



Recommendations from Community Clinics and Health Centers on California's Health Coverage Initiative

Prepared for the California Primary Care Association

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In August 2005, California was granted a Medicaid waiver, which gave the state the flexibility to implement innovative pilot or demonstration projects promoting the objectives of Medicaid. California was allocated \$180 million per year in federal matching funds for the last three years of a five-year demonstration for health coverage expansion (September 1, 2007 through August 31, 2010). Senate Bill 1448 (Stats. 2006, ch. 76) was enacted to provide the statutory framework for the development and implementation of the Health Care Coverage Initiative (CI). Funding for the CI was to be used to provide health care coverage to uninsured individuals who are not eligible for Medi-Cal, Healthy Families or the Access for Infants and Mothers program. As described in the bill [Section 15903(a)-(d)], the CI was intended to achieve the following outcomes:

- (a) Expand the number of Californians who have health care coverage.
- (b) Strengthen and build upon the local health care safety net system, including disproportionate share hospitals, county clinics and community clinics.
- (c) Improve access to high quality health care and health outcomes for individuals.
- (d) Create efficiencies in the delivery of health care services that could lead to savings in health care costs.

In addition, the bill also described preferences for programs that designated a **medical home** for the uninsured individual; had a benefit package that included **preventive and primary care services**, as well as **care management services** to treat patients with chronic care conditions or mental illness; had **quality monitoring** processes to assess health care outcomes; and promoted the **viability of the existing health safety net** [Section 15904(d)(1)-(11)].

Strengthening the Safety Net

The safety net looks different in every county, but generally consists of a combination of federally-qualified health centers, community and free clinics licensed under Section 1204 of the California Health and Safety Code, county clinics, public hospitals and their affiliated clinics, and disproportionate share hospitals. An uninsured or low income patient needing health care services may enter through any door depending on their medical needs, their insurance coverage, and their understanding of where and how to access health care services.

Wherever the encounter takes place, the patient preferably will become established at a medical home, and will access health care before it becomes an emergency.

Increasing access to health care for low income and uninsured individuals requires cooperation and collaboration between all safety net entities. Such cooperation will result in improved health outcomes for the patient, as well as the most cost effective care possible as patients receive health services at the most appropriate level. The CI acknowledged the importance of such cooperation when it required applicants for CI funds to *“strengthen and build upon the local health care safety net system.”*

Community Clinics and Health Centers

Community clinics and health centers (CCHCs) have evolved from grassroots health care organizations run by volunteer physicians in the 1960s, to sophisticated clinics staffed by board certified physicians and other staff who are committed to making a difference in their communities. As one of the few providers who open their doors to anyone regardless of their ability to pay, not-for-profit CCHCs play a critical role in assuring access to health care services in California, serving over four million patients each year. Nearly two-thirds of their patients have incomes below the federal poverty line, 83% live below 200 percent of poverty, and 49% speak a primary language other than English.¹

In addition to primary and preventive care, CCHCs offer a comprehensive continuum of care to their patients that includes access to essential services on-site or by referral including oral health, behavioral health, substance use, and specialty care. These services are supplemented by a broad range of enhanced services that together ensure access to truly patient-centered care including outreach, case management, patient education, translation and interpretation, child care, transportation vouchers, and assistance applying for health insurance coverage.

The comprehensive model used by CCHCs has been shown to provide high-quality and cost-effective care that reduces hospitalizations, emergency department visits, and costly care by specialists. Nationwide, compared with Medicaid patients treated elsewhere, Medicaid patients served at health

Community clinics and health centers deliver the following services:

- Primary health care services including family medicine, internal medicine, pediatrics and ob/gyn
- Diagnostic laboratory and radiologic services
- Preventive health services such as prenatal care, cancer screenings, well child services, immunizations, pediatric vision and hearing screenings, and preventive dental services
- Referrals to specialists and other health-related services such as substance abuse and mental health services
- Patient case management services including counseling, referral and follow-up services
- Services to help eligible patients gain access to health coverage programs, and to provide linkages to social services, housing, educational and other services
- Outreach and transportation services, as well as translation services
- Patient education about the availability and proper use of health services.

centers are between 11% and 22% less likely to be hospitalized for avoidable conditions; 19% less likely to use the emergency room for avoidable conditions; and have lower hospital admission rates, shorter lengths of hospital stays, less costly admissions, and lower outpatient costs. Together, this amounts to 30-33% in total cost savings for each Medicaid beneficiary served in a community health center.^{2,3}

Health centers are funded through government and private funding. In California, Medicaid accounts for about 40% of health center funding. Additional revenue comes from other public sources such as Healthy Families or Medicare; federal, state or county grants or contracts; county indigent care programs; and patient cash payments. About 95% of all patients have incomes below 200% of the federal poverty level. In some communities, CCHCs are the only providers for low income and uninsured people.

In addition, CCHCs:

- Have strong positive relationships with their community. Health center staff are culturally sensitive, and services are offered in many languages. Translation is provided as needed.
- Are in the process of implementing or have implemented electronic health record (E.H.R.) systems, and some are already using disease registries to track health outcomes.
- Monitor and report key health outcome measures for their patient population by gathering data through chart audits, practice management systems and E.H.R.
- Have dispensaries or pharmacies, offer low cost pharmaceuticals with access to 340b discount pricing programs, and help patients access pharmacy assistance programs for free or low cost medication.
- Reach out to the community through mobile units and health fairs, and provide health/dental screenings in schools.

CCHC Roles in the Health Coverage Initiative

Ten counties were awarded CI funding. **Attachment 1** shows the list of awarded counties, target vs. enrollment numbers as of February 28, 2009, as well as the number of clinic subcontractors. Seven counties contracted with a total of 80 CCHCs to provide CI services. CCHCs provided a variety of services depending on how their contract was structured. Some clinics performed **outreach and enrollment services** to link eligible patients with CI covered benefits. Health centers served as **medical homes**, and provided **preventive and primary health care** services, as well as **dental** and **mental health** services. Clinicas del Camino Real in Ventura County reported that many patients received dental care for the first time ever because of the CI. Other patients with diabetes and/or hypertension received **chronic disease management** services in which they obtained medical care and participated in monthly group education classes to help them manage their condition. CCHCs also offered intensive **case management** to assure CI patients were completing their appointments and following through with referrals to specialists.

Partnerships Strengthen the Healthcare Safety Net

While most counties have or will soon meet their CI target numbers, the real value has been in the counties' ability to strengthen the safety net, and to enhance partnerships between safety net providers. The greatest success stories for increasing access to care and improving health outcomes

were in counties where public and private clinic organizations worked together collaboratively during all phases of the CI. CCHCs in several counties reported their relationships were enhanced with county staff and other partners, such as hospitals or community-based programs. The partners recognized a higher level of trust of one another, and they saw the benefits of closer working relationships extend to other health programs where communication and problem solving also improved. For example:

- A few counties initiated **clinician meetings** to gain consistency in the way they were managing patients, particularly with chronic diseases. In Alameda County, a clinician meeting was established for the first time for physicians from private and county health centers. Though their charge was to review medical issues related to the CI, the broader value has been a cross-system clinician's group. They developed common standards of care for patients with diabetes, and they are implementing panel management strategies. Clinician meetings also took place in San Diego County for the first time for CI patients with diabetes and/or hypertension, and again, the value has extended beyond the scope of the CI program.
- CCHCs in Orange County reported that **disease management and care coordination** has improved for all patients as a result of the CI because partners have become more adept at working together.
- Funds from the CI allowed the Los Angeles Department of Public Health to pilot a **centralized database** for all Public Private Partnership (PPP) program patients, which will allow any PPP provider to access patient health information. San Francisco General Hospital has developed a similar database.
- **Data exchange** has been enhanced. In Alameda County, the community clinics have reported information on the number of diabetics and asthmatics in their patient population to the county, and the county has reported on patient characteristics of their County Medical Services Program (CMSP). This patient-specific information has resulted in a better understanding of patient needs, which has helped outreach and enrollment strategies as well as patient care.
- Some counties and clinics who worked closely together to develop and implement the program, **strengthened their working relationships** in the process. **Contra Costa** reported that health centers had several joint meetings with county staff to troubleshoot challenges in CI enrollment. After implementing a number of solutions, the approval rate for applications increased. The result was enhanced communication between community clinics and the county. In **San Diego** County, multiple public and private stakeholders were at the table for the CI program. In both cases there was an extended benefit to programs other than the CI.

Any future CI should support partnerships and encourage all safety net providers to work collaboratively to address the health care needs of low income and uninsured individuals rather than in isolated silos. CCHCs have been involved recently in a number of initiatives involving multiple safety net providers which have resulted from the need to tackle issues collaboratively. For example, implementation of **One-e-App** has helped to develop a uniform approach for streamlining enrollment and retention for state and local health coverage programs in some counties at multiple patient entry points. A number of efforts are underway statewide, such as the California Regional Health Information Organizations (RHIOs), to increase physician access to **patient health information**, whether that patient is seen in a primary care setting or in an emergency room. The statewide **Specialty Care Access Initiative** funded by Kaiser Permanente and the California Healthcare Foundation has resulted in community clinics, county clinics and hospitals, and private hospitals working together to streamline the specialty referral process, develop and implement practice guidelines for specialty care, and identify specialists willing to donate their time for services to low income and uninsured patients. The safety net works together in numerous ways, and needs to continue to do so.

Challenges

The effectiveness of the CI was impaired in some counties where CI funds were not used to strengthen and build upon the safety net as a whole. One of the underlying challenges of the structure of the CI program was requiring health departments to manage the program and budget without any guidelines as to how to fairly allocate funds to other safety net providers. Many if not most health departments face significant budget deficits or inadequate funding for indigent care. The CI was viewed by some counties as a cash infusion that could help to offset these deficits, so funding was targeted as much as possible to their own public clinics and patients. Although the CI legislation required counties to work with community partners, there was no reward for doing so or consequence for avoiding it. As a result, patients suffered because they did not have a choice of providers and could not select the practice setting in which they preferred to receive care, even if that clinic was the only one near their home or workplace. In these situations, relationships were not strengthened, and an opportunity was missed to improve the safety net overall.

Recommendations

At the time this report was written, President Obama had just addressed a joint session of Congress describing his proposal for **health care reform**, and pressing Congress to reach consensus on legislation in support of it. Various proposals have been presented by the House and Senate, including provisions to expand Medicaid income eligibility requirements so more uninsured people are covered, as well as to require prevention and wellness programs. Also referenced in the bills are the requirements to contract with essential community providers such as CCHCs, and for insurers to implement reimbursement structures for care coordination. One version requires a medical home pilot program to evaluate the feasibility of reimbursing health centers and others for providing medical homes. CCHCs support a comprehensive approach to national health care reform that reduces the number of uninsured individuals, and incorporates many of the principles of the California CI as described here.

However if national health care reform does not reach fruition, and California has the opportunity to secure another Medicaid waiver, CCHCs have three recommendations for any future CI. These suggestions are very specific to CCHCs, and they should be taken in a larger context along with recommendations offered more broadly by other organizations. Any future CI or Medicaid waiver should support a coordinated system of care in which all safety net partners work together to improve care to low income and uninsured patients. They should also support innovative programs with demonstrated success in improving quality or reducing cost. The reimbursement structure should match this coordinated system of care. Keeping these broad concepts in mind, CCHCs offer the following clinic-specific recommendations for any future CI or Medicaid waiver, while also supporting recommendations made by other organizations.

CCHC Recommendations

1. Require counties to issue subcontracts to CCHCs and other safety net partners, and develop a methodology to fairly distribute dollars.

The State of California has created incentives in other health coverage programs to support health centers through increased patient flow and reimbursement.⁴ For example, all health plans with Medi-Cal managed care contracts are required to provide access to all FQHC services (see sidebar on Page 2). Medi-Cal local initiative plans are required to offer subcontracts to FQHCs, as well as community and free clinics. These requirements help CCHCs in negotiating reasonable reimbursement rates. In any future CI, the state should strengthen the bill language to require **subcontracts** with CCHCs, rather than only require that the program "*strengthen and build upon the local health care safety net system.*" This requirement would bolster the CCHCs' ability to negotiate a reasonable contract and rates with the county.

To go a step further, the distribution of dollars should be allocated based on several factors including which clinics have capacity to serve patients. CCHCs might also receive funding from the CI in proportion to the relative size of their patient population or the proportion of uninsured served. Either guideline or a combination could be used to help determine the fair distribution of funds by counties.

2. Require counties to submit their CI applications with signatures from representatives of CCHCs and other safety net partners in support of the final proposal.

When counties submit any future applications, the Department of Health Care Services should require a signature not only from a county representative, but also from a representative of other safety net providers in the community, including a clinic association and a hospital association. This process was used on applications submitted by counties to the State of California for hospital bioterrorism preparedness and planning. As a result, counties worked more closely with clinic and hospital leadership during the planning process, and had a better understanding of budgetary implications for program implementation. A similar process should be followed for the next CI.

3. Allocate reasonable funding to CCHCs for start-up activities and direct services.

Assurances need to be put in place not only for subcontracts to be awarded to private CCHCs, but also for those contracts to provide reasonable reimbursement for the required scope of services. The starting point for reimbursement should be the health center's current reimbursement rate for patient visits, the federally determined FQHC rate. If a CI program targets patients with the most challenging conditions, such as diabetes or hypertension, the reimbursement rate should be increased depending on the full scope of services provided. In some counties, health centers were also paid a certain fee for every completed application. In other counties they were paid a monthly flat fee to provide case management services to the target population. Other providers were paid a per-member-per-month rate for case management. Still other counties funded care coordination staff or certified application assistants. Health centers in one county received payment equal to Medicare rates to cover the cost of specialty care.

Administrative dollars should also be provided to all partners for start-up and ongoing programmatic costs such as training, data collection and evaluation. CCHCs operate on a very narrow margin and do not have capacity to add a scope of work without also hiring additional staff or re-assigning existing staff. Reasonable reimbursement is necessary to support CCHCs in providing quality care to diverse patient populations.

Recommendations from Other Organizations

Expand the role of the medical home to include a full scope of services. A UCLA Health Policy Research Brief (June 2009)⁵ reported that participating counties fulfilled the statutory requirements of the CI to link patients with a medical home, which the legislation defined as "*a single provider or facility that maintains all of an individual's medical information*" [Section 15904(d)(3)]. All participating county and clinic providers met this narrow definition of providing a medical home, and also offered some level of care coordination and chronic disease management (see the California Association of Public Hospitals and Health Systems' Policy Brief, April 2009).⁶

However as pointed out in the UCLA paper, the medical home should serve a much more extensive and involved role. The "*Joint Principles of the Patient-Centered Medical Home*" agreed upon in 2007 by the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association add the following additional principles: **coordinated and/or integrated care** facilitated by enhanced communication using information technology and other means; **quality and safety** using evidence-based medicine, information technology, and quality improvement strategies; and **enhanced access** through open scheduling, expanded hours, and other options for communication such as telephone and e-mail. Virtually all CCHCs subscribe to these principles and continue to work toward offering all of these components.

Support a system of care rather than fragmented services. As documented in the report, "*Frequent Users of Emergency Departments: Addressing the Needs of a Vulnerable Population in a Medi-Cal*

*Waiver,*¹⁷ the Corporation for Supportive Housing (CSH) emphasized the importance of managing frequent users, a small group of uninsured and Medi-Cal patients who account for a large share of costs. A national study indicated that 3.6% of Medicaid enrollees with annual costs of more than \$25,000 each accounted for almost half of Medicaid spending. Emergency departments (EDs) are not equipped to meet their multiple ongoing chronic disease, mental illness, substance abuse, and housing needs.

According to CSH, what is needed is patient centered care using a multidisciplinary approach that addresses all of these issues as well as case management and transportation. Essential to care are community based **case managers** to gain the trust of patients who often face social isolation along with their health problems, and work with them to address their multiple complex needs. The report cites a number of model case management programs that resulted in cost savings by reducing the number of frequent user visits to the emergency room. However, despite this evidence, mechanisms have not been put into place to reimburse providers for these services. The next Medicaid waiver provides an opportunity to realign reimbursement mechanisms to support programs like these that work.

Develop a system of care that creates incentives to reduce costs and encourage innovative service delivery solutions. The Blue Shield Foundation concisely summarized the need to develop such a system in its *"State Medi-Cal Waiver Summary of Preliminary Meetings,"* which was provided in public testimony to the state in April 2009:

"The current public health care financing system is unnecessarily fragmented with perverse incentives that needlessly drive costs up and discourage innovation and investments in service delivery reforms, reforms that many believe could result in greater access to care and improvement in health outcomes for the same or less cost."

Taken together, the clinic-specific recommendations, along with those furnished by UCLA, CSH and the Blue Shield Foundation, speak to concepts that should be included in the next CI or Medicaid waiver. In addition to more specific requirements to include CCHCs, the next iteration should require a more extensive role of the medical home. Also needed are proven innovative models that improve service delivery and reduce costs. Funding mechanisms need to be re-aligned to support these innovative practices and reduce fragmentation in the system.

Conclusion

CCHCs bring unique strengths to the safety net system that bolster access to quality cost-effective care. Like public clinics, CCHCs provide a medical home, offer primary and preventive care, and link patients with an extended network for specialty care services. What distinguishes CCHCs from other providers are their rootedness in the community. Health centers have independent boards with a majority of members from the patient community being served. CCHCs provide culturally competent care in the patient's language of choice. They have strong relationships with schools, migrant education programs, community groups, and social service agencies in large part because of their outreach and referral efforts for a variety of clinic programs. Because of this history they have gained the trust of the

community, whose members view CCHCs as resources not only for health care services, but also for linking them with other needed community services.

When patients are linked with CCHCs as medical homes, they are linked with a complete scope of services. CCHCs offer not only medical care, but dental and mental health services, as well as health education, case management, care coordination, discount pharmaceuticals, and other services. Most CCHCs have more capacity than county clinics to see patients, getting them into appointments sooner, offering evening and weekend hours, and offering services at multiple sites throughout an area, including in remote areas where they are the only source of care. As private, independent, 501(c)(3) organizations, they can respond quickly to creative opportunities without the burden of bureaucratic hurdles. Their work in increasing access to specialty care services for their patients is evidence of this creativity and flexibility. CCHC use of health information technology such as electronic data collection and reporting, and most recently implementation of electronic health record with funding from the American Recovery and Reinvestment Act, also reflect the progressiveness of health centers.

In the future, CCHCs hope to see national health care reform that increases coverage and offers many of the same benefits as were offered by the CI. At the same time, discussions are underway at the state level about how to structure the next Medicaid waiver once the current one ends on August 31, 2010 if national health care reform does not pass. While CCHC reaction was mixed to the current CI, some key recommendations have emerged for any future program whose purpose is to increase access to health care for uninsured people. First, require counties to contract with CCHCs and other safety net partners, and distribute dollars fairly based on capacity or proportion of the population served. Second, require clinic and hospital association representatives in each county to sign off on any application submitted on behalf of the safety net to assure they support the final proposal. Third, put mechanisms into place to assure that CCHC subcontracts provide for reasonable reimbursement for the required scope of services. Following these recommendations will help to build up the entire safety net, support collaboration, and maximize access to high quality health care services for diverse patient populations.

¹California Primary Care Association (2009, April). Profile of California's Community Clinics and Health Centers.

² Falik, et al. (2006). Comparative Effectiveness of Health Centers as Regular Source of Care. *Journal of Ambulatory Care Management*. 29(1):24-35.

³ Duggar BC, et al. (1994). *Utilization and Costs to Medicaid of AFDC Recipients in New York Served and Not Served by Community Health Centers*. Center for Health Policy Studies.

⁴ California Healthcare Foundation (2009, July). Issue Brief: Federally Qualified Health Centers and State Health Policy: A Primer for California.

⁵ Pourat N, Reifman C, Roby DH, Meng YY, Diamant AL and Kominski GF (2009, June). Health coverage in the safety net: How California's Coverage Initiative is providing a medical home to low-income uninsured adults in ten counties, interim findings. Los Angeles, CA: UCLA Center for Health Policy Research.

⁶ California Association of Public Hospitals and Health Systems (2009, April). California public hospitals and the Health Care Coverage Initiatives: A model for health care reform, Policy Brief.

⁷ Corporation for Supportive Housing (2009, April). Frequent users of emergency departments: Addressing the needs of a vulnerable population in a Medi-Cal waiver.

Attachment 1: Coverage Initiatives and Target vs. Enrollment Numbers as of February 28, 2009

County	Initiative	Model	Annual Award*	Yr 1 Target Enrollment	Yr 1 Actual (Percent of Target)	Yr 2 Target Enrollment	Yr 2 Actual for 6 months**	# Clinics with CI Contracts	Notes
Santa Clara	Valley Care Coverage Initiative (VC)	A new program to be administered by the existing Valley Health Plan	\$15,250,000	8,300	10,885 (131%)	8,600	17,048 (198%)	10	
Orange	Health Care Coverage Initiative (CI)	Expansion of the Medical Services for the Indigent (MSI) program	\$16,871,578	17,300	20,046 (116%)	17,300	25,036 (145%)	13	
Kern	Kern County Camino de Salud Network (CDSN)	Development of a Public Private Partnership (PPP) as previously implemented in Los Angeles	\$10,000,000	3,500	3,923 (112%)	3,500	4,393 (126%)	0	Breakdown in county/clinic negotiations.
Contra Costa	Contra Costa Health Care Coverage Initiative (HCI)	Expansion of Basic Health Care, a County managed care program	\$15,250,000	8,300	7,118 (86%)	8,600	9,690 (113%)	2	Due to administrative county delays, CCHCs did not begin enrollment until May 2008. As of Feb 2009 only 41 individuals were enrolled at CCHCs.
San Diego	Health Coverage Initiative (CI)	Expansion of the County Medical Services (CMS) indigent care program	\$13,040,000	3,260	1,625 (50%)	3,260	3,545 (109%)	5	
Alameda	Alameda County for Excellence (ACE)	Expansion of the County Medical Services Program (CMSP)	\$8,204,250	4,500	3,805 (85%)	5,000	5,268 (105%)	10	
San Francisco	Healthy San Francisco (formerly Health Access Program)	Expansion of the Healthy San Francisco program	\$24,370,000	10,000	5,674 (57%)	10,000	9,148 (91%)	0	The first year the county drew down \$9 million out of \$16 million available. In Year 2 they drew down \$19 million out of \$25 million as of Feb. 2009.

County	Initiative	Model	Annual Award*	Yr 1 Target Enrollment	Yr 1 Actual (Percent of Target)	Yr 2 Target Enrollment	Yr 2 Actual for 6 months**	# Clinics with CI Contracts	Notes
Ventura	Access Coverage Enrollment Program (ACE)	A new program to expand health coverage	\$10,000,000	12,500	8,465 (69%)	12,500	9,410 (75%)	9	Clinics are capped at 1,250 patients per year (10% of total).
Los Angeles	Healthy Way L.A. (HWLA)	Expansion of the Public Private Partnership (PPP)	\$54,000,000	94,000	17,543	94,000	26,313 (28%)	31	County does not have an executed CI contract with the state, but they are offering CI benefits.

Source of target and enrollment numbers, as well as clinic participation: April 2009 CPCA report.

* Annual award for three years between September 1, 2007 and August 31, 2010.

** Actual enrollment for six months between September 2008 and February 2009

Note: Although San Mateo County received funding they are not included in this analysis.

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