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San Joaquin Valley: Some Hospitals Struggle Financially, and Access Challenges Grow, as Medi-Cal Cuts Loom

Summary of Findings

California's San Joaquin Valley — spanning the counties of Fresno, Kings, Madera, Mariposa, and Tulare — is the food bowl of California and the nation. Although the region's fertile farmland helps feed families across the country, more than 1 in 5 children experience food insecurity in Fresno County, the region's urban hub with more than a million residents.[1] Over half the region's population relies on Medi-Cal for health coverage, another 7.6% are uninsured, and almost 1 in 5 people live in poverty. At the same time, there are pockets of affluence. The COVID-19 pandemic hit the region particularly hard, compounding existing health and health care challenges. High unemployment (8.2%) remains a major regional challenge, along with a dearth of high-wage jobs. Housing affordability, once a regional strength, has worsened.

Compounding tough regional economic conditions, San Joaquin Valley residents report worse physical health status across a range of indicators compared to California overall. For example, the region's infant mortality rate is 5.6 deaths per 1,000 births — markedly higher than the statewide rate of 4.1 deaths per 1,000 births.

The region has experienced a number of changes since the previous study in 2020–21 (see page 25 for more information about the Regional Markets Study).[2] Key developments include:

- **Some hospitals in the San Joaquin Valley experienced a financial downturn during the COVID-19 pandemic, largely brought about by declining inpatient volumes and higher staffing costs.** In the case of nonprofit Madera Community Hospital, financial distress resulted in the hospital closing abruptly in January 2023 and declaring bankruptcy soon after. After receiving a state loan for distressed hospitals, Madera reopened in March 2025 but without maternity services.
- **A large independent practice association (IPA) launched, and national hospitalist groups entered the market.** The IPA, developed by the large regional Federally Qualified Health Center (FQHC), United Health Centers, is now the second-largest IPA in the region. Three hospitals are contracting with two large national hospitalist groups to provide inpatient services.
- **Community health centers (CHCs), which are mostly FQHCs, provide bedrock access to outpatient care, adding sites and serving more patients per capita than CHCs in other study regions and statewide.** Since the last study, CHCs have added services, developed population-health-management acumen, and gained

financial sophistication. Unlike some hospitals regionally, most CHCs in the region are on sound financial footing.

- **The region continues to struggle with chronic shortages across the spectrum of health care professionals.** Hospitals and CHCs partner with local colleges and universities to "grow their own" workforce. Shortages of obstetricians and gynecologists (ob/gyns) are particularly acute, contributing to serious access challenges for maternity care across the region, where infant mortality rates are already among the highest statewide.
- **State Medi-Cal transformation initiatives have brought new benefits and sorely needed behavioral health infrastructure investments.** At the same time, the initiatives and investments have brought complex and resource-intensive implementation. Medi-Cal also expanded coverage to all eligible undocumented immigrants since the last study, a particularly consequential development in a region where 13% of residents are noncitizens. However, these coverage gains are under threat because of state budget shortfalls.
- **Widespread anxiety exists about the coming federal Medicaid budget cuts and policy changes, especially coming on the heels of state cuts to balance the budget.** Tens of thousands of people across the San Joaquin Valley are projected to lose coverage in the coming years through a combination of eligibility changes, administrative requirements, and federal funding cuts. The rise in uninsured people could increase financial and operational pressure on some parts of the delivery system.

Market Background

Legend holds that a palm tree and a pine towering above the bustling Highway 99 median between the cities of Madera and Fresno mark the boundary between Northern and Southern California. But the palm and the pine must make way for progress and expansion of Highway 99, which runs through the heart of the growing San Joaquin Valley region. Unlike California as a whole, which saw a small (–0.2%) population decline over the last five years — to roughly 39.4 million people in 2024 — the San Joaquin Valley population grew 2.9%, reaching more than 1,845,000 residents (Table 1).

With more than a million residents, Fresno County is the region's urban hub, with about a half million people living in the city of Fresno.[3] To the south, near Highway 99 in Tulare County, is the region's second-largest city — Visalia — with a population of about 146,000. Just west of Visalia is Hanford, the largest city in Kings County, with a population of about 60,500. North of Fresno, up Highway 99, the city of Madera, in the county of the same name, is home to almost 70,000 people. The region's remaining county — Mariposa, Spanish for butterfly — has a population of fewer than 20,000 people and is so rural it has no permanent traffic lights.

Bordered by Interstate 5 to the west and the Sierra Nevada mountain range, including Yosemite National Park, to the east, the San Joaquin Valley remains a study in contrasts. The region's economy is largely agricultural, with hundreds of crops ranging from fruits, nuts, and vegetables to hay and cotton. Despite being designated as an urban county, Fresno County is the nation's top county in agricultural production, valued at $7 billion in 2022, followed by Tulare County ($6.4 billion).[4]

Against this backdrop of agricultural plenty, almost 1 in 5 people in the region (17.7%) had incomes below the federal poverty level in 2023 — or $30,000 for a family of four.[5] Although the share of people in the region living in poverty declined by almost two percentage points from 2019, it remained nearly 40% higher than the statewide average of 12.0% in 2023. As one hospital leader noted, poverty in the region often is "generational," not a temporary state.

Moreover, with 1 in 3 residents living in neighborhoods where at least 40% earn less than the poverty level, the Fresno metro area has the highest rate of extreme poverty in California, making Fresno the poorest big city in the state.[6] Median household income in the region in 2023, at $70,973, was barely two-thirds of the statewide median of $96,334. Within the city of Fresno, legacies of segregation, stark health differences, and urban sprawl separate the more affluent and mostly White residents to the north and the poorer and mostly Black and Latino/x residents to the south and southwest.[7]

Latino/x residents account for the highest percentage of residents in the five counties — at 58.6%, well above the 40.4% statewide average and the highest of the seven study regions. The area's population skews younger, with 27.8% of residents younger than 18 years old, compared to 21.7% statewide. Heavy reliance on farming, coupled with lower levels of educational attainment compared to the rest of the state, continue to limit the region's economic growth. This is especially true for high-wage jobs, which declined following the COVID-19 pandemic in the larger Central Valley area.[8] Among San Joaquin Valley residents, 76.8% hold a high school diploma and 20.5% have a college bachelor's degree or higher — well below statewide averages of 84.6% and 36.5%, respectively. High unemployment (8.2%) — the highest among the seven study markets — remains a major regional challenge and was much higher than the statewide unemployment rate (4.8%) in 2023.

The region also lags on other quality-of-life measures. The five counties have some of the worst air quality levels in the state.[9] Housing affordability, traditionally a strength, has declined markedly since 2019, with the share of regional households earning enough to purchase a median-priced home dropping from 50.0% to 28.7%.[10] Nonetheless, the share of regional households able to afford a median-priced home was the highest across the seven study markets and more than double the statewide rate of 13.6%.

TABLE 1. Population Characteristics,
San Joaquin Valley vs. California, 2023 Unless Noted

	San Joaquin Valley	California
Population Statistics		
Total population (2024)	1,845,064	39,431,263
Share of state population	4.7%	100%
Five-year population growth	2.9%	-0.2%
Age of Population, in Years		
Under 18	27.8%	21.7%
18 to 64	59.1%	62.1%
65 and older	13.1%	16.2%
Race/Ethnicity		
Latino/x	58.6%	40.4%
White, non-Latino/x	27.2%	34.3%
Black, non-Latino/x	3.8%	5.6%
Asian, non-Latino/x	7.7%	15.8%
Other, non-Latino/x	2.7%	3.8%
Birthplace		
Outside the United States*	20.3%	27.3%
Education (Age 25 and Older)		
High school diploma or higher	76.8%	84.6%
College bachelor's degree or higher	20.5%	36.5%
Economic Indicators		
Income below 100% federal poverty level	17.7%	12.0%
Household income $100,000+	34.0%	48.4%
Median household income†	$70,973	$96,334
Average (mean) household income	$94,483	$136,730
Unemployment rate	8.2%	4.8%
Households able to afford median-priced home (2024)	28.7%	13.6%

* Does not include Mariposa County, whose population was too small for inclusion in the Census 2023 1-Year Estimates. The 5-Year ACS foreign-born percentages for Mariposa were 5.8% and 7.9% in 2019 and 2023, respectively.

† A weighted blend of county-level median household income figures.

Sources: *Annual Estimates of the Resident Population for Counties: April 1, 2020 to July 1, 2024* (CO-EST2024-POP), *County Population by Characteristics: 2020–2023* (CC-EST2023-ALLDATA-06 and CC-EST2023-AGESEX-06), *Annual Estimates of the Resident Population for Counties in the United States: April 1, 2010 to July 1, 2019* (CO-EST2019-ANNRES-06), "American Community Survey (ACS) 1-Year Supplemental Estimates, K200503, Place of Birth, 2019 and 2023," "ACS 5-Year Estimates Subject Tables, S1501, 2023, Educational Attainment by County," "US Census, ACS 5-Year Estimates Subject Tables, S1901, Income in the Past 12 Months (in 2023 Inflation-Adjusted Dollars), 2023 and (in 2019 Inflation-Adjusted Dollars), 2019," US Census Bureau; "Current Industry Employment and Unemployment Rates for Counties," California Employment Development Department; and "Housing Affordability Index – Traditional (Q2 2024)," California Association of Realtors.

Residents in Poorer Health Than Other Californians

Compounding tough regional economic conditions and compared to California as a whole, San Joaquin Valley residents report worse physical health status across a range of indicators (Table 2). For example, the region's infant mortality rate is 5.6 deaths per 1,000 births — second-highest of the seven study markets and markedly higher than the statewide

rate of 4.1 deaths per 1,000 births. Similarly, San Joaquin Valley residents are more likely to have diabetes (14.1%) and high blood pressure (25.7%) compared to Californians overall (11.3% for diabetes and 21.9% for high blood pressure statewide). In a positive development, the share of people in the region reporting fair or poor health status declined from 21.5% in 2019 to 16.6% in 2023 but still exceeded the statewide rate.

Although the region's suicide rate mirrors the statewide average — 10.2 per 100,000 population versus 10.1 statewide — the San Joaquin Valley has lower rates of drug-related overdose deaths — 22.3 per 100,000 population versus 29.1 statewide — and drug-related emergency department (ED) visits — 129.8 per 100,000 population versus 137.4 statewide. The prevalence of anxiety (10.9%) and depression and other mood disorders (10.1%) closely tracks statewide rates.

Heavy Reliance on Public Health Insurance

Almost two-thirds of San Joaquin Valley residents (65.7%) rely on public health insurance, with 51.1% covered by Medi-Cal, 9.9% by Medicare, and 4.7% dually eligible for Medicare and Medi-Cal (Table 3). Notably, 62% of the Tulare County population has Medi-Cal coverage, the highest percentage in the state (not shown). In recent years, Medi-Cal has systematically expanded coverage to all eligible residents regardless of immigration status. By the end of 2024, about 80,000 San Joaquin Valley children, youth, and adults lacking immigration documentation had enrolled in Medi-Cal, a particularly consequential expansion in a region where 13% of residents are noncitizens.[11]

Compared to the statewide average of 50.8%, only a third of the region's population (33.3%) has commercial insurance — down from 36.1% in 2019. The rate of people without health insurance in the region declined modestly from 8.0% in 2019 to 7.6% in 2023 but remained higher than the 6.4% uninsured rate statewide in 2023.

TABLE 2. Health Status,
San Joaquin Valley vs. California, 2023 Unless Noted

	San Joaquin Valley	California
Physical Health		
Fair/poor*	16.6%	15.5%
Adults with an independent living difficulty†	6.6%	5.8%
Diabetes prevalence‡	14.1%	11.3%
High blood pressure prevalence‡	25.7%	21.9%
Infant mortality rate (deaths per 1,000 live births), 2019–21	5.6	4.1
Behavioral Health		
Anxiety prevalence‡	10.9%	10.3%
Depression, bipolar, or other depressive mood disorders prevalence‡	10.1%	10.5%
Opioid and other drug-related emergency department visits (per 100,000 population)	129.8	137.4
All drug-related overdose deaths (per 100,000 population)	22.3	29.1
Suicide deaths (per 100,000 population), 2020–22, age-adjusted	10.2	10.1

* Fair/poor health status reflects only Fresno, Madera, Tulare Counties due to small cell sizes.

† An independent living difficulty refers to, for example, difficulty doing errands alone, visiting a doctor's office, or shopping because of a physical, mental, or emotional condition.

‡ Prevalence reported from the Healthcare Payments Data (HPD) source reflects data from claims and encounter records, which capture instances of a condition treated during the specified time. Results may differ from prevalence rates obtained by other methods — for example, surveys or record sampling. HPD reporting of measures data suppresses counts from any group (age, sex, payer, and county-specific) with fewer than 30 people; caution is advised when interpreting results for geographic areas with fewer than 30,000 residents.

Sources: "AskCHIS," UCLA Center for Health Policy Research; "American Community Survey, 2023 5-Year Estimates, S1810, Disability Characteristics," US Census Bureau; "Healthcare Payments Data Measures Data (2018–2023)," California Department of Health Care Access and Information, last updated July 8, 2025; "Infant Mortality," California Department of Public Health (CDPH), last updated July 31, 2025; "County Health Status Profiles, 2024: Tables 1–29," CalHHS, last updated August 8, 2024; and "California Overdose Surveillance Dashboard," CDPH, last updated May 19, 2025.

TABLE 3. Sources of Health Insurance,
San Joaquin Valley vs. California, 2019 and 2023

Coverages as Share of Population (Totals > 100%)*	2019		2023	
	San Joaquin Valley	California	San Joaquin Valley	California
Uninsured	8.0%	7.7%	7.6%	6.4%
Medi-Cal and Medicare dually eligible enrollees	4.1%	3.7%	4.7%	4.5%
Medi-Cal (non-dually eligible enrollees)	43.9%	28.6%	51.1%	35.6%
Medicare (non-dually eligible enrollees)	9.9%	12.1%	9.9%	12.8%
Commercial	36.1%	50.6%	33.3%	50.8%

* Percentages may sum to more than 100% due to people being included in more than one category.

Sources: *MA State/County Penetration* (July 2019 and July 2023), US Centers for Medicare & Medicaid Services; "Selected Characteristics of Health Insurance Coverage in the United States, American Community Survey, 1-Year and 5 Year Estimates," US Census Bureau; "By Medicare Dual Status, Certified Eligibles," California Health and Human Services Agency; and Katherine Wilson, *California Health Insurers, Enrollment Almanac, 2025 — Quick Reference Guide*, California Health Care Foundation, February 2025.

Covered California, the state's Affordable Care Act marketplace, plays a small but important role in the San Joaquin Valley. In 2023, Covered California accounted for 2.9 and 4.3 percentage points of commercial enrollment in the region and state, respectively, and up slightly from 2019 (not shown). In 2025, the average monthly premium for the lowest-cost Covered California silver plan was slightly more expensive ($479) regionally than statewide ($472) for a 40-year-old person, assuming no premium subsidy (Table 4). In 2025, monthly premiums (unsubsidized) in the region consumed $2.76 of an hourly minimum wage and nearly 17% of a full-time minimum wage income, similar to statewide figures of $2.72 per hour and 16.5% of minimum wage income. Almost all Covered California enrollees (94.0%) in the San Joaquin Valley receive a premium subsidy that reduces the monthly cost of coverage; the average monthly net premium paid is $82 in the region. By comparison, 89.4% of enrollees statewide receive a premium subsidy, paying an average net monthly premium of $134. As of mid-December 2025, federal premium subsidies authorized by the 2021 American Rescue Plan Act and extended through 2025 by the 2022 Inflation Reduction Act were set to expire if Congress did not intervene. Elimination of the enhanced federal subsidies would have significant implications for the affordability of coverage for San Joaquin Valley residents.[12]

A greater share of San Joaquin Valley residents (12.7%) had medical debt than Californians overall (10.2%) in 2022–23 (Table 5). Among the region's residents with medical debt, 51.0% owed more than $2,000 — up from 47.4% five years earlier.

Medicare covers a slightly smaller share of San Joaquin Valley residents compared to California overall — 14.8% compared to 17.5% in 2024 (Table 6). The share of Medicare enrollees in private Medicare Advantage (MA) health plans regionally increased considerably between 2019 (29.1%) and 2024 (43.0%) but remained much lower than statewide (51.2%). MA enrollment grew by nearly 50% in the region between 2019 and 2024, mirroring MA growth nationally[13] and much larger than the 16% statewide MA growth rate during the same time.

TABLE 4. Covered California Monthly Premiums,
San Joaquin Valley vs. California, 2020 and 2025

Covered California Premiums*	2020		2025	
	San Joaquin Valley	California	San Joaquin Valley	California
Lowest-cost silver monthly premium, 40-year-old	$397	$398	$479	$472
Percentage higher/lower than California average	-0.1%		1.5%	
Average annual premium increase, 2020 to 2025			3.8%	3.5%
Per hour wage needed to pay monthly premium†	$2.29	$2.29	$2.76	$2.72
Monthly premium as share of state minimum wage, full-time†	17.6%	17.6%	16.8%	16.5%
Percent of members that receive premium subsidy			94.0%	89.4%
Average net monthly premium paid by those receiving subsidy			$82	$134
Median net monthly premium paid by those receiving subsidy			$29	$57

* California premiums are weighted averages across all Covered California rating regions. Similarly, regional premiums are weighted averages for the counties that make up the region. Weighting is by enrollment.

† Assumes person pays the entire premium (i.e., no subsidy to offset cost).

Sources: *2025 Individual Product Prices, Covered California; 2020 Individual Product Prices for All Health Insurance Companies*, Covered California; and *Active Member Profiles: June Profile* (2020 and 2025), Covered California.

TABLE 5. Medical Debt,
San Joaquin Valley vs. California, 2018–19 and 2022–23

Medical Debt*	2018–19 Pooled†		2022–23 Pooled†	
	San Joaquin Valley	California	San Joaquin Valley	California
Prevalence (% of adults with medical debt)‡	17.1%	10.8%	12.7%	10.2%
Amount of medical debt they are having trouble paying§				
Less than $2,000	52.6%	45.1%	49.0%	43.7%
More than $2,000	47.4%	54.9%	51.0%	56.3%

* Medical debt measures do not reflect Mariposa County, as the California Health Interview Survey grouped Lassen results with other small counties.

† Data are pooled across two years to increase data stability; confidence intervals on the amount of debt are broad in multiple regions.

‡ Prevalence figure is the percentage of people who answered yes to the question "Ever had problems paying for self or household family's medical bills in past 12 months?"

§ The amount of medical debt reflects the responses of those who said they had experienced problems paying medical bills in the past 12 months.

Source: "AskCHIS," UCLA Center for Health Policy Research.

TABLE 6. Medicare Enrollment Overview,
San Joaquin Valley vs. California, 2019 and 2024

	San Joaquin Valley		California	
	2019	2024	2019	2024
Total Medicare enrollment	251,078	272,752	6,239,477	6,899,496
Medicare as share of population	14.0%	14.8%	15.8%	17.5%
Share of Total Medicare				
Medicare Advantage	29.1%	43.0%	44.1%	51.2%
Original Medicare	70.9%	57.0%	55.9%	48.8%

Source: *MA State/County Penetration* (July 2019 and July 2024), US Centers for Medicare & Medicaid Services.

As of 2024, Kaiser had the largest MA market share but saw a sizable enrollment decline from 37.0% in 2019 to 25.0% in 2024 (Table 7). Blue Cross of California and Alignment Health Plan entered the market after 2019, gaining market share from Kaiser, Universal Care, and Arcadian health plans.

TABLE 7. Largest Medicare Advantage Health Plans and Market Share,
San Joaquin Valley, 2019 and 2024

Health Plan	2019	2024
Kaiser Foundation Health Plan	37.0%	25.0%
Arcadian Health Plan	19.0%	16.0%
Blue Cross of California Partnership Plan	0.0%	10.0%
Universal Care	12.0%	9.0%
Alignment Health Plan	0.0%	7.0%

Source: *Monthly MA Enrollment by State/County/Contract* (July 2019 and July 2024), US Centers for Medicare & Medicaid Services.

Medi-Cal Managed Care Grows

Mirroring statewide trends, nearly all the region's Medi-Cal members were enrolled in managed care plans in 2024 (Table 8). The last Medi-Cal enrollees to move to managed care were people in skilled nursing and intermediate care facilities in 2023 and 2024. Since the 2020–21 Regional Markets Study, Medi-Cal enrollees, providers, health plans, and counties have navigated the ongoing enrollment shift to Medi-Cal managed care plans, along with other policy and regulatory changes.

TABLE 8. Medi-Cal Enrollment Overview,
San Joaquin Valley vs. California, 2019 and 2024

	San Joaquin Valley		California	
	2019	2024	2019	2024
Total Medi-Cal enrollment	859,612	997,609	12,778,575	14,796,389
Medi-Cal as share of population	48%	55%	32%	38%
Share of Medi-Cal in managed care	83%	95%	82%	94%

Source: "Certified Eligibles by Delivery System and Plan" (August 9, 2024), California Health and Human Services Agency.

In the five-county region, there are two models of Medi-Cal managed care: the Two-Plan and the County Organized Health System (COHS) models. Fresno, Kings, and Madera Counties together participate in the Two-Plan model, which features one publicly run local initiative plan and one commercial plan. The local initiative plan, CalViva, holds more than 60% market share across the three counties, although the plan has lost market share to Anthem Blue Cross since 2019 (Table 9). Tulare County also has a Two-Plan model with Health Net Community Solutions as the commercial plan and Anthem Blue Cross as the contracted local initiative plan, roughly splitting enrollment.[14]

In January 2024, after two years of planning, Mariposa County changed from a Regional managed care model with two competing commercial plans to the COHS model with one public plan. For several years, clinics, hospitals, and county leaders had been in discussion with the Central California Alliance for Health, the COHS in neighboring Merced County, to expand to Mariposa County. Regional experts reported that stakeholders wanted a locally governed health plan rather than two large commercial plans with little connection to the region.

With this change in Mariposa County, some 5,000 Medi-Cal members transitioned from California Health and Wellness and Anthem Blue Cross to Central California Alliance for

TABLE 9. San Joaquin Valley Medi-Cal Managed Care Plans,
by County, 2019 and 2024

County	Plan	Market Share by County*	
		2019	2024
Fresno	CalViva Health	73.3%	68.0%
	Anthem Blue Cross Partnership Plan	26.5%	30.1%
	Kaiser	0.0%	1.6%
Kings	CalViva Health	60.8%	60.6%
	Anthem Blue Cross Partnership Plan	39.2%	39.1%
	Kaiser	0.0%	0.3%
Madera	CalViva Health	65.9%	63.0%
	Anthem Blue Cross Partnership Plan	34.1%	35.3%
	Kaiser	0.0%	1.6%
Mariposa	Central California Alliance for Health	0.0%	99.8%
	Anthem Blue Cross Partnership Plan	78.6%	0.0%
	California Health & Wellness	21.4%	0.0%
	Kaiser	0.0%	0.2%
Tulare	Anthem Blue Cross	45.9%	51.2%
	Health Net Community Solutions	54.1%	48.7%
	Kaiser	0.0%	0.0%

* Plan-level Medi-Cal managed care market share is as of December of stated year.

Source: "Medi-Cal Managed Care Enrollment Report (MMCE), data through Jan 2025," California Open Data Portal.

Health. The two commercial plans then exited the market. One health plan expert noted that this transition occurred during implementation of the CalAIM (California Advancing and Innovating Medi-Cal) initiative after the two commercial health plans had invested in infrastructure and provider networks to provide CalAIM services (see "Rocky CalAIM Implementation" on page 20).

Also in January 2024, the California Department of Health Care Services and Kaiser entered into an agreement for Kaiser to serve certain Medi-Cal members in the 32 California counties where Kaiser has delivery system capacity, including all five San Joaquin Valley counties.[15] Kaiser has little Medi-Cal enrollment in the San Joaquin Valley, less than 2% of total regional enrollment. However, with substantial commercial and MA enrollment in the area, Kaiser has facilities or affiliated providers in all five counties and a hospital in Fresno.

Some Hospitals Report Ongoing Financial Struggles

Hospital financial performance attracted significant statewide and local attention in the immediate aftermath of the COVID-19 pandemic. Locally, while some hospitals in the San Joaquin Valley had net income (or profit) margins at or above 10% in the most recent year of audited state filings, several hospital-based respondents for this study noted lingering financial struggles within the sector. Across the region, hospitals had an average net income (or profit) margin of 2.4%, roughly half the statewide rate (Table 10). Two of the 10 largest acute care hospitals reported current ratios (or wealth reserves) below what financial experts generally consider healthy (Table 11).[16] Adventist Health Tulare also reported a financially unhealthy current ratio (not shown). While the average net income margin across all hospitals was positive, eight of the 13 hospitals in the region reported negative net income margins, five of which were large hospitals.

TABLE 10. Acute Care Hospitals Overview,
San Joaquin Valley vs. California, 2023

Acute Care Hospitals	San Joaquin Valley	California
Number of facilities	13	334
Beds (available) per 100,000 population	195	198
Number of discharges	142,025	3,148,191
Net income margin	2.4%	4.5%
Operating expenses per adjusted patient day	$3,691	$5,117

Notes: *Net income margin* is net income divided by the sum of net patient revenue, other operating revenue, and nonoperating revenue. *Operating expenses per adjusted patient day* equal total gross patient revenue divided by gross inpatient revenue times the number of inpatient days.

Source: *2023 Pivot Table - Hospital Annual Selected File*, California Department of Health Care Access and Information.

The most well-known and frequently cited case of recent hospital financial distress in the region is the 106-bed nonprofit Madera Community Hospital, which closed abruptly in January 2023 and declared bankruptcy soon after. The hospital reopened in March 2025 under new management after receiving an interest-free $57 million state loan for distressed

TABLE 11. Largest Acute Care Hospitals,
by Number of Beds, San Joaquin Valley, 2023

Hospital (System)	Available Beds	Occupancy (Available Beds)	Share of Discharges in Region	Distribution of Discharges by Payer Type			Net Income Margin	Current Ratio	Operating Expenses per Adjusted Patient Day
				Medicare	Medi-Cal	Commercial			
Community Regional Medical Center (Community Health System)	921	88%	26%	34%	49%	17%	8%	3.6	$3,905
Kaweah Delta Medical Center	608	66%	16%	38%	38%	23%	-5%	2.1	$2,912
Saint Agnes Medical Center (Trinity Health)	436	72%	17%	57%	30%	13%	-13%	2.9	$3,505
Valley Children's Hospital	358	51%	7%	0%	74%	26%	11%	2.2	$6,774
Clovis Community Medical Center (Community Health System)	292	91%	14%	42%	28%	29%	0%	4.5	$3,604
Adventist Health Hanford (Adventist Health)	235	46%	6%	72%	18%	9%	13%	10.2	$2,944
Kaiser Foundation Hospital – Fresno (Kaiser)	169	51%	6%	51%	2%	47%	10%	n/a	$5,970
Sierra View Medical Center	163	55%	4%	38%	49%	13%	-9%	2.7	$2,234
Coalinga Regional Medical Center (American Advanced Management)	123	53%	0%	40%	26%	34%	-7%	1.4	$1,467
Madera Community Hospital (American Advanced Management)	106	36%	1%	36%	52%	13%	-39%	1.0	$3,807
San Joaquin Valley	3,567	68%	100%	41%	38%	21%	2%	3.3	$3,691
California	77,339	64%	0%	42%	31%	27%	4%	1.6	$5,117

Notes: *Net income margin* is net income divided by the sum of net patient revenue, other operating revenue, and nonoperating revenue. *Current ratio* is current assets divided by current liabilities. This ratio shows the dollar amount of current assets per dollar of current liabilities. It is a gross indicator of the facility's liquidity. Usually, a ratio of 2.0 or more indicates a healthy liquidity position. *Adjusted patient day* equals total gross patient revenue divided by gross inpatient revenue times the number of inpatient days.

Source: *2023 Pivot Table - Hospital Annual Selected File*, California Department of Health Care Access and Information.

hospitals (see "The Fall and Rise of Madera Community Hospital" on page 11). Two other facilities in the region — the 608-bed Kaweah Delta Medical Center in Visalia and John C. Fremont Healthcare District, which operates a facility in Mariposa with 18 acute care beds and 16 long-term care beds — also received state loans for distressed hospitals.

In their applications to the state, the three local facilities receiving loans cited shifts in service volumes and increased operating costs during and after the COVID-19 pandemic. Increased costs were largely attributed to staffing expenses, including a $25 hourly health care minimum wage being phased in through 2026 and high costs for contract per diem nurses and other clinicians. The hospitals also reported that delayed payments tied to Medi-Cal and Medicare billing reconciliations contributed to cash flow pressures and limited access to capital (see "Closure Prompts State Loans for Distressed Hospitals" on page 12).

According to hospital-based respondents for this study, many cost pressures affecting the distressed hospitals also impacted other hospitals in the region. Respondents also cited requirements to meet state seismic safety standards for facilities by 2030 as an additional cost pressure. Hospitals

typically have numerous buildings on their campuses, often with varying degrees of compliance with seismic standards. For example, at the 921-bed Community Regional Medical Center (CRMC), certain hospital buildings fall into the California Department of Health Care Access and Information infrastructure category "do not significantly jeopardize life but may not be repairable or functional following an earthquake" and will need replacement or retrofitting. Other hospitals in the region reported a similar mix of facilities in and out of compliance.

On the revenue side of the equation, one regional respondent noted that hospitals have little market power to negotiate higher payment rates from commercial payers. According to a RAND analysis, average commercial payment rates to hospitals in the region were 225% of Medicare rates for the same services, compared to a statewide average of 312% of Medicare rates.[17]

Hospitals Serving the Region

Overall, 13 acute care hospitals operate across the five counties with an average of 195 beds per 100,000 population, similar to the state overall. The three largest hospitals are clustered in the urban areas of Fresno and Visalia, with smaller hospitals in outlying areas. All but one are nonprofit or district hospitals, which are publicly owned and governed by local communities, and eight are part of larger hospital systems. The lone investor-owned acute care hospital is Coalinga Regional Medical Center in southwestern Fresno County, which is owned by American Advanced Management, the firm that bought, reopened, and operates Madera Community Hospital. The region also has a specialty pediatric facility, Valley Children's Hospital (VCH), in Madera County. Notably, the region does not have any city- or county-owned public hospitals.

Payer mix varies quite markedly among the region's acute care hospitals. At Saint Agnes Medical Center, Adventist Health Hanford, and Kaiser, Medicare accounts for more than half of inpatient discharges. Medi-Cal enrollees represent roughly half or more of discharges at CRMC, VCH, Sierra View, and Madera Community Hospital. Except for Kaiser and Coalinga Regional Medical Center, commercial patients represent less than 30% of the region's acute care hospital discharges.

Located in Fresno, CRMC is the only comprehensive burn and Level I trauma center in the region and the flagship hospital of nonprofit Community Health System (CHS). Along with CRMC, CHS operates Clovis Community Medical Center, Fresno Heart and Surgical Hospital, and the Community Behavioral Health Center. CHS also includes a cancer institute; several long-term care, outpatient, and other care facilities; and Community Health Plan, a commercial health plan. Overall, CHS has more than 1,250 beds and accounts for 40% of all acute care hospital discharges in the region. Of CRMC's 921 beds, over 100 are psychiatric or rehabilitation beds. CRMC discharges are 49% Medi-Cal, the highest share of all hospitals in the region, while sister hospital Clovis Community Medical Center has less than 30% Medi-Cal discharges.

In May 2025, CHS paid $31 million to settle a case with the US Department of Justice alleging a kickback scheme to incentivize physicians with food, wine, and cigars to refer Medicare patients to CHS hospitals.[18] Additionally, two local nonprofit organizations sued CHS in August 2024, alleging the health system misused supplemental Medi-Cal payments by redirecting funds from CRMC, which has more Medi-Cal discharges, to fund a new facility at Clovis Medical Center, which has fewer Medi-Cal discharges and is located in a more affluent area.[19] In January 2025, the parties agreed to pause the suit and, as of December 2025, were still negotiating a resolution.

Kaweah Delta Medical Center is the second-largest hospital in the region with more than 600 beds and 16% of regional discharges, as well as an inpatient psychiatric unit. Medicare and Medi-Cal account for nearly 80% of Kaweah's discharges. A district hospital in Visalia, Kaweah is the largest hospital in Tulare County, which has two other hospitals: Sierra View Medical Center, also a district hospital, and nonprofit Adventist Health Tulare.

Saint Agnes Medical Center in Fresno, with just over 400 beds, accounts for 17% of regional discharges and is part of Michigan-based Trinity Health, a system that owns or operates more than 90 hospitals across 26 states. Just under a third of Saint Agnes's discharges are Medi-Cal patients, 57% are Medicare, and 13% are commercial discharges.

VCH in Madera is the only pediatric specialty care hospital in the region and serves the broader Central Valley from Bakersfield to Sacramento, as well as several Central Coast counties. VCH also has a primary care network and three specialty care centers and operates satellite neonatal intensive care units at Saint Agnes and Adventist Hanford. In addition, VCH supports pediatric care delivery in many of the region's CHCs. While representing only 7% of total regional discharges with 358 beds, nearly three-quarters of VHC's discharges are Medi-Cal patients. As the only other hospital in Madera County, VCH experienced significant impacts when Madera Community Hospital closed in 2023, with a marked increase in adult ED visits.

Adventist Health has three hospitals in the region, with facilities in Tulare (Tulare County), Reedley (Fresno County), and Hanford (Kings County). Of the three, the Hanford facility is the largest, with 235 beds. Adventist Health is a faith-based system of 27 hospitals and other care facilities across California, Oregon, and Hawaii, with 24 hospitals in California. The three Adventist hospitals account for just under 9% of all regional discharges and have occupancy rates below 50% (not shown). Of the three Adventist hospitals, Hanford has the lowest share of Medi-Cal discharges at 18%, and Reedley has the highest at 72% (not shown). Two of the three Adventist hospitals — Tulare and Reedley — had negative net income margins in 2023 (not shown), while Hanford had a positive net income margin.

John C. Fremont Memorial Hospital, a district hospital and the only hospital in Mariposa County, is the smallest facility in the region and designated as a critical access hospital. Nearly two-thirds of the hospital's discharges are Medicare and about 20% are Medi-Cal (not shown).

Madera Community Hospital is now managed as a nonprofit by American Advanced Management, a Modesto-based for-profit company that owns or operates 10 acute care and specialty hospitals, mostly in California (see "The Fall and Rise of Madera Community Hospital" on page 11). American Advanced Management, which has been sued by the California Department of Health Care Services and separately fined by the state for placing patients in "immediate jeopardy," also reopened 123-bed Coalinga Regional Medical Center in Fresno County as a for-profit hospital in 2020.[20] Coalinga Regional had the second-highest proportion of commercial payer discharges in the region after Kaiser.

Other facilities in the region include physician-owned Fresno Surgical Hospital and two psychiatric facilities. River Vista Behavioral Health in Madera County, adjacent to the VCH campus, is part of Universal Health Services, a nationwide for-profit system with 26 California locations providing acute care, outpatient services, behavioral health services, and practice management services. Central Star Behavioral Health in Fresno County is part of a 45-location for-profit behavioral health services system operating in 10 California counties.

The Fall and Rise of Madera Community Hospital

After years of financial challenges common to many small, independent, and rural hospitals, Madera Community Hospital closed abruptly in January 2023 and filed for Chapter 11 bankruptcy protection two months later. Three affiliated rural health clinics (RHCs) also closed, reducing access to outpatient primary and specialty care.

The effects of the hospital and clinic closures, including elimination of ED and labor and delivery services, rippled through the San Joaquin Valley. CHS hospitals in Fresno immediately experienced a surge of Madera County residents seeking emergency care, prompting Madera and Fresno Counties to declare states of emergency.[21] According to a respondent, CHS facilities, compared to 2022, experienced a 100% increase in ED use, a 62% increase in inpatient admissions, and a more than 40% increase in outpatient procedures. CHS worked with other regional hospitals, CHCs, and public health agencies to juggle patient loads and transfers, ambulance traffic, and care for inmates at two state prisons in Madera County.

Saint Agnes Medical Center also saw an increase in patient admissions, ED visits, and births — mostly Medi-Cal patients and many with challenging health needs, including a lack of prenatal care. Saint Agnes hired staff from the closed hospital and partnered with Camarena Health, a large Madera County CHC, to address capacity needs. Several respondents noted Camarena Health "stepping up" to fill gaps in outpatient care with expanded or new sites after Madera and the hospital-affiliated RHCs closed. Similarly, VCH operated the only other ED in the county and experienced an increase in adult patients arriving, especially by ambulance. The adult patients were often quite sick and frequently in mental health crises. The VCH ED and other staff had little experience caring for adults, adding to the pressure of increased patient volumes.

After Madera Community received Chapter 11 bankruptcy protection in March 2023, creditors proposed liquidating the hospital's estimated $39 million in assets. Proposals to acquire or manage the hospital were made by several suitors, including American Advanced Management, Saint Agnes and parent Trinity Health, and a last-minute partnership of Adventist Health and UCSF (University of California, San Francisco) Health. The proposal from Adventist Health and UCSF Health, which was backed by Madera County leaders and local lawmakers, was rejected by the bankruptcy court as coming too late in the proceedings.[22]

Ultimately, American Advanced Management won bankruptcy court approval to reopen Madera Community Hospital, aided by the hospital receiving a $57 million state loan for distressed hospitals. Madera Community reopened in March 2025, continuing as a nonprofit with provisions to authorize an asset transfer to for-profit American Advanced Management and licensing change within three years, subject to review by the California attorney general.[23] Regional leaders have expressed relief with the reopening of the ED and some specialty services. However, they lamented that no plan exists to reopen labor and delivery services, leaving pregnant patients to travel to Fresno or elsewhere to give birth and perpetuating the county's maternal care access challenges. These same leaders also expressed concern over the hospital's long-term financial viability.

Closure Prompts State Loans for Distressed Hospitals

In the wake of the abrupt Madera Community Hospital closing, the state legislature created a Distressed Hospital Loan Program (DHLP) to help reopen the hospital and aid other financially struggling facilities.[24] A total of $300 million in onetime funding was appropriated for DHLP. To date, 17 loans have been awarded, totaling $297.5 million.[25] Of the five San Joaquin Valley hospitals that applied, three gained loans (Table 12). At $57 million, Madera Community Hospital received the largest loan of any DHLP awardee and 71% of its requested amount. John C. Fremont received $9.35 million, more than the $7 million requested. Finally, Kaweah Delta received $20.75 million, about a quarter of the requested $75 million. These three San Joaquin Valley hospitals collectively received $87 million, nearly one-third of the $297.5 million in awards granted statewide. Sierra View Medical Center in Tulare County applied for a $17 million loan, and CHS (CRMC and Clovis together) in Fresno applied for a $77 million loan; both were denied.

The DHLP application assessed various hospital factors and financial indicators, including payer mix, current ratio, days cash on hand, attempts to secure credit, community need if a hospital closed, and proposed financial turnaround strategies.

Hospitals were required to propose strategies for a financial turnaround and describe how a loan could help stabilize finances. All three hospitals proposed improving their revenue cycles and negotiating new rates with managed care plans, other payers, and service vendors. Furthermore, the hospitals proposed pursuing workforce efficiencies, such as renegotiating salaries and benefits and reducing the use of contract nurses. John C. Fremont proposed recruiting selected specialist physicians to increase service offerings at affiliated RHCs, as well as opening a fourth RHC to extend geographic reach. Madera Community Hospital proposed using loan funds for facility renovations and new equipment, reopening the three closed RHCs, and recruiting physicians and staff. In addition, Madera proposed to develop revenue-generating lines of service, such as cardiac catheterization, bariatric surgery, and orthopedic surgery.

Like other hospitals in the region, Kaweah Delta wrestled with financial challenges and high labor costs during COVID, emerging with a "pandemic hangover," as one regional leader said. Kaweah turnaround strategies include workforce reductions and compensation changes, reductions to contract nursing, and renegotiated physician and payer agreements. Kaweah closed diabetes and neuroscience clinics and one skilled nursing facility. Along with these efforts, Kaweah has focused on hospital-wide cost savings and productivity improvement initiatives. As a result, Kaweah returned to a positive operating margin in 2024, but respondents for this study noted that cost pressures remain.

TABLE 12. Selected Financial Measures for Distressed Hospital Loan Program (DHLP) Applicants, 2023

Facility	Net Income Margin	Current Ratio	Loan Request	Loan Award
Distressed Hospital Loan Program (DHLP) Loan Awardees				
Kaweah Delta Medical Center	-5%	2.1	$75,000,000	$20,750,000
John C. Fremont Healthcare District	-7%	2.2	$7,000,000	$9,350,000
Madera Community Hospital	-39%	1.0	$80,000,000	$57,000,000
Applied but Did Not Receive DHLP Loan Award				
Community Health System	8.4% CRMC 0.3% Clovis	3.6 CRMC 4.5 Clovis	$77,400,000	Not awarded loans
Sierra View Healthcare District	-9%	2.7	$17,350,000	
SJV regional averages	2%	3.3		
Statewide averages	4%	1.6		

Sources: Net income margin and current ratio from "2023 Pivot Table - Hospital Annual Selected File," California Department of Health Care Access and Information. Loan awards from the California Department of Health Care Access and Information's Distressed Hospital Loan Program. Loan request amounts from HCAI staff.

New IPA Launches and National Hospitalist Groups Arrive

In 2023, United Health Centers, a large regional FQHC, launched an IPA after five years of planning. The for-profit United Physicians Network (UPN) includes United Health Centers sites in Fresno, Tulare, and Kings Counties. To expand access to specialty care, UPN built a multispecialty practice "from the ground up." Previously, United Health Centers patients had to wait months for a specialty physician appointment.

The IPA, now the second-largest in the San Joaquin Valley after LaSalle Physicians, takes risk for professional services through capitated payments and provides care management for 120,000 Medi-Cal and MA enrollees. UPN's creation demonstrates the growing sophistication of regional CHCs in taking financial risk, expanding to commercially insured populations, and managing large patient populations. With this development, the San Joaquin Valley joins other California regions where FQHCs have similar IPA organizations, including the San Francisco Bay Area, Los Angeles, and San Diego and Imperial Counties. One statewide expert observed that these FQHC-IPA approaches enable CHCs to provide better access to care and wraparound services, including specialty care.

CHS, St. Agnes, and VCH all have medical foundations that contract with local physicians, IPAs, and group practices to provide inpatient and outpatient services. Since the last study, two large national medical groups have entered the region by contracting with two hospital medical foundations. OB Hospitalist Group, with hospital partners in 39 states, has contracts with CHS and Kaweah Delta to provide inpatient ob/gyn services. As part of a financial turnaround, Kaweah Delta Medical Center in April 2023 closed an affiliated medical foundation, which reportedly had been losing millions annually. Kaweah also ended a contract with Visalia Medical Clinic, a multispecialty group with about 60 providers, including physicians, which subsequently partnered with Adventist Health Physicians Network.

Another large national medical group, Vituity, signed a contract with Saint Agnes Medical Center to provide hospitalist services. In late December 2024, a local physician practice, Central California Hospital Medicine Group, sued Saint Agnes Medical Providers to prevent the hospital from exclusively contracting with Vituity, which is physician owned. Nonetheless, the Vituity contract took effect December 29, 2024; the local medical group was able to continue seeing existing patients in the inpatient setting but not admit new patients.[26]

CHCs Provide Essential Outpatient Medi-Cal Access

Serving as the bedrock of outpatient services, CHCs provided 3.2 million patient encounters regionally in 2023. There are more than a hundred licensed CHC sites in the San Joaquin Valley (Table 13). Most are certified as FQHCs and organized into seven large multisite organizations (see Table 14 for the five largest). About 70% of CHC patients regionally have incomes below 100% of poverty and have Medi-Cal coverage — the source of 77% of CHC revenue regionally. CHCs in the San Joaquin Valley have twice the patients and encounters per capita on average, compared to the other study regions and statewide. A few organizations have sites in counties adjacent to the region. Each CHC organization can operate multiple sites under a single license; different sites include medical clinics, school-based services, urgent care, dental care, and mobile vans.

TABLE 13. Community Health Centers, Overview,
San Joaquin Valley vs. California, 2023

Community Health Centers, Overview*	San Joaquin Valley	California
Number of sites	102	1,139
Patients with incomes under 100% poverty level	69%	70%
Patients per capita	0.53	0.21
Encounters per capita	1.75	0.69
Operating margin	6.6%	1.2%
Medi-Cal as share of net patient revenue	77%	78%

*Note: Excludes 30 sites statewide that report 100% of their revenue from California's Program of All-Inclusive Care for the Elderly. Excludes county-owned and -operated FQHCs in the region as this information is not reported to the Department of Health Care Access and Information.

Source: *2023 Primary Care Clinic Annual Utilization Data (November 2024)*, California Department of Health Care Access and Information, last updated October 31, 2024.

TABLE 14. Largest Community Health Center Systems,
San Joaquin Valley, 2023

	Number of Encounters	Patients Incomes Under 100% Poverty Level	Medi-Cal as Share of Net Patient Revenue
Family HealthCare Network	976,564	77%	77%
United Health Centers	853,642	64%	83%
Camarena Health	315,376	40%	80%
Aria Community Health Centers	172,201	54%	64%
Altura Centers for Health	166,949	70%	67%
San Joaquin Valley	3,200,538	69%	77%
California	26,871,453	70%	78%

Note: Excludes 30 sites statewide that report 100% of their revenue from California's Program of All-Inclusive Care for the Elderly. Excludes county-owned and -operated FQHCs in the region as this information is not reported to the Department of Health Care Access and Information.

Source: *2023 Primary Care Clinic Annual Utilization Data (November 2024)*, California Department of Health Care Access and Information, last updated October 31, 2024.

Most CHC systems offer a comprehensive array of services, including primary and specialty care; women's health; behavioral health; pediatrics; dental services; urgent care; and ancillary services, such as pharmacy, laboratory, and diagnostic services. In addition, some offer optometry; podiatry; chiropractic services; and Women, Infants, and Children programs. CHCs in the region also have diversified organizationally to provide new Medi-Cal benefits and services. Most CHC sites offer mental health and substance use disorder (SUD) services as part of Medi-Cal managed care networks, and some CHCs contract with county behavioral health departments. Moreover, CHCs have added staff to provide CalAIM services under contract with Medi-Cal managed care plans, including Enhanced Care Management (ECM) and Community Supports (CS) services, and for tribal providers, delivery of traditional health care practices. Additionally, Family HealthCare Network operates a Program of All-Inclusive Care for the Elderly, or PACE, which helps people — typically seniors eligible for both Medicare and Medicaid — meet their health care needs in the community instead of entering a nursing home or other facility. Some CHCs hire or contract specialists to provide care. Additionally, some CHCs and RHCs have affiliation agreements with Kaiser to treat Kaiser patients.

Principal CHC systems in the San Joaquin Valley include the following:

- **Family HealthCare Network.** Provided nearly one million patient encounters across 40 sites and two mobile vans in Fresno, Kings, and Tulare Counties.
- **United Health Centers.** Provided over 850,000 patient encounters at 34 sites in Fresno, Kings, and Tulare Counties.
- **Camarena Health.** Provided over 300,000 patient encounters across 24 sites in Fresno and Madera Counties.
- **Aria Community Health Centers.** With 26 sites, provided 172,000 patient encounters in Fresno, Kings, and Tulare Counties.
- **Altura Centers for Health.** With seven sites and one mobile van, provided nearly 167,000 patient encounters in Tulare County.
- **Clinica Sierra Vista.** Provided over 155,000 encounters at 58 sites, 27 of which are WIC (Special Supplemental Nutrition Program for Women, Infants, and Children) program sites in Fresno, Kings, and Tulare Counties.

- **Valley Health Team.** Provided 144,000 encounters at 14 sites in Fresno and Tulare Counties.
- **Other CHCs in the region.** Other CHCs in the region include three serving American Indians — Fresno Native American Health Program, Central Valley Indian Health, and the North Fork Indian and Community Health Center. Additionally, Omni Family Health provides care at four sites in Fresno County and two sites in Mariposa County. Previously, there were three Planned Parenthood clinics in the region, with one in Madera closing in July 2025.

More Sites, Patients, and Encounters Build CHC Financial Performance

The CHC organizations all have opened new sites in recent years, expanding capacity to serve more patients and meet demand. Since the last study, each of the large clinic systems has opened more clinical sites, totaling more than 50 additional sites across the region. Noting that four new CHC sites would soon open, one regional expert said, "Their schedules will be full." Compared to five years ago, patients and encounters per capita have increased considerably in the region. For example, when Santé Physicians, a large medical group and IPA in the region, ended Medi-Cal managed care contracts in 2025, thousands of patients transferred to CHCs.

While operating margins vary across CHCs and parent organizations, the regional CHC average operating margin of 6.6% is five times the statewide average of 1.2%. Since the last study, the average operating margin for CHCs more than doubled regionally, increasing from 3.1% in 2018 to 6.6% in 2023 (not shown on Table 13). Regional experts attributed this solid financial performance to Medi-Cal expansions to undocumented immigrants, small increases in commercially insured and MA patients, additional payments for CalAIM ECM and CS services, and increased financial sophistication.

Several CHC leaders noted that the state's minimum wage law contributed to new cost pressures and may ultimately impact operating margins.[27] Respondents reported that the required minimum wage increase for lower-wage staff has "compressed" wages in their organizations and created expectations among higher-wage staff that they too should receive comparable pay raises. Some clinics have been able to accommodate wage increases across multiple staff categories but not all staff categories. Wage increases also triggered higher benefit and retirement costs, with one CHC freezing some salaries to address the financial pressures. Higher wages also increased competition for staff with other CHCs, hospitals, and physician practices. One CHC leader observed that FQHCs' prospective payment system (PPS) rates had not increased despite the higher wages because the law was not considered a triggering event to rebase rates. The minimum wage requirement impacting CHCs will increase to $25 an hour by the end of 2028.

Another CHC expert also cautioned that an increasing number of Latino/x patients were dropping or declining Medi-Cal coverage, despite being eligible, for fear of federal government scrutiny of their immigration status. When this happens, CHCs lose Medi-Cal payments as these patients become uninsured and pay relatively smaller amounts for care based on a sliding-fee scale. This shift away from PPS payments to sliding-fee scale payments will reduce CHC revenues and potentially impact operating margins.

Rural Health Clinics Continue Important Role

There are nearly 70 RHCs in the region, which are certified by the federal Centers for Medicare & Medicaid Services (CMS) to increase access to primary care and preventive services in rural areas with health professional shortages. In California, RHCs also are certified by the California Department of Public Health and, like FQHCs, are paid a PPS rate for Medi-Cal and Medicare services. Unlike FQHCs, however, RHCs are not required to provide services to uninsured patients.

Moreover, RHCs also can be for-profit entities, while FQHCs must be nonprofit or public facilities. As noted in the previous regional study, some FQHC leaders believed RHCs were encroaching on their market areas and competing for their insured patients.

Many RHCs are affiliated with or operated by local hospitals, and others are small chains or stand-alone clinics operated by physicians. Hospitals typically use their RHCs to provide primary and specialty care in outpatient settings and to serve as "feeders" for their inpatient services. This connection to hospitals and hospitals' higher cost structure supports higher PPS rates for RHCs, contributing to additional tensions with FQHCs regionally. For example, Adventist Health has 37 RHCs in 24 small cities and towns near Adventist hospitals in Tulare, Reedley, and Hanford, and in some cases, purchased physician practices to convert them into RHCs.

TABLE 15. Health Care Workforce Supply,
San Joaquin Valley vs. California, 2024

	San Joaquin Valley (Percentage of Statewide Average)	California
Licensed Providers per 100,000 Population*		
License Group†		
Physicians	217 (61%)	358
Advanced practice providers	118 (92%)	128
Nurses	1,258 (93%)	1,353
Behavioral health providers	331 (86%)	384
Physician Detail by Specialty and Hours Worked†		
Physicians per 100,000 Population		
Physicians working 20+ hours/week	191 (65%)	294
Primary care	91 (77%)	118
Specialty	100 (57%)	176

* License groups based on information reported to the California Department of Consumer Affairs and the methods used by the California Department of Health Care Access and Information (HCAI). Physicians are MDs and DOs; advanced practice providers are nurse practitioners and physician assistants; nurses are licensed vocational nurses and registered nurses; behavioral health providers are all licenses in the following types: associate clinical social worker, associate marriage and family therapist, associate professional clinical counselor, licensed clinical social worker, licensed educational psychologist, licensed marriage and family therapist, licensed professional clinical counselor, psychiatric mental health nurse, psychiatric technician, psychologist, and registered psychological associate.

† Allocation of physicians into specialties and hours of practice used the HCAI Physicians by Specialty and Patient Care Hours, as of April 3, 2024.

Source: "2024 License Renewal Survey Data, Representing Active Licenses as of December 3, 2024," custom data request, HCAI, received April 14, 2025.

Widespread and Chronic Workforce Shortages

With 217 physicians per 100,000 population, the San Joaquin Valley has far fewer physicians than the statewide figure of 358 physicians per 100,000 population (Table 15). The gap holds across primary care and specialty physicians when examining physicians working more than 20 hours weekly. Invariably, regional health care leaders cited physician shortages as a significant and chronic challenge across a range of specialties, including cardiology, dermatology, gastroenterology, neurology, ob/gyn, pediatrics, primary care, psychiatry, and rheumatology. The number of psychiatrists per 100,000 population in the region is considerably lower than the statewide figure. One expert said many physicians have retired, are working less, or are planning to retire. Of note, statewide figures are not a recommended benchmark but rather a baseline for comparison on regional disparities in supply.

While shortages are most acute for physicians, regional experts noted that shortages span the continuum of health professionals — from physicians and dentists to medical assistants and medical billers. Regional respondents reported that recruiting challenges for physicians, advanced practice providers, and behavioral health professionals are fueled by bidding battles among hospitals, CHCs, and other providers. Challenges with housing availability and affordability compound recruiting difficulties. In Mariposa County, the behavioral health department focuses on recruiting local behavioral health clinicians who already have housing, because finding a home to buy or rent is difficult for those relocating to the county.

Persistent specialty physician shortages sometimes result in patients being referred as far as Los Angeles or Sacramento for care. Such shortages create access disparities and can be acute for Medi-Cal enrollees. One regional expert said that access to care is stratified by type of insurance coverage: People with commercial insurance generally have adequate provider networks, while Medi-Cal enrollees have access

to fewer providers, particularly specialty physicians and behavioral health professionals. Several experts observed that pervasive geographic inequities exist because counties in the region are generally poor with high disease burden and high Medi-Cal enrollment compared to other California regions. The respondents also noted that resources for training and infrastructure development tend to go to urban and more prosperous regions.

Amid provider shortages, telehealth remains an important post-COVID tool to extend access. CalViva, a Medi-Cal managed care plan in the region, has an initiative to promote telehealth for patients and eConsults for primary care physicians to connect with specialists, helping to reduce the need for in-person visits. However, many patients, especially in outlying rural areas, lack adequate internet access, making telehealth a challenge for them. Patients also may resist downloading needed apps to their smartphones. Respondents reported that most CHCs and counties use telehealth vendors for psychiatry services. More recently, federal immigration crackdowns have made telehealth a more accessible option for patients fearful of an in-person visit.

Little Provider Alignment with Region's Latino/x Population

Across major provider groups in the San Joaquin Valley, clinician race/ethnicity concordance falls far short of the nearly 60% regional Latino/x population (Table 16). And the mismatch is compounded by less than a quarter of providers speaking Spanish. While nearly one-third of behavioral health care providers identify as Latino/x, only 30% of them report speaking Spanish. Language concordance between providers and patients can lead to lower health care costs and improved care delivery.[28]

In the early 2000s, the California legislature established the Licensed Physicians from Mexico Pilot Program that enables CHCs to sponsor primary care physicians and dentists from Mexico to practice in underserved areas for up to three years.[29] In 2024, the program was reauthorized and added psychiatrists to physicians who can be sponsored.[30] Altura Centers for Health participates in the pilot and has had Mexican physicians working in its clinics. These physicians offer language and cultural compatibility for Latino/x patients. A regional leader noted that such temporary programs aren't a long-term solution to staffing shortages and don't address pipeline issues, adding, "These are Band-Aids."

TABLE 16. Physician and Health Workforce Characteristics,
San Joaquin Valley, 2024

	Physicians	Advanced Practice Providers	Nurses	Behavioral Health Providers	Population
Race/Ethnicity of Providers*					
Latino/x, any race	14.1%	24.3%	32.2%	32.2%	58.6%
Asian, non-Latino/x	40.9%	25.1%	24.8%	24.8%	7.7%
Black, non-Latino/x	3.9%	5.8%	3.8%	3.8%	3.8%
White, non-Latino/x	36.9%	38.6%	34.0%	34.0%	27.2%
Languages Spoken‡					
English only	43%	54%	59%	63%	—
Spanish	18%	21%	19%	29%	—

Notes: License groups based on information reported to the California Department of Consumer Affairs and the methods used by the California Department of Health Care Access and Information (HCAI). Physicians are MDs and DOs; advanced practice providers are nurse practitioners and physician assistants; nurses are licensed vocational nurses and registered nurses; behavioral health providers are all licenses in the following types: associate clinical social worker, associate marriage and family therapist, associate professional clinical counselor, licensed clinical social worker, licensed educational psychologist, licensed marriage and family therapist, licensed professional clinical counselor, psychiatric mental health nurse, psychiatric technician, psychologist, and registered psychological associate.

* Not shown: Other, non-Latino/x.

‡ Spoken fluently/well enough to provide direct services to clients. Some providers speak multiple non-English languages (e.g., 8% of physicians statewide); these languages are not captured here.

Sources: "2024 License Renewal Survey Data, Representing Active Licenses as of December 3, 2024," custom data request, HCAI, received April 14, 2025.; and *Annual County Resident Population Estimates by Age, Sex, Race, and Hispanic Origin: April 1, 2020 to July 1, 2023* (CC-EST2023-ALLDATA), US Census Bureau.

Many Strategies to Grow, Recruit, and Retain Workforce

With the support of Medi-Cal managed care plan community investment grants, CHCs are recruiting and retaining employees with higher starting salaries, signing and retention bonuses, and facilitating loan repayments. One CHC supports employees' career advancement with tuition

reimbursement and time off for classes. CHCs also focus on creating an attractive organizational culture through leadership training, operational transparency, and strategies to boost employee satisfaction.

Respondents from CHCs, hospitals, and county agencies all emphasized the importance of workforce development. Most large providers partner with high schools, private technical programs, community colleges, and universities to "grow our own" health care workforce by creating a training pathway to address shortages. Such partnerships also offer professional advancement opportunities for existing CHC staff. Educational partners include UCSF Fresno, the Milan Institute, San Joaquin Valley College, and College of the Sequoias. Students often meet clinical and other training requirements in local CHCs, hospitals, and county agencies. For example, Kaweah Delta Medical Center established a two-year nursing school with Unitek College and funds nursing faculty at Porterville College.

In addition, several CHCs partner with the Hometown Scholars program at A.T. Still University in Arizona to train physician assistants who return to the region for clinical rotations and then stay to work in the area. The region also is home to the College of Osteopathic Medicine in Clovis, part of California Health Sciences University, a private, for-profit university. One regional expert observed, however, that most of the osteopathic graduates do not stay in the region.

CHCs also serve as graduate medical education (GME) training sites for physicians through accredited residency programs. For example, Altura, United, and Family HealthCare Network receive GME funding to pay a training director and attending physician faculty. United Health Centers, the second-largest CHC system in the region, assumed management from Family HealthCare Network of two GME residency training sites at CRMC to serve some 30,000 patients, mostly with Medi-Cal coverage. United Health Centers also supports 36 full-time-equivalent physician trainees of the 325 total UCSF Fresno residents (see "UCSF Fresno, SJV PRIME, and SJV PRIME+ Play Key Roles in Physician Pipeline" on page 19). Managing these training sites provides access to more primary care and specialist physicians for CHC patients.

Statewide Workforce Initiatives Support Regional Training

Numerous California Department of Health Care Access and Information statewide workforce initiatives support health care workforce pathways for several types of providers. The Song-Brown Healthcare Workforce Training Programs brought $3 million to universities, colleges, hospitals, and clinics in the region for fiscal year 2024–25. Most funding went to family and community medicine residency training programs at UCSF Fresno, Adventist Health Hanford and Tulare, and Valley Health Team. A portion also supports nursing programs at local community colleges and a family nurse practitioner and physician assistant training program at Fresno State University.

Another California Department of Health Care Access and Information initiative and its affiliated grants support behavioral health workforce training. Four organizations received nearly $2 million from the Community-Based Organization (CBO) Behavioral Health Workforce Grant Program, including Camarena Health and United Health Centers. This program supports scholarships, stipends, loan repayment, and recruitment and retention for a wide range of behavioral health professionals.[31] Fresno State University and Fresno County together received over $13 million in 2022 to support the expansion of social work training and partnerships for public mental health workforce training.

In 2025, the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) initiatives targeting Medi-Cal behavioral health workforce development started. Applications for the first two workforce

development programs were due August 2025, with the first program supporting behavioral health student loan repayment and the other supporting psychiatry and addiction medicine residencies in Medi-Cal safety-net settings. Other BH-CONNECT programs, such as community-based provider training for alcohol and drug counselors and residency training for psychiatrists and addiction medicine specialists, were yet to launch.

UCSF Fresno, SJV PRIME, and SJV PRIME+ Play Key Roles in Physician Pipeline

The UCSF Fresno program, in its 50th year, trains third- and fourth-year medical students and residents and fellows each year. The SJV PRIME program trains a cohort of 12 medical students to address the needs of underserved populations in the broader Central Valley. The GME training programs include family and community medicine, internal medicine, ob/gyn, orthopedic surgery, pediatrics, psychiatry, and several other specialties.

UCSF Fresno faculty and residents in training provide access to crucial specialty services through multispecialty training sites at CHS, the Veterans Administration, VCH, and other area hospitals. Saint Agnes Medical Center has six accredited GME training programs, several of which are affiliated with UCSF Fresno. Many UCSF Fresno faculty members are affiliated with Inspire Health Medical Group. One regional expert noted that UCSF Fresno was the only provider in the region for some specialty services.

UCSF Fresno has created programs across educational settings to inspire and prepare students to enter medicine. For example, the UCSF Fresno Junior Doctors Academy starts in middle school. In Fresno high schools, there are two Doctors Academies and internship programs. Added to this continuum are premed training and career development programs at regional community colleges, UC Merced, UCSF Fresno, and Fresno State University.

The PRIME+ program, a collaboration among UCSF, UCSF Fresno, and UC Merced, plans to increase the training cohort to 50 and to include bachelor's and medical degrees. The plan, launched in 2023, established UC Merced as a regional branch of the UCSF Medical School. By 2027, UC Merced will welcome the first class of PRIME+ students to the regional UCSF medical school on the UC Merced campus. Together UC Merced and UCSF Fresno will become a full four-year regional medical school campus of UCSF. To accomplish this, the PRIME+ partners will seek to increase training capacity at local hospitals and clinics, recruit and diversify physician faculty members, and seek additional GME funding. An expert observed that the San Joaquin Valley, compared to more urban areas, has less infrastructure to support medical training and that developing these resources and partnership has taken time.

Workforce Shortages and Other Challenges Impact Maternity Care

In three counties — Madera, Tulare, and Kings — access to both inpatient and outpatient ob/gyn care is limited, as the number of ob/gyns practicing has declined. The main Tulare County ob/gyn group closed in December 2024, leaving few options for outpatient services. Madera Community Hospital closed, along with its labor and delivery services, in January 2023, and Adventist Health Tulare closed labor and delivery services in June 2024. These closures pushed inpatient ob/gyn and labor and delivery services to remaining hospitals that already were at capacity, and referrals are frequently difficult to obtain. Furthermore, women needing these services must travel, sometimes great distances, to receive care. A regional expert commented that "this is not alarming just yet, but we're getting close." Another regional expert observed that maternity services have always been difficult to access

in rural areas. Because of the closures and shortages of ob/gyn outpatient providers, even fewer women have access to routine prenatal care, contributing to more high-risk pregnancies and a higher infant mortality rate.

In Tulare County, labor and delivery services are provided at Kaweah Delta Medical Center, Sierra View Medical Center, and Adventist Health Hanford. A regional expert noted that despite these facilities having maternity care, capacity is stretched thin. With four full-time ob/gyns, one obstetrical advanced practice provider, and some community ob/gyns with admitting privileges, Kaweah Delta delivered some 4,500 newborns in 2023 and recruits aggressively for providers. As noted earlier, Kaweah contracts with the OB Hospitalist Group, which staffs some 300 hospitals nationwide, to provide inpatient services. In Fresno County, Kaiser, CRMC, Clovis Community Medical Center, Saint Agnes Medical Center, and Adventist Health Reedley have labor and delivery departments. A regional expert remarked that the high proportion of births to women with Medi-Cal coverage added to financial challenges for hospitals, given low payments.

Rocky CalAIM Implementation

The state launched CalAIM in 2022, which was designed as an ambitious transformation of Medi-Cal through multiple initiatives implemented over several years.[32] CalAIM implementation occurred simultaneously with other Medi-Cal changes, including coverage expansions to undocumented immigrants and the postpandemic eligibility redetermination for all Medi-Cal enrollees.

Two foundational aspects of CalAIM are ECM and CS services. A new Medi-Cal benefit, ECM provides resources for care coordination and care management for patients with complex needs. CS services, which are optional for managed care plans to offer, expand Medi-Cal beyond traditional health care services, adding services for health-related social needs such as housing supports, medically tailored meals, and sobering centers.

Medi-Cal managed care plans are responsible for implementing and coordinating these services. To support implementation, the California Department of Health Care Services (DHCS) provided nearly $2 billion statewide through Providing Access and Transforming Health, or PATH, grants to build capacity and infrastructure among CHCs, CBOs, hospitals, county agencies, and tribes.

In the San Joaquin Valley, about 6,700 people, or 0.7% of Medi-Cal enrollees, received ECM services in 2024 — about half the 1.5% statewide rate (Table 17). The difference is notable given the region's poorer health status and higher rates of chronic diseases. In contrast, enrollment for CS services was greater regionally than statewide — 2.6% versus 1.9%. In the fourth quarter of 2024, the most-used CS service, by far, was medically tailored meals (16,552 enrollees), followed by housing transition navigation (2,354 enrollees), and housing tenancy and sustaining services (450 enrollees).[33] CalViva and Anthem Blue Cross accounted for 46% and 38%, respectively, of Medi-Cal enrollees receiving CS services. A regional expert

TABLE 17. Medi-Cal and CalAIM,
San Joaquin Valley vs. California, 2024

	San Joaquin Valley	California
Enhanced Care Management (ECM) Enrollment*		
ECM enrollment	6,742	206,501
Share of Medi-Cal managed care enrollees receiving ECM	0.7%	1.5%
Community Supports (CS) Enrollment†		
CS enrollment	24,743	258,141
Share of Medi-Cal managed care enrollees receiving CS	2.6%	1.9%

* ECM enrollment is the number of unique members who received ECM in the last 12 months of the reporting period ending September 30, 2024.

† CS enrollment is the number of members receiving services in the 12 months of the reporting period ending September 2024.

Source: *ECM and Community Supports Quarterly Implementation Report* (data through September 30, 2024), California Department of Health Care Services, last updated March 2025, data tables for charts 1.7.1 and 3.9.1.

observed that medical respite, or recuperative care, provided as a CS service has eased some hospital crowding by facilitating discharges.[34]

According to several regional experts, Medi-Cal managed care plans have struggled to build provider networks to deliver ECM and CS services because of the complexity, volume, and back-to-back pace of CalAIM initiative rollouts. Through provider network development, Medi-Cal plans have added and supported CBOs to adequately and consistently deliver services. Many CBOs had never contracted with managed care plans before, so there was a learning curve. Other providers like CHCs and RHCs have diversified and expanded staff and infrastructure to deliver the new services. Other experts interviewed noted that delivering ECM and CS services in rural areas can be a significant challenge.

Almost all CHCs in the region received Capacity and Infrastructure Transition, Expansion, and Development state grants for CalAIM implementation. For example, United Health Centers received $2 million in 2024 to support ECM start-up expenses and to hire care managers, community health workers, and other staff. Altura Centers for Health also received a grant to support ECM for Medi-Cal enrollees experiencing homelessness, as well as working with ED "frequent users" and patients before and after surgeries. Camarena Health also developed alternative care settings for frequent ED users.

Although county behavioral health departments welcomed the new services, like others interviewed, they noted that overly complex requirements hindered implementation. Moreover, county behavioral health agencies reported that contracting with managed care plans to deliver ECM and CS services was particularly challenging and that payment rates didn't "pencil out" to cover their costs. One respondent said that implementation has consumed enormous resources for county behavioral health plans, considering how few Medi-Cal enrollees have accessed services. Furthermore, while DHCS requires reporting on implementation and utilization, there is little focus yet on measuring and reporting outcomes.

Major Investment in Behavioral Health Initiatives, but Pace of Change "Exhausting"

The CalAIM transformation includes numerous initiatives focused on improving the delivery and integration of behavioral health services for Medi-Cal enrollees, including coordination with ECM and CS services. The delivery of Medi-Cal behavioral health services is divided between managed care plans and county behavioral health departments and has long been poorly coordinated and administratively burdensome. Medi-Cal managed care plans provide mild-to-moderate behavioral health services, while specialty mental health and SUD services are the responsibility of county behavioral health plans.

The CalAIM behavioral health initiatives include the Children and Youth Behavioral Health Initiative; mobile crisis infrastructure; improvements to the Drug Medi-Cal Organized Delivery System (DMC-ODS); a "no wrong door" policy to improve access to services across systems; administrative integration; and payment reform. County behavioral health departments have also been planning for the implementation of the Behavioral Health Services Act passed by voters in Proposition 1 in March 2024. Putting each initiative in place has involved complex policy changes and coordination among Medi-Cal managed care plans, county behavioral health departments, CHCs, medical groups and IPAs, and CBOs. According to one regional leader, these back-to-back implementations have been "exhausting." Implementation demands have been particularly acute for small and rural counties where county staff, CHCs, and other providers already have full workloads.

In Madera County, the 2024 passage of the state Proposition 36 drug treatment diversion program motivated the county to implement the improved DMC-ODS system.[35] DMC-ODS provides an evidence-based Continuum of Care for SUD treatment and gives counties more local control over resources. Mariposa County also implemented the DMC-ODS. Both counties were required to submit an implementation plan to DHCS for approval. The three other counties in the region — Fresno, Kings, and Tulare — had already implemented DMC-ODS.

Patients using county mental health and SUD services also have had to adjust to the many changes. A major focus on Medi-Cal behavioral health transformation has been on members experiencing both serious mental illness and homelessness. Several county leaders expressed consternation about how the Behavioral Health Services Act, passed as part of Proposition 1, redirects resources away from prevention and early interventions for children and youth toward adult services. Another respondent observed that providing services and housing assistance to people with serious mental illness is labor-intensive and sometimes met with resistance if people do not want to be housed. To address the multiple needs among community members and help them navigate a changing system, one county behavioral health leader said, "We're being creative one patient at a time."

Regionally, initiatives to improve coordination and integration of behavioral health services have had mixed results. A Mariposa County expert observed that in a small county, the providers still rely on many warm handoffs to ensure coordination and better patient care. In Kings County, implementing behavioral health initiatives has forced typically siloed county agencies to work more collaboratively, an expert said. While DHCS requires agreements between managed care plans and counties to ensure better integration and accountability, counties and managed care plans have been slow to put the agreements in place. One health plan leader lauded the "no wrong door" policy under which Medi-Cal patients can seek care at any provider and be seen immediately or be referred to an appropriate provider. In Mariposa County, the arrival of a new Medi-Cal managed plan, the Central California Alliance for Health, has reportedly been positive but not without some growing pains. For example, integrating mild-to-moderate mental health services with county specialty mental health and SUD services was challenging as the plan transitioned in and contracted with providers.

The Behavioral Health Continuum Infrastructure Program (BHCIP), established through 2021 legislation, aims to address infrastructure needs with "bricks-and-mortar" funding.[36] BHCIP funding was augmented through Proposition 1 bonds, approved by voters in March 2024. Over the five rounds of BHCIP grants, the region's county agencies, hospitals, CHCs, and other providers have received millions in grant dollars.[37] The early rounds included grants to providers in Fresno, Madera, and Tulare Counties that offer SUD services and behavioral health services to children and youth and grants to build the crisis and behavioral health continuum. Organizations receiving funds included Kaweah Delta Health Care District, Fresno American Indian Health Project, Tule River Indian Health Center, and behavioral health agencies in Madera and Tulare Counties.

In 2025, the region received $124 million from BHCIP bonds for seven new facilities across Fresno, Kings, Mariposa, and Tulare Counties. Overall, Fresno County received $97 million, with the county building an outpatient clinic, a residential psychiatric treatment facility, and an inpatient psychiatric health facility, and Community Regional Medical Center received $30 million to expand psychiatric services. Mariposa County plans to use a $3 million grant to build an outpatient SUD treatment facility in the most underserved northern rural area of the county. In Kings County, Good Samaritan, a for-profit organization, received $13 million to build a residential psychiatric crisis stabilization facility. Awarded $11 million, Tulare

County will build a facility for mental health rehabilitation and SUD residential treatment for adults. One regional clinic leader observed that BHCIP bond funds rolled out quickly. These new facilities will add nearly 2,500 outpatient service slots and nearly 200 residential beds across the region.

Adding to the exhaustion, according to another regional leader, was payment reform to move county behavioral health plans and their contracted providers from cost-based reimbursement with burdensome reconciliations to fee-for-service rates established in a fee schedule. Regional behavioral health leaders and service providers remarked about the difficulty of putting the new system in place. One provider said deploying a new payment system and payment rates was foisted on them without consultation. Other providers reported that the new rates are insufficient to cover costs, and one nonprofit provider considered ending its contract with the county altogether. One issue is a requirement that 60% of payments be used for clinical services, limiting how funding can be used. For example, transportation is not considered a "clinical service," and counties have had to find other resources to support transportation to serve clients in settings like schools and rural areas.

Looming Federal and State Medi-Cal Cuts: "A Tsunami Is Coming"

In recent years, the state has invested heavily in infrastructure for behavioral health, new Medi-Cal benefits, and Medi-Cal coverage expansions. However, with the federal House Resolution 1 Medicaid cuts looming and state budget shortfalls forcing cuts to Medi-Cal eligibility and benefits, regional experts forecast difficult times ahead, with one county leader saying, "A tsunami is coming."[38]

Hospital respondents for this study universally believe the anticipated increase in uninsured Californians and reduced Medi-Cal benefits and provider payments will impact the San Joaquin Valley in many negative ways. Hospitals will face more uninsured patients in EDs and increased uncompensated care. New provider tax limitations will reduce Medi-Cal directed payments, which supplement hospital payment. Some hospitals in the region already are struggling financially, and some believe these changes may push them to the financial brink. "We're not too big to fail," said a respondent from a larger hospital.

Some respondents noted that CHCs will face negative financial consequences from growing numbers of uninsured patients, payment rate cuts, and recent changes to Medi-Cal's coverage of undocumented immigrants. To address a budget deficit for fiscal year 2025–26, the state enacted several changes to coverage for undocumented adults including an enrollment freeze.[39] FQHCs must serve all patients regardless of ability to pay, and these changes will bring an increase in uninsured and self-pay patients. While most CHCs regionally have a solid financial foundation, they will be at increasing fiscal risk in the coming years. One expert said, "We finally got our footing again after COVID, and now uncertainty is back."

Counties May Need to Revitalize Medically Indigent Adult Programs

State law designates California counties the "provider of last resort," and all large counties finance and operate programs to provide services to medically indigent adults (MIAs).[40] Smaller counties contract with the County Medical Services Program (CMSP) to provide services to the uninsured, including undocumented immigrants. After Medi-Cal implemented the optional Affordable Care Act adult coverage expansion and subsequent expansions to all eligible residents regardless of immigration status, most counties amended their MIA programs, and two have closed.

In the San Joaquin Valley, three counties — Kings, Madera, and Mariposa — participate in CMSP. The Fresno and Tulare

County MIA programs provide a limited set of services and do not cover undocumented residents. Leaders interviewed for this study believe the rise in the uninsured population will likely cause all counties to revisit MIA program policies and financing. Small counties likely will revisit available financing to participate in CMSP as enrollment grows. As the state took on responsibility for uninsured people over the past decade and "realigned" associated funding away from counties, the future of MIA programs will involve state leadership and challenging negotiations.[41] One county leader said, "We have to start this planning now."

Uncertain CalAIM Future

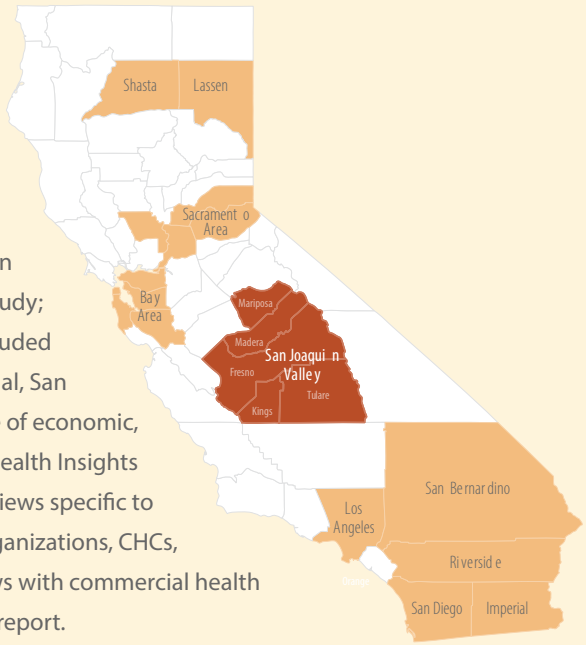
Regional respondents also worried about the future of CalAIM and behavioral health initiatives to transform care delivery and better serve vulnerable Medi-Cal enrollees. These initiatives operate through federal waivers — the CalAIM waivers expire at the end of 2026 and BH-CONNECT expires at the end of 2029 — and state, county, and health system leaders feared CMS would not renew the waivers. DHCS prepared a CalAIM renewal concept proposal reaffirming CalAIM goals, presenting successes, and identifying initiatives to continue.[42] In this proposal, DHCS asserted that some aspects of the CalAIM program, including many Community Supports services, do not depend upon a renewed federal waiver. After a stakeholder process, DHCS will submit waiver renewals to CMS in 2026.

Issues to Track

- How will financially struggling hospitals fare through reductions in Medi-Cal payments and an increase in the uninsured and in uncompensated care? Will some hospitals close?
- Will independent hospitals join statewide or national hospital systems to shore up financial viability?
- Will CHCs continue to expand and further cement their importance to care delivery? How will CHCs adapt to the increase in uninsured and self-pay patients?
- Will more outside medical groups enter the market and contribute to a more consolidated physician services market?
- Will providers in the region — hospitals, CHCs, health plans, county public health and behavioral health agencies, and medical groups — increase collaboration to maintain access to care with fewer financial resources?
- Will shortages of health care providers in the region persist, or will the influx of state workforce investments offer some relief? Will maternity care access advance to a crisis?
- How will new CalAIM services and behavioral health investments contribute to long-term structural changes that better serve the region's most vulnerable Medi-Cal enrollees? How will providers adapt if CalAIM benefits are rolled back?
- How will the region's health status indicators change as more residents lose health insurance?

Background on Regional Markets Study

Between March and June 2025, researchers from Yegian Health Insights, LLC, conducted interviews with health care leaders in the San Joaquin Valley counties of Fresno, Kings, Madera, Mariposa, and Tulare in central California to study the market's local health care system. The San Joaquin Valley is one of seven markets included in the Regional Markets Study funded by the California Health Care Foundation. The purpose of the study is to gain key insights into the organization, financing, and delivery of care in communities across California and over time. This is the fifth round of the study; the first set of regional reports was released in 2009. The seven markets included in the project — Inland Empire, Los Angeles, Sacramento, San Diego/Imperial, San Francisco Bay Area, San Joaquin Valley, and Shasta/Lassen — reflect a range of economic, demographic, care delivery, and financing conditions in California. Yegian Health Insights interviewed over 200 respondents for the overall study, with 25 to 30 interviews specific to each region. Respondents included executives from hospitals, physician organizations, CHCs, Medi-Cal managed care plans, and other local health care leaders. Interviews with commercial health plan executives and other respondents at the state level also informed this report.



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ABOUT THE FOUNDATION

The **California Health Care Foundation** is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford. CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

California Health Care Almanac is an online clearinghouse for key data and analysis examining the state's health care system.

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