

California's Safety Net: The Role of Counties in Overseeing Care

Introduction

All 58 California counties bear significant responsibility for assuring “safety-net” health care services for their lowest-income residents. But how health care services for low-income people are financed and delivered differs significantly among the counties, with varying degrees of county involvement. This variation reflects the state’s size and diversity, including differences in residents’ race and ethnicity, income, and insurance status, and the counties’ different political climates and health care infrastructures. Moreover, meeting their obligation to provide care for indigent residents¹ recently has become more difficult for the counties: The current economic recession has led to a greater need for services obtained through the health care safety net as people lose their jobs and health coverage, while state and local budgets to support the safety net face increased strain.²

This issue brief presents findings from a study by the Center for Studying Health System Change (HSC) that made site visits to six California regions: San Francisco Bay Area, Sacramento, Fresno, Los Angeles, Riverside/San Bernardino, and San Diego. The study explored the role that 11 counties in these regions play in the health care safety net, the factors that shape their roles, and the impact of these roles on care delivery for low-income people.³ Some counties operate their own hospitals and/or clinics and may have local, publicly-operated health plans that provide Medicaid (Medi-Cal in California) managed care services.⁴ Instead of operating county facilities, some counties contract with other

public or private providers, such as University of California (UC) hospital systems, private hospitals, community health centers, and health plans to provide care for their most vulnerable residents.

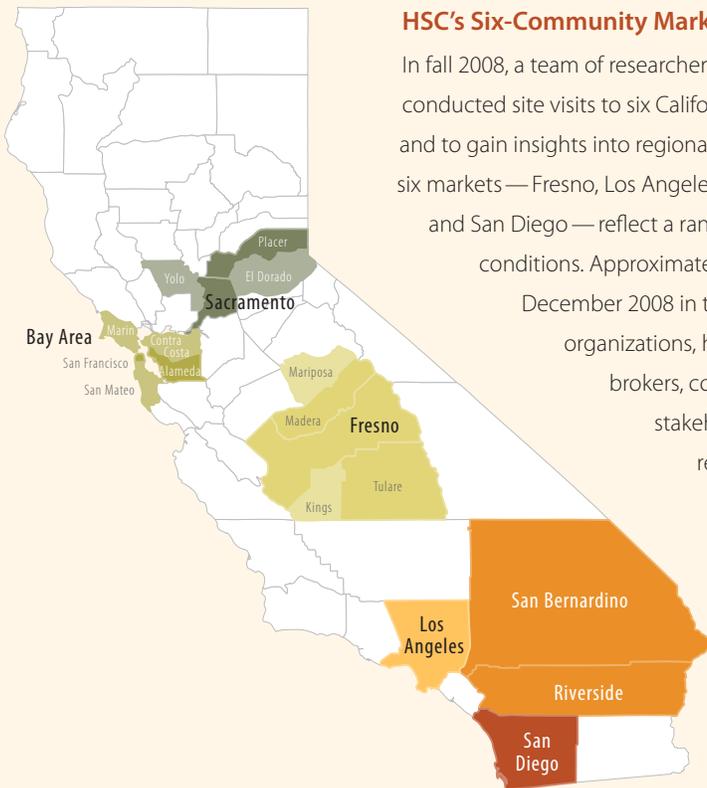
This study revealed a number of often related factors that appear to shape the role that counties assume, including:

- ▶ State and local funding levels;
- ▶ Degree of financial control desired;
- ▶ Extent to which a county is urban or rural;
- ▶ Political environment, including the existence of political champions; and
- ▶ Extent to which county facilities serve as major employers.

These factors play out in diverse ways, with no single factor or formula emerging to explain or predict a county’s safety-net role. The study’s findings suggest that counties that play the most extensive roles have significant opportunities to help coordinate safety-net services through providers and managed care plans and to improve access to care.

County Safety-Net Roles: The Context

California counties have long been health care providers of last resort to their poorest and most vulnerable residents, but county boards of supervisors have discretion to determine who is eligible, how much to spend, what services to cover,



HSC's Six-Community Market Study

In fall 2008, a team of researchers from the Center for Studying Health System Change (HSC) conducted site visits to six California communities to study those markets' local health care systems and to gain insights into regional characteristics in health care affordability, access, and quality. The six markets — Fresno, Los Angeles, San Francisco Bay Area, Riverside/San Bernardino, Sacramento, and San Diego — reflect a range of economic, demographic, health care delivery, and financing conditions. Approximately 300 interviews were conducted between October and December 2008 in the six communities with representatives of hospitals, physician organizations, health plans, major employers, benefit consultants, insurance brokers, community health centers, state and local policymakers, and other stakeholder organizations. This issue brief is based on responses from representatives of safety-net hospitals, community health centers, consumer advocacy organizations, community health center associations, local health departments, state and local policymakers, local medically indigent services program offices, local Medi-Cal enrollment offices and managed care plans, and other experts on the local health care safety net. A two-person research team conducted each interview, and notes were transcribed and jointly reviewed for quality and validation purposes. The interview responses were coded and analyzed using ATLAS.ti, a qualitative data management software tool.

Note: This brief analyzed data from 11 of the 18 counties in the six market regions.

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and how to deliver care.^{5,6} In larger California counties, this obligation is carried out by operating a Medically Indigent Services Program (MISP) that provides inpatient, emergency, and some level of outpatient medical services to uninsured adults (and, in some counties, to children as well). Income eligibility for MISP varies; many counties set MISP eligibility at below 200 percent of the federal poverty guideline (\$21,660 for an individual in 2009). The majority of county MISPs do not cover undocumented immigrants.⁷ The 34 smaller and/or predominantly rural counties in California participate in the state's County Medical Services Program, which provides services—similar to those included in the Medi-Cal program—for adult residents with incomes of up to 200 percent of the federal poverty guideline.⁸

Over the past few decades, counties have had to adapt to substantial changes in state policy and funding related to care for low-income residents. State budget deficits in the early 1990s prompted a significant shift in financial responsibility for health and social services from state to county governments. The state now allocates realignment funds—sales tax revenues and vehicle license fees—directly to the counties for this purpose, with different formulas determining how much each county receives. Within the same time frame, the state began a significant expansion of managed care for Medi-Cal in an effort to control program costs, and removed county responsibility for funding a portion of the program. Counties nonetheless played a key role early on in the development of the public Medi-Cal

managed care plans implemented in many counties, through local, publicly-operated Medi-Cal managed care plans (or local initiatives) and county-organized health systems.⁹ More recently, California counties have experienced an erosion of funds for providing health care to low-income people, relative to costs.¹⁰ An ongoing economic recession and related state and local budget crises have led to declining state tax revenues for realignment funding, to cuts in Medi-Cal and Children’s Health Insurance Programs, and to decreases in counties’ own funds for safety-net care.

Variety of County Safety-Net Roles

A county’s role in the safety net varies according to the extent to which it directly provides health services for low-income people or, instead, contracts with private organizations to serve MISP enrollees and other low-income county residents. Some counties directly operate health services (typically, administered by the local health department) through ownership of hospitals and clinics, and through the creation of local, publicly-operated Medi-Cal managed care plans as a means of maintaining Medi-Cal patients at county facilities (e.g., San Francisco, Alameda, Los Angeles, San Bernardino, and Riverside counties). Other, usually smaller, counties play a less direct role in the safety net, either owning no hospitals or clinics, not having local, publicly operated Medi-Cal plans (e.g., Fresno, Madera, and San Diego counties), or owning only one or two of the three types of health care entities (e.g., Sacramento, Placer, and Tulare counties).¹¹ See Table 1 for a comparison of these roles among counties included in this study.

HOSPITAL CARE

County hospitals assume responsibility for providing inpatient, emergency, and outpatient specialty services for patients regardless of their ability to pay. These patients include Medi-Cal beneficiaries, MISP enrollees, and other uninsured people. Many counties statewide provide this care in hospitals they own and operate: Five counties in

Table 1. Indicators of California Counties’ Safety-Net Roles

| Market Region/County | County-Owned Hospital(s) | County-Owned Clinics | Public Entity Medi-Cal Managed Care Plan |
|--------------------------------|--------------------------|----------------------|--|
| BAY AREA | | | |
| Alameda County | ✓ | ✓ | ✓ |
| San Francisco County | ✓ | ✓ | ✓ |
| FRESNO | | | |
| Fresno County | | | |
| Madera County | | | |
| Tulare County | | ✓ | |
| LOS ANGELES | | | |
| Los Angeles County | ✓ | ✓ | ✓ |
| RIVERSIDE/SAN BERNADINO | | | |
| Riverside County | ✓ | ✓ | ✓ |
| San Bernardino County | ✓ | ✓ | ✓ |
| SACRAMENTO | | | |
| Placer County | | ✓ | |
| Sacramento County | | ✓ | |
| SAN DIEGO | | | |
| San Diego County | | | |

Source: Authors’ analysis of data collected from 2008 study site visits.

the present study— San Francisco, Alameda, Los Angeles, Riverside, and San Bernardino— own at least one hospital. Counties that do not own a hospital contract with private hospitals in order to care for the MISP population. Two counties— San Diego and Sacramento— contract with UC hospitals as well. Also, some counties have health care districts, which are governed by an elected body separate from the local government and have the authority to impose property taxes to pay for the operation of a hospital. These districts are not technically county-owned entities, and so may not have the same mission of serving the uninsured and indigent that county-owned public hospitals do, but in the counties of San Bernardino, Riverside, and Tulare respondents indicated that they serve a significant proportion of low-income people.

CLINIC CARE

Eight of the counties in this study operate their own primary care clinics: the five counties that own at least one hospital, plus Sacramento, Placer, and Tulare. County clinics serve the MISP population as well as, typically, other uninsured and Medi-Cal patients. All of the regions in the study also have

private, nonprofit community health centers (CHCs) that treat uninsured and Medi-Cal patients. Many CHCs and some county clinics have become federally qualified health centers (FQHCs), a designation that enables them to receive federal grants and enhanced Medi-Cal reimbursement, or they have qualified as FQHC look-alikes that do not receive grant funding but are entitled to enhanced Medi-Cal reimbursement. CHCs in San Francisco, Alameda, Los Angeles, and San Diego counties also receive county funding to treat MISP patients.

MEDI-CAL MANAGED CARE

Most counties in the study have adopted one of three Medi-Cal managed care models used in California. Most of these operate a two-plan model, in which the state contracts with a local public plan or local initiative, and with a commercial plan, and beneficiaries choose between them. The five counties in the study that have a public health plan—San Francisco, Alameda, Los Angeles, San Bernardino, and Riverside—also own hospitals and clinics. Although Fresno and Tulare counties also operate under the two-plan model, they use two commercial plans to serve Medi-Cal beneficiaries because no public managed care plan exists there. Sacramento and San Diego counties operate under a geographic managed care model, in which several commercial managed care plans compete for Medi-Cal enrollees. Placer and Madera counties currently operate under the traditional fee-for-service delivery system. Madera is expected to join Fresno and Kings counties to form a regional two-plan model in October 2010.¹²

Factors that Influence Counties' Safety-Net Roles

This study identified several significant factors that appear to shape the role counties play in providing safety-net care: available funding; policymakers' desired level of financial control; the extent to which the county is urban or rural; the county's political environment, including the presence of

effective political champions; and whether county facilities serve as major employers, including related union influence.

These factors carry different significance across counties and, while some patterns emerge, no single formula can fully predict or explain an individual county's role in providing safety-net care. For instance, Fresno and Madera counties, which are predominantly rural and have low available funding and more conservative electorates, play relatively small direct roles in providing safety-net care. Yet Riverside and San Bernardino counties also have relatively low funding and a conservative electorate, but the presence of political champions and the need to respond to particular geographic and economic realities have led these two counties to play more direct roles. In another example, it is unusual for a large California metropolitan county such as San Diego to play a relatively indirect role in the safety net, but its conservative political environment overcomes other factors and limits the county's participation.

AVAILABLE FUNDING

Counties with more health care funding typically play more direct roles in the safety net because ownership, operation, and support of hospitals, clinics, and health plans require significant financial investment. Currently, state realignment dollars represent an important source of funding for county health care and are distributed based on counties' historical spending on health and social services. The realignment payment formula has not been regularly updated to reflect demographic and socioeconomic changes in county populations, however. Respondents and other reports indicate that the level of per capita realignment funds a county receives varies significantly across counties, with San Francisco County receiving the highest, which is significantly greater, for example, than what Riverside and San Bernardino counties receive.¹³ Counties that own hospitals also receive federal dollars through Disproportionate Share Hospital (DSH) payments and Safety Net Care Pool (SNCP) funds, provided through a Medicaid waiver to help defray the costs

of providing uncompensated care. The ability of counties to generate their own funding for health care was significantly hampered by California's Proposition 13, passed by voters in 1978, which limits county property tax assessments to 1 percent of home values, reducing this revenue source to less than half of previous levels.¹⁴

A few counties have enacted their own fees to support their safety net: San Francisco imposes a fee on employers that do not provide health insurance to their employees, to help support Healthy San Francisco, a program to improve access to care for uninsured adults with incomes of up to 500 percent of the federal poverty level; Alameda County voters passed a half-cent sales tax to support the county hospital and safety-net clinics; and Los Angeles voters passed a tax to pay for trauma and other emergency department services.¹⁵ Also, four of the study counties—Los Angeles, San Francisco, Alameda, and San Diego—currently receive funding from the SNCP to operate a Health Care Coverage Initiative to expand access to care for low-income, uninsured adults.

FINANCIAL CONTROL

The amount of control a county wants to exercise over its health care expenditures seems to be a factor in the size and directness of its safety-net role. Because county facilities require increasing capital and operational investment as both the demand for safety-net services and the costs of care rise, counties that own facilities have less control over and less predictability regarding how much they spend on health care compared to counties that solely contract with private providers and the UC system. Many California counties have shed their county hospitals over the last few decades for this reason.¹⁶ As one respondent explained, “It wasn't hard for boards of supervisors to see that if you ran a county hospital, you would spend more of your local tax dollars. [Instead] you could fulfill your statutory responsibility through contracting and, in that process, you had a great opportunity to say who

your patients were... and you restricted that more or less at will.”

Among the counties in this study, Fresno, Sacramento, and San Diego have chosen to contract for hospital (and in some cases, clinic) services as a way to control what they spend on health care. Fresno has a 30-year contract with the major hospital system in the community to provide inpatient and outpatient care to the medically indigent, a set annual amount which respondents reported covers less than half of the actual costs of care. Sacramento County contracts with UC Davis hospital, but has also started using a third-party administrator to contract with other hospitals at lower payment rates (although early reports indicated that the county may not be realizing any savings). Even counties playing large roles are experimenting with the financial ramifications of contracting with some private providers, particularly CHCs. As one such county respondent explained, “We had to see if we could get more by purchasing services or doing them ourselves.”

Perceptions of financial control also appear to affect a county's desire to establish a public Medi-Cal health plan. Public plans tend to serve a majority of Medi-Cal beneficiaries in the market and reportedly steer enrollees, and therefore Medi-Cal funds, to their own providers. The two-plan model arose in numerous counties as a result of a political compromise between the counties and the state, in which the state wanted to contract with managed care plans through competitive bidding and the counties wanted to protect the historic funding streams of their county hospitals and clinics. On the other hand, respondents indicated that Sacramento County—which owns clinics for the medically indigent but no longer a hospital—requested to operate under a geographic Medi-Cal managed care model because they did not want the responsibility of creating a publicly-operated managed care plan that would be required under other Medi-Cal managed care models. In that community, the private not-for-profit community clinics argued that the

geographic managed care model did not adequately protect them financially.¹⁷

URBAN OR RURAL ENVIRONMENT

In some cases, the extent to which a county is largely urban or rural affects the safety-net role it plays. More urban counties, such as San Francisco and Los Angeles, have more money for health care and play a larger, more direct role, while more rural, agricultural counties tend to have fewer resources and play a smaller role. But as one respondent explained, it is not solely a matter of available funds but also of political leverage: “Urban areas are the ones out there really fighting and have the political power to influence where the health care dollars go.”

Some rural counties, such as Fresno and Madera, assume smaller safety-net roles because contracting with existing providers allows them to offer a provider network without making a capital investment. But in Riverside and San Bernardino counties, where the population is widely dispersed—geographically, San Bernardino is the largest county in the continental United States—the county governments assume a larger safety-net role because otherwise low-income residents might not be able to obtain care without traveling long distances. Because of the low number of providers in Riverside and San Bernardino counties, county-owned hospitals attract larger proportions of commercially-insured patients than publicly-owned hospitals usually do, which helps their financial stability. Other factors may also alter the typical urban/rural distinction: Placer County, for example, is a rural area that lacks private community health centers; as a result, the county found it too difficult and expensive to get sufficient participation from private physicians, so it continues to run its own clinics.

POLITICAL ENVIRONMENT AND CHAMPIONS

The counties of Los Angeles, San Francisco, and Alameda appear to have assumed larger roles in the safety net in part due to their politically progressive electorates and well-

organized networks of advocates for low-income people. In these counties, boards of supervisors and mayors can gain politically by using their hospitals as political “medals,” displaying them to constituents and stakeholders to show what they have accomplished for the community. In addition, the progressive electorates in these counties have been willing to pass dedicated taxes to support the safety net.

The presence of a political champion to advocate for the safety net can also foster a larger role for the county. For example, the county administrative officer for San Bernardino County was previously CEO of the county hospital and is collaborating with the county health officer to create an integrated primary care-based safety-net system. In San Francisco, the mayor (who also serves as the county executive) has been a major proponent of county health care facilities and improving access to care for the uninsured. Such political supporters also help protect safety-net funding from local budget cuts.

In contrast, many other counties lack a supportive political environment or political champions to advocate for safety-net health care. This is the case for Fresno County, despite it being an agricultural area dependent on many low-wage, migrant workers. As one respondent put it, Fresno has no “political capital” with which to operate hospitals, clinics, or a local public Medi-Cal managed care plan. There, county supervisors reportedly prioritize public safety and law enforcement over health care and spend a portion of the county’s realignment funds on health care in county jails. Fresno also has the most restrictive MISP income eligibility in the state, enrolling uninsured adults with incomes of only up to 63 percent of the federal poverty level. Similarly, San Diego’s electorate is relatively conservative and particularly opposed to providing services to undocumented immigrants, prompting local leaders to run for office under the banner of “fiscal responsibility” and the county to assume a more hands-off, smaller safety-net role. San Diego County did recently raise the income eligibility for its MISP from 135 percent to 165 percent of the federal poverty level, but

only in the wake of lawsuits alleging the county was shirking its responsibility to be the provider of last resort.

COUNTY FACILITIES AS MAJOR EMPLOYERS, AND UNION INFLUENCE

County-owned hospitals often serve as major employers in a community, a factor that appears to help maintain a county's large safety-net role. Respondents in Riverside and San Bernardino counties indicated that local government continues to play a strong role in the safety net because health care is a major employer and economic driver in an area where construction and manufacturing jobs have dried up. As one respondent from Riverside County noted, "The only area where jobs are increasing in the Inland Empire [the metropolitan area of Riverside and San Bernardino counties] is health care."

Further, heavily unionized workforces tend to protect county facilities in order to preserve county jobs. Union influence contributed to Alameda County's decision to convert its county hospital into an independent public health authority (funded by the county but with a separate board and management structure) rather than into a separate district hospital, which would have potentially reduced union protections for workers. As one respondent explained, "There was pushback from unions and the more progressive elements in the political spectrum who thought that [converting to a district hospital] was a move to privatize. What happened was a compromise and the hospital stayed within the county family." Similarly, in Los Angeles, influential public employee unions supported the election of a new county supervisor who has worked to slow the shift of medically indigent patients from county clinics to community health centers in an effort to reduce costs.

Impact of a County's Safety-Net Role

Counties that play the largest direct safety-net role seem to have greater control over funding streams, and sometimes more leverage with providers and Medi-Cal plans, than those with a more limited role. Study respondents indicated that

this greater role can produce some benefits to low-income residents in access to care and improved coordination of health care delivery, as discussed in this section.

Public ownership of hospitals appears to help improve access for low-income patients for some services.¹⁸ This is partially explained by these facilities' mission to provide care to county residents regardless of their ability to pay, whereas county contracts with other hospitals typically only cover care for people who meet the county's specific MISP eligibility criteria. Also, respondents observed that county hospitals, as well as some hospitals in the UC system, are more likely than private providers to take steps to improve access to specialty care, mental health services, and dental care—services that are especially difficult for low-income people to access. These facilities often operate outpatient specialty clinics staffed with physicians and accept patients regardless of their insurance coverage.

Compared to specialty, dental, and mental health care, primary care is more available to low-income people across all the study counties, regardless of a county's safety-net role. While Sacramento, Alameda, and Tulare counties have reduced the capacity of their county clinics over the last few years because of local budget deficits, county and other community clinics in other counties have achieved or are pursuing federally qualified or look-alike status to obtain additional, and seemingly more stable, revenues. Indeed, increased federal funding for FQHCs over the past decade has sparked significant growth of private community health centers across the counties. One of the reasons Alameda County contracts with FQHCs is to build upon county clinic capacity and obtain a range of culturally competent services for its diverse uninsured population.

For Medi-Cal beneficiaries, many respondents reported that public Medi-Cal managed care plans have helped improve access to care, whereas lack of a locally-developed Medi-Cal managed care plan can generate concerns about access to and quality of care. Sacramento respondents expressed concern that the county does not receive

information on whether access to and quality of care for Medi-Cal beneficiaries are adequate because the participating commercial plans contract directly with the state. Fresno County is working towards creating a regional, two-plan initiative with Kings and Madera counties, which local policymakers expect will allow the three counties to more efficiently address reimbursement and provider network issues and therefore improve access to care.

Counties that assume a large safety-net role have greater control over funding, as well as over provider and Medi-Cal plan activities, which allows them to work toward a more coordinated safety-net delivery system overall. Given safety-net capacity limitations, these efforts typically involve reaching out beyond a county's own providers to private entities. As a San Diego respondent observed, "My impression is that in communities where there is a county hospital, because there is a locus there, they have formal connections with other providers. And because the county has skin in the game, they provide the support to make the connections."

A key example of such coordination is in San Francisco, where the health department combines different funding streams and works with various providers to implement its Healthy San Francisco (HSF) program for uninsured adults. HSF uses the San Francisco Health Plan, originally developed as the Medi-Cal local health plan initiative, as the third-party administrator, and contracts with public providers, private hospitals, and community health centers to encourage use of primary care providers rather than emergency departments and to coordinate access to specialty care. In contrast, respondents in counties that assume smaller roles—particularly in the Central Valley (Fresno, Madera, Tulare counties)—noted a lack of broad efforts to coordinate health care delivery.

Counties that play smaller safety-net roles, however, can still bring private organizations and policymakers together to better coordinate safety-net services. Some of these counties have established safety-net coalitions and

programs with that goal. In San Diego County, for example, policymakers commissioned an assessment of the capacity of private safety-net providers and allocated funding to address identified concerns, such as by implementing an information technology system to share patient information between emergency departments and community health centers. Also, the Healthy San Diego collaboration draws private Medi-Cal managed care plans and providers together with the county and consumer advocates to address access and quality of care.

Conclusion

The funding, politics, and market factors that shape a county's role in the safety net are varied and complex. Examining those factors may help policymakers in their efforts to improve access to care for low-income people. County or other public ownership and operation of health care facilities, as well as locally developed Medi-Cal managed care plans, appear to offer some benefits, including improved access to specialty medical care and stronger coordination of services among both public and private providers.

In responding to the challenges of the current economic climate and of California's ongoing budget crisis, counties that assume the largest roles in their local health system will have more tools—hospital systems, clinics, local public entity health plans—with which to address the problem of increased numbers of uninsured people. On the other hand, they are also at higher risk, as their finances and organizations are strained by budget shortfalls. Counties that instead rely more on contracting out services to private providers may save some money by doing so, but they may soon encounter growing access problems if demand for safety-net services overwhelms what the private safety net is willing or able to provide. Ongoing efforts to better coordinate services may help counties all along the spectrum, from those that operate services directly to those that solely contract with private providers.

Similarly, national health care reform likely would affect counties differently. Counties having large safety-net roles

might be better able to help low-income residents navigate new opportunities for coverage and to help coordinate their care. Should federal legislation expand Medicaid eligibility, local, publicly-operated Medi-Cal managed care plans could gain enrollment and county facilities could gain more Medi-Cal patients and revenue. Alternatively, Medicaid or Medicare changes could eventually diminish public revenue streams that county facilities currently rely upon to care for undocumented immigrants and others who likely will remain uninsured. In that scenario, counties playing large safety-net roles could be left with costly infrastructures that are difficult to reorganize, whereas counties playing smaller roles may be more nimble in shifting resources in response to changes. For example, if the need for medically indigent programs were greatly reduced under federal reform legislation, counties with small safety-net roles would be able to reallocate existing county contracts and funding to other local priorities.

ABOUT THE AUTHORS

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ABOUT THE FOUNDATION

The **California HealthCare Foundation** is an independent philanthropy committed to improving the way health care is delivered and financed in California. By promoting innovations in care and broader access to information, our goal is to ensure that all Californians can get the care they need, when they need it, at a price they can afford. For more information, visit www.chcf.org.

California Health Care Almanac is an online clearinghouse for key data and analysis examining the state's health care system. For more information, go to www.chcf.org/topics/almanac.

ENDNOTES

1. California Welfare and Institutions Code § 17000: “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.”
2. California Association of Public Hospitals and Health Systems. *Growing Numbers of Patients Seek Care at California’s Public Hospitals as Economy Declines*. CAPH Report. Oakland, CA, 2009; Colliver, V. September 9, 2009. “Newly Uninsured Up 50 Percent at Community Clinics,” *San Francisco Chronicle*. September 9, 2009.
3. The six regions are: Bay Area (San Francisco, Alameda, Marin, San Mateo, and Contra Costa counties), Sacramento (Sacramento, Placer, Yolo, and El Dorado counties), Fresno (Fresno, Madera, Tulare, Kings, and Mariposa counties), Los Angeles, Riverside/San Bernardino, and San Diego. This analysis focuses on the 11 counties where interviews on the safety net were conducted, which did not include Marin, San Mateo, Contra Costa, Yolo, El Dorado, Kings, and Mariposa counties.
4. Local Initiative (LI) health plans (in two-plan counties) and County Organized Health Systems (COHSs) are public agencies that can be chartered by county boards of supervisors. LIs and COHSs are licensed as health care service plans under state law but are not legal agencies or departments of the county. County officials typically appoint and serve on the governing bodies of LIs and COHSs to varying degrees, but counties have no legal risk or financial obligation related to the provision of Medi-Cal managed care by LIs and COHSs.
5. The board of supervisors is the governing body in California counties. It is typically composed of five or more members, each representing a separate district within the county.
6. National Health Law Program. *State and Local Responsibility for Indigent Health Care: California*. 1997.
7. Blue Sky Consulting Group. *County Programs for the Medically Indigent in California*. California HealthCare Foundation, Oakland, CA, October 2009 (www.chcf.org/topics/view.cfm?itemID=134110).
8. In addition to MISPs, virtually all of the counties studied operate other programs to improve access to care or health insurance coverage for other low-income people, using federal, state, local, and/or private funding. For example, seven of the counties operate Healthy Kids programs, which provide insurance to low-income children who do not qualify for Medi-Cal or for the Children’s Health Insurance Program (CHIP), using state funding and philanthropy, and four of the counties also operate Health Care Coverage Initiatives to expand access to care for medically indigent adults with funding from a state Medicaid waiver.
9. A few California counties outside of this study operate under a county-organized health system model, in which a sole public health plan contracts with a network of providers to deliver care. Federal legislation placed limits on the number of counties that could have a single county-organized health system and the number of enrollees that could be covered by them. See also Kelch, Deborah Reidy. *Caring for Medically Indigent Adults in California: A History*. California HealthCare Foundation, Oakland, CA, June 2005. Draper, Debra A. and Marsha R. Gold. September/October 2000. “Customizing Medicaid Managed Care—California Style.” *Health Affairs* 19 (5).
10. Kelch, Deborah Reidy, op. cit., 2005.
11. See also Kelch, Deborah Reidy. *The Crucial Role of Counties in the Health of Californians: An Overview*. California HealthCare Foundation, Oakland, CA, July 2004.
12. Department of Health Care Services, Medi-Cal Managed Care Division. *Quarterly Update to the Legislature: Medi-Cal Managed Care Program, January through March 2009*.
13. Hines, Lora. August 23, 2009. “Inland Area Shortchanged on State Funds to Cover Health Care for the Poor.” *The Press Enterprise*.
14. California State Board of Equalization. *California Property Tax: An Overview*. Publication 29, August 2009.
15. Christianson, Jon B., et al. *San Francisco Bay Area: Downturn Stresses Historically Stable Safety Net*. California Health Care Foundation, Oakland, CA, July 2009.
16. Brown, Richard E. *Public Medicine in Crisis: Public Hospitals in California*. California Policy Seminar, Monograph No. 11. Institute of Governmental Studies, University of California, Berkeley, 1981.
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18. Thorpe, Kenneth E., and Charles Brecher. Summer 1987. “Improved Access to Care for the Uninsured Poor in Large Cities: Do Public Hospitals Make a Difference?” *Journal of Health Politics, Policy and Law*, 12 (2). Bindman, Andrew B., Dennis Keane, and Nicole Lurie. December 12, 1990. “A Public Hospital Closes: Impact on Patients’ Access to Care and Health Status.” *JAMA*, 265 (22).