

EXHIBIT 4



THE HEALTHCARE LANDSCAPE IN PRINCE GEORGE'S COUNTY

OPPORTUNITIES FOR IMPROVEMENT



RPCC
Regional Primary Care Coalition

I. Overview of Prince George's County Health Indicators

Life expectancy at birth is one of the most frequently used health status indicators, as it is influenced by a number of determinants including behavioral, environmental, and clinical factors. Life expectancy in Prince George's County is 79.6 years, just slightly higher than the average life expectancy in the rest of Maryland of 79.5 years of age.¹ Although this represents a slight drop in life expectancy from the previous measurement period (79.9 in 2013-2015) to this one (2014-2016), the county has experienced an overall increase in life expectancy since 2009, when it was 78.6 years of age.

	Life Expectancy	Diabetes Prevalence	Adult Obesity	Adolescent Obesity	Heart Disease Death Rate*	Hospitalization Rate due to Hypertension**
Prince George's	79.6	12.5%	30.7%	15.1%	176.8	6.3
Maryland	79.5	10.4%	28.9%	11.5%	169.9	5.2

*deaths per 100,000 population

**hospitalizations per 10,000 population 18+ years old

Chronic diseases have a substantial impact on public health, affecting quality of life as well as health system utilization and costs. Though they are common, many of these conditions are preventable, and complications due to these conditions can be delayed or avoided with proper care. Prince George's County residents fare worse than the average Maryland resident in many key chronic health indicators:

Diabetes

- 12.5% of adults in Prince George's County have been diagnosed with diabetes, higher than Maryland's average of 10.4%.²
- Prince George's County also had higher death rates and hospitalization rates due to diabetes, and higher rates of hospitalizations due to long- and short-term complications of diabetes, compared to other counties in Maryland.
- Rates are highest in adults 65+, males, and Black or African Americans.

Obesity

- 30.7% of adults in Prince George's County qualify as obese, compared to 28.9% of adults statewide.³
- 15.1% of adolescents aged 12-19 in Prince George's County are obese, compared to 11.5% of adolescents across Maryland.

¹ https://health.maryland.gov/vsa/Documents/2016_Annual_Report.pdf

² [PGC Health Zone](#), 2015.

³ [PGC Health Zone](#), 2015.

Heart Disease

- From 2013 to 2015, the death rate due to all heart disease was 176.8 per 100,000 population, higher than Maryland's rate of 169.9 deaths per 100,000 population.⁴
- Rates were even higher among white, non-Hispanic, and black, non-Hispanic residents, whose death rates were 195.2 and 180 per 100,000 population, respectively.
- Rates for Hispanics were much lower, at 75.2 deaths per 100,000 population.

Hypertension

- One in three adults in the county have been diagnosed with hypertension.
- From 2013 to 2015, the age-adjusted hospitalization rate due to hypertension was 6.3 hospitalizations per 10,000 population 18+ years old, higher than the Maryland average rate of 5.2.⁵
- Hospitalization rates due to hypertension are higher in black or African American populations, with a rate of 8.5 hospitalizations per 10,000 population 18+.

	All Cancer Incidence*	Mortality Rate due to All Cancers*	Female Breast Cancer Incidence*	Prostate Cancer Incidence*	Lung and Bronchus Cancer Incidence*	Colon and Rectal Cancer Incidence*
Prince George's	397.0	168.8	116.2	141.3	44.7	37.3
Maryland	442.0	161.8	130.3	119.4	55.8	40.0

*per 100,000 population in 2014

While rates of cancer incidence in Prince George's County are lower than those of Maryland, mortality rates in the county are higher. Prince George's age-adjusted cancer mortality rates are the fourteenth highest of Maryland's twenty-four counties. The four most common cancer diagnoses in Prince George's County are breast cancer, prostate cancer, lung and bronchus cancer, and colorectal cancer. Lung and bronchus cancer is the leading cause of death from cancer in Prince George's County for all genders, followed by breast cancer for females and prostate cancer for males.⁶

- The incidence of breast cancer in Prince George's County has significantly increased in recent years and is highest for black females.⁷

⁴ [Interactive Atlas of Heart Disease and Stroke](#), 2013-2015.

⁵ [PGC Health Zone](#), 2013-2015.

⁶ [2017 Cancer Data](#), Maryland Department of Health.

⁷ [2017 Cancer Data](#), Maryland Department of Health.

- The incidence of prostate cancer has decreased in recent years, although the rate is significantly higher in Prince George's County than in the rest of Maryland. Black men have significantly higher rates of prostate cancer, at 173.7 cases per 100,000 population versus 74.8 for white men.⁸
- Lung and bronchus cancer incidence in Prince George's County has decreased significantly over time and is significantly lower than Maryland's incidence rate. White men have significantly higher incidence rates.⁹
- Although both incidence and death rates due to colorectal cancers in the County have decreased since 2003, they remain higher than Maryland's average rates. Incidence of colorectal cancer in the County is highest in black males.¹⁰

Early detection and access to treatment is a factor in reducing cancer-related fatalities. Screening rates for breast cancer are slightly higher in Prince George's County (83.7%) than Maryland's average rate (82%). Colon cancer screening rates in Prince George's County (74.7%) are slightly higher than Maryland's average rates (73%). The screening rate for cervical cancer in the County is 77.1%, lower than Maryland's average of 79.8%.¹¹

In 2016, there were 328 newly diagnosed cases of HIV in adults and adolescents aged 13 years or older in Prince George's County.¹² Although this is the lowest rate of new diagnoses that Prince George's County has seen in ten years, it is the highest number of total new diagnoses in Maryland. Prince George's infection rate is second only to Baltimore City. In 2016, 63.5% of new diagnoses in Prince George's County were adults aged 20-39; 89% of those were black; and 73.5% were men.¹³

Infant and maternal health are critical to population health, as early life indicators affect later health outcomes. Care before, during, and after pregnancy can significantly reduce infant and maternal mortality and risks associated with pregnancy. Prince George's County fares worse than the rest of Maryland in several key indicators, and significant disparities in outcomes persist between different races and ethnicities. Although rates in Prince George's County have decreased overall since 2007, the infant mortality rate remains higher than the Maryland average, and is much higher for black infants. Notably, Hispanic infant mortality significantly increased, more than doubling between 2015 and 2016.¹⁴

- In 2016, the infant mortality rate in Prince George's County was 7.6 deaths per 1,000 live births, which is higher than Maryland's average rate of 6.5.
- For black infants in Prince George's County, the rate is higher, at 9.7 deaths per 1,000 live births, although this number represents a significant decrease from the 2015 rate of 13.4.
- During the same period, the Hispanic infant mortality rate increased significantly, from 2.6 in 2015 to 6.1 in 2016.

⁸ [2017 Cancer Data](#), Maryland Department of Health.

⁹ [2017 Cancer Data](#), Maryland Department of Health.

¹⁰ National Cancer Institute, 2010-2014.

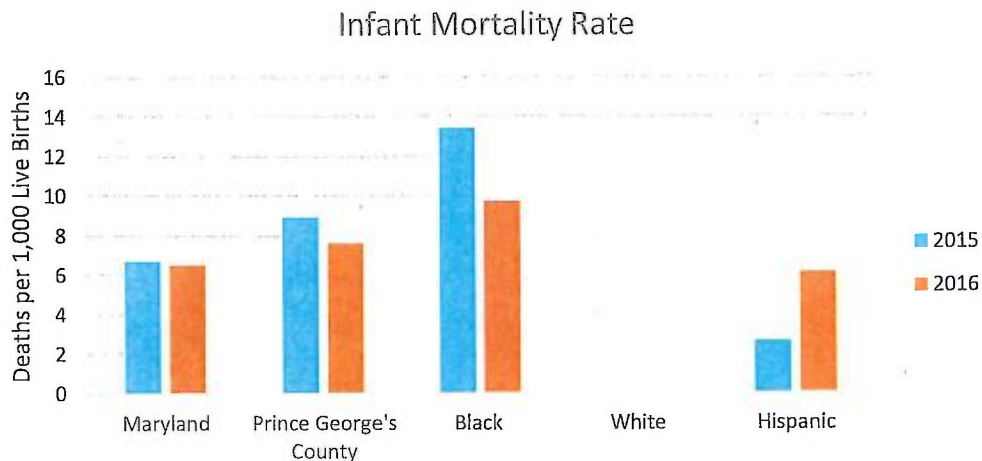
¹¹ [PGC Health Zone](#), 2014.

¹² [National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Infection](#), 2016.

¹³ [Maryland Annual HIV Epidemiological Profile](#), 2016.

¹⁴ Maryland Vital Statistics. [Infant Mortality in Maryland, 2016](#).

- A reliable rate could not be calculated for white, non-Hispanic infants due to a low number of deaths in the county, though the rate for all of Maryland is 4.3.



Source: Maryland Vital Statistics, [Infant Mortality in Maryland, 2016](#)

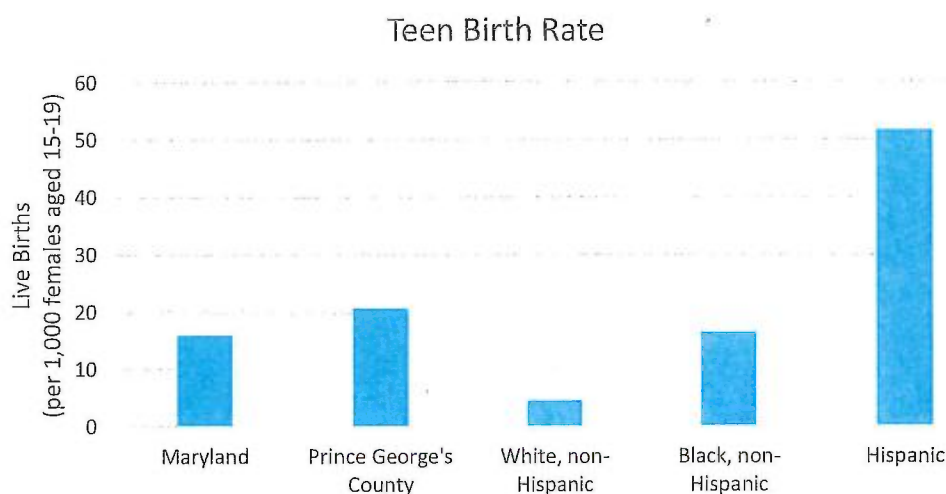
Maternal deaths remain an issue across Maryland. In 2014, the pregnancy-associated death rate (death occurring during pregnancy or within a year of giving birth) in Maryland was 44.8 per 100,000 live births; four deaths occurred in Prince George's County.¹⁵ Across Maryland, the leading cause of death during pregnancy or within a year of giving birth was substance use with unintentional overdose; unnatural causes, also including homicide, injury, and suicide, accounted for 39% of these deaths. About half of maternal deaths were pregnancy-related, at a rate of 21.7 per 100,000 live births; three deaths in Prince George's County in 2014 were pregnancy-related. Among pregnancy-related deaths, the leading cause was hemorrhage.

Teen pregnancy is a serious social issue. Babies born to teen mothers experience health risks and are more likely to suffer later health, social, and emotional problems than children born to older mothers. Teen mothers are more likely to drop out of school, have low or no job qualifications, be unemployed or low-paid, live in poor housing conditions, suffer from depression, and rely on government assistance. The teen birth rate in Prince George's County is higher than Maryland's rate, and is strikingly high among Hispanic teenagers.

- The teen birth rate in Prince George's County was 20.7 live births per 1,000 females aged 15-19 in 2016, higher than Maryland's average rate of 15.9.¹⁶
- This rate varied greatly by race and ethnicity; the rate amongst Hispanic teenagers in Prince George's County was 51.6, compared to 16.4 for black, non-Hispanic teenagers, and 4.5 for white, non-Hispanic teenagers.

¹⁵ [Maryland Maternal Mortality Review](#), 2016 Annual Report

¹⁶ [Maryland Vital Statistics Annual Report 2016](#)



Source: [Maryland Vital Statistics Annual Report 2016](#)

Mental and behavioral health significantly affect physical and social well-being, and can impact an individual's ability to seek the care they need. In 2016, one in ten adults in Prince George's County reported experiencing frequent mental distress, defined as poor mental health for 14 or more of the past 30 days.¹⁷ It is important to keep in mind that this measure relies on self-reported data and may not accurately portray the true extent to which mental and behavioral conditions affect County residents.

- The County's age-adjusted ED rate due to mental health was 1539.3 visits per 100,000 population in 2014, less than half that of Maryland's average rate.¹⁸
- Mental health ED visits are on the rise in the County, having increased more than 200 visits per 100,000 population since 2011.
- Similarly, the age-adjusted ED rate due to alcohol/substance use in the county was 855.6 per 100,000 population. While this rate is also better than the Maryland average rate, it too has increased since 2011.

Indicators suggest that residents of the County experience less access to care than residents in nearby counties. Prince George's averages 890 patients per mental health provider, worse than Maryland's ratio of 460:1.¹⁹ All surrounding counties, including Montgomery (360:1), Howard (400:1), Anne Arundel (650:1), Calvert (560:1), and Charles (790:1), as well as the District of Columbia (230:1) have far more providers for the number of residents than does Prince George's County.

II. Overview of County Demographics²⁰

Prince George's County has experienced shifts in demographics in recent years, which relate to the health and service needs of the County. From 2012 to 2016, the County's total population increased

¹⁷ [County Health Rankings & Roadmaps](#), 2016.

¹⁸ [Maryland Health Services Cost Review Commission](#), 2014.

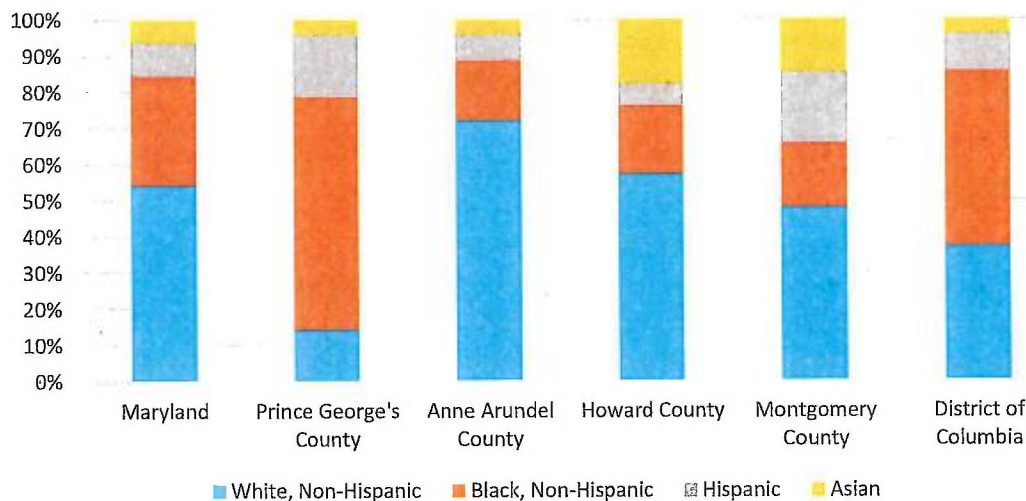
¹⁹ [County Health Rankings & Roadmaps](#), 2017.

²⁰ All data from 2012-2016 American Community Survey 1-year estimates, unless otherwise noted.

from 865,443 to 897,693. The largest inflow of residents was from the District of Columbia.²¹ Although the median age in Prince George's County (36.7) is lower than the median age in Maryland (38.5), the county has been trending older since 2012. Every age group below the age of 55 has had slight decreases in their share of the total population since 2012, with the most significant decrease occurring among 18 to 24-year-olds, whose population decreased 1.3%. Conversely, every age group over the age of 55 years old experienced slight increases in population, with the most significant increase occurring among 65-74-year-olds whose share of the total population increased 1.5%.

Prince George's County has seen the largest relative increase in its Hispanic population, which increased from 15% to 17%. During the same period, the white, non-Hispanic population decreased slightly, from 15% to 14%. Meanwhile, the black, non-Hispanic and Asian populations grew consistently, representing 63% and 4% of the total population, respectively. The population of Prince George's County remains more ethnically and racially diverse than statewide averages; by contrast, Maryland residents on average are 52% white, non-Hispanic, 29% black, non-Hispanic, 9% Hispanic, and 6% Asian.

Race and Ethnicity of Prince George's County Residents vs. Surrounding Areas



The foreign-born population has significantly increased since 2012, now representing 22.2% of the total population. Further, residents who primarily speak Spanish at home have significantly increased, from 12.5% in 2012 to 16.3% in 2016. The number of residents who report that they are not English proficient increased from 7 to 9 percent during the same period.

Educational attainment varies significantly based on race and ethnicity. While 93% of black and white non-Hispanic residents have earned at least a high school degree, only 47% of Hispanic residents have earned at least a high school degree. Further, 45% of white residents have earned at least a bachelor's degree, compared to 32% of black residents and 10% of Hispanic residents.

²¹ <https://flowsmapper.geo.census.gov/map.html>

It is important to keep in mind that not all students enrolled in school have the same opportunities. In 2017, Prince George's County had a higher percentage of students eligible for free and reduced meals (63%) than the state of Maryland (43%).²² Prince George's County accounts for nearly one-fourth of students who drop out of high school in Maryland. Although dropout rates in Prince George's County have decreased since 2013, there are significant racial and ethnic disparities related to educational attainment within the County.²³ While black or African American graduation rates were 88.5% in 2017, slightly higher than Maryland's average for African Americans, the non-Hispanic white graduation rate in the county has hovered around 80%, ten percentage points below the state's average for whites, since 2013.²⁴ The starkest disparities are experienced by Hispanic residents, whose graduation rate was 65.9% in 2017, 8% below Maryland's average for Hispanics.

Economic indicators for Prince George's County have trended positively since 2012. The County's unemployment rate decreased from 9.5% to 6.3% in 2016, although it remains slightly higher than Maryland's average of 5.4%. During the same period, the median household income increased from \$69,879 in 2012 to \$79,184 in 2016, higher than Maryland's average of \$78,945; and the poverty rate decreased from 10.2% to 9.1%, lower than Maryland's average of 9.7%. Poverty decreased for every age group, except for adults aged 65 and over, who experienced an increase in poverty from 7.5% to 9.5%. Poverty varies only slightly by race and ethnicity: rates are highest for white residents, at 10%, followed by Hispanic residents (9.6%) and black residents (8.6%). According to the County Health Rankings and Roadmaps, Prince George's County has less income disparity than most other counties in the United States.

III. Health Services

Health insurance coverage directly affects access to health services. 68.4% of Prince George's County residents have private insurance; 29% are covered by public insurance. Since the ACA was implemented, the County has aggressively enrolled eligible residents in Medicaid and assisted others with purchasing subsidized insurance. The uninsured population has decreased from 15.6% in 2012 to 10.3% in 2016. This rate remains higher than Maryland's average uninsured rate of 6.1% primarily because of the large number of foreign-born residents who are ineligible for Medicaid or subsidized health insurance.

Though many service providers in the County deliver high-quality health care, Prince George's County is experiencing health professional shortages, and many residents travel outside of the County to seek care. There are 1,910 patients to every one primary care physician located within the County, a higher ratio than Maryland's average of 1,140 patients per PCP.²⁵ Similar shortages occur among oral health care providers. There are 1,650 patients per dentist in the County, more than Maryland's average

²² [Maryland State Report Card](#), 2017.

²³ [Kids Count Data Center](#), 2017.

²⁴ [Maryland State Report Card](#), 2017.

²⁵ County Health Rankings and Roadmaps, 2015.

of 1,320 patients per dentist.²⁶ In Prince George's County, only 65% of children and 69% of adults report having visited a dentist in the last year.²⁷ This number has declined since 2011.²⁸

These shortages are particularly concentrated in certain areas of the county. There is a HRSA-designated mental health care Health Professional Shortage Area (HPSA) located in a strip of the County bordering Montgomery County that encompasses Hyattsville, Langley Park, and Adelphi/Hillandale. This overlaps with a larger primary care HPSA that encompasses the remainder of the County located within the Capital Beltway. There is a second primary care HPSA located in southern Prince George's County that encompasses Brandywine, Aquasco, and Upper Marlboro and overlaps with a dental HPSA that also includes Accokeek.



The health care safety-net in Prince George's County is primarily composed of Federally Qualified Health Centers (FQHCs). Federally Qualified Health Centers are federally-funded, community-based nonprofit health centers that provide primary care services to individuals without insurance, regardless of their ability to pay, in addition to people with both public and private insurance. Community Health Centers play a significant role providing culturally competent services to immigrants and serving historically underserved racial and ethnic minority communities. Six FQHCs serve patients at eleven facilities in Prince George's County. Four sites have opened in the County since 2013: CCI Health and

²⁶ County Health Rankings and Roadmaps, 2016.

²⁷ [PGC Health Zone](#), 2016.

²⁸ [PGC Health Zone](#), 2015.

Wellness opened a new location in Franklin Park in 2013; La Clínica del Pueblo opened a new location in Hyattsville in 2016; Family and Medical Counseling Services, Inc. opened in Seat Pleasant in 2016; and Elaine Ellis Center of Health opened a new location in College Park in 2017. One facility, Greater Baden Medical Services at Brandywine, is located within a primary medical, mental health, and dental care Health Professional Shortage Area (HPSA). Though not an FQHC, the Susan Denison Mona Center is a non-profit health and wellness center that offers health, dental, and social services in Temple Hills through a partnership between Catholic Charities of Washington, D.C., Doctors Community Hospital and the University of Maryland, School of Public Health.

Six hospitals are located within Prince George's County: Doctors Community Hospital, Fort Washington Medical Center, Laurel Regional Hospital, MedStar Southern Maryland Hospital Center and Prince George's County Hospital Center, which has historically provided care to the county's safety-net population. In 2021, the University of Maryland Regional Medical Center will replace Prince George's County Hospital with a state-of-the-art facility and expanded services. The Malcolm Grow Medical Center, an Air Force hospital, and the Southern Prince George's County VA Clinic are also located within the County in Camp Springs, Maryland.

IV. Prince George's County FQHC Services and Patients²⁹

Six Federally Qualified Health Centers (CCI Health and Wellness; Elaine Ellis Center of Health; Family and Medical Counseling Services, Inc.; Greater Baden Medical Services; La Clínica del Pueblo; and Mary's Center) serve Prince George's County residents at eleven locations in Prince George's County. In 2017, FQHCs served 34,000 Prince George's County residents, providing 61,500 medical visits, 5,500 behavioral health visits, and 2,500 dental visits.³⁰ Mary's Center is the largest FQHC, seeing the most patients in the region; however, Greater Baden Medical Services, Inc. is the only FQHC with headquarters in Prince George's County, and serves the largest number patients within the county.

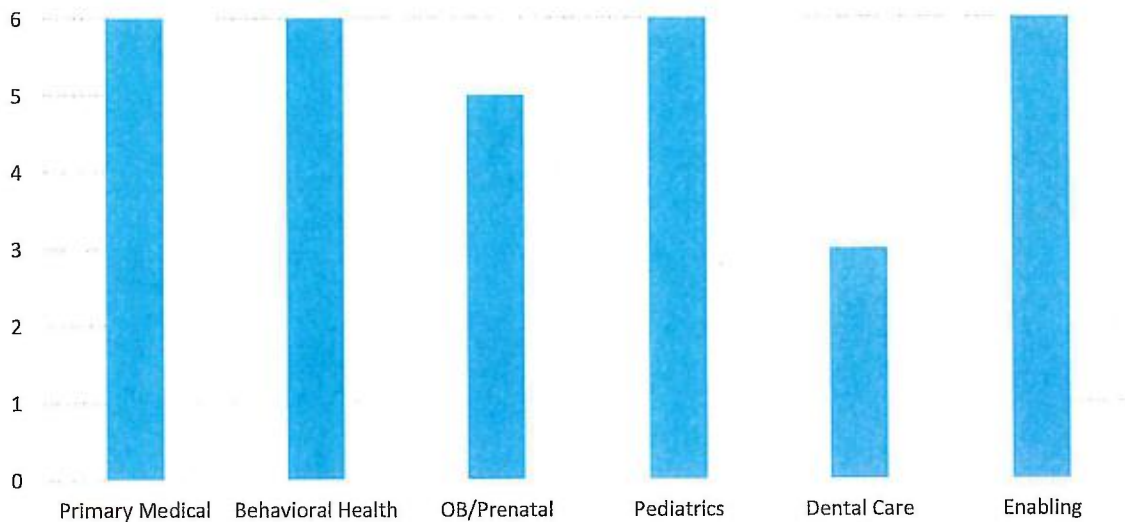
Across all sites of these six FQHCs, budgets vary based on the size of the organization. Total costs per patient vary for a number of reasons, including the organization's size, the complexity of patients served which includes those with multiple chronic conditions, and the level of services provided. Cost is not indicative of the quality of care but a measure of investment made in the health of the community.

	CCI Health and Wellness	Elaine Ellis Center of Health	Family and Medical Counseling Service, Inc.	Greater Baden Medical Service, Inc.	La Clínica del Pueblo	Mary's Center
2016 Total Budget	\$24,488,377	\$2,307,816	\$9,934,307	\$14,997,849	\$12,143,674	\$38,347,475
2016 Cost per Patient	\$852.66	\$1,678.41	\$3,116.16	\$880.16	\$3,117.76	\$935.21

²⁹ Data (other than data on types of services and cost) does not include Family and Medical Counseling Services, Inc. or Elaine Ellis Center of Health.

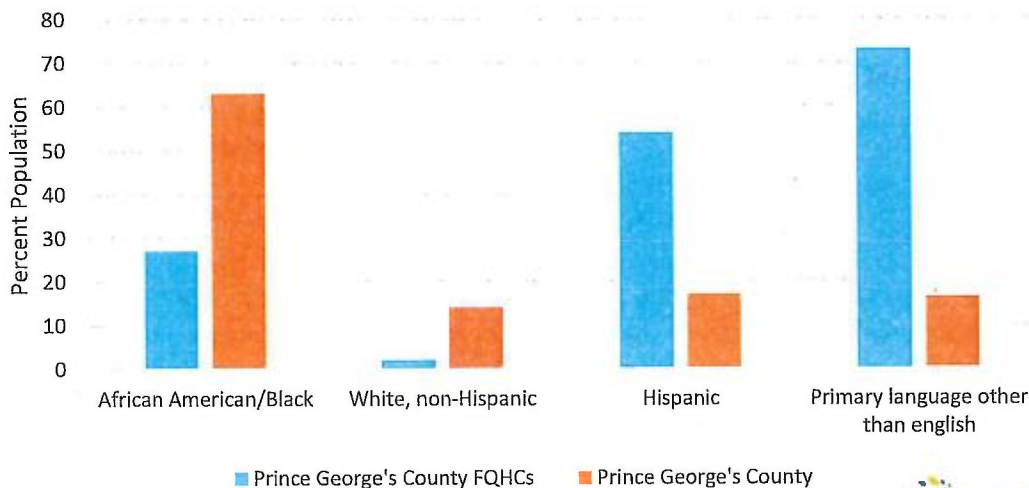
³⁰ Greater Baden Medical Services patient numbers and type of visits are estimates based on available data.

Services Provided by FQHCs in Prince George's County

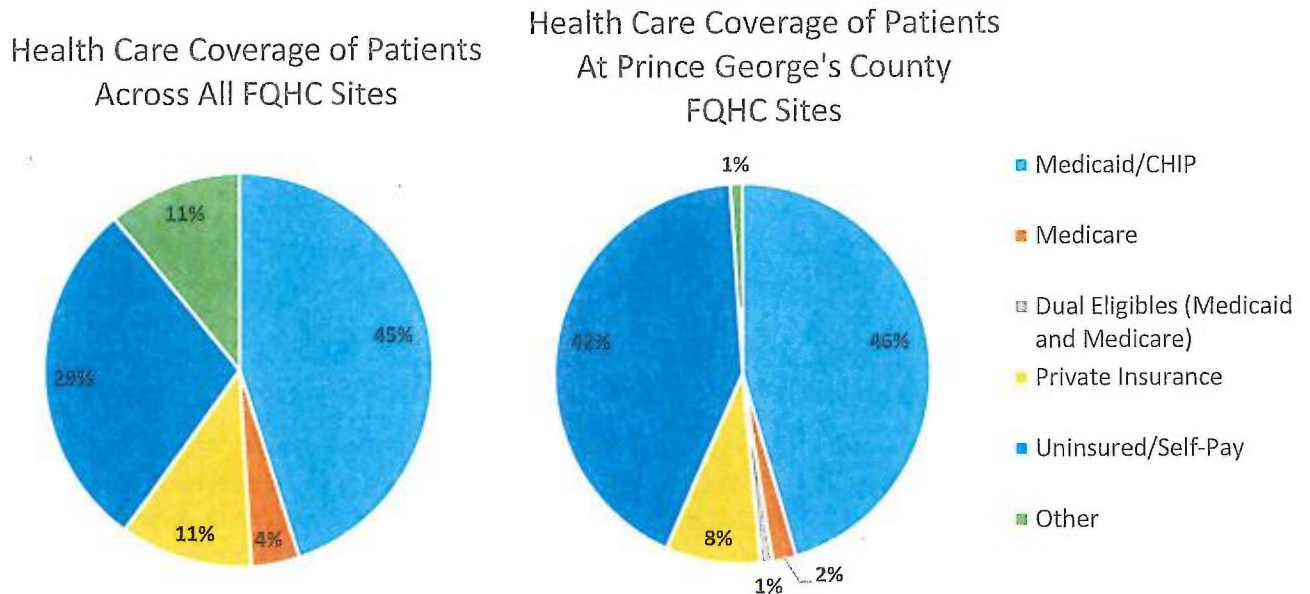


FQHCs play a critical role in ensuring access to health care and related services for the County's most vulnerable families. In 2016, 39% of patients were children under the age of 18; 58% were adults and 3% were seniors over the age of 65. The racial and ethnic breakdown of FQHC patients is very different from the overall demographics of the County, with FQHCs serving a higher proportion of racial and ethnic minorities. In 2016, Prince George's FQHC patients were 54% Hispanic, 27% Black or African American, 2% white, non-Hispanic, and 1% Asian. Further, a staggering 73% of patients spoke a primary language other than English. Several FQHCs provide on-site services in a variety of languages including Spanish, Portuguese, French, Amharic, Vietnamese, Arabic, Hindi, Urdu, Bambara and Armenian and all had access to language line interpretation services to meet the needs of those speaking other languages. Many health centers also provide culturally and linguistically diverse resources to support their communities, including health education and outreach, interpretation services, HIV prevention services targeting LQBTQ populations, chronic disease self-management groups, behavioral health interventions, and community health workers.

Patient Demographics of FQHCs in Prince George's County



Patients served at the FQHC facilities located within Prince George’s County are more likely to be uninsured and/or self-pay than patients served across all facilities, with 42% lacking any form of health care coverage. Of the total patient population served, 29% are uninsured and/or self-pay while 11% had coverage through locally funded programs, including the DC Alliance and Montgomery Cares.



In addition to serving patients, the FQHCs contribute significantly to the local economy and primary health care work force, employing 322 Prince George's County residents across all of their sites. In Prince George's County, FQHCs employ 37.5 full-time equivalent, independently licensed clinicians and six full-time equivalent behavioral health professionals. Several sites offer training programs for health professionals, including a medical assistant training program, prenatal care training for Howard University Hospital residents, clinical rotations for graduate social workers and training for community health workers.

V. Improving the Health of Prince George’s County Residents

Historically, Prince George’s County has not had a sufficient supply of medical, dental, behavioral health or specialty care providers to meet demand with as many as 60% of its residents seeking health care services outside of the County. With progress implementing the Prince George’s County Primary Care Strategic Plan and construction of the new Regional Medical Center underway, this is changing. Several private practices and Federally Qualified Health Centers have opened facilities in some of the most under-resourced communities in the County. One long-standing FQHC is expanding and will be opening a new site during the next year. However, without addressing the cost of care for low-income residents who are ineligible for federally funded health programs, the FQHCs and Regional Medical Center will bear the burden of uncompensated care for a population with significant health needs. Inevitably, this will threaten the long-term sustainability of these organizations and hinder future growth.

VI. Models: Providing Care for the Uninsured

Communities across the country, particularly those with large immigrant populations, have developed local solutions to improve the health and well-being of residents who are ineligible for federally subsidized health services. Although programs have different administrative mechanisms, enrollment processes, and coverage, each dedicate locally-generated funds to ensure that all residents have access to primary health care services. The attached chart highlights how nearby Montgomery County, Fairfax County and the District of Columbia are providing care for low-income, uninsured residents—populations with similar socio-economic challenges and health concerns as many Prince George’s County residents. It also details programs considered best practices nationally in Massachusetts and San Mateo County, California, as well as a pilot program in Contra Costa County. All programs share some key characteristics that are worth highlighting:

Vision and Leadership: Each of these communities share a commitment to improving the health and well-being of their residents and each community has leaders who prioritize health and support a systemic approach to ensuring that all residents have access to quality healthcare.

Partnerships: Each program demonstrates the value of public/private partnerships in building a healthcare system capable of meeting the needs of all residents. In most communities, one or more hospitals, community health centers, health departments and non-profit organizations came together to weave the safety-net system together.

Health Resources and Competencies: Each partner contributed assets including funding, services, financial management systems, operations and management expertise, enrollment capability, data management, cultural competency and community engagement to build robust primary care systems that work in their communities.

Planning for the Long Haul: These programs did not begin by immediately providing coverage for the entire population that needed services. Montgomery Cares grew from six providers serving 6,000 people in 2005 to twelve providers serving 26,000 in 2010. One of the most recent efforts, Contra Costa Cares, established a pilot program with start-up funds provided by Kaiser Permanente and local foundations with a goal of providing 3,000 people with medical homes during its first year of operation. Long-standing programs in Massachusetts and the District of Columbia have expanded to the extent that these jurisdictions have the lowest uninsured rates in the nation, in addition to offering the most generous benefits packages.

Return on Investment: Investing in health services yields high returns for residents who, having consistent access to care, are better able to care for themselves and have an opportunity to live healthy, productive lives. As the health of the community improves, fewer funds are required for expensive health interventions and crises that result from unmanaged chronic conditions. Savings in overall healthcare expenditures are available to invest back into the community to expand early intervention services and improve the overall quality of life for residents.

Comparison of State and Locally Funded Health Care Programs Serving Uninsured Residents

Key Areas for Consideration	Massachusetts Health Safety Net	DC Healthcare Alliance	Montgomery Cares	Community Health Care Network	San Mateo Access to Care for Everyone (ACE)	Contra Costa Cares
Administration	Massachusetts State Medicaid Office	DC Health Care Finance Administration through contracted Medicaid MCOs.	Montgomery County DHHS contracted to Primary Care Coalition.	Fairfax County Health Department contracted to INOVA.	San Mateo County Health System contracted to Health Plan of San Mateo.	Partnership with Contra Costa Health Plan, Contra Costa Health Services and the Community Clinic Consortium.
Funding Source	Health Safety Net Trust Fund- acute hospitals contribute 1.5% of private revenue annually.	Line item in HCFA budget.	Line item in DHHS budget.	Line item in Health Department budget.	Line item in San Mateo County Health Department budget.	Pilot program funded by County, Kaiser, John Muir Health and Sutter Delta Medical Center.
Eligibility	<150% FPL >150 to 300% Partial/ with a deductible based on income. State resident.	<200% FPL Cash assets under \$4,000 p/individual or \$6,000 p/family. District resident.	<200% FPL Ineligible for Medicaid/Medicare. County resident.	<200% FPL Ineligible for Medicaid. County resident.	<200% FPL 225% w/financial hardship due to chronic illness. Ineligible for Medi-Cal or APTC. County resident.	Low-income (?) Ineligible for Medi-Cal. County resident.
Enrollment	Annual On-line Enrollment CACs at provider sites	6-month In-person certification at DC-ESA Offices	Annual certification at the point of entry.	Annual on-site enrollment at each clinic site.	Annual enrollment at clinic sites or contracted community partners.	Annual enrollment at point service/designated provider of choice. Verification by CCHP and card issued.
Fees & Co-Pays	No enrollment fees. No co-pays. Deductible amount based on income paid as a percentage of the bill. Pharmacy co-pays up to \$250 annually.	No enrollment fees or provider co-pays.	No enrollment fees. Co-Pays vary by provider up to \$35 per visit.	No enrollment fees.	\$360 annual enrollment fee. \$15 co-pay for most services capped at \$1,000 p/year. All fees and co-pays are waived with income <100% FPL.	No enrollment fees. Co-pays vary by facility and service.
Services	ALL SERVICES deemed medically necessary provided to eligible recipients at certified providers. NOTE: May also be used as co-insurance to cover costs not covered by other programs.	Outpatient primary medical care including labs, pharmacy and specialty care. Dental care. In-patient hospital care. Home health care. Behavioral health care is NOT covered.	Outpatient primary and preventive medical care. Limited specialty care. Pharmacy. Behavioral Health. Dental Care.	Outpatient primary medical care and behavioral health care.	Outpatient medical and specialty care, pharmacy and labs. Limited vision and behavioral health care. Emergency dental. Acupuncture/Chiropractic In-patient at SM Medical Center and home health care.	Assignment to a medical home. Outpatient medical care. All routine medical care provided by CHCs. Specialty care, behavioral health care and dental care are NOT covered.
Provider Network	50 state certified community health centers. Acute care hospitals. Private providers are NOT eligible to participate.	Providers contracted with Medicaid MCOs.	12 contracted non-profit clinics. 1 contracted dental provider.	3 County Facilities. Services provided by INOVA.	San Mateo Medical Center, SMMC clinics, Ravenswood Family Health Center and North East Medical Services.	3 FQHCs receive a per-member-per-month fee to serve enrollees.
Population Served	274,000 (2015)	16,000 (2017)	26,000 to 30,000 annually based on utilization.	12,000 to 15,000 annually based on utilization.	22,000 (2017)	Target 3,000 of estimated 28,000 eligible.
Annual Cost	\$403 million for services and administration.	\$75 million for services and administration.	\$10.8 to \$14 million for services and admin.	\$10.8 million for services and administration.	\$46 million for services and administration.	\$1 million for services.



