

# Advancing Local Healthcare Solutions for California's Remaining Uninsured

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## Introduction

In 2014, there were an estimated 3.8 million uninsured in the state of California, a number that has dropped significantly as a result of the Affordable Care Act (ACA). In fact, between 2013 and 2014, the percentage of uninsured California residents dropped from 16% in 2013 to 11% in 2014.<sup>i</sup> While the largest gains in insurance enrollment were seen in young adults between the ages of 21 and 24, approximately 25% of the state's remaining uninsured are between the ages of 25 and 34 years. Yet, despite these gains, it is estimated that by 2019 there will still be 2.7 to 3.4 million Californians who will remain uninsured, the majority of whom will be low-income and Latino.<sup>ii</sup>

While the ACA offers opportunity for many, it does not offer health insurance for all. Millions of undocumented residents remain ineligible for coverage, and affordability continues to be a barrier for low-income individuals and families throughout the state. The policy climate for expanding health coverage to immigrant populations continues to evolve in California. In spite of the recent implementation of SB75, which enables all uninsured children below 200% Federal Poverty Level (FPL) to access health coverage through full-scope Medi-Cal, and the passage of legislation that would potentially allow undocumented adults to purchase unsubsidized coverage through Covered California, significant challenges and uncertainties remain. Without further action from the state or counties to address the prevailing healthcare needs of uninsured adults, the ACA cannot – and will not – reach its goals. Achieving “coverage for all” requires new solutions and programs to ensure that no one is left behind.

This paper aims to highlight the opportunity for California counties to demonstrate leadership on this issue, and outlines important steps, policies, and recommendations to help counties as they move toward more comprehensive care and coverage for those who remain uninsured. Produced in concert with a grantmaking initiative led by Blue Shield of California Foundation to support 11 communities across the state in the development and implementation local programs for the remaining uninsured, as well as a recent [webinar learning series](#) on the same topic, this paper provides additional insights and resources for expanding access to healthcare for some of our most vulnerable communities.<sup>iii</sup>

## Services Provided to the Uninsured

As state policies continue to change, counties are finding new ways to provide care to their uninsured residents and transform existing approaches and delivery systems. The local efforts that are already underway are at different stages – from well-established programs to those that are just getting the conversation started. Regardless of where counties currently stand, each and every one can improve and expand their healthcare services for the remaining uninsured.

The term “remaining uninsured” refers to those who are not currently eligible for any of California's coverage programs or healthcare subsidies. These individuals generally fall into three categories:

- 1) Those who qualify for Medi-Cal or Covered California, but are not enrolled
- 2) Citizens or legal immigrants ineligible for subsidies because they are over income limits
- 3) Undocumented residents

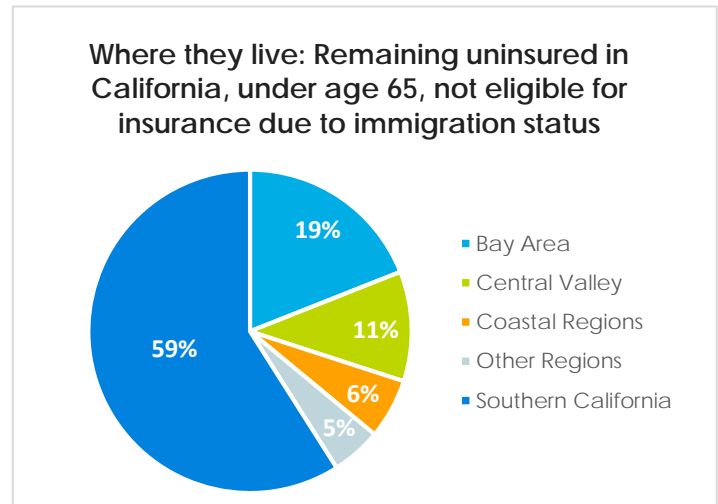
For those who are eligible for Medi-Cal, or subsidized coverage under Covered California, the most cost-effective way to meet their healthcare needs is by enrolling them in the program for which they are eligible. Counties may need to enhance their enrollment assistance efforts, address administrative barriers<sup>iv</sup>, or improve community outreach and education to reduce this sub-group of eligible Californians who still remain uninsured. While that is an important first step, this paper will focus more on potential coverage solutions for low-income individuals who are not eligible for any other program (e.g., undocumented residents).

As counties begin this important work, there are a number of elements that must first be clearly examined and understood:

### 1. Demographics<sup>v</sup>

Roughly one-quarter of California's uninsured population is made up of individuals who qualify for subsidies or state programs, but are not currently enrolled. Among adults, the most common reason cited for not enrolling is the perceived cost of insurance being too expensive.<sup>vi</sup>

Projections suggest that the largest group, however, is California's undocumented residents – who account for up to half of the total uninsured population. These individuals do not qualify for any of California's coverage programs or healthcare subsidies. Though estimates vary significantly, we do know that the majority are of Latino or Asian/Pacific Islander descent, are male, and that they are concentrated in Southern California and the Bay Area.<sup>vii</sup> In order to best meet their individual communities' needs, counties should begin by making efforts to understand the total number and unique demographics of their undocumented residents.



### 2. Available Services

Even for geographic regions that do not have a program in place to address the healthcare needs of their uninsured residents, under the Emergency Medical Treatment & Labor Act, counties are required to ensure that emergency services be publicly available, regardless of a patient's immigration status or ability to pay.<sup>viii</sup> However, this type of episodic care is often expensive and does not encourage consistent access to primary care and preventive services.

Many communities already provide access primary care through free clinics, county-run clinics, and/or Federally Qualified Health Centers that serve low-income and uninsured families and individuals. In addition, there are programs that offer coverage for specific services, including restricted Medi-Cal, which covers emergency and stabilization services as well as maternal healthcare for undocumented residents who are otherwise ineligible for full-scope Medi-Cal.

### 3. Policy Opportunities

At the state and county levels, decisions on how to address the needs of the remaining uninsured are being made in a changing and dynamic policy environment. Counties must continuously monitor existing and pending policy opportunities and be aware of some of the key policy drivers affecting their work. These include:

- **Federal Immigration Policy** – As of July 2016, the Supreme Court issued a split-decision on a court order that has blocked implementation of the President’s Deferred Action for Parents of U.S. Citizens and Lawful Permanent Residents (DAPA) program and expansion of the Deferred Action for Childhood Arrivals (DACA) program. Several efforts are underway challenging the legality of this court order. If ultimately overturned, the order would have the potential to extend state Medi-Cal benefits to an additional 360,000-500,000 Californians.<sup>ix</sup>
- **Medicaid Waiver** – In December 2015, California received approval for a five-year renewal of the state’s Medicaid Section 1115 Waiver, known as Medi-Cal 2020.<sup>x</sup> The waiver features four core programs, including the development of a global payment methodology that would incentivize public hospitals and clinics to deliver quality, coordinated care to the uninsured, with an emphasis on prevention.
- **SB75 (Medi-Cal for All Children)** – In June 2015, Governor Brown signed SB75 into law, which expands full-scope Medi-Cal eligibility to all children under the age of 19 in families with incomes up to 266% federal poverty level, regardless of immigration status. The program took effect on May 16, 2016, offering coverage for an estimated 250,000 children in the state.
- **SB10 (Covered California Access)** – Signed by Governor Brown in June 2016, SB10 paves the way for California to request a waiver to allow undocumented residents to purchase unsubsidized coverage through Covered California.

#### 4. Legal Context

Decisions regarding California’s remaining uninsured population are largely being made at a county level, instead of at the state level. This is due to Section 17000 of California’s Welfare and Institutions Code<sup>xi</sup>, which states that “*counties hold the responsibility to assure that medically indigent residents have access to healthcare services*”. Each county interprets this responsibility differently in terms of income threshold, scope of services, reasonable cost, and documentation status.<sup>xii</sup> County programs are also legally limited to their defined county network and are not allowed to provide medical assistance to individuals outside of that network (for example, if an Alameda County resident is enrolled in the Health Program of Alameda County and is in an accident in San Francisco, services provided in San Francisco would not be covered). This paper emphasizes the benefits of developing county programs that are separate from the §17000 obligation, which is often already met through episodic care available through “sliding fee scale” or “ability to pay” programs.

#### County Medical Services Program (CMSP) eligibility and benefits changes:

In early 2016, the CMSP program enacted several changes to eligibility and benefits for this program, which is available to uninsured residents in 35 counties in California. Changes include:

##### Eligibility:

- Increased eligibility from 200% FPL to 300% FPL
- Modified assets testing for those above 138% FPL, and eliminated testing for those below 138% FPL
- Reduced share of costs for beneficiaries: eliminated for those below 138% FPL and reduced by 75% for those above 138% FPL

##### Benefits:

- 3 combined primary care/specialty care visits, a range of diagnostic tests, and up to \$1,500 in prescription drug coverage during each CMSP enrollment term
- No cost to participants for covered healthcare services, and limited copayments for prescription drugs

**Note: These changes do not impact undocumented residents below 138% FPL.**

## 5. Environmental Scan of the Remaining Uninsured

As counties begin to move toward more comprehensive healthcare solutions for their uninsured residents, stakeholders should start by identifying and understanding the local population as well as existing resources available to serve those who do not qualify for full-scope state-level coverage programs. This step includes a landscape analysis of:

- Where the remaining uninsured are utilizing emergency and high-cost inpatient services;
- The number of Federally Qualified Health Centers, free clinics, volunteer medical services, and non-profit hospitals that provide primary care to the uninsured;
- Existing relationships among public and county hospitals and primary care providers;
- Benefits provided to hospitals by the county government (for example, land use or buildings);
- Specialty networks for the Medi-Cal population and volunteer services offered to the remaining uninsured; and
- First-hand perspectives from patients and families regarding what healthcare services they most value and prioritize.

Counties will also need to assess their financial and available planning resources. These may come from the county board or health department, or from community stakeholders. In either case, it is useful to bring county and community stakeholders together and collaborate towards a common mission.

### Strategies to understand the needs of the remaining uninsured – Sonoma and Marin:

Covered Sonoma recently concluded a study of the remaining uninsured using ACS and CHIS data, along with clinic utilization data. Sonoma also surveyed nearly 300 undocumented residents living in the county to assess access gaps and disparities in care, ultimately informing the target population for its program.

The Marin Access to Care Collaborative (MACC) recently completed a series of focus groups with Spanish-speaking residents of Marin County, 60% of whom were uninsured. The focus groups examined health-seeking behaviors, experience in accessing care, unmet health needs, care improvements, and access priorities among this population.

Need	Available Resources	
	Financial	Planning
<ul style="list-style-type: none"> <li>• Estimate of how many people remain uninsured. How many of the remaining uninsured are eligible for other programs (Medi-Cal, Covered California, etc.) versus those who are ineligible?</li> <li>• What are the existing resources for the “ineligible” remaining uninsured (county clinics, FQHCs, free clinics, etc.)?</li> <li>• What is an appropriate income threshold to expect cost-sharing?</li> </ul>	<ul style="list-style-type: none"> <li>• Existing General Fund or remaining Realignment dedicated through contracts or department budget for indigent care</li> <li>• Potential for reimbursement if additional funding spent based on AB 85 for formula-based counties</li> <li>• Hospital charity care that could be directed to coordinated program</li> <li>• Potential to tax</li> <li>• Opportunities through Medi-Cal 2020 waiver</li> </ul>	<ul style="list-style-type: none"> <li>• Board of Supervisor support</li> <li>• Capacity of various players including County, Managed Care Plan(s), Hospital, and/or clinic consortium</li> <li>• Community stakeholders- have stakeholders come together to support and advocate for services?</li> </ul>

## Building a Local Program

Moving from episodic care for the uninsured towards more comprehensive coverage that emphasizes prevention and population-level health management would help reduce costs and achieve a healthier California overall. In some California counties, there is still limited support for the provision of healthcare services to undocumented residents. However, survey findings show that most California voters are in favor of providing primary care over emergency services – regardless of a patient’s immigration status – and more than four out of five would support greater access to preventive care to reduce costs and limit the spread of disease.<sup>xiii</sup> Research also shows that undocumented immigrants visit the emergency room less often than U.S. citizens, and when they do utilize emergency services, they often delay seeking care until they are critically sick.<sup>xiv</sup>

Once a county has a clear view of current needs and resources and understands the existing safety net, specific decisions must be made about how coverage or covered services will be provided. These decisions include: funding sources and budget, eligibility, scope of services, provider network, provider payment structure, enrollment, quality improvement, and administration.

### 1) Funding Sources and Budget

#### Funding sources

Established programs already have general funds dedicated to basic healthcare services and care coordination; however, there are additional ways to put a program together, or enhance an existing program, through some combination of the following financial resources:

- Local tax initiatives
- Community benefits programs
- Clinic grants
- Contributions from private hospitals<sup>xv</sup>
- Premiums or cost-sharing
- Billing to maximize available resources such as restricted Medi-Cal, presumptive Medi-Cal, FamilyPACT, MAA, etc.
- Remaining health realignment funding<sup>xvi</sup>

#### Budget

Establishing the true cost of care is very difficult, and counties with coordinated programs do not generally contract for healthcare services at rates that would fully cover all costs because there are other funding streams that exist. In addition, many county programs include services that are not specifically tied to a budget dedicated to the uninsured, but are instead included within broader county hospital or county health department budgets. While it can be tempting to try to establish the true cost of programming before starting or expanding, this is a task that may be prohibitively difficult. Few of the counties consulted in this project knew the full cost of serving the uninsured, but most can report on contracted amounts for specific services.

#### Local tax initiative – Santa Clara and Alameda:

In November 2012, Santa Clara County passed a one-eighth-cent sales tax to be put in place for ten years. Since implementation, it has generated approximately \$45 million annually for county programs, including Santa Clara Valley Medical Center, youth-focused initiatives, and public health campaigns. While these efforts are not mandated, the wellbeing of all residents is a priority for the Board of Supervisors, which awarded a \$10 million grant to clinics in the Community Health Partnership from the funds that were raised through the tax initiative.

In June 2014, Alameda County passed Measure AA to reauthorize a 0.5% sales tax until 2034. The tax currently generates approximately \$100 million per year for improving healthcare services in the

One way counties can approach the budgeting process is to first understand available resources, establish eligibility criteria and develop a target number of enrollees, and incrementally grow the program there. Once a program has been established, utilization data and demand can then be tracked to continually assess whether scope and eligibility should be changed or additional resources allocated.

## 2) Eligibility and Scope of Services

### Eligibility criteria

In order to ensure efficient use of services, counties will need to establish clear criteria for determining who is eligible, and for which services. Generally, counties that have implemented

programs restrict the scope of services to residents of the county. Additional restrictions can also be made based on income (thresholds based on FPL), and eligibility for other programs.

In order to use resources effectively, most counties do not allow those who are eligible for full scope Medi-Cal to enroll in additional county programs. There are, however, a handful of counties that encourage enrollment in restricted scope Medi-Cal as a complement to their separate coverage program. At least two counties currently allow uninsured residents who are eligible for Covered California, but not enrolled, to enroll in their coordinated county programs. Both of these counties are tracking the enrollment of these individuals over time to determine whether it makes sense to maintain this option and approach.

### Scope of services

Within any program, the scope of services that are included can range from very comprehensive (similar to the services covered under Medi-Cal) to much more limited (just primary care or certain specialty services). The more comprehensive the program is, more effective it will be in improving the overall health of the community; however, starting with services that emphasize prevention is a step in the right direction. From the outset, the scope of the program should explicitly say whether any out-of-network costs will be covered (most county programs do not cover these costs).

### Innovative funding – Contra Costa:

In 2009, Contra Costa County stopped including undocumented immigrants in their indigent health program because of budget constraints. County stakeholders, part of the Access to Care Stakeholder Collaborative, came together to develop an alternative solution to serve the remaining uninsured. Those involved included key members of the County Health Services and County Health Plan, community health centers and consortium, and representatives from each major hospital. In the fall of 2015, after a successful advocacy effort, a total of \$1M was secured from the community to support healthcare services for approximately 3,000 undocumented adults.

### Access to specialty services – Monterey:

It is estimated that between 30,000 and 50,000 Monterey County residents have no health insurance. The Monterey County Health Department and local safety net clinics still provide access to care for this population, however no funding was previously available to support specialty or other critical services. In September 2015, the County Board of Supervisors set aside \$500,000 for a pilot project to provide specific pharmacy, laboratory, and radiology services for their uninsured patients. As of May 2016, nearly 900 individuals have been enrolled in the pilot.

## 3) Defined Network

The provider network that serves uninsured residents should be established based upon community resources (including some combination of county hospitals, clinics, public hospitals, private hospitals, and/or private providers). This network should be large enough and sufficiently geographically diverse to accommodate

both the location and the expected number of people in need of services. Increasing the number of providers within the network may improve access, particularly to culturally and linguistically diverse providers, but may have a negative impact on network management, including communication between providers.

#### 4) Payment Structure

Once a network has been built, the mechanism for payment must be established. As mentioned before, payment does not necessarily reflect true cost, and clinics are compensated in different ways for the services provided. Some counties have been exploring models for primary care in which reimbursement follows the client (see the sidebar on My Health LA). This model is generally the most effective way to promote preventive care among the uninsured population. In addition, it creates incentives for provider to strive for greater patient satisfaction so that their clients don't move to other clinics. Funding models that follow enrollees also work best if they are tied to outcome measures that ensure that patient receive timely and appropriate care.

Other approaches, such as the model currently used in Alameda County, pay lump-sum contracts to providers to support the safety net's ability to provide services to their uninsured residents. This method is simplest administratively, and provides consistent support for coverage, but also limited opportunity to incentivize high-quality care.

Another option is to establish per-visit rates or fee-for-service reimbursement. While this ensures that payment is only tied to the services rendered, there is still limited incentive for the contractor to provide lower-cost preventive services.

Many of the counties that have already established coordinated programs – like Los Angeles, Alameda, and San Mateo – rely on their public hospitals to provide much or all of specialty and inpatient care. In San Francisco, many private doctors and hospitals are part of the network that serves the uninsured population, and provide primary, specialty, and inpatient care to program enrollees.

A number of counties have chosen to focus their reimbursement on primary care. Fresno, for example, does not have an official program for their undocumented residents, but has established a contract with a third-party administrator to reimburse hospitals and specialty care providers for services rendered up to a certain amount. Primary care is provided through Federally Qualified Health Centers (not subsidized by the county) who can then use the third party administrator to approve patient referrals for specialty care services.

#### 5) Enrollment System

An enrollment process with a system-of-record is necessary to effectively manage any program designed for the remaining uninsured. If a program does not have a method for tracking and recording its enrolled

#### **Payment-follows-the-client model – Los Angeles:**

My Health LA (MHLA) is a no-cost health access program for uninsured residents in Los Angeles County. To qualify for the program, individuals must be age six or older, ineligible for publicly-funded health insurance, and have a household income at or below 138% FPL. MHLA uses a medical home model in which participants select a single community clinic (not a county-operated clinic) as their main source of care. The county then contracts with each clinic and reimburses them on a per-member/per-participant basis to provide primary care. Under the program, the payment follows the client. Clinics are currently paid \$32 per member, per month and also receive funding to support pharmacy services. The total amount will soon be reduced to \$28 per member when the county establishes its own pharmacy plan for the program. The rate was developed based upon the amount the county previously gave to community clinics under a former program, as well as utilization data, and the cost of new and additional services that clinics are being tasked to provide.

members, it's likely only providing episodic care and therefore not effectively managing the healthcare needs of the population.

There are a variety of options for developing both a screening and recording process, and ideally the overall system will:

- 1) Help to enroll clients in the program that is most appropriate for them based on their eligibility and providers' ability to draw-down funding;
- 2) Not require multiple steps or applications for the patient;
- 3) Be inexpensive to maintain; and
- 4) Allow the county to track clients by medical home to inform utilization management and quality improvement efforts.

## 6) Quality Measures

Local programs have an opportunity to focus on quality improvement efforts through the collection and analysis of enrollment and utilization data among their uninsured population. This information can be used to improve services, make business decisions, and help counties advocate for ongoing or additional funding for their programs. Based on the experiences of existing programs, counties should work with their local coalitions to establish standardized measures around access, patient experience, services provided, and costs.

Of the counties that have already implemented local programs, San Francisco has successfully established these measures for its Healthy San Francisco program and produces an annual report that is available to the public. The program has found that limitations do exist in the way that data is collected and reported, particularly around enrollees who receive services outside of the program's established provider network.

### **Choosing metrics that complement existing measurement requirements – Alameda:**

Alameda County has recently adopted *quality* measures for its program, HealthPAC, to complement existing utilization measures. To arrive at this set of metrics, the county has identified existing quality metrics within its provider network, and prioritized and organized these metrics to build on HEDIS measures currently in use for the Medi-Cal population. As a result of this process, the county is collecting data on the following three measures:

- Third next available appointment,
- A1c for individuals with diabetes, and
- High blood pressure.

### **Utilizing existing enrollment systems – Fresno:**

Fresno County has approved funding for specialty care for the remaining uninsured. It is not a program, but a contract with a third-party administrator, Advantek, to reimburse hospitals and specialty care providers for services rendered up to a cap. The county requires that individuals go through a Medi-Cal application and get prequalified for Restricted Medi-Cal in order to be eligible for the specialty care services offered.

### **Aligning enrollment systems – San Mateo:**

San Mateo County has established a system whereby all uninsured adults that enroll in its local program, Access and Care for Everyone (ACE), are simultaneously enrolled in restricted Medi-Cal. To do this, the county has structured its application for ACE to mirror the Restricted Medi-Cal application. The county has also aligned its systems to enable a turnaround time of approximately 24 hours for application approval.

## 7) Administration

A lead program administrator should be identified and made responsible for making payments to providers, customer service, and collecting and analyzing data. Ideally, county programs are not segregated from



other local systems of care, and should be coordinated with Medi-Cal for administrative efficiency as well as to reduce stigma for the uninsured population involved in the program. For example, Santa Clara County's local program, Primary Care Access Program (PCAP) is administered by Valley Health Plan, a county entity, which also manages a commercial plan for county employees and a Covered California plan.

## Improving Existing Programs

There is still not a single county in California with a comprehensive program for the remaining uninsured. Existing programs can take steps and make changes to improve in the following critical areas:

- **Breadth of services offered** – While there are county programs that include robust scopes of service for the uninsured, they can still be extended to include dental and vision services. For example, Los Angeles offers a separate dental program, “MHLA Dental”, for its uninsured residents and contracts with local clinics to provide dental services to those who are enrolled. And though behavioral healthcare is offered in some counties, these services are often not integrated with broader primary care. Steps should be made to further connect mental health and substance abuse services across providers as part of county programming for the uninsured.
- **Renewals** – As counties implement or expand their programs, patient renewals and retention in will need to be considered. Of recent note are challenges in Los Angeles County, where re-enrollment in MHLA had to be done in person, making it difficult for clinics to contact all of their patients during within the established renewal timeframe.
- **Return on investment** – It will be helpful to have program evaluations that track both costs and savings from the provision of preventive services for the uninsured. While we know that individuals and whole communities benefit from prevention efforts, having this information and evidence of return on investment can help make the business case for further program expansion and support.

## Moving Forward

Many low-income Californians continue to lack access to high quality, affordable healthcare – particularly preventive services – due to their exclusion from statewide health insurance options and significant variation in community-level coverage programs across the state. While promising conversations are underway regarding new statewide solutions, county stakeholders must not hold back in moving forward to implement local options and programs in the meantime. California's counties have the potential to not only serve the individuals left out of healthcare reform, but also to help support the entire safety net and contribute to a healthier future for all Californians.

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<sup>i</sup> <http://www.chcf.org/-/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20C/PDF%20CaliforniaUninsured2016.pdf>

<sup>ii</sup> <http://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1363>

<sup>iii</sup> Funded counties include: Alameda, Contra Costa, El Dorado, Fresno, Los Angeles, Marin, Monterey, Placer, Santa Clara, Solano, and Sonoma.

<sup>iv</sup> Under the Affordable Care Act, enrollment was supposed to be streamlined, but in many ways it has become more complicated. Individuals interested in coverage can go through a Covered California Certified Enrollment Counselor (CCCEC) or through their Social Services agencies. CCCECs use CalHEERS and county Social Service departments use SAWS. CalHEERS and SAWS do talk to each other, but there are many technical difficulties. In addition, the streamlined application is long and can be complicated, especially for vulnerable populations like homeless, individuals with unstable housing, or those with a serious mental illness. And while individuals can enroll in Restricted Medi-Cal through either CalHEERS or SAWS, this information is not communicated to county indigent programs.

<sup>v</sup> <http://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1363>

<sup>vi</sup> <http://www.chcf.org/-/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20C/PDF%20CaliforniaUninsured2016.pdf>

<sup>vii</sup> <http://kff.org/report-section/coverage-expansions-and-the-remaining-uninsured-introduction/>

<sup>viii</sup> <https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/>

<sup>ix</sup> <http://laborcenter.berkeley.edu/health-daca-dapa/>

<sup>x</sup> [http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/MC2020KCFR\\_032715.pdf](http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/MC2020KCFR_032715.pdf)

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

<sup>xii</sup> For more information on legal requirements, visit <http://www.healthlaw.org/publications/remaining-uninsured>.

<sup>xiii</sup> Fairbank, Maslin, Maullin, Metz & Associates and GS Strategy Group, statewide telephone survey of 800 registered voters, August 2014.

<sup>xiv</sup> <http://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1279>

<sup>xv</sup> With more individuals eligible for restricted Medi-Cal and Hospital Presumptive Eligibility, hospitals now have fewer unreimbursed visits, but many visits for the uninsured remain uncovered. See list of qualified providers at <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/HospitalPE.aspx>.

<sup>xvi</sup> When counties took over the responsibility for the indigent, they received 1991 Realignment funding. With the implementation of healthcare reform, AB85 was signed as part of the state budget, redirecting county savings. Counties have to choose between an option that redirects 60% of their 1991 realignment funds plus the county's health Maintenance of Effort, or a more complex "shared saving formula" that looks at costs and revenue. As counties look at funding allocated for serving the remaining uninsured, they need to look at the impact the spending might have on their realignment funding.