospital in Modesto. Outside services require prior authorization.

Applications are taken by appointment only at one of the medical clinics in Modesto. Coverage periods vary based on income stability and range from one to six months. Persons with income levels up to 250% of FPL are eligible, and no medical need is required for eligibility.

The **Tulare County** Medical Services program serves low income adults ages 21-64 through six County operated clinics located throughout the County and seven private hospitals for inpatient care. Outside services must be pre-authorized.

Applications for the program are taken at county social services offices and health care clinics throughout the county. County eligibility workers determine eligibility and coverage is generally for two months at a time with income recalculation at re-enrollment. Patients up to 275% of FPL are eligible for the program and asset limits apply. No current medical need is required for eligibility.

**Table 3 - Select Medically Indigent Programs in Other California Counties**

County	Total Population*	Adults 18-64 under FPL*	Per capita county spending per uninsured resident**	Ages covered	Eligibility (FPL)	Immigrants	County-operated clinics	Locations county-wide	Length of eligibility	Requires medical need
<b>Fresno</b>	886,074	17.8%	\$86	21-64	63%	Covers all	No	Limited	1-3 mos.	Yes
<b>Merced</b>	242,173	17.2%	\$53	21-64	200%	Legal immigrants only after 5 years	No	No	7 days – 6 mos.	Yes
<b>Orange</b>	2,988,407	8.6%	\$79	21-64	200%	Legal permanent resident only	No	Yes	6 mos.	Yes
<b>Sacramento</b>	1,373,773	11.2%	\$266	All	200%	Undocumented not eligible	Yes	Limited	12 mos.	No
<b>San Diego</b>	2,954,960	10.4%	\$90	21-64	350%	Undocumented not eligible	No	Yes	1-6 mos.	Yes
<b>San Luis Obispo</b>	260,278	15.3%	\$86	21-64	250%	Legal residents only	No	Yes	1-6 mos.	Yes
<b>Santa Barbara</b>	402,968	14.1%	\$191	21-64	200%	Legal residents only	Yes	Yes	1-4 mos.	Yes
<b>Stanislaus</b>	506,405	12.8%	\$109	21-64	200%	Undocumented not eligible	Yes	Yes	1-6 mos.	No
<b>Tulare</b>	413,933	19.5%	\$68	21-64	275%	Emergency only for undocumented	Yes	Yes	2-3 mos.	No
<b>CMSP Counties</b>	n/a	n/a	n/a	21-64	200%	Emergency only for undocumented	Depends on county	Depends on county	3-6 mos.	No

Sources: \* US Census Bureau, 2005-2007 American Community Survey 3-Year Estimates

\*\*Insure the Uninsured Project 2004.

## **8. Best practices: What are innovations that can be applied to Fresno County to improve care for the medically indigent?**

Several recent key developments in Fresno County may profoundly affect the future of the MISP program. These developments provide an opportunity for transforming the system by moving to a “medical home” and prevention model while drawing down federal funds to match the County’s approximately \$20 million annual contribution to indigent care.

- National health reform will provide coverage for many low-income adults who are U.S. citizens or legal residents.
- Litigation is pending against the county over the MISP eligibility limits. This lawsuit has the potential to dramatically change the MISP program, increase the County’s financial liability, and impact its contract with Community Regional Medical Center.
- A Fresno County community coalition called the Coalition for Patient Care has been holding a series of town hall meetings on access to care for low-income persons and pressuring the County Board of Supervisors to make changes to the MISP.
- Community Regional Medical Center, the contract facility for MISP, has reported uncompensated care losses in excess of \$34 million annually.
- Fresno County has recently joined with Kings County and Madera County in forming a regional Medi-Cal managed care health plan – the Fresno-Kings-Madera Regional Health Authority Commission. The Commission may be an appropriate venue for administering an indigent care system.
- Fresno County is one of the sites for the Kaiser Permanente-funded Specialty Care Initiative which is developing systems for improving access to specialty care for the county’s medically indigent population.
- The State is pursuing a renewal of its Medi-Cal waiver that would expand the ten-county Coverage Initiatives to additional counties to enable them to draw down federal funds to form more comprehensive indigent care systems. Fresno County previously applied for the Coverage Initiative but was unsuccessful in its bid. Fresno County is well situated to pursue these funds if it can develop a community-wide plan to meet the program’s focus of managing chronic care and establishing medical homes for indigent persons.

In its current configuration, Fresno County’s Medically Indigent Program is much more of a payment system for episodic care for individuals rather than a health care delivery system that focuses on the health of a defined population. To be efficient and effective in health care, the system must orient more towards prevention and providing comprehensive health services to keep its enrollees well and manage their chronic conditions, rather than responding on an episodic basis to each course of treatment.

In order to manage care more effectively, the County should move towards:

- a more streamlined and consumer friendly enrollment process utilizing electronic enrollment tools such as One-e-App
- broader program eligibility mirroring other Valley counties of at least 200% of FPL
- longer periods of eligibility to support disease management and reduce administrative costs
- a broader network of primary and specialty providers located throughout the county in partnership with Federally Qualified Health Centers (FQHCs).
- an emphasis on prevention and chronic care management to control costs and improve care
- technology improvements to integrate and enhance the enrollment and care processes
- seeking state and federal funding to enhance the system's long-term viability

### Models of county innovations for indigent care – the Coverage Initiative

In order to encourage county-level innovation to enhance indigent care, the State selected ten California counties to be part of the Health Care Coverage Initiative (CI) in 2007. The CI is funded for three years by the federal government through the Medi-Cal hospital financing waiver providing counties \$180 million dollars in funding annually. All but two of the counties have county-operated delivery systems, although some of the counties with their own delivery systems also partner with private providers. San Diego and Orange Counties rely entirely on a network of private hospitals and clinics.

A recent report on the CI highlights some of the common elements of the county programs that are critical to reforming local health systems.<sup>15</sup> These critical elements include:

- **Provider networks** – Comprehensive provider networks which include primary and specialty providers, with primary care physicians serving as enrollees' medical homes were developed in the counties. Where counties did not have sufficient in-network providers they contracted with a wide range of private providers. For the medical home model to succeed the counties required systematic coordination and close communication among providers.
- **Enrollment processes and systems** – Counties used formal, centralized enrollment processes to track and manage CI enrollees, assist with the renewal process and maintain continuity of care. Three of the counties used One-e-App<sup>16</sup>. The citizenship verification requirements imposed by the federal government added significantly to the burdens of the enrollment process.

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<sup>15</sup> California's Health Care Coverage Initiative: County Innovations Enhance Indigent Care (2009). Accessed October 6, 2009 from <http://www.chcf.org/topics/medi-cal/index.cfm?itemID=134061>.

<sup>16</sup> One-e-App is used in Fresno for determining potential other health coverage programs, but not MISP.

- **Chronic care management** – Counties implemented chronic care management to improve enrollees' health status and shift costs from costly emergency and inpatient services to outpatient services. Some counties focused on specific conditions such as diabetes and hypertension, while others used patient self-management tools and disease registries.
- **Information technology (IT)** – IT was used to coordinate care across providers by sharing access to patient information in enrollment systems. One county contracted with an outside vendor to develop a health information exchange; another is developing an e-referral tool to facilitate the specialty referral process.
- **Strong leadership** – Key to the success in the reform efforts was committed senior-level executives and policymakers in the CI counties.
- **Financial sustainability** – A significant challenge is the funding to continue the CI program. The federal grant is expiring in 2010, but is expected to be renewed and possibly expanded to additional counties. Fresno County was not successful in its application in 2007 in part due to the lack of committed County funds but future opportunities might be pursued.

### Opportunities for federal funding

Most large counties rely on local, state and federal funding to maintain their indigent care system. Counties with public delivery systems – hospitals and clinics – receive funding for hospitals that serve a disproportionate share of indigent patients (DSH), or enhanced Medi-Cal reimbursement for their clinics as federally qualified health centers.

In Fresno County, Community Regional Medical Center receives DSH funding (\$42,207,224 in 2007). Under a plan developed through negotiation between the hospital and the State Medi-Cal office, CRMC would have received approximately \$17 million annually from the federal government if Fresno County would have agreed to changes in its method of transferring the indigent care funds it already pays to CRMC. At the advice of County Counsel, the Board of Supervisors declined to agree to the plan, and the federal funds were lost.

Additional federal and state funding might be available to the county but officials in the health systems need to be more aggressive and creative in pursuing the funding. The State recently released its concept paper on a new Section 1115 Medicaid Waiver to replace the current one.<sup>17</sup> The State's draft plan calls for expansion of the Coverage Initiative (discussed above) to additional counties. If approved by the federal government, Fresno County could be one of the expansion counties if it were to pursue a "Coverage Initiative" model of indigent care which

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<sup>17</sup> <http://www.dhcs.ca.gov/provgovpart/Pages/WaiverRenewal.aspx>.

included components such as a primary care based medical home, case management of chronic conditions, longer term eligibility, performance measurement and quality improvement. An estimate of potentially eligible residents by county is provided in the Appendix. This shows the potentially large population in Fresno County in relationship to other counties.

Another opportunity is that Fresno County has just formed a regional Medi-Cal managed care health plan with Kings and Madera Counties. Governed by the Fresno-Kings-Madera Regional Health Authority Commission with appointees from all three counties, this Authority will create one of the largest Medi-Cal managed care systems in the state. It will also create infrastructure to take advantage of new opportunities that may arise from local, state or national health care coverage efforts. The regional authority can also explore an insurance risk approach to covering MIAs.

### **Eligibility and enrollment processes**

The current eligibility levels for MISP are the lowest in California and until recently had not changed since the early 1980s. In addition to the low limits, the eligibility criteria do not take into account the amount of medical and other living expenses. If an applicant is \$1 over the eligibility limit (\$764 monthly income for an individual), then they are denied coverage, regardless of the cost of their medical care. These limits appear to be contrary to state law and are the subject of a lawsuit filed by an applicant who was denied coverage due to the “cliff” in the eligibility criteria. As mentioned above, the County Board of Supervisors adjusted the income limits upward in February 2010 to just over 100% of FPL and is determining an implementation date. Despite these changes, Fresno County’s income limits are significantly stricter than any other county in the Central Valley and it continues to rank at the very bottom statewide.

The length of coverage also makes comprehensive treatment difficult. Coverage in Fresno is only for a three month period after which the patient must renew their application. It often takes that amount of time to get into a specialty appointment after being referred by a primary care doctor, so the patient has to reapply for each appointment. Eligibility could be provided for longer periods of time based upon the patient’s condition or for a course of treatment. A more comprehensive approach also holds tremendous potential for cost savings.

Consumers have reported that the enrollment processes are confusing and sometimes appear arbitrary. A better job could be done in explaining how to apply for benefits, the reasons for denials, how the appeals process works, and what is covered under the program. Not only should this information be made available at a low-literacy level but it should be available in the multiple languages of the target population.

In addition, patients who are denied MISP should be made aware of other possible opportunities such as the hospital’s charity care program or a clinic’s sliding scale program. If applications

were electronically processed through a system such as One-e-App (available in Fresno County), this information could be automatically available to the case worker and the patient.

### **Location of services**

MISP generally covers only services in downtown Fresno through Community Regional Medical Center's clinic system. The outlying clinics in Mendota and Coalinga only provided 9% of total MISP outpatient clinics. Reimbursement is not provided for care at the federally qualified health centers located in over 20 locations throughout the county. United Health Centers which provides 36% of the self pay and free care visits in Fresno County receives funding for only 2% of the county indigent visits under contract with Community Regional Medical Center.

Most other medically indigent programs provide coverage for visits at clinics that are geographically dispersed throughout the county and often include several networks of providers and several sites to apply for coverage.

## **9. Conclusion**

Care for the medically indigent in Fresno County will always be a challenge given the high demand for services and the lack of sufficient resources to meet the needs. However, periodic review and revision of the system for caring for Fresno County's most vulnerable population is necessary to ensure that resource are being used efficiently and that adequate services are being provided to the target population. Many local providers have expressed their intentions to collaborate on this issue.

There are some serious deficiencies in the current system but there are also some upcoming opportunities to improve the situation. The most prominent of these is the renewal of California's Section 1115 Medicaid Waiver and the expected expansion of the Coverage Initiative (CI). The CI provides the potential to revamp the medically indigent system to focus more on prevention and better meet the needs of the recipients, providers and payers. Talks are currently underway to expand the CI to additional counties including Fresno beginning late 2010. HCAP has been actively involved in the discussions. Over the past three years, the Coverage Initiative has provided \$180 million in annual matching funds to ten California counties to support the delivery of care to low-income population. Various reports have highlighted the significant achievements of the CI.

The County cannot afford to miss these opportunities; it must proactively seek participation in programs to draw down new federal funding to help it improve the health of its residents. The CI is Fresno County's most promising option. It is our intent this document serve as a *call to action* for the health care leaders in Fresno County to improve the services for the medically indigent in Fresno County and provide access to high-quality healthcare services for all residents. The work on the Medicaid 1115 Waiver is coming to an end and it is time for the entire community to come together and move forward collaboratively.

## **Appendix**



## **Glossary of Terms**

### **Bad Debt**

As defined by Office of Statewide Health Planning and Development (OSHPD): Accounts receivable which, although the patients have the ability to pay, are regarded as uncollectible and are charged as a credit loss against gross patient revenue. Bad debt is not included in Total Operating Expenses.

### **Breast and Cervical Cancer Control Program (BCCCP)**

Women in California are eligible for BCCCP services if they are at 200% of the federal poverty level or below, have no other insurance coverage, and meet age criteria for a particular service. The focus is upon women over 50. BCCCP also collaborates with the State of California Breast Cancer Early Detection Program for public education/outreach.

### **Charity Care**

As defined by OSHPD: Free or reduced fee care provided based on the financial situation of patients. Other organizations also have “sliding fee scale” arrangements.

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

The Child Health and Disability Prevention (CHDP) is a preventive program that delivers periodic health assessments and services to low income children and youth in California. CHDP provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services.

### **Discounted Health Care**

Discounted payment plan for adults below 400% of FPL accessing services through CRMC and the associated clinics. Other organizations also have “sliding fee scale” arrangements.

### **Disproportionate Share Hospital Funding**

The amount of supplemental Medi-Cal payments received by those hospitals which serve a high percentage of Medi-Cal and other low-income patients, as provided by SB 855 (Statutes of 1991). These payments are funded by intergovernmental transfers from public agencies (counties, districts, and the University of California system) to the State and from federal matching funds. SB 855 Disproportionate Share Payments are received by qualifying hospitals for each Medi-Cal paid inpatient day, up to a certain maximum, and are included in Medi-Cal Net Patient Revenue.

### **Expanded Access to Primary Care**

The mission of the EAPC Program is to improve the quality of health care and to expand access to primary and preventive health care to medically underserved areas and

**(EAPC)**

populations. Beneficiaries are those persons at or below 200% of the federal poverty level who do not have any third-party health or dental coverage.

**California Family Planning,  
Access, Care and Treat-  
ment  
(Family PACT)**

Family PACT provides comprehensive family planning services to eligible low-income men and women. This clinical program increases access to services by expanding the provider network to include medical providers, pharmacies and laboratories.

**Federal Poverty Level  
(FPL)**

The set minimum amount of income that a family needs for food, clothing, transportation, shelter and other necessities. This level is determined nationally by the Department of Health and Human Services and is not adjusted for cost-of-living differences across the country. FPL varies according to family size. The number is adjusted for inflation and reported annually in the form of poverty guidelines. Public assistance programs define eligibility income limits as some percentage of FPL.

**2010 Guidelines (100% of FPL)**

<b>Family Size</b>	<b>Annual Income</b>
1	\$10,830
2	\$14,570
3	\$18,310
4	\$22,050
5	\$25,790
6	\$29,530

**Federally Qualified Health  
Center (FQHC)**

Federally qualified health centers (FQHCs) include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors. The board of directors must have a majority of consumer members.

**Sliding Fee Scale**

Sliding Fee Scale allows an individual without health insurance to pay for medical services at a discounted rate based on his/her ability to pay. For each level of ability to pay, a fee structure exists. Clinica Sierra Vista and United Health Centers are examples of clinics that provide these discounted services.

## Estimate of Health Care Coverage Initiative Eligible Population 2007

**Table 4 - Eligible Population in Current Coverage Initiative Counties**

<b>COUNTY</b>	<b>AVERAGE ELIGIBLE POPULATION (RANGE)</b>
<b>ALAMEDA</b>	24400 (14,800 - 34,000)
<b>CONTRA COSTA</b>	33900 (13,600 - 54,100)
<b>KERN</b>	62600 (39,000 - 86,100)
<b>LOS ANGELES</b>	560700 (496,900 - 624,500)
<b>ORANGE</b>	106800 (72,700 - 140,900)
<b>SAN DIEGO</b>	111400 (86,500 - 136,400)
<b>SAN FRANCISCO</b>	24,000* (5,400 - 42,500)
<b>SAN MATEO</b>	6,200* (0 - 13,200)
<b>SANTA CLARA</b>	41,000* (14,100 - 67,900)
<b>VENTURA</b>	25,400* (8,200 - 42,600)

**Source: California Health Interview Survey 2007**

Note: \* The estimate is statistically unstable due to large variation in survey respondent characteristics  
More information can be found at <http://www.dhcs.ca.gov/provgovpart/Pages/TechnicalWorkgroupHCCI.aspx>

**Table 5 - Eligible Population in Potential Coverage Initiative Counties**

<b>COUNTY</b>	<b>AVERAGE ELIGIBLE POPULATION (RANGE)</b>
<b>RIVERSIDE</b>	109,500 (76,700 - 142,400)
<b>SAN BERNARDINO</b>	90,400 (67,400 - 113,400)
<b>FRESNO</b>	54,500 (31,300 - 77,600)
<b>SACRAMENTO</b>	45,000 (32,500 - 57,400)
<b>SAN JOAQUIN</b>	38,800 (23,000 - 54,500)
<b>STANISLAUS</b>	29,500 (13,100 - 45,900)
<b>TULARE</b>	29,000 (14,600 - 43,400)
<b>MONTEREY</b>	20,600 (8,300 - 32,900)
<b>MERCED</b>	18,400* (5,400 - 31,400)
<b>SHASTA</b>	17,500 (9,500 - 25,600)
<b>IMPERIAL</b>	16,700 (9,900 - 23,600)
<b>SANTA CRUZ</b>	12,000 (5,400 - 18,700)
<b>MADERA</b>	12,000 (5,500 - 18,500)
<b>SANTA BARBARA</b>	11,900 (6,100 - 17,600)
<b>SONOMA</b>	9,900* (1,200 - 18,700)

<b>COUNTY</b>	<b>AVERAGE ELIGIBLE POPULATION (RANGE)</b>
<b>SAN LUIS OBISPO</b>	9,600* (0 - 19,600)
<b>BUTTE</b>	8,400 (5,000 - 11,900)
<b>TEHAMA / GLENN / COLUSA</b>	8,200 (4,200 - 12,100)
<b>KINGS</b>	7,500 (5,100 - 10,000)
<b>SOLANO</b>	7,000* (1,100 - 12,900)
<b>DEL NORTE / SISKIYOU / LASSEN / TRI- NITY / MODOC / PLUMAS / SIERRA</b>	6,800 (4,200 - 9,400)
<b>YOLO</b>	6,300* (2,100 - 10,500)
<b>YUBA</b>	4,600 (3,200 - 6,000)
<b>PLACER</b>	4,400 (1,900 - 6,800)
<b>SUTTE</b>	4,200 (2,700 - 5,800)
<b>HUMBOLDT</b>	4,100 (2,300 - 5,800)
<b>MARIN</b>	3,900 (1,100 - 6,700)
<b>TUOLUMNE / CALAVERAS / AMADOR / INYO / MARIPOSA / MONO / ALPINE</b>	3,600 (1,200 - 5,900)
<b>SAN BENITO</b>	3,500* (0 - 7,600)
<b>NEVADA</b>	3,400 (2,200 - 4,500)
<b>LAKE</b>	3,000 (1,800 - 4,200)
<b>MENDOCINO</b>	2,800 (1,800 - 3,900)
<b>NAPA</b>	2,500 (800 - 4,100)
<b>EL DORADO</b>	1,400 (500 - 2,300)

**Source: California Health Interview Survey 2007**

Note: \* The estimate is statistically unstable due to large variation in survey respondent characteristics

## HCAP Mission Statement

To ensure access to affordable and appropriate health care for the underserved populations of Fresno County and the San Joaquin Valley, focusing on enhancing insurance coverage and improving delivery systems.

The corporation shall pursue these objectives through:

- Pursuing opportunities for expanding health coverage for underserved populations;
- Partnering with safety net and other health care delivery institutions to develop programs to improve access to affordable and quality health care;
- Exploring the use of technology to improve access to health care programs for underserved populations; and
- Providing educational programs for the general public and health care professionals on how to improve access to affordable and quality health care for underserved individuals

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