AN OPPORTUNITY FOR CHANGE: ADDRESSING THE HEALTH NEEDS OF UNDOCUMENTED ADULT RESIDENTS IN CONTRA COSTA COUNTY

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A policy analysis for the Community Clinic Consortium of Contra Costa County

Linda Melody Alves

An Opportunity for Change: Addressing the Health Needs of Undocumented Adult Residents in Contra Costa County

A POLICY ANALYSIS FOR THE COMMUNITY CLINIC CONSORTIUM OF CONTRA COSTA COUNTY

DISCLAIMER

The author conducted this study as part of the program of professional education at the Goldman School of Public Policy, University of California at Berkeley. This paper is submitted in partial fulfillment of the course requirements for the Master of Public Policy degree. The judgments and conclusions are solely those of the author, and are not necessarily endorsed by the Goldman School of Public Policy, by the University of California, or by any other agency.

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EXECUTIVE SUMMARY

The Community Clinic Consortium (CCC) represents the private, non-profit health centers in Contra Costa County, which currently confront the challenge of serving the undocumented adult population in the absence of County funding. Between 2002 and 2009, Contra Costa Health Services (CCHS) provided health coverage to undocumented residents through its Basic Health Care (BHC) plan. In 2009, CCHS confronted major budgetary shortfalls and eliminated adult undocumented residents from the BHC plan, but contracted health services for this population to CCCs member clinics. After 3 years of contracting with the member clinics, CCHS indicated in late 2012 that it will no longer continue to provide this financial support and recommended that other health providers and hospitals partner in addressing the needs of the undocumented resident population. CCCs member clinics are faced with continuing to provide health care services to undocumented residents with less financial support.

This report informs the County's proposal by examining the various ways the County could respond to the health care needs of its undocumented adult population -- in the absence of County funding to CCCs member clinics. If the County passes its proposal, the following policy options are available to the County to provide health care services to the undocumented adult population. The outcomes of each option were projected against cost to the County, political feasibility, access, and equity:

- **Refer undocumented residents to County emergency rooms.** This policy option ranks as the worst alternative. Despite it being the third best accessible option, referring undocumented residents to the County ED is the most costly option, the least politically feasible alternative, and one of the least equitable options.
- **Refer undocumented residents to the County's stationary or mobile health clinics (MHCs).** This alternative is rated the second worst policy option. Although this policy option is moderately equitable, it is the second most costly option, the third least politically feasible option, and the third least accessible option for the County.
- **Refer undocumented residents to private hospital emergency rooms.** This alternative ranks as the third worst alternative. This alternative is the second least politically feasible option and one of the least equitable alternatives, but it is also the least costly and second best accessible option for the County.
- **Refer undocumented residents to privately-run MHCs.** This alternative is rated the third best alternative. Although this alternative is the third most costly alternative, it is the third most politically feasible option, the most accessible option, and one of the most equitable options for the County.
- **Refer undocumented residents to CCCs member clinics for health care services.** This policy option is rated the second-best alternative. Even though this alternative is the least accessible option, it is the least costly, most politically feasible, and one of the most equitable options for the County.
- **Request funding from private stakeholders to support CCCs member clinics in providing health services to undocumented adult residents**. This alternative is ranked as the best policy option. The stakeholder solution will likely consist of providing a nominal amount of funding to CCCs member clinics. Although it is the second least accessible option, it is it the second least costly option, the most politically feasible option, and one of the most equitable options for the County.

Based on the findings, the report produced the following policy recommendations for the County:

- **The private stakeholder solution has major flaws.** The County may determine that the stakeholder solution is the best policy option because it is the second least costly option and the most politically feasible option, but selecting this alternative ignores important flaws with this solution.
- **Select the best policy option for the patient.** Referring undocumented residents to CCCs member clinics may not necessarily be the best option for every undocumented resident. The best policy option for the resident is the one that best meets his or her needs, given the eligibility requirements of the alternative.
- **Go beyond a "quick-fix" policy solution.** Referring each undocumented resident to the alternative that best suits him or her does not obscure the fact that these alternatives are merely quick fixes for a larger problem relating to the lack of undocumented health services in the County.

The report produced the following policy recommendations for CCC:

- **Advocate for a better policy solution during stakeholder subcommittee meetings.** CCC needs to advocate for subcommittee solutions that have sufficient buy-in and provide an adequate amount of funding for health services to the undocumented population.
- **Implement a transition plan for undocumented residents.** A transition plan is needed to prevent the displacement of undocumented residents from CCCs member clinics while the subcommittee determines a better solution. If the County provides CCCs member clinics with transitional funding, it can ensure that the clinics are maximizing the use of these funds through a conditional payment structure based on cost-effectiveness.
- **Generate political pressure through a campaign.** CCC needs to build a campaign that will generate political pressure on the County, so that it considers a transition plan while a better solution is being sought. The County has been slow to find a better solution and is likely to allow present trends to continue if it does not feel accountable to the public.
- **Maximize County partnerships.** CCC can leverage funding opportunities available to the County under the Affordable Care Act.
- **Advocate for immigration reform (the ultimate solution).** Despite its best efforts, any solution that the subcommittee produces will fall short of the solution that could be gained through immigration reform. Because immigration policies are affecting the County health's system, CCCs long-term campaign goal should be to collaborate with the County and with the state to lobby the federal government for immigration reform.

This report examines the health care options available to undocumented adult residents in the County, given that the County may no longer fund CCCs member clinics to provide these services. The available options are limited in many ways and do not provide a basic level of primary care services that undocumented residents have become accustomed to with the County's support of CCCs member clinics. When the County grant to the member clinics is exhausted, undocumented residents who relied on the member clinics may find themselves without a regular source of health care. This not only affects the member clinics' capacity and the health of undocumented residents, but it also impacts long-term County costs and the overall health of the community. The County currently has the opportunity to find a better health care solution for this population, and CCC has the opportunity to hold the County accountable to this through the implementation of the policy recommendations.

Table of Contents

DEFINING THE PROBLEM

The Community Clinic Consortium's member clinics are important safety net providers in Contra Costa County

The Community Clinic Consortium (CCC) represents the private, nonprofit community health centers in Contra Costa and Solano Counties. The CCC member community health centers operate 23 sites in both counties, serving more than 190,000 patients. CCC administers programs that improve community clinic operations and clinical outcomes. It advocates for county and state policy changes that enable its clinics to meet the increasing demand for services. CCC also collaborates with a sister organization in Washington, DC to influence policy at the federal level (Community Clinic Consortium, 2010). This analysis will focus on CCCs member clinics in Contra Costa County, so hereafter any mention of CCCs member clinics will refer to those in Contra Costa County.

CCCs member clinics are designated by the federal government as federally-qualified health centers (FQHCs), which confers upon them special responsibilities and privileges. As FQHCs, CCCs member clinics must provide primary care services for all age groups to medically underserved populations or areas, regardless of ability to pay. In return, FQHCs receive federal grants, federal programs, medical malpractice coverage, and discounted drug purchases (Rural Assistance Center, 2012).

CCCs member clinics function as safety net providers because they provide primary care services largely to people at or below 200% of the FPL (Gardner, 2012). Indeed, 92% of the patients served in 2011 were at or below 200% of the FPL (OSHPD, 2013c). Because the majority of patients served are low-income individuals, the member clinics primarily serve people who:

- receive health coverage through public health insurance programs, such as Medi-Cal
- self-pay (i.e., pay out-of-pocket for their own insurance) because they are ineligible for public health insurance programs and cannot afford to purchase their own health insurance.

CCCs member clinics mainly serve patients in the latter category. In 2011, 71% of the member clinics' patients were self-pay (OSHPD, 2013c). CCCs member clinics primary serve low-income individuals who cannot afford to purchase their own health coverage.

CCCs member clinics serve undocumented residents who may experience greater barriers to accessing care than undocumented residents in other counties. Among the uninsured, the Bay Area is one of two areas in California that has the highest percentage of undocumented residents. Compared to other Bay Area counties, undocumented residents in Contra Costa County are more likely to live in locations with poor access[1] to clinics (Lee, Hill, & McConville, 2012). The high proportion of undocumented residents living in a county with low access to clinics underscores the need for safety net providers like CCCs member clinics in Contra Costa County.

[1] Access includes proximity to a clinic, as well as clinic capacity to provide services relative to demand.

Undocumented residents will continue to rely on safety net providers, in spite of the Affordable Care Act

The Patient Protection and Affordable Care Act (ACA) aims to expand affordable health insurance coverage to most Americans. On January 1, 2014, the ACA will require all employers with more than 50 employees to provide health insurance coverage to its full-time employees (Kaiser Family Foundation, 2012). Also on January 1, 2014, the ACA will require all US citizens and legal residents to have qualifying health coverage (Kaiser Family Foundation, 2011; Kaiser Family Foundation, 2012). People who do not have employer-sponsored health insurance will be able to purchase a health plan in health insurance exchanges, or virtual marketplaces comprised of a variety of health insurance plans. Low-income individuals will be able to cover the cost of obtaining coverage through tax subsidies (Holahan, 2011), and many low-income people will become newly eligible for Medicaid in states that choose to expand their Medicaid programs (Jost, 2012). California's Medicaid program, Medi-Cal, will be expanded to extend full-scope benefits to Californians with incomes under 133% of the federal poverty line (FPL; Yoo, 2012). These provisions of the ACA will ensure that most US legal residents and citizens have access to affordable health insurance coverage.

Although millions of Californians will be newly insured in 2014, between 27-33% of Californians will not be eligible for insurance when the ACA is fully implemented in 2019 due to their immigration status (Lucia, Jacobs, Dietz, Graham-Squire, Pourat, & Roby, 2012). California has the largest population of undocumented residents than any other state in the nation (Hill & Johnson, 2011). In 2016, they will comprise the largest share – 40% -- of the state's uninsured population (Long & Gruber, 2011). Undocumented residents will be one of the largest subpopulations in California that may remain uninsured after the ACA is implemented because they will be:

- exempt from the individual mandate
- ineligible to receive full-scope benefits from the expanded Medi-Cal program
- ineligible to purchase health plans in the health insurance exchanges – with or without subsidies (Yoo, 2012)

For which type of health coverage will undocumented Californians be eligible under the ACA? As before the implementation of the ACA, undocumented residents will continue to be eligible for emergency Medi-Cal services[2] (Yoo, 2012) and medical services provided by safety net providers (Driscoll & Vane, 2011). A significant number of California's uninsured population will have incomes equal to or below 200% of the FPL in 2019 (Lucia, et al., 2012) and will be likely unable to afford to pay out-of-pocket for health insurance coverage. Because undocumented residents comprise a large share of the low-income uninsured population (State Health Access Data Assistance Center, 2013), the majority of undocumented residents obtain health care services from safety net providers (Driscoll & Vane, 2011). As a result, undocumented residents in California may continue to rely on the emergency department (ED) or safety net providers for medical care (Lee, Hill, & McConville, 2012).

[2] Emergency Medi-Cal provides coverage for pregnancy- or emergency-related medical services (Driscoll & Vane, 2011).

Uninsured, undocumented residents in Contra Costa County will largely rely on safety net medical providers, such as CCCs member clinics, for medical care after the ACA is implemented. The most recent Office of Statewide Health Planning and Development (OSHPD) data for CCCs member clinics indicates that 95% of their patients would be eligible for health insurance coverage through expanded Medi-Cal or the health exchanges if eligibility was solely based on income (OSHPD, 2013c). Because eligibility for such coverage also depends on one's legal status, it is reasonable to assume that a portion of these patients will not be able to qualify for any health coverage under the ACA due undocumented immigrant status. The reliance of undocumented Contra Costa residents on safety net providers demonstrates how funding for safety net providers, such as CCCs member clinics, is more important than ever.

The funding of safety net providers under the Affordable Care Act is uncertain

Safety net providers in California rely on a mix of county, state, federal, and private funding. Medi-Cal provides the majority of the funding for safety net providers. FQHCs, in particular, receive enhanced Medi-Cal reimbursement according to a prospective payment system (PPS) rate that estimates the expected cost of a patient visit (Lee, Hill, & McConville, 2012). FQHCs are able to undergo a reconciliation process with the state, which allows them to receive the PPS reimbursement rate, plus reimbursement for any remaining costs that the PPS rate did not cover (A. Fuentes, personal communication, January 25, 2013). FQHCs may also receive up to $650,000 in federal funding under Section 330 of the Public Health Services Act (Rural Assistance Center, 2012). Additional funding for safety net providers is derived from state programs that provide restricted health coverage for particular health conditions (e.g., HIV/AIDS) or populations (e.g., pregnant women; Kelch, 2011; Lee, Hill, & McConville, 2012). Patient fees, private donations, and county indigent programs comprise another funding source for safety net providers (Lee, Hill, & McConville, 2012). These different funding streams provide safety net providers with a mix of financial support.

The ACA will provide safety net providers with new funding opportunities, but these opportunities are uncertain. Safety net providers may enjoy new revenue generated by patients who are newly insured under the ACA. However, a 2011 Blue Shield of California Foundation study reveals that low levels of consumer loyalty exist for clinics (as cited in Gardner, 2012), so a newly insured patient population for a safety net provider may not necessarily be permanent. Safety net providers may also experience a decrease in local government and philanthropic support as the public learns that many people who will remain uninsured are undocumented residents (Lee, Hill, & McConville, 2012). The ACA will provide new sources of funding for community clinics and health centers, which may result in an increase in FQHC grants, Medi-Cal revenues, and Medicare reimbursement rates. Despite these potential sources of funding, they are not guaranteed due to political and economic threats to this funding. Furthermore, California's governor has proposed waiving the PPS system; if passed, safety net providers who are currently paid a PPS rate – which include CCCs member clinics -- may need to decrease access to their services, decrease capacity, and even close (Gardner, 2012). [3] These challenges and opportunities will greatly impact how safety net providers can continue to provide medical care for the uninsured under the ACA.

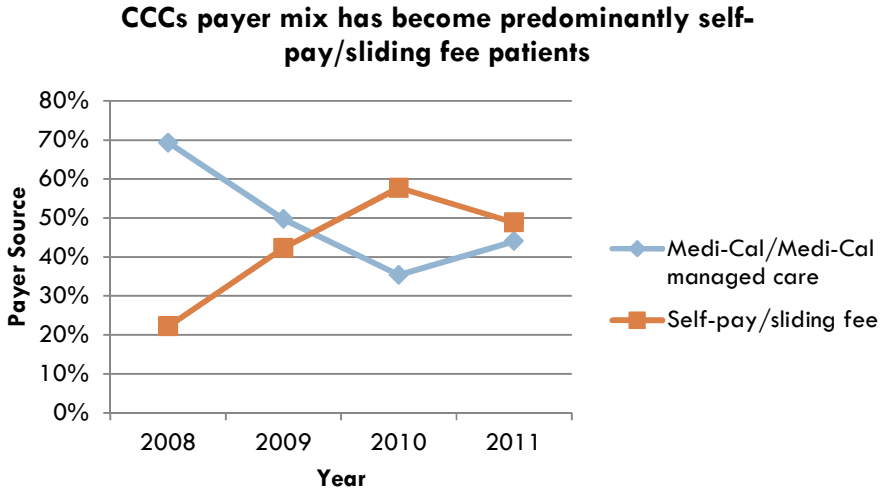
[3] The Governor proposed supplanting the PPS system with a Per Member Per Month (PMPM) rate (Gardner, 2012).

The financial outlook for CCCs member clinics is bleak

The financial outlook for CCCs member clinics seems bleak, based on the projected payer mix, operating margins, and revenue sources for the clinics providing primary care services. These four clinics include La Clinica de La Raza Pittsburg Medical, La Clinica de La Raza Monument, Lifelong Brookside San Pablo, and Lifelong Brookside Richmond. The County's proposal to withdraw funding to the clinics could exacerbate this potentially poor financial outlook.

Payer mix

The payer mix for CCCs member clinics significantly changed after undocumented adults were eliminated from the County's BHC plan and referred to CCCs member clinics (see chart below). Before undocumented adults were eliminated from the County's BHC plan, almost 70% of the member clinics' patients were either Medi-Cal or Medi-Cal managed care patients,[4] and less than one-quarter of its patients were self-pay/sliding fee patients. Once undocumented residents were eliminated from the BHC plan, the proportion of self-pay patients increased insofar that they comprised the largest payer source of CCCs member clinics. After 2009, the majority of the patient population shifted from Medi-Cal or Med-Cal managed care patients to self-pay patients (OSHPD, 2013c).



Source: OSHPD (2013c).

The ACA is expected to increase the number of people who are insured, but how will it change the payer mix for the member clinics? Based on FPL estimates for the clinics' patient population, approximately 76.4% of the clinics' payer mix is expected to be comprised of patients eligible for expanded Medi-Cal in 2014. Only

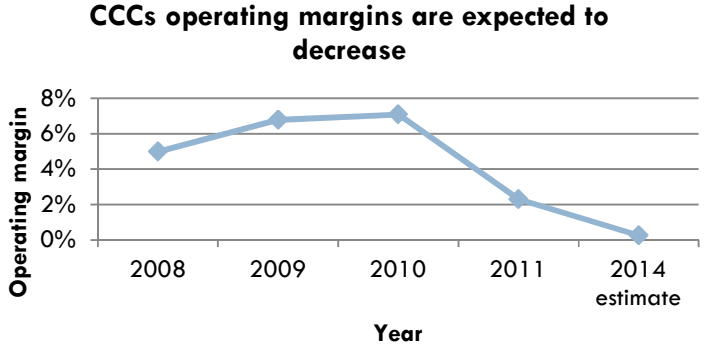
[4] Medi-Cal managed care provides Medi-Cal patients with a network of health providers (Department of Managed Health Care, 2012).

11.8% of patients are estimated to be eligible for health plans through the Basic Health Program[5] or the health benefits exchange.[6] These estimates do not account for the fact that a portion of these patients will not qualify for any of these health insurance programs under the ACA due to immigration status. The CEO at one of the member clinics estimates that less than 20% of the patient population is comprised of undocumented residents (M. Lynch, personal communication, March 12, 2013). A representative at another member clinic reports that the number of undocumented patients is increasing (V. Lujan, personal communication, March 15, 2013). Even though 88.2% of the member clinics' patient population is expected to be eligible for health coverage under the ACA in 2014, a potentially growing portion of this population will continue to be uninsured as a result of being undocumented.

Operating margins

CCCs member clinics enjoyed healthy operating margins from 2008-2010, but are currently facing a poor operating margin (see chart below). After undocumented residents were eliminated from the BHC plan in 2009, the member clinics' operating margins increased from 5.0% in 2008 to 7.1% in 2010. The operating margin for the CCC member clinics averaged 6.3% between 2008 and 2010 (OSHPD, 2013c). This means that the clinics made, on average, about 7 cents of net profit for every dollar of revenue. However, the clinics' operating margins dropped to 2.3% in 2011 (OSHPD, 2013c). This means that the clinics were earning about 2 cents of net profit for every dollar of revenue in 2011. According to Dr. Annette L. Gardner (2012), an operating margin that is healthy for a community health center is at least 3%. The member clinics have experienced healthy operating margins, but these margins have recently suffered.

The operating margins for CCCs member clinics are estimated to plummet in 2014. Operating margins have decreased for the clinics at an average percentage rate of -0.68%. At this rate, operating margins are expected to decrease to less than 1% by 2014.



Source: OSHPD (2013c).

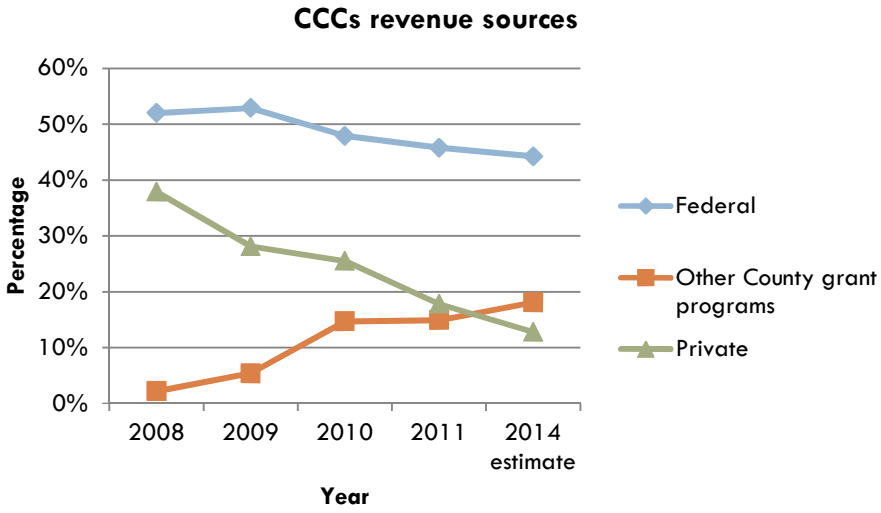
[5] The Basic Health Program is currently being considered in the California legislature as a federally-subsidized health insurance program that would provide coverage to people who do not qualify for expanded Medi-Cal, but have incomes under 200% of the FPL (Cassidy, 2012).

[6] FPL estimates were unknown for the remainder of the patient population.

Revenue sources

Although County grant programs for CCCs member clinics have increased since 2008, federal and private funding have decreased to their lowest since 2008 (see chart below). Federal funding is the largest source of revenue for CCCs member clinics. In 2011, federal funding was the lowest it has been for CCCs member clinics since 2008. Private revenue sources comprise the second largest source of revenue, but they have decreased over time, down 6.2% from 2008 (OSHPD, 2013c). County grant programs increased since 2008, likely due to the contract that the County established with the member clinics in 2009.

Federal and private funding is estimated to continue to decrease in 2014, whereas other County grant programs are expected to increase in 2014. Federal funding may continue to comprise the largest share of additional funding for the member clinics, but private funding may become the smallest share. If the County rescinds its proposal to withdraw funding from CCCs member clinics, it is likely that other County grant programs would become the second largest source of additional revenue for the member clinics. Thus, federal and private funding are projected to decrease in 2014, whereas County funding is expected to increase (i.e., if the County does not pass it proposal).



Source: OSHPD (2013c).

County health care funding for undocumented residents is not a legal obligation

Counties currently receive a few key sources of funding for medically indigent care that could be used to provide care to undocumented residents:

- Medi-Cal subsidizes medical care for undocumented residents who are treated in county-run (and non-county-run) hospital emergency departments and would otherwise qualify for Medi-Cal based on income. Under the ACA, these hospitals will be reimbursed for providing emergency services to

undocumented residents who would otherwise qualify for expanded Medi-Cal (Lee, Hill, & McConville, 2012).

- The federal government currently provides county-run (and non-county-run) hospitals with disproportionate share hospital (DSH) payments to offset the cost of uncompensated care, but the ACA will cut DSH payments annually. This could particularly affect hospitals in counties with high numbers of undocumented residents, such as the Bay Area (Lee, Hill, & McConville, 2012).
- Funding from the 1991 Health and Welfare Realignment program is another major source of funding for county indigent health care programs. However, this funding can be variable because it is derived from sales tax and vehicle license fee (VLF) revenues, which are subject to changes in economic conditions (Kelch, 2011).
- The Medi-Cal Bridge to Reform Waiver is an additional funding source for counties that could provide California with $10 billion in federal funding from 2010-2015. The majority of this funding will be dedicated to county indigent health care programs, health care delivery systems in the county, further expansion of health coverage, and improvements to the county health system (Kelch, 2011).
- Each county has access to General Fund revenues, which could be used to address the needs of its residents. The use of these revenues depends on the county's priorities (Gupta, 2012).

Although counties could allocate some of these funding streams towards undocumented care, they are not legally obligated to do so. As "providers of last resort" (Kelch, 2011, p. 31), counties play a pivotal role in providing services to its undocumented residents. Section 17000 of the California Welfare and Institutions Code obligates counties to provide health care to their low-income, uninsured residents who have no other sources of care (i.e., the medically indigent). Under Section 17000, counties need to establish a standard for the services provided to the medically indigent, but they have great latitude related to the amount and system of health care services provided to this population. Some counties provide health care services only to medically indigent people who are citizens or legal residents, whereas other counties also provide services to undocumented residents (Kelch, 2011). The health of undocumented residents may largely depend on the county in which they live because counties are not legally obligated to provide health care to medically-indigent undocumented residents.

Contra Costa County may no longer support the health coverage of its undocumented adult residents in CCCs member clinics

As part of its Section 17000 obligation, Contra Costa Health Services (CCHS) developed a Basic Health Care (BHC) plan for its residents (W. Session, personal communication, February 28, 2013). The BHC plan provides health care services to the County's medically indigent residents. The BHC plan covers doctor's visits, hospitalizations, pharmacy, X-rays, specialty care, and adult dental preventative care (Contra Costa Health Services, 2012). Medical care can be accessed at the County's hospital or health centers for a quarterly, sliding scale fee (Basic Health Care, 2012). The BHC is funded solely by the County, without any state or federal funding (A. Fuentes, personal communication, January 25, 2013).

Between 2002 and 2009, the eligibility criteria for the BHC plan did not require permanent legal residency in Contra Costa County, so people who were undocumented were eligible for this plan (W. Session, personal communication, February 28, 2013). After 2009, CCHS has provided diminishing financial assistance to cover medical services for the undocumented adult population over time:

- In 2009, CCHS confronted major budgetary shortfalls due to the recent economic recession. On March 31, 2009, the Board of Supervisors adopted the recommendation to eliminate adult undocumented residents from the BHC plan, but directed that a transition plan be implemented with community clinics (Contra Costa County Board of Supervisors, March 31, 2009).
- On April 21, 2009, Contra Costa County negotiated a one-time, one-year $1.5 million contract with CCCs member clinics to provide medical services to undocumented residents (Contra Costa County Board of Supervisors, April 21, 2009). The goal of this contract was to develop a referral system that would direct this population to a medical home.[7] The County's financial counselors would refer eligible undocumented residents to the CCCs community health centers for medical services. The County would then reimburse the community health centers $100 for every patient visit, with each patient eligible for three visits per year. The $1.5 million was eventually exhausted by 2012 (A. Fuentes, personal communication, January 25, 2013).
- Prior to a lapse in funding, CCC renegotiated a contract with CCHS in early 2012. The County allocated $300,000 to CCCs community health centers. The money was nearly exhausted before the end of the year (A. Fuentes, personal communication, January 25, 2013).
- At the end of 2012, CCHS agreed to provide the community health centers with $200,000, with the condition that CCHS would no longer be responsible for providing new referrals to the community health centers. CCHS made clear to CCC that this negotiation was the final monetary commitment that it was going to make to the member clinics. CCHS indicated that continuing to make similar negotiations would be unsustainable and recommended that other health providers and hospitals partner in addressing the needs of the undocumented adult population (A. Fuentes, personal communication, January 25, 2013). This proposal could potentially affect approximately 21,000 uninsured, undocumented adult residents in Contra Costa County in 2014 (Health Management Associates, 2011).

CCCs member clinics have relied on County funding to cover much of their patient care for undocumented adults. Section 330 federal grant funding provides FQHCs with enhanced Medi-Cal reimbursement rates for patients eligible for Medi-Cal. However, this funding does not cover patient care for undocumented residents. As a result, CCCs member clinics depend on county funding to help cover losses incurred from providing patient care to undocumented residents (A. Fuentes, personal communication, January 25, 2013).

Objectives of this analysis

The objectives of this analysis are the following:

- Project the potential impacts of the County's proposal on the County and on CCCs member clinics.
- Examine the various ways the County could respond to the health care needs of its undocumented adult population in the absence of County funding for CCCs member clinics. **This analysis will explore alternatives to the status quo of the County providing continued funding to CCCs member clinics from the County's perspective.**

[7] A medical home is a primary care model that involves a primary care team providing care that is coordinated, comprehensive, and patient-centered (Grossmann, Witgert, & Hess, 2012).

- Provide recommendations as to how CCC could advocate for continued County funding for medical services provided to undocumented adult residents.

METHODOLOGY

How the best policy option was selected

The policy options available to the County were determined based on findings from the literature and key informant interviews. Each policy option was weighed against important criteria in order to project the outcomes of each policy option. Each policy option was subsequently ranked based on the projected outcomes.

Data on undocumented adult residents is sparse

Data related to undocumented adult residents and their use of health care services in Contra Costa County is sparse, so the analysis relied heavily on a literature review and key informant interviews to make projections for each of the policy options. CCHS and CCCs member clinics do not currently record data on the undocumented residents to which they provide health services. Consequently, estimates found in the literature and obtained from 20 key informants[8] were used to make the projections for each policy option.

Quantitative data was used whenever possible

Quantitative data was used whenever possible in this analysis, but the analysis could not solely rely on quantitative data for two main reasons. First, quantitative data was not available for all of the criteria used to weigh the policy options. In such cases, qualitative data from the literature review and key informant interviews had to be used. Second, when quantitative projections on the policy options could be made, the results of such projections did not differ greatly between policy options. Thus, qualitative data was used to help ordinally rank these quantitative projections. This analysis aimed to use quantitative data as much as possible, but qualitative data was used when this was either not possible or to ordinally rank policy options.

POLICY OPTIONS

Neither private markets nor private voluntary action seem to produce sufficient health care services in terms of quantity and quality for undocumented adult residents. This is a private market failure, which requires government intervention (i.e., a public market solution). In this analysis, the County is viewed as the public intervention for this private market failure.

CCC wants to inform the County's proposal to withdraw funding for health care services provided to the County's undocumented adult residents by exploring policy options from the County's perspective. As such, this analysis will focus on the following policy options available to the County -- in the absence of continued County funding:

- refer undocumented residents to CCCs member clinics for health care services

[8] See Appendix A for a list of key informants interviewed.

- refer undocumented residents to the County's mobile health clinics or stationary clinics
- refer undocumented residents to County emergency rooms for health care services
- refer undocumented residents to private emergency rooms for health care services
- refer undocumented residents to privately-run mobile health clinics for health care services
- request funding from private stakeholders to support CCCs member clinics in providing health services to undocumented residents

EVALUATIVE CRITERIA

Because this analysis is conducted from the County's perspective, each policy option was weighed against four criteria that the County considers to be most important. The information obtained from key informant interviews and a literature review yielded four important criteria to the County:

- cost to the County
- political feasibility
- access
- equity

Cost to the County

The cost to the County is the most important criterion because budgetary shortfalls were the main driver behind the County's decision to eliminate undocumented adults from its BHC plan. Supervisor John Gioia reports that funding issues are important for the Board of Supervisors when considering how the County should fund care for undocumented residents (personal communication, February 27, 2013). Both the short-term and the long-term costs of an alternative may greatly influence whether or not the County supports it. Long-term costs are important to the County because the County's Health Services Director has expressed that continuing to provide CCCs member clinics with County funding is unsustainable in the long-term. However, short-term costs may be more important to the County than long-term costs because some key informants report that the policy decisions that the County has made with regards to undocumented health care seem short-sighted. Cost is perhaps the most important criterion to the County.

Political feasibility

Political feasibility is the second most important criterion because County employees are accountable to the public, so political support matters greatly to them. Political feasibility is the degree to which the alternative has political support. Political feasibility not only includes the support of different levels of government, but also includes the opinions of constituencies that matter to the County. Some key informants argue that the County would not have proposed withdrawing support for undocumented health care services if this proposal had not been politically feasible. Political feasibility is thus very important to the County.

Access

Access is the next most important criterion, though not as important to the County as the cost and political feasibility of the alternative. Access is the ability of each alternative to absorb the undocumented residents who may be displaced from CCCs member clinics, if the County withdraws financial support to the clinics to serve this population. Access is essential because absorbing as many undocumented residents as possible may

quite possibly solve the problem, but many key informants believe that the County seems more concerned with the cost and the political feasibility of the alternative.

Equity

Equity is the least important criterion for the County. Equity is the degree to which the alternative ensures equal opportunity of access, conditional on medical and financial need. Some County residents, such as those with limited financial resources and chronic health conditions, may require more health care resources than other residents. The County may be interested in targeting health care resources to segments of the population in a manner that is proportionate to need because it has been tracking the demographics of its patients to target care to populations experiencing unequal health care access and health disparities (Wulsin, Driscoll, & Cohen, 2012). Perhaps this is why the County has decided to allocate much of their resources to providing health services for homeless residents in its stationary and mobile health clinics (MHCs). Conversely, many key informants opine that the County's proposal demonstrates that equity is a low priority for the County because many of undocumented residents have great medical needs and few financial resources to pay for these health care services. Equity may be important to the County, but not as important as the other criteria.

PROJECTED OUTCOMES OF EACH POLICY OPTION

The outcomes of each alternative were projected against each criterion. Outcomes were projected with the following assumptions in mind:

- All projections are for the year 2014.
- By 2014, the County chooses to withdraw financial support to the CCC member clinics for health services provided to undocumented residents.
- Alternatives can be combined.

Please refer to Appendix B for detailed calculations of projected costs.

Refer undocumented residents to the CCCs member clinics

CCCs member clinics are prohibited from denying services to anyone based on one's inability to pay. Most of CCCs member clinics are Section 330(e) FQHC grantees under the Public Health Services Act. One major requirement of being a Section 330(e) grantee is to serve all people who reside in the service area of the clinic, regardless of the resident's ability to pay for services (Health Resources and Services Administration, 2007). As a result of this federal requirement, CCCs member clinics are not allowed to deny services to people in their service areas.

If the County defunds services for undocumented residents provided by the clinics, the County could nonetheless continue to refer these residents to CCCs member clinics for health care. This does not necessarily have to be a formal referral process, as it was when the first County contract with the member clinics was established. Referring undocumented residents to CCCs member clinics is not unreasonable, given that the member clinics are Section 330(e) grantees and are tasked with the primary purpose of serving everyone in their service areas, regardless of ability to pay. County officials could refer undocumented residents to the member clinics, knowing that member clinics may be required to serve them.

Cost to the County

Key informants agree that this alternative would save the County money in grants to CCCs member clinics, but would incur costs in terms of increased County ED services. Almost all of the key informants interviewed recognize that the clinics will need to continue providing the same level of services with less financial resources and predict that the clinics will eventually function at or over their capacity. According to the Director of Business and Community Relations at La Clinica de la Raza, "with funding limitations, we can't afford to continue seeing these patients who are paying a small portion of the cost of their services; we are concerned about being able to financially operate the centers" (V. Lujan, personal communication, March 15, 2013). Likewise, the CEO of Lifelong Brookside clinic reports that "we will bear the whole cost, as opposed to a portion of the cost…we can't promise to see every undocumented person because we are not sure we will have the resources to do so" (M. Lynch, personal communication, March 12, 2013). As a result, key informants generally agreed that the clinics may need to wait list patients, refer acute patients to EDs, cut services, and/or reduce operating hours. Many key informants recognize that undocumented residents seeking services at the clinics may be referred to an ED if their condition is acute or becomes acute because they are unable to obtain timely care at the clinics. This may result in increased costs for the County ED.

Referring undocumented residents to CCCs member clinics is the third least costly alternative for the County. The County's Sustainability Audit indicates that at least 5% of all visits to the CCRMC ED "could be safely seen in a primary care office" (Health Management Associates, 2011, p. 58). CCRMCs ED is estimated to have approximately 78,000 visits in 2014 (OHSPD, 2013b), so about 4,000 of those visits could have been treated at a primary care clinic. If only 5% of those 4,000 visits would have instead been referred to CCCs member clinics, the County could have saved approximately $32,000-$130,000 per year in County ED and ED follow-up care costs. This alternative would save the County at least $165,000 in clinic grants, but would cost the County about $470,000 to $1.77 million per year. The actual cost is likely to be closer to the upper-bound of $1.77 million per year for reasons explained in Appendix B. With 85% confidence, this alternative is likely to be slightly more expensive than referring patients to the private stakeholder solution because the stakeholder solution may temporarily relieve capacity strain on the member clinics that would have led to increased County ED visits.[9] With 95% confidence, this option is likely to be much less costly than referring undocumented residents to private MHCs because the member clinics provide a greater breadth of services to undocumented residents than do the private MHCs – potentially resulting in reduced visits to the County ED. This option is the third least expensive alternative for the County.

Political feasibility

Referring undocumented residents to CCCs member clinics is the second most politically feasible option. Key informants noted that the contract between CCCs member clinics and the County would not have been possible without political support. Most key informants note that the member clinics have been viewed as the primary provider of health services for the County's undocumented residents since this population was eliminated from the BHC plan in 2009. Furthermore, many key informants recognize that the main purpose of the member clinics is to provide health services to anyone, regardless of their ability to pay. On the other

[9] See "Request funding from private stakeholders" section on page 26 for more information about this private stakeholder solution.

hand, almost all of the key informants report that expecting the clinics to provide the same level of care with fewer resources to an entire population that was displaced from the BHC is unfair to the clinics. Tanir Ami, former Executive Director of CCC, believes that "Doing the referrals without the subsidy means you're not ensuring they [the undocumented residents] get the services, and the FQHCs just feel like a dumping ground…These clinics will have to take more than their fair share of uncompensated care" (personal communication, February 26, 2013). Despite the perceived unfairness of the proposal, this alternative is more politically feasible than most of the other policy options because it provides more appropriate care to more undocumented residents than the less politically feasible alternatives. This alternative seems to be the second most politically feasible policy option.

Access

This alternative rates the worst in terms of access because it is the only option that will likely result in decreased access. Key informants generally agreed that CCCs member clinics would likely continue providing the same services to undocumented residents, but with fewer financial resources. This means that the clinics may eventually operate at or over capacity, resulting in decreased access to care for undocumented residents. The Director of Business and Community Relations at La Clinica de la Raza expects that visits will continue to increase, and the CEO of Lifelong Brookside predicts that capacity will decrease as County funding decreases. Patients currently wait for at least two weeks to see a provider after making an appointment at one of CCCs member clinics. Although no wait list exists for services at these clinics, an increase in the demand for appointments and/or a decrease in capacity means that it may take longer for a patient to see a provider after making an appointment (M. Lynch, personal communication, March 12, 2013; V. Lujan, personal communication, March 15, 2013). As a result, undocumented residents may be referred to an ED if they require acute care or they may choose to seek care at an ED if unable to receive timely care at the member clinics. With 95% confidence, this option will be much less accessible than the County clinics because the County clinics will likely be able to adjust their capacity according to demand. Less funding for health services provided to undocumented residents translates into decreased access for this population in CCCs member clinics. Referring undocumented residents to CCCs member clinics is the least accessible alternative, compared to the other policy options.

Equity

This alternative will likely be high on equity in the absence of County funding. Patients who present at the member clinics with more acute conditions will still be seen sooner than patients with less acute needs. Patients with limited financial resources for health care will continue to be served at the member clinics. The member clinics are equitable in providing equal access to their services, conditional on medical and financial need.

Refer undocumented residents to the County's mobile health clinics or stationary clinics

The County's clinics are not held to the same requirement as CCCs member clinics to serve everyone in their service areas. All of the County's clinics are Section 330(h) FQHC grantees under the Public Health Services Act (R. Birch, personal communication, April 23, 2013; A. Fuentes, personal communication, January 25, 2013). These grantees must use their FQHC funding to target services to homeless individuals and make them available to all members of this target population (Health Resources and Services Administration, 2007). Unlike Section 330(e) grantees, Section 330(h) grantees "are not subject to the requirement to serve all

residents of the service area" (Health Resources and Services Administration, 2007, p. 3). Unlike CCCs member clinics, the County's clinics could theoretically turn away people who are not homeless in their service area without violating their FQHC regulations.

Under the Section 330(h) grant, the County supports mobile health clinics that only serve people who are homeless and at risk of being homeless (R. Birch, personal communication, April 19, 2013).[10] The County operates mobile health clinics (MHCs) four days a week to provide health care services to homeless people in Antioch, Concord, Richmond, El Cerrito, Walnut Creek, and Bay Point (Contra Costa Health Services, 2013). According to Rachael Birch, Project Director for Healthcare for the Homeless, only people who are served at the MHCs are not charged for services, regardless of their insurance status (personal communication, April 19, 2013).

Despite the Section 330(h) grant, all of the County's stationary clinics serve both homeless and non-homeless individuals. People seen in the County's stationary clinics are automatically referred to a financial counselor before the appointment is made to determine eligibility for services. People who have health coverage will be charged a co-pay corresponding to their insurance plan. People who are ineligible for coverage, but are homeless or at risk of being homeless, receive services at no charge (R. Birch, personal communication, April 19, 2013). The Assistant to the Director of CCHS, Wanda Session, reports that uninsured patients who are ineligible for health program coverage are billed for the cost of their services in accordance with the fee schedule approved by the Board of Supervisors.[11] Low-income uninsured patients may be eligible for a discount under AB774 (personal communication, February 28, 2013), which provides discounted services for people whose family incomes are at or below 150% of the FPL and meet other specific eligibility requirements (Contra Costa Health Services, 2011a).

Uninsured, undocumented residents could thus receive health care services at both the County's stationary clinics and the County's MHCs. Undocumented residents who are homeless/at risk of being homeless are eligible to receive free services at the County's MHCs – regardless of their eligibility for health care coverage. Undocumented residents who are homeless/at risk of being homeless and are ineligible for health coverage will receive services at no cost from the County's stationary clinics. Undocumented residents who do not qualify for any type of health coverage would pay the fee schedule rate for services at the stationary clinics if they do not qualify for a discount under AB 774. The cost of health services to an undocumented resident at the County's clinics or MHCs therefore depends on whether or not that resident is homeless/at risk of being homeless, qualifies for some type of health insurance coverage, or is eligible for discounted services under AB 774.

Cost to the County

Referring undocumented residents to the County clinics is the second most costly option for the County in terms of County ED visits and ED follow-up care for some of these visits. This alternative would save the County at least $165,000 in clinic grants. The County would not suffer a financial loss for undocumented residents who

[10] Generally, people at-risk for homeless include anyone who is currently living in a temporary living situation or who has been recently housed but was homeless in the last 12 months.
[11] Go to http://cchealth.org/medicalcenter/common-charges.php to see this fee schedule.

pay the fee schedule rate for services at the county's stationary clinics. However, the County clinics occasionally provide short-term follow-up care at no charge to undocumented, non-homeless, uninsured residents who are discharged from the County ED (D. Goldstein, personal communication, March 8, 2013). These visits would cost the County at least about $23,000 per year. Thus, this alternative would cost at least $500,000 to $1.90 million per year for uninsured, non-homeless, undocumented residents who require acute care in the County's ED and subsequent follow-up in the County's clinics (see Appendix B). The actual cost is likely to be closer to the upper-bound estimate of $1.90 million per year for reasons explained in Appendix B. With 95% confidence, this alternative is likely to be much less costly than referring undocumented residents to the County ED because some undocumented residents would qualify for covered, discounted, or free services in the County clinics and could thus be treated there before their medical conditions require ED care. Conversely, with 85% confidence, this option would be more much more expensive than the private stakeholder solution because the undocumented residents who do not qualify for covered, free, or discounted health care in the County's clinics are charged the fee schedule rate for care; these charges may motivate undocumented residents to delay seeking care at the County clinics until their medical conditions require acute treatment in the County ED, which is more costly to the County than clinic care provided through the private stakeholder solution. This is therefore the second most costly alternative for the County.

Political feasibility

Referring undocumented residents to the County clinics is the third worst option in terms of political feasibility. This option is publically-funded, potentially resulting in less support for it than the privately-funded alternatives. Most key informants speculated that the public may not support this option because it provides affordable health care only to undocumented residents who are homeless/at risk of being homeless, have health coverage, or meet all of the eligibility requirements under AB 774. Despite the limited undocumented population that the County's stationary and mobile clinics may serve, informants do agree that providing eligible undocumented residents with some free or discounted services is better than not providing any free or discounted services to the undocumented population. Many key informants agreed that this option would be much more politically feasible than inappropriately referring undocumented residents to the County or private EDs. This option is the third least politically feasible alternative.

Access

Referring undocumented residents to the County clinics ranks as the third worst alternative in terms of access. Access is expected to remain the same for undocumented residents seeking care at the County's stationary and mobile clinics. Dr. Nishant Shah, Primary Care Physician at one of the County's stationary clinics and Medical Director for Health Care for the Homeless (HCH), estimates that the number of undocumented residents seeking care at the County's stationary and mobile health clinics will increase by approximately 5-15%. However, Dr. Shah does not expect access to change because the County mobile and stationary clinics have been able to expand access to services when demand has increased. He reports that the homeless population's needs for medical care ebb and flow throughout the year, so the County clinics are prepared to respond to changes in demand (personal communication, April 2, 2013). With 95% confidence, this option is likely to be much more accessible that the private stakeholder solution; although access is expected to remain the same for the County clinics, it may likely decrease for the private stakeholder solution. With 85% confidence, access to the County clinics is going to be slightly less than the County ED, which may experience

increased access. Access to the County's stationary and mobile clinics is likely to remain the same for undocumented adults, making this option the third least accessible option.

Equity

This alternative will probably be moderate on equity. This alternative ensures that everyone has equal access to the County's clinics, but not to its MHCs. Undocumented residents who are homeless/at risk of being homeless likely possess a high medical and financial need for health care services and may be eligible for free services at the County's MHCs and stationary clinics. Similarly, undocumented residents with a high medical and financial need for health services may qualify for discounted services at the County's stationary clinics. This is a moderately equitable policy option.

Refer undocumented residents to County emergency rooms

Uninsured, undocumented residents could receive health care services at the County's ER. The County's public hospital, Contra Costa Regional Medical Center (CCRMC), could provide acute care for undocumented residents. According to the Emergency Medical Treatment and Active Labor Act of 1986, hospital emergency rooms are legally mandated to screen and treat any patient requiring medical care (Hill & McConville, 2012). Because the County's hospital emergency room cannot turn away anyone in need of medical care, uninsured, undocumented residents could be referred to the County's emergency room for medical services.

Cost to the County

Referring undocumented residents to the County ED is the most costly option for the County in terms of County ED costs and ED follow-up visits in the County clinics. The County may save $165,000 in County grants awarded to the member clinics. However, County ED costs and subsequent ED follow-up visits for undocumented residents in the County clinics may cost the County at least $500,000 to $1.90 million per year (see Appendix B). The actual cost is likely to be closer to the upper-bound of $1.90 million per year for reasons explained in Appendix B. With 95% confidence, this alternative is likely to be much more costly to the County than referring undocumented residents to the County's clinics or privately-run MHCs because services from these options are likely to be significantly less costly than County ED care. This is the most expensive alternative for the County.

Political feasibility

Referring undocumented residents to the County ED is the least politically feasible option. Private hospitals may support this alternative because it relieves them from the costs of providing care for undocumented residents in their own EDs. Conversely, key informants generally agree that referring undocumented residents to EDs is poor public policy. They report that this proposal is more expensive and less healthy for the community than providing these residents with regular primary care services. Indeed, the Policy Director at Insure the Uninsured Project (ITUP) reports that the County's proposal is "driving them [undocumented residents] into a situation where they will only seek care when their health becomes worse. The goal is to seek care when they're at their baseline when it's cheap" (K. Yoo, personal communication, February 8, 2013). Furthermore, many key informants predict that this proposal would result in an inappropriate use of the ED. Vanessa Cajina, Legislative Advocate at the Western Center on Law and Poverty (WCLP), reinforces this belief, stating that "the emergency room should not be used as a dumping ground, but should be used for real emergencies" (personal communication, February 25, 2013). Consequently, the public may not support this

alternative because it involves an inappropriate use of public funds. The County may also oppose this option because the Disproportionate Share Funds (DSH) it receives to offset the cost of uncompensated care are slated to incrementally decrease after 2014 (Lee, Hill, & McConville, 2012). This alternative is much less politically feasible than referring undocumented residents to private hospitals and the rest of the alternatives due to the aforementioned reasons. This policy option is the worst option in terms of political feasibility.

Access

Referring undocumented residents to the County EDs is the third worst option in terms of access. Access to the County's ED will likely remain the same or increase for undocumented residents seeking care. Dr. Nishant Shah, primary care physician at one of the County's stationary clinics and Medical Director for HCH, predicts that visits at the CCRMC ED may increase once more people become insured under the ACA. However, he is not sure by how much visits will increase because people may choose health plans under the ACA that are not within the County's managed care system. As a result, a portion of the newly insured may visit private EDs for care, which may leave access unchanged for CCRMCs ED. However, Dr. Shah reports that the CCRMC ED has been expanding its capacity in the last year and a half in order to prepare for an increase in demand due to the ACA (personal communication, April 2, 2013), which may increase access to CCRMCs ED. Despite this expansion, the County has one ED for the entire population of Contra Costa County, so access to the County ED is likely to be much worse than access to the several private hospital EDs. This is third worst option in terms of access.

Equity

This alternative is low on equity. By law, anyone who requires medical care will be screened and treated in the ED (Hill & McConville, 2012), regardless of medical or financial need.

Refer undocumented residents to private hospital emergency rooms

Uninsured, undocumented residents could also receive health care services at private hospital emergency rooms in the County. By law, such residents who require medical care cannot be turned away from these hospitals (Hill & McConville, 2012). Uninsured, undocumented residents could be referred to private hospital emergency rooms.

Cost to the County

Referring undocumented residents to private EDs is the least costly alternative because it would incur costs on the private hospitals, but not on the County. In fact, this alternative would likely save the County at least $165,000 in grants provided to CCCs member clinics. This alternative would also save the County at least $500,000 to $1.89 million per year in services provided in its own ED and ED follow-up care in the County clinics (see Appendix B). The actual cost is likely to be closer to the lower-bound of -$1.89 million per year for reasons explained in Appendix B. This is the least expensive alternative for the County.

Political feasibility

Referring undocumented residents to private EDs is the second worst option in terms of political feasibility. CCHS and the Board of Supervisors support this alternative because they have both proposed partnering with private hospitals to address the health needs of this population. Compared to referring undocumented

residents to the County ED, the public may be more likely to support this alternative because it would use less public funding. However, private hospitals may oppose this alternative, regardless of whether or not they receive DSH funds to offset the cost of providing uncompensated care. According to an anonymous representative at the Contra Costa Health Plan, hospitals that do not qualify for DSH funds end up covering a great deal of bad debt resulting from uncompensated care. The two private hospitals that do qualify for DSH funds are concerned that the DSH funds will incrementally diminish (Anonymous, personal communication, March 22, 2013). According Legislative Advocate Vanessa Cajina at WCLP, "Private hospitals would find as many ways to turn people away. Recouping on charity care isn't as simple as some may make it out to be. The County is asking them to do more with less" (V. Cajina, personal communication, February 25, 2013). Key informants generally oppose this alternative because they believe that referring undocumented residents to EDs is a poor public policy and a poor public health decision, compared to offering primary care services to this population. For these reasons, this option is only slightly more politically feasible than referring undocumented residents to the County ED. This option is significantly less politically feasible than referring undocumented residents to County clinics because it involves more inappropriate use of ED services. Compared to the other alternatives, this is the second least politically feasible option.

Access

Referring undocumented residents to private EDs is the second best alternative in terms of access. A representative from a private hospital in Contra Costa County does not anticipate that the County's proposal will have a significant impact on the number of undocumented residents served by the hospitals in the area: "There will be an impact. I'm not sure if we can measure it, but I don't think it will be incredibly large for the hospitals." This representative also reports that all health care organizations have been preparing to provide more uncompensated care due the people who will be residually uninsured[12] under the ACAs health coverage expansions in 2014 (M. Balin, personal communication, March 6, 2013). Even though undocumented residents may not impact the number of private ED visits, the 2014 health coverage expansions may impact undocumented residents' access to private ED services. Dr. Nishant Shah, primary care physician at one of the County's stationary clinics and Medical Director for HCH, reports that the ACA will expand coverage to the previously uninsured, which may result in increased ED use. However, he does not know what proportion of the newly insured will choose a private health care provider or choose to be covered under the County's managed care plan (personal communication, April 2, 2013). Consequently, access to the private EDs for undocumented residents may increase or remain unchanged. With 95% confidence, access to the private hospital EDs is likely to be much higher than that of the County EDs because eight private hospital EDs operate in seven different cities in the County, compared to the County's single ED. With 90% confidence, access to the private EDs is likely to be slightly lower than access to privately-run MHCs because access may remain the same in private EDs, whereas they are likely to increase in the private MHCs. This is the second most accessible alternative.

Equity

[12] The residually uninsured include people who are (a) exempt from the ACA individual mandate; or (b) not exempt from the individual mandate but are not insured either by choice or involuntarily (e.g., they do not know how to obtain health insurance).

This alternative is low on equity. Anyone who requires medical care will be screened and treated in the ED (Hill & McConville, 2012), regardless of their medical or financial need.

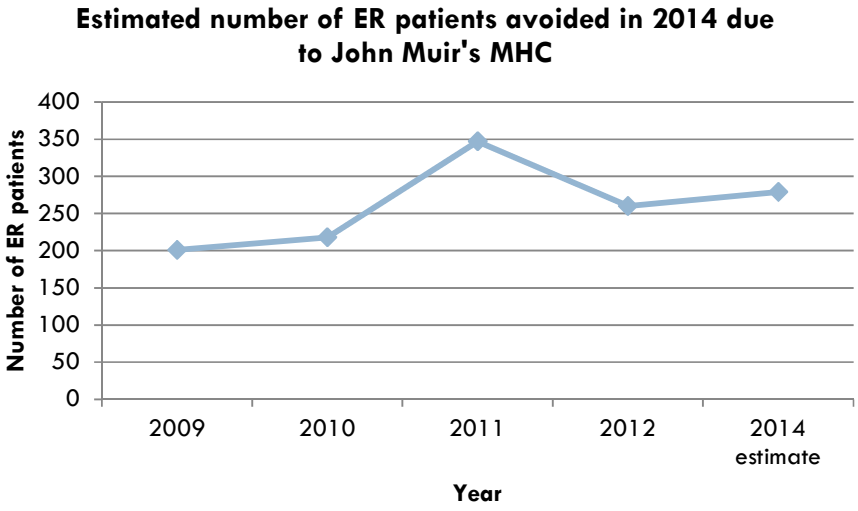
Refer undocumented residents to privately–run mobile health clinics

Uninsured, undocumented residents could receive health care services at one of five MHCs. John Muir Health operates an MHC that provides free preventative and urgent medical care for uninsured, low-income community members in Brentwood for 4 hours per week on a first-come, first-served basis (John Muir Health, 2013; Campos & Olmstead-Rose, 2012). RotaCare, Inc.'s MHCs provide services to uninsured individuals with limited ability to pay for services (RotaCare, Inc., 2012b). RotaCare, Inc. operates an MHC in Pittsburg for 3-6 hours per week (RotaCare, Inc., 2012c). It also operates two MHCs in Concord: one provides free preventative and urgent care for 4 hours per week by appointment, whereas the other provides women's health services for 2 hours per week by appointment or walk-in (Campos & Olmstead-Rose, 2012; RotaCare, Inc., 2012a). RotaCare, Inc. recently began operating an MHC in Richmond that provides free urgent care by appointment for 3 hours per week (RotaCare, Inc., 2012d). Uninsured, undocumented residents could be referred to one of these four MHCs for medical services.

Cost to the County

Referring undocumented residents to privately-run MHCs is the third most costly alternative in terms of costs related to County ED visits and subsequent follow-up ED care in the County clinics. This policy option would save the County at least $165,000 in grants provided to CCCs member clinics. The estimated number of John Muir MHC patients who will avoid becoming ED patients in 2014 because of John Muir's MHC will be 279 patients in 2014 (see chart below; John Muir Health, 2012; John Muir Health, 2011; John Muir Health, 2010; John Muir Health, 2009).[13] It is reasonable to assume that nearly none of these patients are homeless because homeless residents have access to primary care at the County clinics and MHCs. Assuming that only 5% of these 279 patients are undocumented and would have sought care in the County ED, the County would save about $4,500 to $11,000 per year in County ED and ED follow-up costs. Thus, this alternative may cost the County approximately $500,000 to $1.89 million per year in visits to its ED and subsequent ED follow-up costs (see Appendix B). The actual cost is likely to be closer to the upper-bound of $1.89 million per year for reasons explained in Appendix B. With 95% confidence, this alternative is much less costly to the County than referring undocumented residents to the County clinics because it serves a less restricted undocumented patient population than the County clinics – potentially resulting in reduced County ED visits. With 95% confidence, this option may be slightly more expensive to the County than referring undocumented residents to CCCs member clinics; the private MHCs provide a smaller breadth of services to undocumented residents than the member clinics, which could result in increased County ED visits. This is the third most costly alternative for the County.

[13] John Muir surveys its MHC patients to determine the number of patients who would have sought medical care in an ED if the MHC was not available. These estimates are based on this data.



Source: John Muir Health (2012); John Muir Health (2011); John Muir Health (2010); John Muir Health (2009)

Political feasibility

Referring undocumented residents to privately-run MHCs is the third best alternative in terms of political feasibility. CCHS and the Board of Supervisors would likely support this option because they are currently focused on finding a private solution to address the health needs of the undocumented population. The public may also support this option because it does not use as much public funding as the alternatives that rate lower on political feasibility. Compared to referring undocumented residents to County clinics, greater political support may exist for this option because privately-run MHCs serve a less restricted undocumented patient population that the County clinics. On the other hand, most of the key informants expressed opposition to this proposed solution because it provides limited services for a limited amount of hours per week. Tanir Ami, former Executive Director of CCC, does not believe that the MHCs provide good primary care: "It's band-aid primary care. It's not health- and wellness-driven primary care. They [undocumented residents] need to be in a more robust primary care home. It's not a good use of resources…" (personal communication, February 26, 2013). This option may have less support than referring undocumented residents to CCCs member clinics, which provides a greater breadth of services to undocumented residents than the MHCs. This alternative is the third most politically feasible option.

Access

Referring undocumented residents to the privately-run MHCs is the best alternative in terms of access. Based on key informant interviews, access to privately-run MHCs is expected to increase. A representative from one of the private hospitals in the County reports that RotaCare, Inc. is expanding its capacity to prepare for an increased number of undocumented residents seeking services (M. Balin, personal communication, March 6, 2013). Barbara Hunt, Development Director for the RotaCare, Inc. MHC in Pittsburg, expects the number of undocumented residents served at her clinic to increase if the County's proposal passes, but is unsure by how much. Barbara reports that her clinic is currently functioning at capacity, so to absorb this new population, additional funding would be needed to expand. Barbara seems optimistic that additional funding could be

obtained to expand her clinic's services by hiring staff (personal communication, March 27, 2013). Access is likely to increase due to a likely increased expansion of services provided by RotaCare's MHCs. Access is likely to be much greater than access to the private EDs because access may remain unchanged in the private EDs. This is the most accessible option.

Equity

This alternative is high in terms of equity. Everyone will have equal access to the MHCs. Access will be conditional on medical and financial need because almost all of the clinics provide urgent care services to uninsured individuals who are unable to pay for medical care (John Muir Health, 2013; Campos & Olmstead-Rose, 2012; RotaCare, Inc, 2012b).

Request funding from private stakeholders to support CCCs member clinics in providing health services to undocumented adult residents

Wanda Session, Assistant to the Director of CCHS, reports that stakeholders in the County are in the process of forming a subcommittee tasked with addressing the health care access of the residually uninsured, including uninsured, undocumented adults (personal communication, February 28, 2013). Preliminary conversations about the formation of this subcommittee began in February 2013 (A. Fuentes, personal communication, April 8, 2013). Wanda reports that she and the Executive Director of CCC are co-chairing the subcommittee. She states that the subcommittee may include representatives from stakeholders, including hospitals and community-based organizations (CBOs). Wanda also reports that and no new County funds have been identified by the Board of Supervisors for CCCs member clinics, so one of the goals of the committee is to explore new funding resources for the clinics, as they continue to provide care to the uninsured, undocumented population (personal communication, February 28, 2013).

It is difficult to project the outcomes of a policy option that has not yet materialized, but one could confidently speculate what such an alternative would probably look like, based on the findings of this report. Private hospitals may be unwilling to provide more than a nominal amount of funding to CCCs member clinics because they are currently preparing to provide uncompensated care to residually uninsured people – both undocumented and documented -- in 2014. Private hospitals and CBOs may not be willing to provide much funding for this population because they may not be interested in providing services to this population. Indeed, the Chief Medical Officer of CCRMC reports that "plenty of tax-exempt organizations and nonprofits…have explicitly stated their lack of interest in serving the Medi-Cal, indigent, and undocumented population" (D. Goldstein, personal communication, March 8, 2013). Private CBOs that have a mission to serve the medically indigent population, such as RotaCare, Inc., may be the only stakeholders that may be willing and able to invest in funding care to undocumented residents. The solution is likely to provide the member clinics with some additional funding. However, this additional funding will probably be significantly less than the amount of funding that the County has historically provided to CCCs member clinics, and the funding will probably not be enough for CCCs member clinics to continue being the main provider of primary care for the undocumented population.

Cost to the County

The stakeholder solution is the second least costly option for the County. The County would expect private stakeholders to shoulder the cost of providing health services to undocumented residents, so the County would

save at least $165,000 in grants to CCCs member clinics. However, this alternative would still result in costs related to County ED and ED follow-up care in the County clinics if the additional funding is insufficient to meet the demand for care at CCCs member clinics. If CCCs member clinics do not have adequate funding to operate under capacity, this alternative may result in costs similar to than those related to referring undocumented residents to CCCs member clinics: approximately $470,000 to$1.77 million per year in County ED costs and ED follow-up care in County clinics (see Appendix B). The precise estimate will likely be closer to the upper-bound of $1.77 million per year for reasons explained in Appendix B. With 85% confidence, the precise estimate is likely to be lower than $1.77 million per year due to fewer potential ED visits resulting from additional funding for the member clinics. As a result, with 85% confidence, this option may be slightly less costly than referring undocumented residents to CCCs member clinics because it may help reduce strains on capacity at the member clinics that would lead to increased County ED visits. However, with 85% confidence, this option is likely to be much more costly than referring undocumented residents to private EDs, which incur no costs to the County. This is the second least expensive alternative for the County.

Political feasibility

The private stakeholder solution is the most politically feasible option. Some key informants oppose this option because it appears as if the County is "dumping" its responsibility onto private stakeholders. Cary Sanders, Director of Policy at the California Pan-Ethnic Health Network (CPEHN), is a such key informant who expressed her opposition to this alternative:

> Community members, private charities, and foundations cannot cover the enormity of the expense of providing medical services to this population. I don't think there is a very good private market solution for this…Health care funding and health care delivery is such a complicated system that it doesn't make sense to put this on foundations or charity (personal communication, February 8, 2013).

Furthermore, private hospitals may not support this alternative because it would incur greater costs for them in the form of higher community benefits. On the other hand, CCHS and the Board of Supervisors both support a private solution to this problem. The public may also support this option because it is not publicly-funded. Some key informants agree that private stakeholders should be involved in addressing the needs of the undocumented population. The Director of Business and Community Relations at La Clinica de la Raza is even supportive of this alternative: "Everyone is very interested in this subcommittee. The convening of that group has a high interest, and it appears that everyone is interested in addressing and figuring out solutions" (V. Lujan, personal communication, March 15, 2013). Plus, this option provides funding that would likely help ease strains on the member clinics' capacity. This option would be slightly more politically feasible than referring undocumented residents to CCCs because this option would ensure that the member clinics receive some form of financial support for providing care to the undocumented population. This is the most politically feasible option.

Access

The private stakeholder solution is the second worst option in terms of access. Increased funding may increase access to CCCs member clinics. As a result, access is likely to be slightly higher than referring undocumented residents to CCCs member clinics without financial support. However, the private stakeholder solution will unlikely provide sufficient funding for CCCs member clinics to meet the demand for undocumented health care services in the long-term. Consequently, CCCs member clinics may eventually deplete the funding obtained

from this solution; less funding places strains on the member clinics' capacity, which may result in undocumented residents being referred to the ED if they require acute care, or seeking care at an ED if they cannot receive timely care at the member clinics. Access will be significantly less than the other alternatives, which may have more public and private funding sources to absorb the health needs of the undocumented population. Thus, this option is the second least accessible option.

Equity

This alternative is likely to be high on equity. The solution being sought by the subcommittee is to support the member clinics in continuing to provide health care to the undocumented population. As previously mentioned, the member clinics provide equitable access to care because access is conditional on financial and medical need. This option is thus likely to be high on equity.

PROJECTING OUTCOMES MATRIX

Total ranking	**Alternatives**	**Cost** *(Most important)*	**Political feasibility** *(2nd most important)*	**Access** *(3rd most important)*	**Equity** *(Least important)*
#6 (Worst)	County emergency room	≥-$165,000/year in County grants to CCCs member clinics ~$500,000 to $1.90 million/year in County ED costs and ED follow-up care in County clinics Most costly	Worst	Third best	Low
#5	County stationary and mobile health clinics	≥-$165,000/year in County grants to CCCs member clinics ~$500,000 to $1.90 million/year in County ED costs and ED follow-up care in County clinics Second most costly	Third worst	Third worst	Moderate
#4	Private emergency rooms	≥-$165,000/year in County grants to CCCs member clinics ~-$500,000 to $1.90 million/year in County ED costs and ED follow-up care in County clinics Least expensive	Second worst	Second best	Low
#3	Private mobile health clinics	≥-$165,000/year in County grants to CCCs member clinics ~$500,000 to $1.89 million/year in County ED costs and ED follow-up care in County clinics Third most costly	Third best	Best	High
#2	CCCs member clinics	≥-$165,000/year in County grants to CCCs member clinics ~$470,000 to $1.77 million/year in County ED costs and ED follow-up care in County clinics Third least expensive	Second best	Worst	High
#1 (Best)	Additional private stakeholders	≥-$165,000/year in County grants to CCCs member clinics <~$470,000 to $1.77 million/year in County ED costs and ED follow-up care in County clinics Second least expensive	Best	Second worst	High

WEIGHING THE TRADE-OFFS

Each policy option available to the County was appraised using the criteria found to be most important to the County. Each alternative was subsequently ranked according to how well it stacked up against the criteria, relative to the other policy options (see the Projecting Outcomes Matrix on the previous page for the results of this process). The tradeoffs for each alternative are described below, in order from the worst-rated alternative to the best-rated alternative.

Refer undocumented residents to the County's emergency room

This policy option ranks as the worst alternative. Referring undocumented residents to the County ED is the most costly, the least politically feasible option, and one of the least equitable alternatives for the County. However, this alternative is the third best accessible policy. Despite it being the third best accessible option, referring undocumented residents to the County ED is the most costly option, the least politically feasible alternative, and one of the least equitable options.

Refer undocumented residents to the County's stationary and mobile health clinics

This alternative is rated the second worst policy option. Referring undocumented residents to the County's stationary and mobile health clinics is the second most costly option for the County. It is also be the third worst option in terms of political feasibility and access. On the other hand, this alternative is moderately equitable. Although this policy option is moderately equitable, it is the second most costly option, the third least politically feasible option, and the third least accessible option for the County.

Refer undocumented residents to the private hospital emergency rooms

This alternative ranks as the third worst alternative. Referring undocumented residents to the private ED is the second least politically feasible alternative and one of the least equitable alternatives for the County. Conversely, this is the least costly alternative for the County and the second best alternative in terms of access. This alternative is the second least politically feasible option and one of the least equitable alternatives, but it is also the least costly and second best accessible option for the County.

Refer undocumented residents to the privately-run mobile health clinics

This alternative is rated the third best policy option. Referring undocumented residents to private MHCs is the third most costly alternative for the County. However, this policy option is the third best option in terms of political feasibility and the best option in terms of access. It is also one of the most highly equitable policy options. Although this alternative is the third most costly alternative, it is the third most politically feasible option, the most accessible option, and one of the most highly equitable options for the County.

Refer undocumented residents to CCCs member clinics

This policy option is rated the second best alternative. Referring undocumented residents to CCCs member clinics would be the third least costly alternative for the County, the second most politically feasible option, and one of the most equitable policy options. However, this option is the worst in terms of access. Even though this alternative is the least accessible option, it is the least costly, most politically feasible, and one of the most equitable options for the County.

Request funding from private stakeholders

This alternative is ranked as the best policy option. The stakeholder solution will likely consist of providing a nominal amount of funding to CCCs member clinics. This option is likely to be the second least costly alternative for the County, the most politically feasible option, and is one of the most equitable options. However, it is the second worst alternative in terms of access. Although it is the second least accessible option, it is it the second least costly option, the most politically feasible option, and one of the most equitable options for the County.

POLICY RECOMMENDATIONS FOR THE COUNTY

The private stakeholder subcommittee solution has major flaws

The County may determine that the private stakeholder subcommittee solution is the best policy option because it is the second least costly and most politically feasible option for the County, but selecting this alternative ignores important considerations. Because the solution would likely consist of providing the member clinics with nominal funding for undocumented health services, this funding is unlikely to be sustainable. Consequently, the member clinics may continue to experience insufficient funding to meet the demand for undocumented health services and may eventually operate at or above capacity. This option would thus result in greater long-term costs for the County in terms of County ED services than the cost of providing the clinics with sustainable funding for undocumented health care services. Furthermore, in choosing this option, the County would overlook an important criterion for selecting the best solution for this problem: selecting the best policy option for the patient. Requesting funding from private stakeholders is determined to be the best policy option, but this policy option has flaws that the County must recognize.

Select the best policy option for the patient

The County needs to ensure that each patient is referred to the policy option that best meets his or her needs. Although referring undocumented residents to CCCs member clinics with private stakeholder support is determined to be the best policy option for the County, it may not necessarily be the best option for every undocumented resident. The best policy option for the resident is the one that best meets his or her needs, given the eligibility requirements of the alternative. For example, homeless, uninsured undocumented residents who require medical care that is non-urgent should be referred to the County's stationary clinics instead of to the privately-run MHCs. The County's financial counselors already assist uninsured residents with applications and enrollment for health care coverage, such as Medi-Cal (W. Session, personal communication, February 28, 2013). Even though the financial counselors assist with connecting residents to programs that best meet their financial needs, they may not refer residents to the alternative that best meets their medical needs. The best policy option for any given undocumented resident will vary, depending on that resident's medical needs and ability to meet eligibility requirements for care. The County needs to ensure that each patient is referred to the policy option that best meets his or her medical and financial needs.

Go beyond a "quick-fix" policy solution

Referring each undocumented resident to the alternative that best suits him or her does not obscure the fact that these alternatives are merely quick fixes for a larger problem relating to the lack of undocumented

health services. None of these options meet the undocumented population's demand for primary care services. The alternatives can be pieced together to form a haphazard health care system for undocumented residents, but collectively, they fall short of providing a comprehensive health care solution for this population.

POLICY RECOMMENDATIONS FOR CCC: GOING BEYOND A "QUICK FIX"

Advocate for a better policy solution during private stakeholder subcommittee meetings

CCC needs to ensure that the subcommittee of private stakeholders considers better solutions for the undocumented population. The County recognizes that providing continued grant funding to CCCs member clinics is not a comprehensive solution, but it remains to be seen if this subcommittee would produce a better solution. Even if private stakeholders agreed to participate in this subcommittee, the question still remains if sufficient buy-in exists from these private stakeholders to provide funding for this population. Would these private stakeholders believe it is in their best interest to provide some funding to serve undocumented residents? If private stakeholders agreed to provide some funding, would they provide enough funding to sustainably serve an entire population that relies on CCCs member clinic network for primary care? CCC needs to raise these questions during the subcommittee meetings to avoid another stop-gap solution for undocumented residents. CCC needs to advocate for subcommittee solutions that have sufficient buy-in and provide an adequate amount of health services to the undocumented population.

Implement a transition plan for undocumented residents

On the other hand, the subcommittee solution could become an opportunity to reshape how the County provides better and more stable primary care to the undocumented adult population, but a transition plan is needed. The current health system is failing to provide sufficient health care services to this population, which indicates that change is necessary. Preliminary discussions about the subcommittee began in February 2013, but the subcommittee has not yet formed. Thus, it is highly unlikely that it will produce a comprehensive solution before the final County grant for CCCs member clinics is exhausted. Without a transition plan, the final grant for CCCs member clinics will be depleted, and undocumented residents will find themselves displaced from care. Kiwon Yoo, Policy Director for Insure the Uninsured Project (ITUP), reinforces this estimation: "Once the undocumented immigrants are accustomed to seeking care, and you want to encourage them to be healthier, if this funding is cut, where do they go?" (personal communication, February 8, 2013). A transition plan is needed to prevent this displacement while the subcommittee determines an adequate solution.

CCC is ready to provide that transition plan, but continued County support is needed to implement it. CCC is requesting additional funding so that undocumented residents can continue to receive care while the subcommittee finds a better solution. CCCs Executive Director, Alvaro Fuentes, states that CCCs goal is not to obtain additional County funding, but to ensure that undocumented residents have access to health services (personal communication, April 1, 2013). A transition plan can help ensure continued access.

If the County provides CCCs member clinics with transitional funding, it can ensure that the clinics are maximizing the use of these funds through a conditional payment structure based on cost-effectiveness. In other words, the County could provide transitional grant funding on the condition that CCCs member clinics use

it in a cost-effective manner. For instance, the County could decrease the grant or reimbursement rate per visit if CCCs member clinics fail to maximize cost-effectiveness. An alternative payment structure could address concerns about the member clinics spending County grant funding in a cost-effective manner. These concerns are real, as Supervisor John Gioia believes that it is important for CCC to provide the maximum amount of services to the undocumented population in the most cost-effective way (personal communication, February 27, 2013). The County has not provided a conditional grant to CCCs member clinics, so this would be an opportunity for the clinics to demonstrate successful outcomes. With a conditional payment structure, the County could ensure optimal use of the transitional funding by CCCs member clinics.

Generate political pressure through a campaign

CCC needs to build a campaign that will generate political pressure on the County, so that it considers a transition plan while a better solution is being sought. The County has been slow to find a better solution and is likely to allow present trends to continue if it does not feel accountable to the public. Political pressure can be generated by effectively framing the issue and organizing important stakeholders to deliver this messaging. Building a campaign may motivate the County to feel accountable to someone other than the CCC representatives.

Frame the issue effectively

Effectively framing the issue of the County's undocumented health care crisis helps produce a strong, unified, and clear message about what needs to be done to address the County's proposal. Framing will help stakeholders recognize that this proposal is indeed a problem and that the problem affects them. Stakeholders can also use this messaging to appeal to decision makers.

The County's proposal will not save money in the long-term

CCC needs to create evidenced-based messaging that frames the County's proposal as being more expensive to the County in the long-term than providing transitional funding to the member clinics. Cost was the reason that the County eliminated undocumented residents from the BHC plan, and it seems to be the motivating factor behind the County's proposal to defund the member clinics. Some County representatives are not aware of the impact that this proposal would have on the County ED and clinic costs. This lack of knowledge is not surprising, given that the County does not collect data about the number of undocumented residents it serves. CCC needs to publicize data about the impact that the proposal would have on the County in terms of long-term costs. Messaging that is focused on the importance of healthy clinics and medical homes in reducing unnecessary hospital visits is crucial. Demonstrating to the County that transitional funding is less expensive than potential County ED and clinic costs may provide a strong argument against the County's proposal.

The County faces an ethical and moral dilemma with its proposal

CCC needs to frame the County's proposal as an ethical and moral dilemma that the County confronts by choosing to reduce access to primary health care services to one segment of the population (i.e., uninsured, undocumented residents). County representatives acknowledge the challenge of making such a proposal when lives are at stake, but actions speak louder than words. Even though grant funding for CCC may be depleted soon and the 2014 health coverage expansions are only a few months away, the County only recently began having preliminary discussions about forming a subcommittee to discuss better solutions for this population. Undocumented residents may soon find themselves without a stable source of primary care. CCC needs to message that the proposal is not just an economic issue, but a moral and ethical issue that affects a specific

portion of the County's population. Adam Kruggel, Executive Director of the Contra Costa Interfaith Supporting Community Organization (CCISCO), echoes this sentiment: "CCC needs to make a really clear political argument that it's unacceptable for public officials to pit communities against each other along racial and ethnic lines" (personal communication, February 15, 2013). This type of framing will hold the County accountable to the ethical and moral dilemma of its proposal.

Health is a community issue, not merely "an undocumented issue"

CCC needs to frame the County's proposal as affecting more than merely undocumented residents. Protecting the health of the entire community is more politically popular than providing health services to undocumented residents, so CCC needs to develop messaging that appeals to the broader community. CCC needs to promote the idea that the health of undocumented residents affects the health of the entire County population. Supervisor John Gioia recognizes this notion of community health:

> The health of the community is based on addressing health across the board. When you have a public health issue, there is no difference between those who are documented and those who are not. Health is based on the health of the whole population (personal communication, February 27, 2013).

Furthermore, CCC needs to produce messaging demonstrating how the proposal will reduce health care access in general if the health safety net is weakened. According to the CEO and President of the California Primary Care Association (CPCA), "If they [CCCs member clinics] lose a funding stream, it impacts access more broadly to everyone" (C. Castellano, personal communication, February 25, 2013). CCC needs to frame the proposal as something that would not only impact the health and health access of undocumented residents, but also the County's residents.

All health care providers form a collective network of providers that share the responsibility of providing care to the undocumented population

CCC needs to convey the message that all health care providers in the County form a collective network that share responsibility for caring for medically indigent undocumented residents. County representatives report that they currently seek "a community solution" with a subcommittee comprised of private stakeholders, suggesting that the County is not part of the community. However, most key informants view the County as a part of the community, especially because it is a provider of health care services in the community. Tanir Ami, former Executive Director of CCC, states that the County should contribute to the solution because "this County provides more primary care than most other counties. Most counties have exited the system of providing direct primary care" (personal communication, February 26, 2013). As a collective network, all providers – including the County -- should share the responsibility of providing care to undocumented residents, so that some providers are not disproportionately burdened by the financial loss of serving this population. Tanir Ami echoes this sentiment: "Everyone at the hospital, specialty, and primary care level should be working together so that no one is buried by this" (personal communication, February 26, 2013). CCC needs to reinforce the message that all health care providers comprise a collective network that should receive their fair share of this responsibility to care for this population.

CCCs member clinics do not have a payer mix that will offset the costs of undocumented health care

CCC needs to produce evidenced-based messaging that the member clinics' payer mix may not offset the cost of providing unsubsidized care to undocumented residents, even under the health coverage expansions of the

ACA. Some key informants believe that CCC currently has a sufficient number of insured patients to offset the cost of providing care to undocumented residents. Other key informants believe that CCCs member clinics will have enough newly insured patients under the ACA to offset any losses resulting from the provision of undocumented health care. However, this may not be necessarily true. The best way to dispute this claim is by collecting and publicizing data about the number of undocumented residents that the member clinics are currently serving and using this data to make projections about their potential payer mix in 2014. CCCs member clinics currently only have self-pay data, which is not an accurate proxy for the number of undocumented patients served. Although CCC is currently in the process of gathering this data, this data needs to be collected as soon as possible so that it can be presented during the campaign. Data could help the stakeholders recognize that the member clinics' capacity will be strained without transitional funding while the subcommittee is trying to find a better solution.

CCCs member clinics are maximizing County funding through cost-effectiveness

CCC needs to demonstrate that its member clinics are currently maximizing County grant funding in a cost-effective manner. Supervisor John Gioia believes that CCCs member clinics should maximize services in a cost-effective way and reports that it is crucial for the member clinics to "leverage any County financial support with other dollars so that the County financial support is a piece of the larger puzzle" (personal communication, March 13, 2013). Although cost-effectiveness is a salient goal, CCCs member clinics have already been taking measures to be cost-effective in maximizing County funds. For example, La Clinica de la Raza organizes fundraisers to generate unrestricted funds, constantly searches for grants and foundations that will cover program costs, and helps enroll patients in health coverage to obtain reimbursement for services rendered (V. Lujan, personal communication, March 15, 2013). CCC needs to make known that its member clinics are already stretching County dollars as far as possible in a cost-effective way.

The County's proposal requires a sense of urgency

CCC needs to frame the County's proposal as something that needs to be addressed urgently. The County has been slow to find alternative and better health care solutions for the undocumented population, even though:

- the member clinics' have almost exhausted their County grant funding
- health care programs that currently provide health services to undocumented residents (e.g., Access for Infants and Mothers) may be integrated into expanded Medi-Cal in 2014 (Yoo, 2012), for which undocumented residents are ineligible under the ACA
- the County expects that there will continue to be both documented and undocumented uninsured persons after ACA is implemented in 2014, who will seek care in the County's healthcare delivery system (W. Session, personal communication, February 28, 2013).

Creating a sense of urgency will not only help ensure that continuity of care is preserved for undocumented adults, but it may also help reduce the amount of uncompensated care the County will have to provide to the residually uninsured in its clinics and hospital in 2014. CCC needs to instill in the County a sense of urgency regarding its proposal.

Organize pertinent stakeholders to deliver the messaging

CCC needs to ensure that the County feels accountable to stakeholders in addition to CCC. Messaging to County decision makers will be more effective if they hear the messaging come from many people, especially those with influential voices. CCC has been hesitating to mobilize these voices because no formal policy for the County's proposal has yet been created. However, CCC needs to start organizing stakeholders as soon as possible so that they are prepared to act quickly when CCC requests their support. These stakeholders need to reinforce CCCs messaging and be willing to contribute their support to CCCs campaign. CCC can provide direction to these stakeholders about when and how to lobby the County. Organizing will help stakeholders feel empowered that they can do something about the County's proposal. Generating pressure from multiple diverse stakeholders may motivate the County to reconsider passing its proposal without implementing a transition plan.

Taxpayers and their advocates

Most key informants believe that the opinions of taxpayers and their advocates matter greatly to the County. This constituency includes documented residents who may be impacted by decreased access to CCC clinic care. The taxpayers who live in the districts of the Board members can "speak to the merits of health centers" and express their concerns about how the policy would impact access to health services (C. Castellano, personal communication, February 25, 2013). The County values the opinions of taxpayers and their advocates.

Health care providers

Almost all of the key informants believe that health care providers and their associations are powerful constituencies in the County. Health care providers can attest to the direct impacts that the County's proposal may have on the care they provide to undocumented and documented residents, especially health care providers who work for Contra Costa Health Services (CCHS). One of the key informants noted that "Physicians carry a lot of clout with politicians and can speak articulately about the impacts. Physicians are excellent advocates, as well as constituents" (C. Castellano, personal communication, February 25, 2013). In addition to physicians, CCC should enlist the support of associations that represent health care providers, such as the California Association of Public Hospitals and Health Systems (CAPH) and the Alameda-Contra Costa County Medical Association (ACCMA). These associations represent a large number of health care providers in Contra Costa County. Health care providers and their associations have some of the most influential voices in the County.

Private hospital CEOs

The CEOs of all of the private hospitals in Contra Costa County could be influential stakeholders. All of the private hospitals in Contra Costa County would be impacted by the County's proposal. If CCCs member clinics lose the County's financial support, undocumented residents may seek services in the private EDs. If undocumented residents are unable to pay their hospital bills, these hospitals will either have to cover this bad debt (M. Balin, personal communication, March 6, 2013) or offset it with any available Disproportionate Share Hospital (DSH) funding because the ACA will not cover health services for undocumented adults (Yoo, 2012). Because DSH funding is expected to incrementally decrease after 2014 (Lee, Hill, & McConville, 2012), this proposal will especially affect hospitals in Contra Costa County that receive DSH funding for uncompensated care, such as Sutter Delta and Doctors Medical Center (Anonymous, personal communication, March 22, 2013). At a minimum, CCC should form partnerships with the CEOs of these two hospitals. It is in the best interest of all private hospitals in Contra Costa County to ensure that transitional funding is provided

to CCCs member clinics while the private stakeholder subcommittee reaches a better health care solution for undocumented residents. Hospital CEOs may have the political clout to greatly contribute to CCCs campaign and influence County decision makers.

Community-based organizations

Many key informants noted that community-based organizations (CBOs) comprise an important constituency to the County. CBOs, such as RotaCare, Inc., may be greatly impacted by the County's proposal. If CCCs member clinics do not have the capacity to serve this population, these CBOs may see an increase in the patients they serve, which may negatively affect their capacity. It is in their best interest to ensure that they are not adversely impacted by this proposal. CBOs are another important stakeholder group to the County.

The immigrant rights community

Many key informants thought that the immigrant rights community could be a more influential stakeholder group than undocumented residents. Key informants tended to believe that the undocumented resident population does not have much political power in the County. Marty Lynch, CEO of Lifelong Brookside, reinforces this idea, stating that "The opinion of the undocumented do not matter, unless represented by someone else" (personal communication, March 12, 2013). Key informants generally believed that engaging leaders and advocates in the immigrant rights community has more political appeal than enlisting the support of undocumented residents. This group may include local and state immigrant rights groups, such as the California Immigration Policy Center (CIPC). The immigrant rights community could influence the County to reconsider its proposal, more so than the undocumented immigrant population.

Other important stakeholders

- *City council members and local state legislators.* They represent taxpayers and voters in the County. They can address the effects of the County's proposal on their constituencies and express their opinions about the proposal.
- *County labor unions.* The labor unions represent County employees, whose workloads may be strained if undocumented residents are displaced from care at CCCs member clinics.
- *Coalitions.* Coalitions, such as the Contra Costa Interfaith Supporting Community Coalition (CCISCO), represent a large number of diverse organizations who may be impacted by the County's proposal.
- *Nonprofit providers of social services and health educators.* They often provide direct services to undocumented residents and can speak to the effects that the County proposal will have on the overall County population.
- *Clergy.* They can understand the impact of the County's proposal on their congregations, which may include undocumented residents. They can build support for the campaign through their congregations.

Spreading the word about the campaign

Disseminating information about CCCs campaign is crucial to building support for it. Information about the campaign can be spread through media outreach, educational outreach, and closed-door negotiations with County decision makers.

Media outreach

Media outreach can effectively convey the messages of the campaign to a broad audience and enlist the public's support in the following ways:

- CCC can stage press conferences with important stakeholders about the negative impacts of the County's proposal. CCC did this in 2009 with CCHS medical providers who objected to the elimination of undocumented residents from the County's BHC plan (Geierstanger & Tjernell, 2010).
- CCC can publicize negotiations and action events with the County through its web blog, Hub & Spoke, which has not been updated since June 2012 (Community Clinic Consortium, 2012). Hub & Spoke can use social media outlets, such as Facebook and Twitter, as tools to disseminate current information about these negotiations and events.
- As CCC did in 2009, it can produce a fact sheet that clearly describes the impacts of the County's proposal. Specifically, this fact sheet could present arguments regarding how the proposal would negatively impact public health, result in "false savings, " and lead to increased ED visits --which are more costly than primary care visits (Geierstanger & Tjernell, 2010). The information in this fact sheet can be used as talking points for stakeholders involved in the campaign, in closed-door negotiations with County officials, during Board testimony, and during press conferences.

Media outreach can be effective in spreading the word about the campaign and soliciting broad support for it.

Educational outreach

More effective educational outreach needs to occur with influential stakeholders so that they are made aware of the County's proposal and its impacts. CCC has already been outreaching to stakeholders to inform them of this proposal, but some important stakeholders, such as RotaCare, Inc., are not even aware of this proposal. CCC needs to be more effective in its outreach efforts to these key stakeholders. Education is not merely about educating stakeholders about the proposal, but it is also about showing them how this proposal will directly impact them and equipping them with the confidence and tools to contribute to the campaign. CCC should hold private meetings with as many key stakeholders as possible in order to educate them about the proposal. CCC should present information about the campaign at community meetings and CBO staff meetings to enlist additional support. Educational outreach needs to be an ongoing effort before, during, and after the campaign so that CCCs messaging is reinforced and supporters are continuously recruited. More effective educational outreach will alert pertinent stakeholders to the County's proposal.

Closed-door negotiations

CCC needs to engage in more targeted closed-door negotiations with County decision makers so that it can achieve the goals of the campaign. CCC has been meeting with decision makers, but these meetings need to have very specific objectives so that CCC can make specific asks of each decision maker. CCC should meet with each Supervisor on the Board of Supervisors and other key County administrators to:

- relay community concerns about the proposal
- provide evidence-based messaging that this proposal will ultimately harm the County in terms of long-term costs and political support from powerful stakeholders involved in CCCs campaign

- request a detailed and budgeted amount of transitional funding for CCCs member clinics to provide health services to undocumented adults while the private stakeholder subcommittee devises a better solution

CCC should identify and enlist a champion on the Board of Supervisors (M. Lynch, personal communication, March 12, 2013), who will back the campaign and contribute support. Having a champion on the Board of Supervisors will lend credibility to CCCs campaign because it demonstrates political will for CCCs campaign within County administration. CCC could accomplish the goals of its campaign with more targeted closed-door negotiation efforts.

Maximize County partnerships

Leverage opportunities available to the County under the ACA

Realignment money, which is an important concern for the County, can be used as leverage in CCCs negotiations with County decision makers. It is uncertain whether California will use realignment funds to manage expanded Medi-Cal or if the counties will be able to retain these funds to expand Medi-Cal on their own (Wulsin, 2013). Assistant to the Director of CCHS, Wanda Session, expressed such concerns with realignment dollars:

> If the state chooses the statewide [state-managed] option for expanded Medi-Cal, it is proposing to take back from counties health realignment funds that help support counties' indigent care. If the state eliminates or decreases counties' realignment funds, it will have a significant financial impact because not everyone is going to be enrolled on January 1, 2014…The County will continue to be a safety net for the uninsured and will experience uncompensated care for those who remain uninsured beyond January 2014 (personal communication, February 28, 2013).

As Cary Sanders at the California Pan-Ethnic Health Network (CPEHN) suggests, CCC could support the County in its efforts to retain these realignment dollars (C. Sanders, February 8, 2013). If successful, a portion of these realignment dollars could be used to provide transitional funding to CCCs member clinics while the County works with private stakeholders to devise a better health care solution for undocumented residents. Conversely, if the state-managed Medi-Cal expansion is passed, CCC can use this as an opportunity to partner with the County to ensure that the number of residually uninsured residents is as minimal as possible. For instance, CCC could negotiate the County for transitional funding if it participates in a County outreach effort to enroll as many people in health insurance programs as possible in 2014. CCC can use the County's realignment funding concerns to its advantage when negotiating transitional funds with the County.

CCC can also leverage the fact that California counties will have additional funding under the ACA (Kelch 2011). Granted, the County may require a period of time to enroll the majority of the residually uninsured in health insurance programs, such as Medi-Cal. However, once most eligible individuals are transitioned into Medi-Cal, the County will receive a 50% match from the state and 50% match from the federal government for providing health care services to Medi-Cal enrollees (Rosenstein, Davis, & Fosdick, 2012). The savings the County will experience with this 100% Medi-Cal match could be used to fund services for uninsured, non-homeless, undocumented adults. CCC needs to urge the County to allocate some its savings resulting from the ACA to funding health services for the undocumented residents.

Foster an environment of collaboration

CCC must continue to keep lines of communication open with the County and other stakeholders in a respectful and objective manner, so that CCC fosters an environment that is conducive to collaboration. It is very easy for this issue to become personal and emotional, especially because so many lives are at stake. Dr. David Goldstein, Chief Medical Officer for CCRMC, recognizes that addressing the problem "shouldn't be finger-pointing. People tend to expect someone else to take care of it" (D. Goldstein, personal communication, March 8, 2013). As expressed in most of the key informant interviews, many health care organizations have been experiencing tighter financial constraints over the years and are currently feeling the stress of preparing for health care reform. CCC should openly acknowledge this and express that it is willing to collaborate with the County and other stakeholders to find a better health care solution for undocumented residents. CCC must clearly convey this recognition to the County and other stakeholders in order to foster a collaborative environment.

Fostering a collaborative environment includes CCC and the County having a basic and common understanding of the legal requirements of the County's FQHCs. A great deal of time is currently being spent attempting to determine if the County is meeting its legal obligations as an FQHC Section 330(h) grantee. A few key informants insist that the County's FQHCs are obligated to see all low-income undocumented residents on a sliding-fee scale, regardless of whether or not they are homeless. While this basic understanding is important, advocacy efforts need to be prioritized because the member clinics' County grant funding is being depleted, and is 2014 is rapidly approaching. Once the County and CCC have the same understanding about the County's legal obligations, both parties may feel more comfortable collaborating to determine a better health care solution for undocumented residents.

Advocate for immigration reform (the ultimate solution)

Despite its best efforts, any solution that the subcommittee produces will fall short of the solution that could be gained through immigration reform. Dr. David Goldstein, Chief Medical Officer of CCRMC, articulated the challenge of finding viable health care solutions for undocumented residents in the absence of health-related immigration reform:

> The solution is immigration reform…There is an opportunity to develop band-aids to try to piece together pieces of a delivery system, but until there is a source of funding for this care, I don't believe there'll be an overarching solution identified...It's not logical to build some kind of parallel haphazard delivery system. It makes sense to incorporate the [undocumented] population into a larger delivery system. Immigration reform would include some element of health care reform for the undocumented. All counties are trying to serve this population, and we're trying to do it because there's no source of funding (personal communication, March 8, 2013).

Immigration reform could help ensure that undocumented residents receive access to the same health care opportunities as citizens. Until that is achieved, less than optimal solutions to serve this population will exist.

Because immigration policies are affecting the County health's system, CCCs long-term campaign goal should be to collaborate with the County and the state to lobby the federal government for immigration reform. Advocacy efforts do not necessarily have to involve broader immigration issues (e.g., labor issues), but could instead be focused on the health care aspects of immigration reform. The Assistant to the County's Health

Services Director recognizes the importance of advocating for immigration reform: "When some members of our community are left out of health care reform, it impacts all of us, and we should all do our part to support immigration reform" (W. Session, personal communication, February 28, 2013). Health-related immigration reform needs to be a crucial aspect of CCCs campaign. CCCs campaign should involve working on this long-term goal in tandem with its short-term goals.

CONCLUSION

This report examines the health care options available to undocumented adult residents in the County, given that the County may no longer fund CCCs member clinics to provide these services. The available options are limited in many ways and do not provide a basic level of primary care services that the undocumented residents have become accustomed to with the County's support of CCCs member clinics. When the most recent County grant to the member clinics is exhausted, undocumented residents who relied on the member clinics may find themselves without a regular source of health care. This not only affects the member clinics' capacity and the health of undocumented residents, but it also impacts long-term County costs and the overall health of the community. The County currently has the opportunity to determine a better health care solution for this population.

CCC also has the opportunity to hold the County accountable to finding a better solution for undocumented adult residents. CCC needs to generate political pressure on the County by building a campaign that effectively frames the issue, organizes stakeholders, and disseminates information about the County's proposal. CCC also needs to leverage opportunities available to the County under the ACA. All of these actions can be effectively achieved by fostering a collaborative environment with respectful and objective communication and a basic and common understanding of the County's FQHC obligations. By engaging in these efforts, CCC may be able to obtain transitional funding for the member clinics while the subcommittee works on finding a better solution. The resulting solution may not be as good as one that could be produced through immigration reform. However, until immigration reform recognizes undocumented residents as legitimate recipients of federally-funded health care services, the County and CCC have the opportunity to go beyond a "quick-fix" solution and improve the current system of undocumented health care services in Contra Costa County.

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APPENDIX A

List of key informants

- Anonymous, Contra Costa County Health Plan representative
- Tanir Ami, former Executive Director of the Community Clinic Consortium in Contra Costa County
- Marianne Balin, Local Community Benefit Manager at Kaiser Permanente in Martinez
- Rachael Birch, Project Director for Health Care for the Homeless at Contra Costa Health Services
- Vanessa Cajina, Legislative Advocate at the Western Center of Law and Poverty
- Carmela Castellano, CEO and President of the California Primary Care Association
- Alvaro Fuentes, Executive Director of the Community Clinic Consortium in Contra Costa County
- Dr. Annette L. Gardner, Assistant Professor in the Department of Social and Behavioral Sciences at the School of Nursing at the University of California, San Francisco
- Supervisor John Gioia, member of the Contra Costa County Board of Supervisors
- Dr. David Goldstein, Chief Medical Officer of the Contra Costa Regional Medical Center
- Barbara Hunt, Development Director for RotaCare, Inc. Pittsburg Free Medical Clinic at St. Vincent de Paul
- Adam Kruggel, Executive Director of the Contra Costa Interfaith Supporting Community Organization
- Viola Lujan, Director of Business and Community Relations at La Clinica de la Raza
- Marty Lynch, CEO of Lifelong Brookside
- Cary Sanders, Director of Policy Analysis and the Having Our Say Coalition at the California Pan-Ethnic Health Network
- Vanessa Saavedra, Assistant Director of Policy at the California Primary Care Association
- Wanda Session, Assistant to the Director of Contra Costa Health Services
- Dr. Nishant Shah, Primary Care Physician at North Richmond Center for Health and Medical Director for Health Care for the Homeless
- Anthony Wright, Executive Director at Health Access
- Kiwon Yoo, Policy Director at Insure the Uninsured Project in Los Angeles

APPENDIX B

Calculation of Projected Costs

County grants awarded to CCCs member clinics for providing health care to undocumented residents decreased at an average rate of 17.33% since 2009. Thus, County grants to the member clinics are estimated to decrease to approximately $165,000 in 2014. The County is expected to save roughly $165,000 if it decides to withdraw funding to support the member clinics in 2014.

What is the size of the population of undocumented residents in Contra Costa County in 2014? Based on a Pew Hispanic Center report, the population of undocumented residents in the US declined at an average rate of 1.5% between 2007 and 2011 (Pew Hispanic Center, 2013). According to a Public Policy Institute of California (PPIC) report, the population of undocumented residents increased at an average rate of 3.5% between 2001 and 2008. The PPIC report estimates that 79,000 undocumented residents lived in Contra Costa County in 2008 (Hill & Johnson, 2011).[14] If the population of undocumented residents in Contra Costa County decreased at the same rate as found in the Pew Hispanic Center report, the lower-bound estimate for the County's population of undocumented residents in 2014 is approximately 72,000. If the population of undocumented residents increased at the rate found in the PPIC report, the upper-bound estimate for the population of undocumented residents in 2014 is approximately 93,000. Thus, approximately 73,000-96,000 people in Contra Costa County are estimated to be undocumented residents in 2014.

It is important to know the number of non-homeless, undocumented residents in 2014 because the County's mobile health clinics and stationary clinics primarily provide health services to people who are homeless or at risk of being homeless. According to the County's Health Services Department, in 2011, approximately 4,000 people were homeless on any given day in the County (McSweeny, 2011). Flynn (2013) reports that about 7,000 people in the County were estimated to be homeless in 2013. The population of homeless people increased at an average rate of 37.5% between 2011 and 2013. Thus, the population of homeless people in Contra Costa County in 2014 is estimated to be about 10,000 people. The population of the County increased at an average rate of 2.01% between 1980 to 2011 (Google Public Data, 2013), so the estimate for the County's population in 2014 is 1,108,953 people. Therefore, homeless people will comprise 0.90% of the total population in Contra Costa County in 2014. Assuming that 0.90% of the undocumented population is also homeless, approximately 700-900 undocumented people are estimated to be homeless in Contra Costa County in 2014. Thus, approximately 72,000 to 95,000 undocumented residents in the County will *not* be homeless in 2014.

How many non-homeless, undocumented people will be uninsured in 2014? According to the 2011 Sustainability Audit of CCRMC and the County's clinics, 21,000 undocumented residents are estimated to be uninsured in 2014 (Health Management Associates, 2011). Assuming all homeless, undocumented people are uninsured, about 20,000 non-homeless undocumented residents are estimated to be uninsured in Contra Costa County in 2014.

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[14] This is the most recent estimate that could be found for the County.

How many non-homeless, undocumented, uninsured people use the ED in Contra Costa County? The Kaiser Family Foundation (KFF) found that 13% of noncitizens in 2008 used the ED in the previous year (Kaiser Family Foundation, 2008). This means that approximately 3,000 non-homeless, undocumented, uninsured people use the ED in Contra Costa County per year.

How much do ED visits cost the County for non-homeless, undocumented, uninsured people in Contra Costa County who use the ED in one year? The average charge for an ED visit at the County's hospital is between $160-$630 (OSHPD, 2013a). Average ED charges can be used as a proxy for average County ED costs. Assuming that each person has only one ED visit, County ER visits for about 3,000 non-homeless, undocumented, uninsured residents will cost the County approximately $480,000 to $1.89 million per year.

How much does ED follow-up care cost the County? County clinics occasionally provide short-term follow-up care at no charge to undocumented, non-homeless, uninsured residents who are discharged from the County ED (D. Goldstein, personal communication, March 8. 2013). The number of these visits is unknown, but key informants generally agreed that CCCs member clinics may refer an increasing number of patients to the ED if it is operating at or above capacity. If only 5% of the non-homeless, uninsured, undocumented population who use the ER in one year received only one follow-up visit and were charged the typical flat fee of $150 for an outpatient visit at a County clinic (Dr. Shah, personal communication, April 2, 2013), these visits would cost the County at least about $23,000 per year. Thus, County ED visits and subsequent follow-up in the County's clinics for non-homeless, uninsured, undocumented residents would cost the County at least $500,000 to $1.90 million per year.

All estimates produced from these cost calculations are likely to be closer to the upper-bound estimates because these estimates are lower than actual costs. Actual costs are expected to be higher than these estimates because (a) common charges do not include professional fees (Contra Costa Health Services, 2011b); (b) each person may experience more than one ED visit; and (c) the homeless population estimates do not include those who are at risk of being homeless.