
HMA

HEALTH MANAGEMENT ASSOCIATES

*Financing a Managed System
of Care for the Low-Income
Uninsured in Orange County*

APRIL 23, 2010

*Research and Consulting in the Fields of Health and Human Services Policy, Health Economics
and Finance, Program Evaluation, Data Analysis, and Health System Restructuring*

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Executive Summary

While California and the rest of the nation prepare to implement the many complex pieces of health reform, Orange County is prepared to take a leadership role by implementing a managed system of care (MSC) for the uninsured. Characteristics of a MSC include:

- Enrollees have a medical home
- Care is not episodic (i.e., crisis-based) in nature
- General agreement exists on use of community resources
- Providers follow established procedures for referrals, etc.
- All levels of care (i.e., primary, specialty, inpatient, behavioral, long term care) are effectively utilized and coordinated
- Services are developed based on the needs of a population
- There is a commitment to enhance and a mechanism to evaluate quality of care and health status of the population

In terms of the benefit to Orange County, this system of care will serve three important functions beyond delivering needed health services to low-income uninsured individuals during the interim period before health insurance exchanges and the Medicaid expansion take effect.

First, by coordinating existing programs and leveraging additional federal dollars, the County will receive a much-needed infusion of funding that will aid in developing the medical homes that will be needed to provide services to the many thousands of individuals who will carry new health insurance cards four years from now. Second, given that many of those to be served through this network will be expected to transition into Medicaid and the health insurance exchanges, they will be better prepared by virtue of learning how to receive their care through a managed model sooner rather than later. Third, because they will be receiving care during this interim period, they will be in better health and there should be less pent-up demand when health reform takes full effect.

January Report

In January 2010, Health Management Associates (HMA) completed an analysis of the current delivery system for medically underserved populations in Orange County and issued a report intended to serve as a work plan to guide the community as it develops a more rational, equitable and sustainable delivery system. HMA's January report made specific recommendations in each of the following areas:

- Formalizing the network and governance. The delivery system network must be built upon a sound governance structure – a not-for-profit or quasi-public organization – that is representative of the provider, patient and civic community. The governing body must have the authority to make binding decisions with respect to the target population, care coordination, network management, quality and finance.

- Defining the target population. HMA recommended that the County target individuals with incomes below 133% of the federal poverty level (approximately 80% of the current Medical Services Initiative [MSI] population), who will likely move into Medicaid beginning in 2014 pursuant to the national health reform legislation. Chronically ill individuals who can most benefit from care coordination should also be targeted.
- Developing the components of a structured delivery system. HMA made specific recommendations with respect to developing additional capacity and care coordination across primary care, specialty care, emergency/urgent care services and inpatient care. Expanding FQHC capacity is a critical piece of the overall strategy to add primary care capacity (and potentially specialty care capacity) and improve care coordination.
- Managing the population. The January report recommended an aggressive population health management approach to seek out and enroll chronically ill patients, stratify the enrollees by health status and utilize evidence-based interventions ranging from minimal to full care management. The report further recommended building off of existing care management initiatives in the County, including those offered by CalOptima, MSI and Kaiser Permanente.
- Financing the network. Finally, the report outlined strategies for optimizing current resources and generating new resources to support the functions discussed above.

This report focuses on two key areas from the January report:

- Financing the network. As described in the January report, a sustainable financing strategy includes two major components: 1) maximizing the funds available to support the provision of care to the population through the provider network; and 2) a provider payment system that supports the overall goals of the network. More specifically, the financing system should ensure that all available dollars that could be used as match for additional federal funds are maximized. The financing system should also ensure an equitable distribution of resources across providers based on each provider's role within the system of care.
- Expanding FQHC capacity in the County as a critical piece of the structured delivery system for uninsured patients. FQHCs have the potential to bring substantial new resources into the community – through enhanced reimbursement and federal grants -- to support access for the uninsured. In addition, recent federal guidance may create additional opportunities for FQHCs to incorporate limited specialty services within their scope.

Since the submission of the January report, HMA has conducted preliminary analysis of the existing programs with the purpose of determining whether funding is available, and how much funding could be placed into a managed network for the purpose of leveraging new federal dollars. This phase of the project has focused on determining the most promising avenues for leveraging the new funds. The guiding principles in this process are:

- All segments of the local health care system have “skin in the game,” and make financial and in-kind investments in the system of care accordingly;
- The funding mechanisms with the greatest chance of success are prioritized;
- Wherever possible, funding mechanisms that can be utilized under existing legal authority are prioritized; and
- Solutions that can be implemented in a relatively short time frame (six months or less) are prioritized.

Given the impending changes due to health care reform, any low-probability ideas or ideas with an implementation timeline of more than six months to a year were eliminated from consideration.

Health Care Reform

Health care reform has created significant opportunities not first contemplated when this project began, and HMA has tailored its approach to the new realities. The most significant new opportunity is the impending Medicaid expansion set to take effect in 2014, and the ability of states to implement this expansion early. While HMA does not expect that the State of California will exercise this option, the fact that it exists does open the door for the State to request substantial new federal funding when the current section 1115 waiver is renewed later this year. The recommendations in the report serve to not only provide a structure for the new federal funding to flow into the County, but also to leverage these dollars with existing funds in the system that can be redeployed to maximum advantage.

In addition to the Medicaid expansion, the health reform law explicitly acknowledges the importance of the work being done by communities such as Orange County to develop organized systems of care for the uninsured. Specifically, Section 10333 establishes the “Community-based Collaborative Care Network Program” to support consortiums of health care providers to coordinate and integrate health care services for low-income uninsured and underinsured persons. Community-based Collaborative Care Networks (CBCCNs), made up of safety net hospitals, community health centers and other safety net providers, will offer coordinated care for vulnerable patients in their areas – increasing health care access and quality.

Financing Summary

The major financial aspects of HMA’s recommendations cover a comprehensive list of new uses of funding that are designed to draw additional federal funds into the local health care system. These include an expanded Coverage Initiative (reconfigured as a managed system of care or MSC), additional payments to FQHCs at the University of California at Irvine, enhanced payments to pediatric subspecialty providers, and Medi-Cal administrative claiming for increased outreach activities designed to increase Medicaid enrollment. In addition, there would be new infrastructure costs such as grants for new FQHC start-ups and new access points, information technology systems capital, urgent care/FQHC capital, and network development.

Uses of Funds

In terms of coverage, the overall goal was to cover a total of 120,000 individuals. Based on likely take-up rates and affordability, however, we believe a goal of 85,000 individuals in a managed system of care (MSC) by 2013 is more realistic. Based on analysis of programs in Orange County and elsewhere, it is estimated this will cost \$225 per member per month (PMPM), or \$2,700 for a full year of enrollment. At full ramp-up, this results in an annual cost of \$229.5 million, exclusive of the behavioral health services for a subset of 4,700 enrollees with serious mental illness. With average costs of \$500 PMPM for the behavioral health services, this group adds \$28.2 million annually to the cost of the program. Therefore, the total cost for physical and behavioral health services in the MSC at full enrollment is \$257.5 million. The projected cost for 2011 is \$176.7 million (assuming average enrollment of 55,000) and for 2012 is \$217.2 million (assuming average enrollment of 70,000).

The University of California has expressed a willingness to discuss making an IGT to assist in this effort. They would want to secure additional funding for their FQHCs in the community. These payments would be bonuses for certain activities helpful to a successful managed system of care including serving individuals who would still lack a payment source even after health care reform was initiated. These payments could total \$15 million annually.

Since an important part of a well-functioning local health care infrastructure is to ensure that all potentially eligible individuals are enrolled in Medicaid, it is essential that the County increase its outreach efforts. Therefore, HMA is recommending that an increased \$5 million annually in Medicaid administrative costs be sought to finance enhanced outreach services.

The HMA recommendations include an additional \$45 million annually in spending for a range of purposes. The 2011 proposed levels for these items include enhancing pediatric subspecialty rates (\$5 million), providing grants for new access points (\$400,000), IT systems capital expenditures (\$7.5 million), urgent care/FQHC capital (\$5 million), network development (\$3 million), assistance with current County responsibilities in order to free up matching funds (\$22.5 million), and other purposes (\$1.6 million).

The total of these payments annually in 2011 is \$241.7 million. The non-federal share of this amount is \$120.9 million. The next subsection discusses the sources of funding to cover the non-federal share. At full implementation, in 2013, the total annual payments would be \$322.5 million, of which \$161.3 million in non-federal share would be needed.

Sources of Funds

The first potential source of funds is Mental Health Services Act money that the County currently uses to purchase behavioral health services. If behavioral health is integrated into the MSC, these funds can go into the intergovernmental transfer (IGT) mechanism to be used as matching funds. HMA estimates, based on discussions with County staff, that at least \$14.1 million could be made available through this mechanism annually.

In addition, \$63 million is available through the MSI¹ program, which would be folded into the MSC. Of the \$63 million, \$46 million is new matching funds, i.e., not already matched in the current Coverage Initiative waiver.

The next potential source of funding is an IGT from the University of California at Irvine. Based on discussions with university officials, they may be willing to provide \$10 million through an intergovernmental transfer.

An additional \$10 million could be pumped into the system by CalOptima, assuming they are able to work with physicians, hospitals and other key players in the local health care system to increase their dual eligible penetration in their Medicare Advantage plan.

Even with these sources of funding, there will still be a significant shortfall if additional County matching funds are not identified. In order to make these funds available, however, they must be replaced with alternative sources. This is where the assistance from CalOptima becomes important. Part of the County obligation can be covered from funds CalOptima will receive as increased margin. In addition, HMA recommends that the hospitals work together to formulate an investment strategy built upon voluntary financial contributions to the system that would reflect the disproportionate burden and benefit of the new system to certain hospitals. HMA recommends that up to \$20 million be generated by this mechanism, which would translate to the ability to serve nearly 15,000 additional enrollees.

¹ The MSI program is Orange County's mechanism for paying local providers for care provided to uninsured individuals. Part of the program is already matched through the Coverage Initiative portion of the state's section 1115 waiver.

Enrollment, Sources and Uses	2011	2012	2013	3- yr
Enrollment	55,000	70,000	85,000	
Weighted PMPM (includes SMI add-on)	\$ 268	\$ 259	\$ 253	
				
Uses (millions)				
Cost of Care				
Benefit costs	\$ 176.7	\$ 217.2	\$ 257.5	\$ 651.4
UCI/FQHC bonus payments	\$ 15.0	\$ 15.0	\$ 15.0	\$ 45.0
Medi-Cal outreach	\$ 5.0	\$ 5.0	\$ 5.0	\$ 15.0
Pediatric subspecialty	\$ 5.0	\$ 5.0	\$ 5.0	\$ 15.0
Infrastructure Costs				
New access points/new starts grants	\$ 0.4	\$ 0.4	\$ 0.4	\$ 1.2
IT systems capital	\$ 7.5	\$ 7.5	\$ 5.0	\$ 20.0
Urgent Care/FQHC capital	\$ 5.0	\$ 5.0	\$ 3.0	\$ 13.0
Responsibility sharing with county	\$ 22.5	\$ 22.5	\$ 27.0	\$ 72.0
Network development	\$ 3.0	\$ 3.0	\$ 3.0	\$ 9.0
Other	\$ 1.6	\$ 1.6	\$ 1.6	\$ 4.8
Total Uses	\$ 241.7	\$ 282.2	\$ 322.5	\$ 846.4
Non-federal Share (regular FMAP)	\$ 120.9	\$ 141.1	\$ 161.3	\$ 423.3
Sources of Funds (millions)				
Mental Health Services Act (Prop 63)	\$ 14.1	\$ 14.1	\$ 14.1	\$ 42.3
MSI	\$ 63.0	\$ 63.0	\$ 63.0	\$ 189.0
UC Irvine IGT	\$ 10.0	\$ 10.0	\$ 10.0	\$ 30.0
Cal Optima duals	\$ 10.0	\$ 10.0	\$ 10.0	\$ 30.0
Other County Match	\$ 23.8	\$ 44.0	\$ 64.2	\$ 132.0
Total Sources	\$ 120.9	\$ 141.1	\$ 161.3	\$ 423.3
County match needed	\$ 23.8	\$ 44.0	\$ 64.2	\$ 132.0
Assistance with County expenditures				
Cal Optima	\$ 22.5	\$ 22.5	\$ 27.0	\$ 72.0
Hospital contributions	\$ 20.0	\$ 20.0	\$ 20.0	\$ 60.0
Total assistance	\$ 42.5	\$ 42.5	\$ 47.0	\$ 132.0

Being able to direct the right payments to the County, and securing the ability to use the funds identified by HMA as available will depend upon taking action on a set of recommendations around the structure of the program and the flow of funds. These recommendations are as follows:

Recommendation 1: Use 1115 Waiver Authority to Expand Coverage Initiative

The County should request that the State seek authority from the Centers for Medicare and Medicaid Services (CMS) to approve a greatly expanded Coverage Initiative program. The State should ask that CMS use the section 1115 waiver mechanism to permit counties to implement the health care reform eligibility expansion early. This should be done in the context of waiver authority in order to provide for geographic diversity in eligibility levels and benefit package. Since the State can now cover individuals up to 133 percent of the federal poverty level (FPL) pursuant to health care reform, the State should ask CMS to treat Coverage Initiative enrollees up to that level as a state plan population for the purpose of

calculating budget neutrality. The implication of this technical request is that the State would be able to expand the Coverage Initiative program well beyond the existing \$180 million annual size of the program.

There are a number of required implementation steps that can take place simultaneously. The first is to design the benefit package for the expanded population. HMA assumes this design process would take place in the context of a facilitated planning process involving key stakeholders, including the Orange County Healthcare Agency (OCHA) and sister agencies, hospitals and other providers, and CalOptima.

In addition, there is action required at both the state and federal levels. In conjunction with the waiver renewal, the state would have to make the request of CMS. Typically this involves submitting a concept paper, having preliminary discussions with CMS, submitting a formal proposal, and then entering into negotiations on programmatic and financial elements of the waiver. Given that some of this process has already unfolded, time is of the essence in communicating to the state that the waiver proposal should include these elements. Orange County has already submitted a concept paper to the State that has enough flexibility to accommodate this framework. The state has also started the process with CMS and is attempting to complete negotiations for a September 1, 2010 start date.

Layered on top of that is the federal review and approval process. This proposal does not work unless CMS and its budget counterpart, the Office of Management and Budget (OMB), agree to a preferential budget neutrality calculation based on the fact that states can now expand Medicaid to childless adults under the health care reform law.

Recommendation 2: Use Unmatched County Funds as Intergovernmental Transfer to Draw Down Federal Funds

The County should make available, in the form of an intergovernmental transfer (IGT), currently unmatched funding from the MSI and other programs. The purpose of this transfer would be to provide the non-federal share of payments that the Department of Health Care Services (DHCS) would make for the expanded Coverage Initiative program in Orange County. HMA understands that not all expenditures that are currently financed with the County funds that would constitute the IGT could be included in the waiver payments; however, under the following recommendation CalOptima could by contract shoulder some of the burden for the MSI obligation.

The first step is to identify the unmatched funds. At a minimum, these include the funds currently paying for the MSI program, Realignment funds, and Mental Health Services Act funds. As long as appropriate payment mechanisms for new federal funds can be identified, other County funds could be included as well. The basic elements for determining whether County funds can be used in an IGT are:

- There are no legal barriers to transferring the funds to the state (e.g., such as if the existing program is structured in such a way that the County would not have the flexibility to use the funds to leverage federal dollars); and
- The money is not already being used to draw down other federal funds.

The main limiting factor is identifying sufficient approvable conduits for returning the County funds along with new federal funds.

The next step in the process is to categorize the current uses of the money in terms of the following factors:

- The current use could conceivably be folded into the MSC benefit package (e.g., current MSI services and enrollees, behavioral health services provided to individuals who would meet MSC eligibility criteria)
- The current use would not fit into the new MSC construct, but could be financed in another way, such as funds that could be routed through CalOptima as explained in Recommendation 3 (e.g., behavioral health services provided to individuals who would not meet MSC eligibility criteria)
- The current use would not fit into one of the above categories, either because there are insufficient funds or the services do not meet any of the stated criteria.

Once the universe of available funds is identified, and the County has a handle on where the current uses will crosswalk to the new structure, it is necessary to develop methodologies for paying for the services. Behavioral health services that are added to the MSC benefit package can be paid for on a capitation basis, with the PMPM rate being based on eligibility and utilization data. This has the advantage of providing a steady stream of funding that is not dependent on providers submitting claims. The County can continue to pay providers according to its preferred methodology, but one major benefit is that the federal funding that will flow based on the IGT, in addition to permitting for expanded eligibility in the MSC, can provide for expanded behavioral health services. Behavioral health services for non-MSC individuals, as well as other services that do not meet Medicaid criteria, would be paid for with funding that would be routed through CalOptima (this is discussed in further detail in Recommendation 3).

Simultaneously with these exercises, the County would need to obtain the required approvals for any changes to the way the money is spent. This consideration mainly applies to the MHSA money, as there is a formal process for approval of the uses of MHSA money.

Recommendation 3: Request a Capitation Rate Increase for CalOptima

CalOptima should request that the State use existing legal authority to increase the margin component of its capitation payment from the current 2 percent to the maximum 6 percent. The nonfederal share of this increase would come from a portion of an additional County IGT. This amounts to \$45 million at current levels. This money would be used for a variety of purposes including taking greater responsibility for certain care for which they share responsibility with the County. This includes certain behavioral health opportunities, pediatric subspecialties, and potentially some responsibility for jail health. This will also have the effect of increasing the number of individuals who can be served in the Coverage Initiative.

Authority already exists to include a profit margin of up to 6 percent for CalOptima. The only action required by the state would be to submit an amended contract to the CMS regional office for review.

Because no covered services or populations would be changed, this action should not require a SPA or section 1915(b) waiver amendment. Since this is not a state plan amendment, CMS does not have the opportunity to ask its standard set of financing questions, so the review and approval process should not be controversial.

Another part of the implementation is to secure an agreement with CalOptima that funnels the money back to the County. This agreement can take any form and does not require CMS approval. The agreement should cover the amount and nature of the payments and the purpose. The funding should be used to cover services that cannot be folded into the MSC capitation rate that will flow from the state to the County through the waiver.

Recommendation 4: Secure Contributions from Hospitals for the Managed System of Care

In order to cover the maximum possible number of uninsured individuals, the County's hospitals should make financial contributions according to a rational methodology that takes into consideration other existing and new tax burdens the facilities already face. This contribution will have the effect of maximizing the number of people covered, negating the need to forego MSI revenue, and giving all of the facilities a stake in the system. Ideally, the methodology would recognize that the population that is served in the Coverage Initiative program is unevenly spread amongst the County's hospitals.

Because these funds would be generated and spent locally, there are no state or federal hurdles to clear. Therefore, this part of the plan becomes a matter of developing a rational methodology for developing a voluntary and predictable level of contributions from the hospitals.

The first step would be to meet with hospitals to secure buy-in and discuss a target amount. In addition, it is necessary to develop and review a methodology for calculating the hospitals' contributions. It may be necessary to develop several alternative methodologies. One possible methodology would be to collect a percentage of the value of each hospital's fixed assets. It might make sense to impose a heavier burden on not-for-profit hospitals, since they are exempt from property taxes but unlike other areas they serve a disproportionately low number of Medicaid and uninsured.

The key to this proposal succeeding will be explaining the benefit of the investment to be made, both in terms of the number of people who can be covered as well as the federal funds that are leveraged by virtue of the hospital contribution freeing up County funding to provide to the state in the form of an IGT.

The final step is to identify who will receive the payments and develop a system for tracking the collection and expenditure of the contributions from hospitals.

Recommendation 5: Increase Local Medi-Cal Outreach Efforts

In order to use local resources wisely, the County should ensure that all eligible individuals are enrolled in Medi-Cal. Toward that end, outreach efforts should be stepped up. The County should plan to spend at least \$5 million annually on these efforts, and this should be financed as a Medicaid administrative expense.

The benefit of ensuring that all eligible individuals are enrolled in Medi-Cal is self-evident. Each potentially eligible individual who is not enrolled is a person who can potentially end up using local health care services as an uninsured person, thus drawing away from the funds that can otherwise be used for those who are not eligible for any other program. States have the ability to pay for outreach services out of Medicaid administrative funds, and it is likely that Orange County agencies are performing many of these functions without reimbursement.

In addition to the major funding pieces outlined here, there are additional opportunities for lesser, but still significant, amounts of money. These include health information technology (HIT) funding targeted toward integration of systems of care between behavioral health and physical health as well as opportunities to improve care for individuals dually eligible for both Medicaid and Medicare. This is an area in which Orange County is well ahead of most of the nation and CMS is clearly aware of and interested in funding these efforts.

In addition, there are new funds available for community networks and new grant dollars for FQHCs. Many of these ideas are highlighted in the report, but the major recommendations are targeted towards large dollar values that we can currently access and evaluate.

We would also be remiss in not discussing the significant FQHC application activity in the County from a variety of clinics as well as the significant revenues the conversion of the Children's Hospital of Orange County clinics to an FQHC status would create (approximately \$4.2 million per year in Medi-Cal reimbursement). These activities and monies are essential to a managed system of care for low income populations, but still do not rise to the level of major funding recommendations. With significant efforts by the County and CalOptima and critical assistance from the hospital community a conservative estimate of new money is \$80 million. It could be considerably more over time as the system participants learn to work together.

With regard to FQHCs, HMA recommends that Orange County:

- Create additional FQHC capacity in the County through at least one new FQHC (with multiple locations) that would, ideally, incorporate the Children's Hospital of Orange County outpatient clinics.
- Support the efforts of community providers including VNCOC, Friends of Children and Camino Clinic that are in various stages of applying for FQHC or Look-Alike designation.
- Establish clear community expectations with respect to the responsibility of FQHCs to care for the uninsured.
- Explore opportunities for integrating specialty care into the FQHC setting.

The remainder of this report serves to provide additional detail on the financing plan and HMA's specific recommendations.

Introduction

In January 2010, Health Management Associates (HMA) completed an analysis of the current delivery system for medically underserved populations in Orange County and issued a report intended to serve as a work plan to guide the community as it develops a more rational, equitable and sustainable delivery system. HMA's January report made specific recommendations in each of the following areas:

- Formalizing the network and governance. The delivery system network must be built upon a sound governance structure – a not-for-profit or quasi-public organization – that is representative of the provider, patient and civic community. The governing body must have the authority to make binding decisions with respect to the target population, care coordination, network management, quality and finance.
- Defining the target population. HMA recommended that the county target individuals with incomes below 133% of the federal poverty level (approximately 80% of the current MSI population), who will likely move into Medicaid beginning in 2014 pursuant to the national health reform legislation. Chronically ill individuals who can most benefit from care coordination should also be targeted.
- Developing the components of a structured delivery system. HMA made specific recommendations with respect to developing additional capacity and care coordination across primary care, specialty care, emergency/urgent care services and inpatient care. Expanding FQHC capacity is a critical piece of the overall strategy to add primary care capacity (and potentially specialty care capacity) and improve care coordination.
- Managing the population. The January report recommended an aggressive population health management approach to seek out and enroll chronically ill patients, stratify the enrollees by health status and utilized evidence-based interventions ranging from minimal to full care management. The report further recommended building off of existing care management initiatives in the County, including those offered by Cal-Optima, MSI and Kaiser Permanente.
- Financing the network. Finally, the report outlined strategies for optimizing current resources and generating new resources to support the functions discussed above.

This report focuses on two key areas from the January report:

- Financing the network. As described in the January report, a sustainable financing strategy includes two major components: 1) maximizing the funds available to support the provision of care to the population through the provider network; and 2) a provider payment system that supports the overall goals of the network. More specifically, the financing system should ensure that all available dollars that could be used as match for additional federal funds are maximized. The financing system should also ensure an equitable distribution of resources across providers based on each provider's role within the system of care.

- Expanding FQHC capacity in the County as a critical piece of the structured delivery system for uninsured patients. FQHCs have the potential to bring substantial new resources into the community – through enhanced reimbursement and federal grants -- to support access for the uninsured. In addition, recent federal guidance may create additional opportunities for FQHCs to incorporate limited specialty services within their scope.

Both of these areas are discussed in more detail below, along with specific recommendations, next steps and timelines.

Managed System of Care – Cost Considerations

Estimating Cost of Care

In any system of care, the cost will depend upon the number of individuals enrolled in the plan and the average cost of meeting that population's health care needs. This is usually expressed as a per member per month (PMPM) cost. The projected cost of the Orange County Managed System of Care (MSC) depends upon estimates of these two variables, the number of persons enrolled and the PMPM. Since the program design will vary somewhat from the current Coverage Initiative program, it is necessary to approximate the projected cost using several sources of information. These include experience and data from Orange County and other local programs similar to MSC in California and other states. The cost of the individual components of the MSC, which may in total be different from other programs, can also be estimated from others' experiences.

Number of enrollees

The current patients of the Medical Services Initiative (MSI), the Orange County program to cover the indigent, will be subsumed into the newly formed MSC. The enrollment experience of MSI will provide some guidance on the enrollment estimates for the MSC. MSI enrolled 20,000 patients in its first program year, and an additional 9,000 in year two, and 6,000 in the first six months of the current year. Some of the slowed growth was due to restrictions on enrollment placed upon the program. Currently, persons eligible for the MSC are estimated to number 107,000 in Orange County. Recently, the Orange County Health Care Agency had estimated that, if funding were available, it would be capable of expanding MSI by 30,000 new enrollees, from its current 35,000 to 65,000 within one year, and then by an additional 20,000 newly enrolled to 85,000 total in the following year. This seems to be an ambitious enrollment growth for the MSC to assume over a two-year period. Recent national health reform legislation will, by 2014, provide Medicaid coverage for an estimated 80% of the population that MSC intends to serve. However, incremental reform measures in this legislation will provide new coverage opportunities for this same population within each of the next four years. Although these federal health reform measures are relatively modest compared to the Medicaid expansion, they are real and substantial enough to decrease some percentage of the uninsured in Orange County. Therefore, new enrollment into MSC of 20,000 in year one, 15,000 in year two, and 15,000 in year three seems still ambitious but realistic for the MSC program, bringing total enrollment to 85,000 persons enrolled in MSC by the third year.

Overall Cost Experience

The Orange County MSI program recently projected the expanded program costs of \$213 PMPM based on its historical experience. Its average PMPM cost over the last two years was approximately \$185 although provider reimbursement was low for certain health services. However, services were paid in a fee for service manner and, at times with retroactive payments. Utilization management and care

management could be more robust components of MSI in future phases and this would serve as the basis for calculating the estimated PMPM going forward.

Healthy San Francisco is a program created by the city of San Francisco that makes health care services accessible and affordable for its uninsured residents. According to a recent report by the San Francisco Department of Health, coverage through Healthy San Francisco cost about \$280 per month per person. However, approximately \$50 PMPM of this is due to behavioral health services, making a comparable PMPM of \$230 PMPM.

Genesee Health Plan (GHP) of Genesee County Michigan is a limited health benefit program for residents of Genesee County. There is no cost to join GHP and no monthly fees, but there are minimum co-pays for services and prescriptions. GHP pays for doctor visits, prescriptions, lab tests and x-rays; it does not cover hospitalization. PMPM costs are approximately \$140 for the average person enrolled in the plan.

A local IPA in Orange County reported that they could provide a medical home, outpatient specialty care, diagnostics and lab including medication, but excluding behavioral health and inpatient care for \$80 to \$96 PMPM. It is important to note this was an estimate not a quote.

Health Status of the MSC population.

The California Health Interview Survey (CHIS) measures the health status of uninsured residents of Orange County as somewhat worse than San Francisco. However, due to the past methods of enrollment that recruited the current MSI patients, the sickest persons are likely to already be enrolled. Few persons without a serious health event or a chronic illness have been enrolled in MSI. This means that the 50,000 new persons to be enrolled in the program will have a significantly better health than the average health status of the uninsured persons described in the CHIS report.

PMPM Estimate:

Based on the above factors it seems that a base PMPM of approximately \$190 could provide care for the entire 85,000 persons enrolled in MSC if well managed. In addition, increases to this figure are listed below.

Upfront investment in MSC:

Some upfront investment in MSC is warranted to gain efficiency through vigorous management of its population's health. Improved health and cost savings are usually demonstrated by the second program year. Supportive infrastructure and additional care management are the main areas that warrant investment. The current MSI program, IPAs within Orange County, and CalOptima all have some level of infrastructure and care management, but most recognize the benefits of these components to health care delivery and plan to increase the level of both. MSC has the opportunity to address these areas upfront.

The needs for information technology include the following:

- A Chronic Disease Registry
- ER Connect, to efficiently manage emergency room visit and re-connect the patient with the Medical Home
- Clinic Connect, to be aware, coordinate and manage care at the Medical Home level
- E referral/consult, to provide efficient, accessible, effective initial and follow-up specialty consultation
- eCeda, a real time inpatient census monitor to reduce length of stay
- Pharmacy monitor capability to monitor under and over usage and manage chronic conditions
- Care Management software

The cost of the above are expressed in PMPM and are sensitive to enrollment volume, but would average approximately \$1.40 PMPM. Additional HMO administrative costs would add an estimated \$8.60 PMPM.

Care management is included in the PMPM in most plans. However, more effort in care management is necessary to meet the best health status goals and achieve care within the base PMPM proposed above. Recent studies published by the Orange County Health Care Agency have documented opportunities to decrease emergency room use by persons who are likely to be enrolled in MSC. ED diversion programs are needed for the small number (200-300 persons) that are in the highest tier of ED use and represent major opportunities to affect ED costs. Experience in California Counties affirms the ability to reduce the use of EDs by these patients at a yearly cost of \$ 3,000-5,000 per client. These costs are estimated at \$2.80 PMPM.

The Medical Home is expected to provide some measure of care management in all health plans, however the level of care coordination and management is heightened in plans for the MSC and perhaps \$10 additional PMPM is appropriate to reimburse for increased expectations.

Additional care management staff, based on highly managed populations adds approximately \$2 PMPM over what is included in conventional PMPM payments. Finally, behavioral health services (non-SMI) are expected to add an additional \$10 PMPM. After addition the additional service, care management and IT costs to the base PMPM, the final estimated PMPM is \$225.

Financing Summary

The major financial aspects of HMA's recommendations cover a comprehensive list of new uses of funding that are designed to draw additional federal funds into the local health care system. These include an expanded Coverage Initiative (reconfigured as a managed system of care or MSC), additional payments to FQHCs at the University of California at Irvine, enhanced payments to pediatric subspecialty providers, and Medi-Cal administrative claiming for increased outreach activities designed to increase Medicaid enrollment. In addition, there would be new infrastructure costs such as grants for new FQHC start-ups and new access points, information technology systems capital, urgent care/FQHC capital, and network development. The uses and sources of funding as recommended by HMA are described below. This is followed by a detailed set of recommendations concerning the steps that must be taken to secure the funding sources and set up the appropriate uses of the new federal funds.

Uses of Funds

In terms of coverage, the overall goal was to cover a total of 120,000 individuals. Based on likely take-up rates and affordability, however, we believe a goal of 85,000 individuals in a managed system of care (MSC) by 2013 is more realistic. Based on analysis of programs in Orange County and elsewhere, it is estimated this will cost \$225 per member per month (PMPM), or \$2,700 for a full year of enrollment. At full ramp-up, this results in an annual cost of \$229.5 million, exclusive of the behavioral health services for a subset of 4,700 enrollees with serious mental illness. With average costs of \$500 PMPM for the behavioral health services, this group adds \$28.2 million annually to the cost of the program. Therefore, the total cost for physical and behavioral health services in the MSC at full enrollment is \$257.5 million. The projected cost for 2011 is \$176.7 million (assuming average enrollment of 55,000) and for 2012 is \$217.2 million (assuming average enrollment of 70,000).

The University of California has expressed a willingness to discuss making an IGT to assist in this effort. They would want to secure additional funding for their FQHCs in the community. These payments would be bonuses for certain activities helpful to a successful managed system of care including serving individuals who would still lack a payment source even after health care reform was initiated. These payments could total \$15 million annually.

Since an important part of a well-functioning local health care infrastructure is to ensure that all potentially eligible individuals are enrolled in Medicaid, it is essential that the County increase its outreach efforts. Therefore, HMA is recommending that an increased \$5 million annually in Medicaid administrative costs be sought to finance enhanced outreach services.

The HMA recommendations include an additional \$45 million annually in spending for a range of purposes. The 2011 proposed levels for these items include enhancing pediatric subspecialty rates (\$5 million), providing grants for new access points (\$400,000), IT systems capital expenditures (\$7.5 million), urgent care/FQHC capital (\$5 million), network development (\$3 million), assistance with current County responsibilities in order to free up matching funds (\$22.5 million), and other purposes (\$1.6 million).

The total of these payments annually in 2011 is \$241.7 million. The non-federal share of this amount is \$120.9 million. The next subsection discusses the sources of funding to cover the non-federal share. At full implementation, in 2013, the total annual payments would be \$322.5 million, of which \$161.3 million in non-federal share would be needed.

Sources of Funds

The first potential source of funds is Mental Health Services Act money that the County currently uses to purchase behavioral health services. If behavioral health is integrated into the MSC, these funds can go into the intergovernmental transfer (IGT) mechanism to be used as matching funds. HMA estimates, based on discussions with County staff, that at least \$14.1 million could be made available through this mechanism annually.

In addition, \$63 million is available through the MSI² program, which would be folded into the MSC. Of the \$63 million, \$46 million is new matching funds, i.e., not already matched in the current Coverage Initiative waiver.

The next potential source of funding is an IGT from the University of California at Irvine. Based on discussions with university officials, they may be willing to provide \$10 million through an intergovernmental transfer.

An additional \$10 million could be pumped into the system by CalOptima, assuming they are able to work with physicians, hospitals and other key players in the local health care system to increase their dual eligible penetration in their Medicare Advantage plan.

Even with these sources of funding, there will still be a significant shortfall if additional County matching funds are not identified. In order to make these funds available, however, they must be replaced with alternative sources. This is where the assistance from CalOptima becomes important. Part of the County obligation can be covered from funds CalOptima will receive as increased margin. In addition, HMA recommends that the hospitals work together to formulate an investment strategy built upon voluntary financial contributions to the system that would reflect the disproportionate burden and benefit of the new system to certain hospitals. HMA recommends that up to \$20 million be generated by this mechanism, which would translate to the ability to serve nearly 15,000 additional enrollees.

Being able to direct the right payments to the County, and securing the ability to use the funds identified by HMA as available will depend upon taking action on a set of recommendations around the structure of the program and the flow of funds. These recommendations are described in the following section.

² The MSI program is Orange County's mechanism for paying local providers for care provided to uninsured individuals. Part of the program is already matched through the Coverage Initiative portion of the state's section 1115 waiver.

Enrollment, Sources and Uses	2011	2012	2013	3- yr
Enrollment	55,000	70,000	85,000	
Weighted PMPM (includes SMI add-on)	\$ 268	\$ 259	\$ 253	
				
Uses (millions)				
Cost of Care				
Benefit costs	\$ 176.7	\$ 217.2	\$ 257.5	\$ 651.4
UCI/FQHC bonus payments	\$ 15.0	\$ 15.0	\$ 15.0	\$ 45.0
Medi-Cal outreach	\$ 5.0	\$ 5.0	\$ 5.0	\$ 15.0
Pediatric subspecialty	\$ 5.0	\$ 5.0	\$ 5.0	\$ 15.0
Infrastructure Costs				
New access points/new starts grants	\$ 0.4	\$ 0.4	\$ 0.4	\$ 1.2
IT systems capital	\$ 7.5	\$ 7.5	\$ 5.0	\$ 20.0
Urgent Care/FQHC capital	\$ 5.0	\$ 5.0	\$ 3.0	\$ 13.0
Responsibility sharing with county	\$ 22.5	\$ 22.5	\$ 27.0	\$ 72.0
Network development	\$ 3.0	\$ 3.0	\$ 3.0	\$ 9.0
Other	\$ 1.6	\$ 1.6	\$ 1.6	\$ 4.8
Total Uses	\$ 241.7	\$ 282.2	\$ 322.5	\$ 846.4
Non-federal Share (regular FMAP)	\$ 120.9	\$ 141.1	\$ 161.3	\$ 423.3
Sources of Funds (millions)				
Mental Health Services Act (Prop 63)	\$ 14.1	\$ 14.1	\$ 14.1	\$ 42.3
MSI	\$ 63.0	\$ 63.0	\$ 63.0	\$ 189.0
UC Irvine IGT	\$ 10.0	\$ 10.0	\$ 10.0	\$ 30.0
Cal Optima duals	\$ 10.0	\$ 10.0	\$ 10.0	\$ 30.0
Other County Match	\$ 23.8	\$ 44.0	\$ 64.2	\$ 132.0
Total Sources	\$ 120.9	\$ 141.1	\$ 161.3	\$ 423.3
County match needed	\$ 23.8	\$ 44.0	\$ 64.2	\$ 132.0
Assistance with County expenditures				
Cal Optima	\$ 22.5	\$ 22.5	\$ 27.0	\$ 72.0
Hospital contributions	\$ 20.0	\$ 20.0	\$ 20.0	\$ 60.0
Total assistance	\$ 42.5	\$ 42.5	\$ 47.0	\$ 132.0

Managed System of Care – Financing Recommendations

While California and the rest of the nation prepare to implement the many complex pieces of health reform (See Appendix C for a summary), Orange County is prepared to take a leadership role by implementing the MSC for the uninsured. This system of care will serve three important functions beyond delivering needed health care to low-income uninsured individuals during the interim period before health insurance exchanges and the Medicaid expansion take effect.

First, by coordinating existing programs and leveraging additional federal dollars, the County will receive a much-needed infusion of funding that will aid in developing the medical homes that will be needed to provide services to the many thousands of individuals who will carry new health insurance cards four years from now. Second, given that many of those to be served through this network will be expected to transition into Medicaid and the health insurance exchanges, they will be better prepared by virtue of learning how to receive their care through a managed model sooner rather than later. Third, because they will be receiving care during this interim period, they will be in better health and there should be less pent-up demand when health reform takes full effect.

Health Management Associates (HMA) has conducted preliminary analysis of the existing programs with the purpose of determining whether funding is available, and how much funding could be placed into a managed network for the purpose of leveraging new federal dollars. This phase of the project has focused on determining the most promising avenues for leveraging the new funds. The guiding principles in this process are:

- All segments of the local health care system have “skin in the game,” and make financial and in-kind investments in the system of care accordingly;
- The funding mechanisms with the greatest chance of success are prioritized;
- Wherever possible, funding mechanisms that can be utilized under existing legal authority are prioritized; and
- Solutions that can be implemented in a relatively short time frame (six months or less) are prioritized.

Given the impending changes due to health care reform, any low-probability ideas or ideas with an implementation timeline of more than six months to a year were eliminated from consideration. With these guiding principles in mind, HMA makes the following recommendations for financing the managed system of care.

Recommendation 1: Use 1115 Waiver Authority to Expand Coverage Initiative

The County should request that the State seek authority from the Centers for Medicare and Medicaid Services (CMS) to approve a greatly expanded Coverage Initiative program. The State should ask that CMS use the section 1115 waiver mechanism to permit counties to implement the health care reform eligibility expansion early. This should be done in the context of waiver authority in order to provide for

geographic diversity in eligibility levels and benefit package. Since the State can now cover individuals up to 133 percent of the federal poverty level (FPL) pursuant to health care reform, the State should ask CMS to treat Coverage Initiative enrollees up to that level as a state plan population for the purpose of calculating budget neutrality. The implication of this technical request is that the State would be able to expand the Coverage Initiative program well beyond the existing \$180 million annual size of the program.

Recommendation 2: Use Unmatched County Funds as Intergovernmental Transfer to Draw Down Federal Funds

The County should make available, in the form of an intergovernmental transfer (IGT), currently unmatched funding from the MSI and other programs. The purpose of this transfer would be to provide the non-federal share of payments that the Department of Health Care Services (DHCS) would make for the expanded Coverage Initiative program in Orange County. HMA understands that not all expenditures that are currently financed with the County funds that would constitute the IGT could be included in the waiver payments; however, under the following recommendation CalOptima could by contract shoulder some of the burden for the MSI obligation.

Recommendation 3: Request a Capitation Rate Increase for CalOptima

CalOptima should request that the State use existing legal authority to increase the margin component of its capitation payment from the current 2 percent to the maximum 6 percent. The nonfederal share of this increase would come from a portion of an additional County IGT. This amounts to \$45 million at current levels. This money would be used for a variety of purposes including taking greater responsibility for certain care for which they share responsibility with the County. This includes certain behavioral health opportunities, pediatric subspecialties, and potentially some responsibility for jail health. This will also have the effect of increasing the number of individuals who can be served in the Coverage Initiative.

Recommendation 4: Secure Contributions from Hospitals for the Managed System of Care

In order to cover the maximum possible number of uninsured individuals, the County's hospitals should make financial contributions according to a rational methodology that takes into consideration other existing and new tax burdens the facilities already face. This contribution will have the effect of maximizing the number of people covered, negating the need to forego MSI revenue, and giving all of the facilities a stake in the system. Ideally, the methodology would recognize that the population that is served in the Coverage Initiative program is unevenly spread amongst the County's hospitals.

Recommendation 5: Increase Local Medi-Cal Outreach Efforts

In order to use local resources wisely, the County should ensure that all eligible individuals are enrolled in Medi-Cal. Toward that end, outreach efforts should be stepped up. The County should plan to spend at least \$5 million annually on these efforts, and this should be financed as a Medicaid administrative expense.

The next section examines each of these recommendations in detail, including a discussion of the County, state, and/or federal barriers to implementing each one and the projected timeline.

Discussion of Recommendations

Recommendation 1: Use 1115 Waiver Authority to Expand Coverage Initiative

The County should request that the State seek authority from the Centers for Medicare and Medicaid Services (CMS) to approve a greatly expanded Coverage Initiative program. The State should ask that CMS use the section 1115 waiver mechanism to permit counties to implement the health care reform eligibility expansion early. This should be done in the context of waiver authority in order to provide for geographic diversity in eligibility levels and benefit package. Since the State can now cover individuals up to 133 percent of the federal poverty level (FPL) pursuant to health care reform, the State should ask CMS to treat Coverage Initiative enrollees up to that level as a state plan population for the purpose of calculating budget neutrality. The implication of this technical request is that the State would be able to expand the Coverage Initiative program well beyond the existing \$180 million annual size of the program.

Additional Detail

Under the newly enacted health care reform law, all individuals with income up to 133 percent of the FPL will become eligible for Medicaid in 2014. There will be full federal funding for these newly covered individuals. Before this time, however, states have the option to implement this expansion using Medicaid state plan amendment (SPA) authority at the regular Medicaid matching rate.

While HMA does not expect the state of California to exercise this option, the state does have the ability, through the section 1115 waiver that will be up for renewal in September, to request authority to implement this expansion on a County-by-County basis. Since this would be done through the waiver, CMS would have the authority to permit geographic diversity in terms of eligibility levels, benefit package, cost sharing, and delivery system.

Given that health care reform allows for such an expansion, and given that California already has a Coverage Initiative in the current waiver, this authority would not be groundbreaking. The key new element, however, is that the state can ask CMS to change the way it treats the Coverage Initiative programs for the purpose of budget neutrality. Now that it is conceivable to cover childless adults through the state plan, HMA believes that CMS may be persuaded to treat Coverage Initiative enrollees up to 133 percent of the FPL in the same fashion as a state plan population for the purpose of calculating budget neutrality. In other words, the cost of coverage could be included on both the “with waiver” and “without waiver” sides of the budget neutrality equation. This is a highly technical point, but the importance of it is that the size of the Coverage Initiative program, across the entire state as well as in Orange County, could be greatly expanded. Receiving a favorable decision on calculating budget neutrality would mean that Coverage Initiative programs would no longer need to be limited in size to a subset of the Safety Net Care Pool.

Once this authority is secured, the state could allow Orange County to expand its Coverage Initiative to cover 85,000 enrollees total.

Implementation Steps and Potential Barriers

There are a number of required implementation steps that can take place simultaneously. The first is to design the benefit package for the expanded population. HMA assumes this design process would take place in the context of a facilitated planning process involving key stakeholders, including the OCHA and sister agencies, hospitals and other providers, and Cal-Optima.

In addition, there is action required at both the state and federal levels. In conjunction with the waiver renewal, the state would have to make the request of CMS. Typically this involves submitting a concept paper, having preliminary discussions with CMS, submitting a formal proposal, and then entering into negotiations on programmatic and financial elements of the waiver. Given that some of this process has already unfolded, time is of the essence in communicating to the state that the waiver proposal should include these elements. Orange County has already submitted a concept paper to the State that has enough flexibility to accommodate this framework. The state has also started the process with CMS and is attempting to complete negotiations for a September 1, 2010 start date.

Layered on top of that is the federal review and approval process. This proposal does not work unless CMS and its budget counterpart, the Office of Management and Budget (OMB), agree to a preferential budget neutrality calculation based on the fact that states can now expand Medicaid to childless adults under the health care reform law.

By way of background, CMS has never written a regulation governing the use of section 1115 authority, and the requirement for budget neutrality is not included in the law but has rather evolved as a matter of policy. This means that CMS and OMB have the authority to do what is described here, but they are not required to approve this proposal. Budget neutrality is a matter of negotiation, policy, and often politics.

Historically, CMS has exercised the flexibility to give favorable budget neutrality treatment to populations that could be covered under a SPA. However, the more the design of a waiver deviates from what could otherwise be accomplished under a SPA, the more reluctant the agency has been to grant this flexibility. The expansion contemplated in this proposal would be implemented on a geographic basis, but a SPA is required to be statewide. This is a significant deviation and will require extensive discussions with CMS. As stated above, however, CMS and OMB do have the statutory authority to approve the proposed budget neutrality treatment for a geographic waiver.

Timeline

A proposal should be submitted to the state as soon as possible. Assuming timely federal approval, the program could be approved as soon as August 31, 2010 and implemented soon thereafter.

Recommendation 2: Use Unmatched County Funds as Intergovernmental Transfer to Draw Down Federal Funds

The County should make available, in the form of an intergovernmental transfer (IGT), currently unmatched funding from the MSI and other programs. The purpose of this transfer would be to provide

the non-federal share of payments that the Department of Health Care Services (DHCS) would make for the expanded Coverage Initiative program in Orange County. HMA understands that not all expenditures that are currently financed with the County funds that would constitute the IGT could be included in the waiver payments; however, under the following recommendation CalOptima could by contract shoulder some of the burden for the MSI obligation.

Additional Detail

While the first recommendation provides a vehicle for providing services through the MSC while easing the federal budget neutrality requirement, this recommendation is essential in providing the matching funds that are needed to provide the financial underpinnings of the program. In effect, Recommendation 1 describes HMA's recommendation for finding federal budget neutrality room for the MSC, while Recommendation 2 speaks to making sure there is a sufficient source of non-federal funding to match the federal dollars that could flow through the waiver.

An IGT describes the process for using non-state funds to match federal funds. There are certain limitations on the possible sources of non-state matching funds, including a prohibition on provider donations and strict requirements for structuring provider taxes. But other non-state funds, such as County funds, can be used for matching as long as they are not being used to match other federal funds.

California has historically used IGTs in its program, but in the current hospital waiver CMS imposed a requirement that the state move away from IGTs and instead use certified public expenditures (CPEs) as the vehicle for contributing non-state funds to the program. From the point of view of counties and providers, however, IGTs are a vastly better mechanism for financing the program. This is because CMS has adopted policies around the CPE process that result in the state having a great deal of latitude to keep the federal funding that is generated by a CPE, potentially returning only a small portion of it to the entity that made the initial expenditure. By contrast, CMS enforces a strict requirement that payments financed by an IGT must be paid to providers, not retained by the state.

Although CMS' expressed preference and indeed requirement in the current waiver is for the CPE mechanism, the IGT method of financing the program is still completely legal. CMS does not have a legal basis to deny a request from California to use IGTs to finance the program.

Because the County funds that could be subject to the IGT process come from multiple sources, this recommendation is multi-faceted in nature. Below is a discussion of the implementation steps, likelihood of succeeding, and a timeline.

Implementation Steps and Potential Barriers

The first step is to identify the unmatched funds. At a minimum, these include the funds currently paying for the MSI program, Realignment funds, and Mental Health Services Act (MHSA) funds. As long as appropriate payment mechanisms for new federal funds can be identified, other County funds could be included as well. The basic elements for determining whether County funds can be used in an IGT are:

- There are no legal barriers to transferring the funds to the state (i.e., the existing program is structured in such a way that the County would not have the flexibility to use the funds to leverage federal dollars); and
- The money is not already being used to draw down other federal funds.

The main limiting factor is identifying sufficient approvable conduits for returning the County funds along with new federal funds.

The next step in the process is to categorize the current uses of the money in terms of the following factors:

- The current use could conceivably be folded into the MSC benefit package (e.g., current MSI services and enrollees, behavioral health services provided to individuals who would meet MSC eligibility criteria)
- The current use would not fit into the new MSC construct, but could be financed in another way, such as funds that could be routed through Cal-Optima as explained in Recommendation 3 (e.g., behavioral health services provided to individuals who would not meet MSC eligibility criteria)
- The current use would not fit into one of the above categories, either because there are insufficient funds or the services do not meet any of the stated criteria.

Once the universe of available funds is identified, and the County has a handle on where the current uses will crosswalk to the new structure, it is necessary to develop methodologies for paying for the services. Behavioral health services that are added to the MSC benefit package can be paid for on a capitation basis, with the PMPM rate being based on eligibility and utilization data. This has the advantage of providing a steady stream of funding that is not dependent on providers submitting claims. The County can continue to pay providers according to its preferred methodology, but one major benefit is that the federal funding that will flow based on the IGT, in addition to permitting for expanded eligibility in the MSC, can provide for expanded behavioral health services. Behavioral health services for non-MSC individuals, as well as other services that do not meet Medicaid criteria, would be paid for with funding that would be routed through Cal-Optima (this is discussed in further detail in Recommendation 3).

Simultaneously with these exercises, the County would need to obtain the required approvals for any changes to the way the money is spent. This consideration mainly applies to the MHSA money, as there is a formal process for approval of the uses of MHSA money.

In HMA's experience, the main barriers to implementing this type of a plan are the funding agencies themselves – it is notoriously difficult to get agencies to “think outside the box” and cooperate with one another, even when the payoff is a significant infusion of new funding. Orange County has a head start in this regard, since much of the increased funding would be used to expand an existing program that has broad support. However, there will still be a need for approval from the Board of Supervisors. A

concerted effort by County agencies, Cal-Optima and the local hospitals will be necessary to secure approval from the Supervisors.

Another challenge will be getting the state on board. In some respects, the potential new opportunities for collaboration and cooperation should make the difficult job of negotiating all the pieces somewhat easier. The many moving pieces of this proposal present exciting opportunities for better coordination between programs, which should result in a vastly improved health care system. The success of this strategy does depend upon the state. The state will need to agree to make the structural changes (i.e., the waiver and the Cal-Optima rates) that would direct the IGT-funded federal payments to the County. As explained elsewhere in this section, HMA has concentrated on funding strategies that have a high likelihood of success. Assuming the state signs onto these strategies, accepting the IGT from the County is not only beneficial, it is a necessity.

Timeline

Given that the redirecting the MHSA money would necessitate going through the planning process, it would take longer than the other sources of funding to free up for an IGT. The most readily available funding is probably the MSI money. Other sources of funding could be freed up as soon as successful negotiations could take place to backfill the current uses of funding. However, it is important to remember that there will be a ramp-up period for the new MSC, so not all new IGT money will be needed immediately. Assuming timely CMS approval, it is reasonable to expect that a sufficient portion of the County funding could be made available in an IGT by the time the waiver would be approved and the MSC is ready to be implemented.

Recommendation 3: Request a Capitation Rate Increase for CalOptima

CalOptima should request that the state use existing legal authority to increase the margin component of its capitation payment from the current 2 percent to the maximum 6 percent. The nonfederal share of this increase would come from a portion of an additional County IGT. This amounts to \$45 million at current levels. This money would be used for a variety of purposes including taking greater responsibility for certain care for which they share responsibility with the County. This includes certain behavioral health opportunities, pediatric subspecialties, and potentially some responsibility for jail health. This will also have the effect of increasing the number of individuals who can be served in the Coverage Initiative.

Additional Detail

This recommendation is necessary because the MSC alone will not provide sufficient authority to ensure that all the necessary activities of the Orange County Health Agency and its sister agencies can continue to be funded and enhanced with federal funding. Thus, it is necessary to create a conduit for the additional federal funds that will be generated by the IGT(s).

Implementation Steps and Potential Barriers

Authority already exists to include a profit margin of up to 6 percent for Cal-Optima. The only action required by the state would be to submit an amended contract to the CMS regional office for review.

Because no covered services or populations would be changed, this action should not require a SPA or section 1915(b) waiver amendment. (If the state and County decide to adopt other recommendations, such as carving the services that are now carved out to CCS, a waiver amendment would be needed.)

Since this is not a state plan amendment, CMS does not have the opportunity to ask its standard set of financing questions, so the review and approval process should not be controversial.

Another part of the implementation is to secure an agreement with Cal-Optima that funnels the money back to the County. This agreement can take any form and does not require CMS approval. The agreement should cover the amount and nature of the payments and the purpose. The funding should be used to cover services that cannot be folded into the MSC capitation rate that will flow from the state to the County through the waiver.

Timeline

The CMS approval process for the contract amendment should not be lengthy. The holdup will be the identification of County funds to be transferred to the state to provide the non-federal share of the increase. The contract amendment should be submitted as soon as possible, so that the increased payments can begin to flow as soon as the IGT discussed in Recommendation 2 is implemented.

Recommendation 4: Secure Contributions from Hospitals for the Managed System of Care

In order to cover the maximum possible number of uninsured individuals, the County's hospitals should make financial contributions according to a rational methodology that takes into consideration other existing and new tax burdens the facilities already face. This contribution will have the effect of maximizing the number of people covered, negating the need to forego MSI revenue, and giving all of the facilities a stake in the system. Ideally, the methodology would recognize that the population that is served in the Coverage Initiative program is unevenly spread amongst the County's hospitals.

Additional Detail

Even with an expanded Coverage Initiative, an IGT, and the Cal-Optima financing mechanism, there will continue to be functions that must be paid for outside the construct of the waiver and the state plan. Examples of these would be residential services in the mental health system that cannot be covered by actuarially sound rates for behavioral health services and/or the funding provided through Cal-Optima. However, if the County is unable to use the funds currently dedicated to these purposes in an IGT, the MSC would have to be proportionately smaller.

This represents an opportunity for hospitals, ideally in conjunction with philanthropic organizations, to show leadership by making an investment in the system. This is an investment with a tangible outcome. For every \$1 million that can be added to the system by the hospitals, more than 700 additional low-income individuals can be covered for an entire year because of the "multiplier" effect of freeing up county funds for an IGT.

A potential way to increase the local investment, demonstrate leadership, and free up the maximum possible amount of County funds, is to seek other funding that is not subject to federal matching. The obvious place to look is the hospitals located in the County. These facilities cannot provide the non-federal share of Medicaid payments, either through the state plan or in a waiver, because of the prohibitions contained in section 1903(w) of the Social Security Act (codified in regulation at 42 CFR 433.54) that govern provider donations.

For providers that participate in the MSC, payments for services would follow the patient and would be at approximately Medi-Cal rates, though the MSC may want to make special payment provisions for certain groups (e.g., capitation for SMI populations). As a sector, hospitals should see a total net payment increase of approximately \$39 million. This assumes that hospital payments under the MSC are roughly 40% of total payments. In addition to direct payments, hospitals should experience meaningful reductions in unnecessary ED visits, due to improved care management and access for this population.

Implementation Steps and Potential Barriers

Because these funds would be generated and spent locally, there are no state or federal hurdles to clear. Therefore, this part of the plan becomes a matter of developing a rational methodology for developing a voluntary and predictable level of contributions from the hospitals.

The first step would be to meet with hospitals to secure buy-in and discuss a target amount. In addition, it is necessary to develop and review a methodology for calculating the hospitals' contributions. It may be necessary to develop several alternative methodologies. One possible methodology would be to collect a percentage of the value of each hospital's fixed assets. It might make sense to impose a heavier burden on not-for-profit hospitals, since they are exempt from property taxes but unlike other areas they serve a disproportionately low number of Medicaid and uninsured.

The key to this proposal succeeding will be explaining the benefit of the investment to be made, both in terms of the number of people who can be covered as well as the federal funds that are leveraged by virtue of the hospital contribution freeing up County funding to provide to the state in the form of an IGT.

The final step is to identify who will receive the payments and develop a system for tracking the collection and expenditure of the contributions from hospitals.

Timeline

The funding can be made available as soon as the hospitals reach agreement on the funding methodology and amount. Since the money is not needed until such time as there is a County IGT to backfill, there should be plenty of time for negotiation. The hospitals should plan for the money to be collected as soon as January 1, 2011 so that it is available when needed.

Recommendation 5: Increase Local Medi-Cal Outreach Efforts

In order to use local resources wisely, the County should ensure that all eligible individuals are enrolled in Medi-Cal. Toward that end, outreach efforts should be stepped up. The County should plan to spend at

least \$5 million annually on these efforts, and this should be financed as a Medicaid administrative expense.

Additional Detail

The benefit of ensuring that all eligible individuals are enrolled in Medi-Cal is self-evident. Each potentially eligible individual who is not enrolled is a person who either uses the county's facilities as an uninsured person, or possibly ends up in other County programs, thus drawing away from the funds that can otherwise be used for those who are not eligible for any other program. States have the ability to pay for outreach services out of Medicaid administrative funds, and it is likely that Orange County agencies are performing many of these functions without reimbursement.

Implementation Steps and Potential Barriers

The way to implement this recommendation is to enter into an agreement with the state to submit Medicaid administrative claims to CMS for outreach activities designed to enroll all eligible individuals in Medi-Cal. This would be tied to the IGT that would be provided to pay for new activities related to the MSC.

Timeline

Assuming there are no significant issues of which HMA is unaware, this recommendation should be able to be adopted in sync with the start of the new waiver, or September 1, 2010.

Additional Thoughts

In addition to the formal recommendations listed above, HMA recommends that the County work with the state to explore options to modernize the local operation of the California Children's Services (CCS) program, including options that would fold CCS into the Medi-Cal benefit package. This would have the advantage of decreasing confusion for families, improving care for children, and enabling the implementation of payment increases across the spectrum of pediatric subspecialists. When the specialists are enrolled in and paid for by two separate programs, the unintended consequence is that rates are artificially kept low and access to care is a casualty.

Additional Detail

CCS covers children with a variety of medical conditions, and includes children who are eligible for Medi-Cal, Healthy Families, or state-only coverage. CCS-covered conditions include conditions such as cancer, AIDS, hemophilia, sickle cell anemia, neonatal intensive care and broken bones. In some counties with County Organized Health Systems, CCS is included in the managed care plan, but in Orange County it is carved out. The carve-out of the CCS program from CalOptima creates perverse incentives to fragment care and to artificially hold rates down. For example, Cal-Optima has expressed an interest in increasing payment rates for pediatric subspecialty providers in order to address access issues. However, in a carved out model, the unintended consequence of increasing rates in one program and not the other is that providers would not have an incentive to refer children to the CCS program. If children who would

otherwise be served in CCS stay in the managed care plan, but Cal-Optima's capitation payments from the state continue to assume a carve-out, the plan will be disadvantaged.

Implementation Steps and Potential Barriers

HMA understands that this is a complex issue involving many different stakeholders, and that a statewide work group is examining options for CCS. The County likely would not support carving CCS into CalOptima without further study. As for stakeholders, the main barrier to implementing a change would be resistance based on a fear that the system could get worse instead of getting better.

The major steps that would be involved in implementing this change are convening the appropriate stakeholders, including providers and advocates, documenting the problems and issues associated with the carve-out, and getting buy-in for the potential benefits. In order for a merged system to work, it is essential that all interested parties feel as though they had input into a redesigned system.

Likelihood of Success

The likelihood of success is uncertain, because there are too many unknowns. However, because of the improvements that could result from changing the current CCS model, HMA recommends that discussions begin in earnest immediately.

Timeline

Because of the complexity of this issue, it would take a year or more to implement.

Expanding FQHC Capacity

As described in HMA's January report, the lack of a public hospital system in Orange County dictates that private providers, including Federally Qualified Health Centers (FQHCs) must play an even greater role in the care and management of vulnerable populations. Unfortunately, Orange County's FQHCs appear to be seeing few uninsured patients relative to non-FQHC clinics in the County and relative to their FQHC counterparts nationally.

FQHCs are uniquely positioned to care for indigent populations as a result of:

- An array of federal requirements that are intended to ensure access to services for all patients, regardless of ability to pay, and that mandate a broad array of preventive, primary care and enabling services (e.g., transportation, patient education) for patients; and
- Financial benefits including cost-based reimbursement for Medicaid and Medicare visits and grants to offset the cost of caring for uninsured patients.

Background on FQHCs

The authorizing legislation for the FQHC program uses the term "health center" to refer to four programs that receive federal funding under Section 330 of the Public Health Services Act, as amended by the Health Centers Consolidation Act of 1996 and the Safety Net Amendments of 2002 to provide primary care services to "medically underserved populations." The programs included under Section 330 are:

- Community Health Centers (Section 330(e))
- Migrant Health Centers (Section 330(g))
- Healthcare for the Homeless (Section 330(h))
- Public Housing Health Centers (Section 330(i))

In addition, the federal government recognizes an additional class of health centers that meet all of the statutory requirements for receiving a Section 330 grant, but do not actually receive grant funding. These health centers are commonly referred to as FQHC "Look-Alikes." While the process for becoming a Section 330 grantee is highly competitive, the application for FQHC Look-Alike status is a largely technical process.

The goal of the FQHC program is to maintain, expand and improve the availability and accessibility of essential primary and preventive health care services (and related enabling services) for low income, medically underserved and vulnerable populations that have traditionally had limited access to affordable services and face the greatest barriers to accessing care. FQHCs must be located in and/or serve areas in the greatest need; must serve the full "life cycle" of care (prenatal, pediatrics, adolescent, adult, geriatric) through a core staff of primary care providers; and must be governed by a community

board with a majority of members who are users of the health center. In addition, FQHCs must maintain systems that can produce accurate, auditable financial and utilization information, as well as a variety of demographic and other data required by the federal government.

In exchange for meeting rigorous federal requirements, FQHCs are entitled to a range of benefits, which are summarized below.

FQHC Grantees	FQHC Look-Alikes
Eligible for Section 330 Bureau of Primary Health Care grant of up to \$650,000 annually to offset the cost of caring for the uninsured	Not eligible for Section 330 grant
Eligible for free tort protection under the Federal Tort Claims Act	Ineligible for tort protection
Eligible for cost-based reimbursement from Medicare and Medicaid, with “wrap-around” payments for individuals enrolled in Medicaid or Medicare managed care plans	Eligible for cost-based reimbursement from Medicare and Medicaid, with “wrap-around” payments for individuals enrolled in Medicaid or Medicare managed care plans
Access to discounted drug prices through the federal 340(b) program	Access to discounted drug prices through the federal 340(b) program
Access to out-stationed Medicaid eligibility workers	Access to out-stationed Medicaid eligibility workers
“First-dollar” Medicare coverage (i.e., Medicare deductible is waived for FQHC services)	“First-dollar” Medicare coverage (i.e., Medicare deductible is waived for FQHC services)
Access to the federal Vaccines for Children (VFC) program	Access to the federal Vaccines for Children (VFC) program
Access to National Health Service Corps providers and resources	Access to National Health Service Corps providers and resources
Eligible for a variety of other Bureau of Primary Health Care and other HRSA federal grant programs	Not eligible for Bureau of Primary Health Care expansion grants

In addition to the benefits listed above, FQHCs were the recipients of substantial federal funding pursuant to the American Recovery and Reinvestment Act of 2009 (ARRA). More than \$2 billion in grant funds was made available for FQHCs to establish new access points, e.g., new centers or new sites tied to a current center, meet the increased demand for services and undertake capital improvements. The recently passed national health reform legislation includes funding for FQHCs that dwarfs the levels included in the ARRA, indicating that FQHCs are likely to play an even more significant role post-reform. Please see Appendix A for a summary of FQHC-related health reform provisions.

FQHC Reimbursement

As noted above, one of the primary benefits of FQHC designation is enhanced reimbursement under Medicare and Medicaid. Specifically, Medicare reimburses FQHCs for services on a reasonable cost basis per encounter up to a cap (currently \$125.72 for urban FQHCs and \$108.81 for rural FQHCs). The cap is inflated each year by the Medicare Economic Index (MEI), which has averaged approximately 2.0 to 2.5 percent annually. Certain services, including labs, are excluded from the encounter rate and reimbursed separately through Medicare Part B. According to recent analysis by the National Association of Community Health Centers (NACHC), the majority (approximately 75%) of health centers have actual costs that exceed the current Medicare cap. In response to this, Congress enacted a one-time adjustment that increased the 2010 Medicare cap by an additional \$5.

Like most Part B services, Medicare pays 80 percent of the rate and the beneficiary is responsible for 20 percent. FQHC services, however, are exempted from the Part B deductible (i.e., the beneficiary receives “first dollar” coverage for FQHC services). Services provided to Medicare Advantage enrollees are reimbursed at the same cost-based rate via a “wrap-around” payment. The Medicare Advantage plan must reimburse the FQHC at a rate comparable to what the plan would pay for the same service in other provider settings; the federal government pays the FQHC the difference between the cost-based rate and the Medicare Advantage payment.

Pursuant to the Benefits Improvement and Protection Act (BIPA) of 2000,³ state Medicaid programs have the option of implementing a cost-based prospective payment system (PPS), alternative methodology or a combination of both. California utilizes a PPS methodology. Under PPS, existing FQHCs established their base PPS rate by calculating their average 1999 and 2000 allowable cost per visit.⁴ This base rate is adjusted annually by the MEI. New FQHCs have their initial rate set based on the average rates of existing FQHCs in the same geographic area with similar services. This initial rate is then increased annually by the MEI. If comparable FQHCs do not exist, the new FQHC may request an interim rate based on projected costs. The interim rate is then cost settled and increased annually by the MEI. States must also have a process in place to allow FQHCs to adjust their rates due to a change (increase or decrease) in the scope of services provided. States electing to use an alternative payment methodology (APM) must ensure that: 1) the alternative payment rate is at least as high as the PPS rate; and 2) FQHCs must agree to be reimbursed under the APM.

³ P.L. 106-554, Section 702.

⁴ Note that California allows health centers to be reimbursed under an alternative PPS methodology that sets the PPS base rate based on one year of cost data (2000).

As with Medicare, FQHCs are eligible for “wrap-around” payments for their Medicaid managed care patients, which make up the difference between the payment received from the plan and what the FQHC would have received under the fee-for-service system.⁵

Recommendations and Next Steps

HMA recommends that Orange County:

- Create additional FQHC capacity in the County through at least one new FQHC (with multiple locations) that would, ideally, incorporate the Children’s Hospital of Orange County outpatient clinics.
- Support the efforts of community providers including VNCOC, Friends of Children and Camino Clinic that are in various stages of applying for FQHC or Look-Alike designation.
- Establish clear community expectations with respect to the responsibility of FQHCs to care for the uninsured.
- Explore opportunities for integrating specialty care into the FQHC setting.

Create Additional FQHC Capacity

HMA recommends that Orange County seek to expand FQHC capacity within the County by securing additional FQHC New Access Points. Specifically, an FQHC (or Look Alike) consisting of the Children’s Hospital of Orange County’s outpatient clinics -- in partnership with another provider who can provide services for the adult population – would bring substantial additional resources into the community and support additional access for uninsured in the network. Grantee designation would also afford the opportunity to benefit from future Section 330 grants that become available for capital, expanded medical capacity, IT, or other targeted efforts.

As described above, FQHCs must serve the full patient life cycle. As a result, CHOC would be unable to meet the FQHC requirements without partnering with another provider who could provide services for the adult population. CHOC’s reputation in the community and its favorable payer mix, make it an extremely attractive partner for any current or prospective FQHC. CHOC has indicated a willingness to consider such a model.

In the context of health reform, the opportunities for FQHCs are likely to grow exponentially, as the final bill contains unprecedented levels of funding to support FQHC growth and improve access. Based on preliminary information on the distribution of new funds, approximately 2,000 new access points will be funded over the next five years. A substantial number of these are likely to be in California. In addition,

⁵ Pursuant to Section 1903(m)(2)(A)(ix) of the Social Security Act, Medicaid managed care organizations must “provide payment that is not less than the level and amount of payment which the entity would make for the services if the services were furnished by a provider which is not a Federally-qualified health center or a rural health clinic.” This provision prevents the MCO from shifting costs to the state and federal government through a larger wrap-around payment. A parallel provision for Medicare Advantage plans may be found at 1857(e)(3)(A).

FQHCs and Look-Alikes will benefit from cost-based Medicaid reimbursement for previously uninsured patients who become eligible for coverage under a major Medicaid expansion.

The table below illustrates the estimated revenue impact of FQHC reimbursement for CHOC clinic visits, as well as the estimated additional access that could be supported under an FQHC model. Based on 2008 Medi-Cal fee-for-service and managed care reimbursement rates, the CHOC clinics would see an increase in reimbursement ranging from \$23 to \$117 per visit. It is important to note that this is a high-level estimate intended to illustrate the scale of potential impact. Detailed impact analyses would require specific information on the operations and cost structure of the entity(ies).

Estimated Impact of FQHC Rate on CHOC Clinics

	Encounters			2008 Net Revenue per Encounter			Estimated FQHC Revenue Impact*			
	Medi-Cal FFS	Medi-Cal MCO	Healthy Families	Medi-Cal FFS	Medi-Cal MCO	Healthy Families	Medi-Cal FFS	Medi-Cal MCO	Healthy Families	TOTAL
Garden Grove	503	7,464	2,581	\$ 36.03	\$ 48.52	\$ 81.41	\$ 57,327	\$ 757,447	\$ 177,031	\$ 991,804
Orange	1,100	22,460	6,673	\$ 42.16	\$ 83.44	\$ 126.60	\$ 118,624	\$ 1,494,938	\$ 156,148	\$ 1,769,710
Costa Mesa	356	6,556	2,855	\$ 33.29	\$ 53.03	\$ 43.49	\$ 41,549	\$ 635,735	\$ 304,086	\$ 981,370
Boys and Girls Club	201	3,874	2,274	\$ 41.10	\$ 77.37	\$ 100.94	\$ 21,889	\$ 281,369	\$ 111,562	\$ 414,820
Total	2,160	40,354	14,383				\$ 239,389	\$ 3,169,488	\$ 748,827	\$ 4,157,704

*Assumes FQHC encounter rate of \$150

While some of this additional revenue would likely be dedicated to capital needs, expanded services (e.g., enabling services required to be provided by FQHCs) and ensuring the FQHC is financially sustainable (i.e., break-even) a substantial portion could be used to expand access for uninsured individuals. For example, if \$2 million of the additional revenue were targeted toward uninsured access, the FQHC could see approximately 5,300 additional patients or 13,300 additional visits.⁶ If \$3 million were targeted toward uninsured access, the FQHC could see 8,000 additional patients or 20,000 additional visits. When combined with the maximum annual FQHC grant award of \$650,000, the FQHC could see between 7,000 and 9,700 additional uninsured patients assuming 2.5 encounters per patient per year. As discussed below, both existing FQHCs and new FQHCs should be held to clear community expectations with respect to network participation and caring for the uninsured.

HMA understands that the next New Access Point grant cycle is likely to occur this summer -- as early as June -- which may not provide enough time to address the complex operational and governance issues inherent in the partnership outlined above. Based on preliminary information from the Bureau of Primary Health Care on how and when FQHC health reform funds will be made available, HMA recommends the following timeline and next steps.

⁶ Assumes an average cost per visit at the encounter rate of \$150 and an average of 2.5 visits per patient per year.

- Apply for HRSA planning grant with a goal to apply for FQHC status in 2011. HMA understands that HRSA will likely issue a planning grant application this summer. Planning grants support the efforts of communities/entities that are in the process of preparing to submit a Section 330 grant application. Awards have traditionally been for up to \$80,000.
- Begin dialogue between CHOC and the identified partner organization around the parameters of the relationship and the benefit that will accrue to the partners and the community.
- Begin drafting applications for both a Look-Alike and a New Access Point. While there may be another grant cycle as early as December or January, developing a Look-Alike application would allow the entity to begin drawing cost-based reimbursement in the event that the next grant cycle is delayed well into CY 2011. If a Look-Alike application were submitted by January 2011, approval and cost-based reimbursement should be secured by no later than July 1, 2011.
- Submit New Access Point (NAP) application during the CY 2011 cycle.

Support Current FQHC Expansion Efforts

While the upcoming NAP grant cycle is expected to fund perhaps the largest number of health centers ever funded in a single cycle, there will still be significant competition for grant funds, especially within Orange County. Several clinics that HMA met with for this project indicated that they were planning to submit applications in the next grant cycle, anticipated to be June 2010. Each of these applications represents expanded resources and access in the County and should be strongly supported by the provider community and other stakeholders. Current and future FQHCs that are willing to play a meaningful role in serving the uninsured are a critical component of the managed system of care. These applicants are also potential partner organizations for a future CHOC clinic application.

In addition, the community should investigate whether FQHCs are eligible for the Medi-Cal PPS rate under the Coverage Initiative. If eligible, the County would likely be required to provide the non-federal match.

Hold FQHCs Accountable

HMA reiterates the recommendation from our January report that Orange County establish clear community expectations for both new and existing FQHCs in the County with respect to caring for the indigent. Relative to their non-FQHC peers – that do not receive the financial benefits of FQHCs – and FQHCs in other counties, Orange County's FQHCs are seeing relatively few uninsured patients.

Nationally, 38% of FQHC patients are uninsured; statewide nearly 44% of FQHC patients are uninsured.⁷ According to OSHPD data, only 16% of Orange County FQHC patients are uninsured. Clear expectations on the provision of care by FQHCs to the uninsured will be critical for ensuring that new federal resources that come into the County through Section 330 grants and enhanced cost-based FQHC reimbursement are targeted toward the overall goals of the network. In addition, clear expectations are necessary to ensure that FQHCs are fully engaged in the system of care. This would include expectations

⁷ 2008 Uniform Data Set.

around provision of (or access to) specialty care and participation in network initiatives with respect to referral systems, urgent care, ER diversion, etc.

2008 OSHPD Primary Care Clinic Profile Statistics
Cal Optima Community Clinics – Adjusted for UCI Self-Reported Data
Based on Total Encounters

	All Clinics	FQHC Clinics Only
Payor	Orange County	Orange County
Medi-Cal	32%	44%
Health Families	4%	1%
Uninsured	25%	16%
All Other	39%	39%
Total	100%	100%

Incorporate Specialty Care

Recent federal guidance has provided more clarity around the ability of FQHCs to incorporate limited specialty care within their scope of services.⁸ More specifically, FQHCs may be able to receive cost-based reimbursement for specialty services if they can document that the services are in high demand by their patients, complement the existing primary care services, and meet other operational, technical and governance requirements outlined in the guidance (see Appendix B). The ability of California FQHCs to incorporate specialty care is further limited by a state requirement that FQHCs must provide services “within the four walls” of the clinic generally cannot bill for services provided outside of the clinic. Nevertheless, there may be significant opportunities to integrate specialty care into the FQHC setting, especially if sufficient volumes exist to support the “four walls” requirement.

In addition, a provision in the health reform legislation will make substantial federal dollars available to support the integration of behavioral health within FQHC settings. Specifically, the law provides \$25 million for 125 service expansion grants to expand the integration of behavioral health into existing primary care systems. Orange County FQHCs should explore and, where appropriate, apply for these funds.

⁸ See PIN 2009-02.

Conclusion

This report lays out an interconnected, and somewhat complex, set of recommendations for leveraging federal funds to help finance a managed system of care for the uninsured in Orange County. In order to implement all recommendations, cooperation from every level of government – County, state, and federal – is required. Buy-in, cooperation, leadership and in some cases financial support will also be needed from health care providers.

If one or more parties are unable or unwilling to participate as envisioned (e.g., CMS does not approve an expanded Coverage Initiative program, or a portion of the County funds cannot be made available for unforeseen reasons), the participants in Orange County could still press forward with designing a more rational system of care for the uninsured. However, the size and scope would likely be smaller. HMA is hopeful, however, that the unparalleled leadership demonstrated by the coalition, combined with the unprecedented opportunity created by health care reform, will result in a managed system of care that will serve as a model for the rest of the nation.

Appendix A – Summary of Health Reform Law: FQHC Provisions

This appendix outlines the primary FQHC-related provisions in the final health reform legislation adopted earlier this year. It also provides a brief overview of the proposed FQHC funding levels in the President’s 2011 Budget, as submitted to Congress in February 2010.

Coverage and Reimbursement

The final bill includes a large expansion of the Medicaid population to include all documented uninsured below 133% FPL. For FQHCs, each of these newly insured individuals will be reimbursed at the FQHC’s PPS rate. The bill also includes other provisions that will require non-Medicaid-eligible uninsured to purchase insurance through a publicly operated exchange, and several provisions that improve Medicare coverage and reimbursement of FQHC services.⁹

National Health Reform: Key FQHC Coverage and Reimbursement Provisions

	Final Legislation
Medicaid Expansion	<133% FPL
Mandate/Exchange	Individual Mandate; 400% FPL; plans participating in exchanges must pay FQHCs at PPS rate
Medicare	Eliminates Medicare cap and updates the PPS rate based on costs; expands list of preventive services covered by Medicare in FQHCs

FQHC Grants/Funding

The final bill includes unprecedented increases in grant support for Federally Qualified Health Centers, which is expected to be expended through a combination of New Access Points, base grant adjustments, capital investments and other targeted investments.

⁹ According to 2008 UDS, between 67-76% of ALL FQHC patients in CA live below 100% poverty. Another 12% are between 101-150% poverty.

National Health Reform: FQHC Funding Provisions

	2011	2012	2013	2014	2015	Total
Community Health Center Funding*						
Final Bill	\$9.5B over 5 years					\$9.5B
Community Health Center Construction/Renovation						
Final Bill	\$1.5B over 5 years					\$1.5B
National Health Service Corps Program Funding						
Final Bill	\$1.5B over 5 years					\$1.5B

*Funding levels are in addition to current discretionary base funding levels.

It is important to note that a significant portion of the grant dollars in the legislation for community health centers will be required to maintain annual grant funding for New Access Points funded in 2011 and subsequent years. Specifically, of the \$9.5 billion, approximately \$3.5 billion is estimated to go toward funding New Access Points, Expanded Medical Capacity, planning grants, etc., over the five-year period while the remaining \$6 billion would be dedicated to maintaining annual grant support for these newly funded health centers.

Other Provisions

The final bill also includes several other provisions that will have a direct impact on health centers. These include:

Teaching Health Centers

Creates new grant programs to support development and operation of “teaching health centers” to ease primary care shortages.

- Authorizes \$25 million for FY2010, \$50 million for FY2011, \$50 million for FY2012 and such sums as necessary thereafter to establish new or expanded primary care residency programs. A teaching health center is defined as community-based, ambulatory patient care center operating a primary care residency program.
- Creates a new Title III program that will provide per-resident payments to teaching health centers for the expansion of existing or establishment of new approved graduate medical residency programs. It appropriates \$230 million over 5 years, FY2011 through FY2015, for the Title III payments, and the funds may cover both direct and indirect costs.

HPSA/MUA Shortage Designation Guidelines

- Requires negotiated rulemaking process to determine new methodology. Bureau of Health Professions must publish the initial notice no later than 45 days from enactment (somewhere around early May). Negotiated rulemaking ensures that the relevant stakeholders, including health centers, have a seat at the table. There are also some strict rules, which the federal register will lay out. Once the comment period for the initial notice is over, the Secretary of HHS has 30 days to appoint the negotiated rulemaking committee.
- Could significantly impact current and future designations of MUAs and HPSAs, with implications for FQHC, National Health Service Corps and other programs that rely on these designations.

Additional Provisions

Nurse-Managed Health Clinics: Authorizes grants under Title III for the development and operation of nurse-managed health clinics. The legislation authorizes \$50 million for FY2010 and such sums as necessary for each of fiscal years 2011 through 2014.

School-Based Health Centers: grants for facilities, equipment or similar expenditures-\$50 million for each of fiscal years 2010 through 2013. Title III grant program for acquiring and leasing equipment; providing training related to the provision of health services; the management and operation of health center programs; payment of salaries for physicians, nurses and other personnel; and construction. The legislation authorizes such sums as necessary for each of fiscal years 2010 through 2014.

Training: Authorizes grants to 15 eligible entities, which may include FQHCs, to establish training programs to train or employ dental health care providers in order to increase access to dental health care services in rural and other underserved communities. The demonstration projects will begin within two years and conclude within 7 years. Each grant will be no less than \$4 million for the 5-year period of the demonstration. Provides grants for up to three years to employ and provide training to family nurse practitioners who provide primary care in FQHCs and nurse-managed health clinics. Funds will be appropriated for five years beginning in FY2011.

President's FY 2011 Proposed Budget

The President's Budget includes a relatively modest increase in health center funding, when compared to the program growth in recent years. Specifically, the President's Budget includes a \$289,971,000 increase over the federal fiscal year (FFY) 2010 appropriation which will:

- Fund the extension of 127 New Access Points that were created under ARRA
- Extend the Increased Demand for Services (IDS grants) that were awarded under ARRA
- Provide \$16 million to support 25 New Access Points
- Provide \$25 million for 125 service expansion grants to expand the integration of behavioral health into existing primary care systems

While modest, these sums, combined with the health reform provisions, will create unprecedented opportunities for the new FQHCs and the growth of existing FQHCs.

Appendix B - Specialty Care

In December 2008, the BPHC released guidance (PIN 2009-02) for health centers interested in adding limited specialty care services through the change of scope process (i.e., no new grant funds). Health centers that want to secure additional Section 330 funding to support the new services must apply through the competitive grant process. This guidance technically does not apply to Look Alikes, though, presumably, the BPHC would apply similar logic in considering change of scope requests for Look Alikes requesting to add specialty care.

Like most BPHC guidance, the new PIN is subject to a range of interpretations. In general, however, BPHC appears to be taking an approach that specialty care services may be included within an FQHC's scope as long as the health center can make a strong, data-driven case (based on the health center's current patient population and target population) that its patients have a strong need for the proposed services, and the services will support/enhance the provision of primary care within the health center.

Background

Health centers are allowed to provide "additional" health services, beyond those required in statute, that are "necessary for the adequate support of the [required] primary health services" and that are "appropriate to meet the needs of the population served by the health center" (Public Health Services Act section 330(a)(1)). Federal approval is required in order to include additional services within a health center's official scope of project, thereby extending certain FQHC benefits (e.g., cost-based reimbursement) to the new service.

Process and Factors in Consideration

Health centers wishing to add specialty services must file a formal change of scope request with HRSA. As part of this process, the health center must demonstrate that it is prepared to offer the service and that it has evaluated the costs, benefits and risks of adding the new service. When evaluating change of scope requests for specialty care, the BPHC will specifically look at the following factors:

Support for primary care. The health center must demonstrate that the new service will support, or serve as a "logical extension of," the required primary care services within the health center. For example, cardiology screenings in a health center that sees a large number of patients at risk for heart disease, would meet this standard.

Demonstrated need for the proposed service. The health center must demonstrate and document with data the target population's need for the proposed service. The health center must also demonstrate that it will be able to maintain its current level of primary care services for the target population.

Funding/financial risk. The health center must demonstrate that it can add the service without additional 330 grant support and that the addition of the new service will not jeopardize the health center's financial stability.

Location. The service must be provided at a current FQHC site or a new site that is being incorporated into the FQHC's scope. Regardless of the service site, services must be provided without regard to ability to pay and must be provided in a culturally and linguistically appropriate manner.

Other considerations. Providers must be properly licensed, pursuant to applicable state law, and must be properly credentialed and privileged to perform the activities expected of them. Health centers must also provide a clear description of the staffing arrangements that will be used to provide the new service (e.g., direct employment, contract). Certain arrangements may require a formal affiliation agreement.

As with all change of scope requests, federal tort coverage does not automatically apply to the new service. The health center must complete a separate Federal Tort Claims Act (FTCA) deeming process in order to ensure coverage. Certain staffing arrangements (e.g., group contracts) may not be eligible for FTCA coverage.

Appendix C – Summary of Health Reform Bill: Other Provisions

Patient Protection and Affordable Care Act

H. R. 3590 - Amended by H. R. 4872 - Public Law 111-148

Provisions Impacting Network Development

(Excerpts from Henry J. Kaiser Family Foundation Summary March 26, 2010)

Individual Mandate

Requires U.S. citizens and legal residents to have qualifying health coverage or pay a tax penalty – penalties in 2014 are the greater of \$95 a year or 1% of taxable income and increase for 2016 to the greater of \$695 a year or 2.5% of taxable income

Penalty exemptions for financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, those for whom the lowest plan option exceeds 8% of an individual's income, those with incomes below the tax filing threshold

Employer Requirements

Assesses fees (\$2,000 per full time employee) to employers that don't offer coverage, have more than 50 employees and have at least one employee who receives a premium tax credit

Assesses fees (\$3,000 per employee receiving a premium credit or \$2,000 per full time employee) to employers that offer coverage, have more than 50 employees and have at least one employee who receives a premium tax credit

Employers with less than 50 employees are exempt.

Requires employers that offer coverage to provide a non-taxable free choice voucher to employees (voucher offsets premium costs of Exchange plan that employee chooses) with income under 400% FPL if employee's share of the employer's premium is between 8% and 9.8% of income and employee chooses to enroll in the Exchange

Requires employers with more than 200 employees to auto-enroll employees into employer-sponsored health insurance plans (employees may opt out after enrolled)

Expansion of Public Programs

Expands Medicaid to all individuals under age 65 with income up to 133% FPL (based on modified adjusted gross income) with no income disregards or asset tests, appears to make recent legal immigrants (in U.S. less than 5 years) eligible

Undocumented immigrants are not eligible

Guarantees a benchmark benefit package to all newly eligible Medicaid adults

Provides federal funding for newly eligible Medicaid adults at the following rate (states which have already expanded eligibility to non-pregnant childless adults with income up to 100% FPL will receive phased in federal funding to achieve the following levels):

- 2014-2016 - 100% FFP
- 2017 - 95% FFP
- 2018 - 94% FFP
- 2019 – 93% FFP
- 2020 and after – 90% FFP

Beginning 4-1-10, states have the option to expand Medicaid to cover non-pregnant childless adults before 2014 and receive current federal funding (FMAP) levels.

Increases Medicaid payments for (fee-for-services and managed care) primary care doctors (family practice, general internist or pediatrician) to 100% of the Medicare payment rate for 2013 and 2014, with 100% federal funding of increased rates

States are required to maintain current income eligibility levels for Medicaid and CHIP children until 2019

Beginning in 2015, states will receive 23 percentage point increase in CHIP match rate up to 100% maximum

If state CHIP program enrollment is capped, CHIP eligible but un-enrolled children are eligible for Exchange tax credits

Premium and Cost-Sharing Subsidies to Individuals

Premium credits and cost-sharing subsidies through Exchanges are available only to U.S. citizens and legal immigrants who meet income requirements

To be eligible for premium credits, an employee's employer-sponsored coverage must have an actuarial value less than 60% of total plan costs and the employee's premium share cannot exceed 9.5% of income

Legal immigrants barred from Medicaid for first 5 years in the U.S. are eligible for premium credits

Refundable, advanced Exchange premium credits are provided to individuals and families with income between 133 and 400% FPL.

Premium credit amount varies as a % of income based on FPL. Credits will be provided to assure that persons with income up to 133% FPL pay 2% of income in premiums and will increase such that persons with income between 300% and 400% FPL pay premiums equal to 9.5% of income

Cost sharing subsidies are provided to reduce cost sharing for individuals and families which increases the actuarial value of the basic benefit plan, on a sliding scale such that the plan has an actuarial value equal to 94% of the basic benefit plan's actuarial value income 100% - 150% FPL decreasing to 70% of full value for those with income 250-400% FPL

Requires that income and citizenship status be verified to determine eligibility for premium credits

Premium Subsidies to Employers

Provides tax credits to employers that offer qualifying coverage, have 25 or fewer employees and have average annual wages less than \$50,000

Creates a temporary reinsurance program for employers providing health insurance coverage to retirees over 55 who are not eligible for Medicare – payments from reinsurance used to lower enrollee costs in employer's plan

Tax Changes Related to Health Insurance or Financing Health Reform

Establishes new tax on individuals without qualifying coverage – greater of \$695 to \$2,085 a year or 1 to 2.5% of household income

Makes Health Reimbursement Arrangement, Health Flexible Spending Account and Health Savings Account changes

Increases itemized deductions threshold for unreimbursed medical expenses

Increases the Medicare Part A tax on wages for higher income earners (over \$200,000 individuals and \$250,000 married couples)

Imposes excise tax on insurers of employer-sponsored health plans with aggregate values over \$10,200 for individuals and \$27,500 for family coverage

Eliminates tax deduction for employers who receive Medicare Part D retiree drug subsidy payments

Establishes new annual fees for pharmaceutical manufacturing sector

Establishes annual fees on the health insurance sector

Establishes excise tax on sale of taxable medical devices

Limits deductibility of health insurance executive and employee compensation to \$500,000 per person

Establishes tax on indoor tanning services

Health Insurance Exchanges

Requires states to establish an American Health Benefit Exchange that facilitates purchase of qualified health plans and includes a Small Business Health Options Program (“SHOP”) Exchange for small businesses (up to 100 employees) (Sec. 1311)

Permits states to allow businesses with more than 100 employees to purchase coverage in the SHOP Exchange

Permits states to form regional Exchanges or multiple Exchanges serving different geographic areas of one state

Only U.S. citizens and legal immigrants who are not incarcerated may purchase Exchange coverage

Requires federal Office of Personnel Management to contract with insurers to offer at least two (At least one not-for-profit plan) multi-state plans in each Exchange

To foster creation of non-profit member-run health insurance companies, creates the Consumer Operated and Oriented Plan (CO-OP) program to offer qualified plans in all 50 states and DC (not an existing health insurer and not sponsored by state or local government)

Creates four Exchange plan benefit categories (bronze, silver, gold, platinum) and one separate catastrophic Exchange plan

Reduces out-of-pocket limits for those with incomes at or below 400% FPL

Provides for guarantee issue and renewability of Exchange plans and allows rating variations based only on age, premium rating area, family composition and tobacco use

Establishes Exchange plan requirements regarding marketing, provider network adequacy, contracts with essential community providers, contracts with outreach and enrollment assistance navigators, accreditation, reporting

Establishes Exchange requirements regarding call centers, enrollment procedures, application forms, application methods, financial reporting and permits Exchange contracts with state Medicaid agencies for tax credit eligibility determinations

Gives states the option to create a Basic Health Plan for uninsured persons with income 133-200% FPL who would otherwise be eligible for Exchange premium subsidies as an alternative to the Exchange

Benefit Design

Creates a comprehensive Essential Health Benefits Package to be defined and annually updates by the Secretary of HHS

Requires all qualified health plans, including Exchange plans and individual and small group plans offered outside Exchanges, to offer at least the Essential Health Benefits Package

Exempts grandfathered employer-sponsored plans from Essential Health Benefits Package requirements

Changes to Private Insurance

Creates temporary national high-risk pool to insure persons with pre-existing medical conditions - U.S. citizens and legal immigrants who have been uninsured at least 6 months can enroll and receive subsidized premiums

Health plans required to report portion of premium dollars spent on clinical services, quality and other costs

Provides rebates to enrollees when a plan spends less than 85% of premiums in large market and 80% in individual or small group markets on clinical services

Establishes process reviewing health plan premium increases and requires plans to justify increases

Promotes administrative simplification with financial and administrative transaction standards

Allows dependent coverage for all individual and group policies for children up to age 26

Prohibits individual and group health plan lifetime and annual limits

Prohibits plans from rescinding coverage except in case of fraud

Prohibits pre-existing condition exclusions for children by 9-23-10 and for adults by 2014

Provides for guarantee issue, premium rating and prohibits pre-existing condition exclusions for individual and small group plans

Requires all new policies (except stand alone dental, vision or long term care insurance plans) to meet one of Exchange plans benefit categories

Limits small group health plan deductibles to \$2,000 for an individual and \$4,000 for a family unless contributions offset these limits

Limits coverage waiting periods to 90 days

Creates temporary reinsurance program for individual and group health insurers to pay individual plans that cover high risk persons

Allow states option to merge individual and small group markets

Establishes an Internet website to allow individuals to identify coverage options and standards for insurers to use to provide benefit and coverage information

Permit states to form Health Care Choice Compacts – insurers could sell policies in any state in Compact and would be subject to laws of state in which policy is written or issued

Establishes the Health Insurance Reform Implementation Fund in HHS

State Role

Requires states to create and oversee individual and small group health plans in the American Health Benefit Exchange with a Small Business health Options Program (SHOP) exchange

Requires states to enroll newly eligible Medicaid beneficiaries into Medicaid by January 2014 and to coordinate Medicaid enrollment with Exchanges

Requires states to maintain current Medicaid and CHIP coverage levels for children until 2019 and current Medicaid levels for adults until Exchange is fully operational

Beginning January 2011, allows states which certify a current or future budget deficit to be exempt from maintaining current Medicaid coverage levels for non-disabled adults with income over 133% FPL

Requires states to create an office of health Insurance Consumer Assistance as an advocate for persons with individual and small group private insurance

Gives states the option to create a Basic Health Plan for uninsured persons with income 133-200% FPL who would otherwise be eligible for Exchange premium subsidies as an alternative to the Exchange

Cost Containment

Requires adoption of a single set of rules for:

- eligibility verification and claims status by July 2011
- electronic funds transfer, health care payment and remittance by July 2012
- health claims or equivalent encounter information, health plan enrollment and disenrollment, premium payments and referral certification and authorization by July 2014

Establishes penalties for plans that do not comply with these rules once they become effective

Medicare

- Restructures Medicare Advantage payments
- Reduces annual market basket updates for inpatient hospital, home health, skilled nursing facility, hospice and other services and set productivity adjustments
- Freezes Part B premiums
- Creates Independent Payment Advisory Board to submit legislative proposals to reduce per capita rate of Medicare spending growth
- Reduce Medicare DSH payments by 75%, increase to reflect portion of population uninsured and amount of uncompensated care provided
- Allow Accountable Care Organizations that meet quality thresholds to share in Medicare cost savings achieved
- Creates CMS Innovation Center to test, evaluate and expand Medicare, Medicaid and CHIP payment structures to reduce costs and improve care
- Reduce Medicare payments to hospitals for excessive preventable hospital readmissions and for hospital acquired conditions

Medicaid

- Increase Medicaid drug rebate %
- Reduce Medicaid DSH allotments and requires Secretary of HHS to develop a DSH methodology to make the largest DSH reductions to states with the lowest uninsurance rates or those states that don't target DSH, accounts for 1115 waivers usage of DSH allotment and imposes smaller DSH reductions on low DSH states
- Prohibits Medicaid payment of federal funds for services related to health care acquired conditions

Allows FDA to approve generic versions of biologic drugs and gives biologic manufacturers 12 years of exclusive use before generics can be developed

To reduce fraud, waste and abuse in Medicare and Medicaid, allows provider screening and enhanced oversight periods for new providers, requires provider compliance

programs, establishes a database to share provider data across federal and state programs, increased fraud provider penalties and strengthens standards for community mental health centers

Improving Quality/Health System Performance

Establishes a non-profit Patient-Centered Outcomes Research Institute to support research on clinical effectiveness of medical treatments – Institute findings can be used as payment requirements, etc.

Creates five-year demonstration grants to states to develop, implement and evaluate alternatives to current tort litigation

Medicare

- Establish Medicare pilot program to develop and evaluate bundled payments for acute, inpatient hospital services, physician, outpatient and post-acute services for 33 day episodes
- Creates Independence at Home demonstration program of primary care services in the home for high-need Medicare beneficiaries, allows participating providers to share in savings from reduced preventable hospitalizations or readmissions, improved health outcomes and efficient, reduced cost and improved patient satisfaction
- Creates hospital value based purchasing program to pay hospitals based on quality measures
- Develops plans to implement value based purchasing program to pay for skilled nursing facility, home health and ambulatory surgical services

Improves care coordination for dual eligibles (Medicare and Medicaid) with new office in CMS

Medicaid

- Establishes new state plan option to permit Medicaid enrollees with two or more chronic conditions (including mental health conditions) to designate a provider as a health home
- Creates Medicaid demonstration projects for:
 - bundled payments including hospitalizations,
 - global capitated payments to safety net hospital systems
 - shared cost savings to pediatric Accountable Care Organizations

- Institute for Mental Disease payments for adults requiring emergency stabilization
- Expands Medicaid and CHIP Payment Commission role to include adult services assessments

Increases payments for (fee-for-services and managed care) primary care doctors (family practice, general internist or pediatrician) to 100% of the Medicare payment rate for 2013 and 2014, with 100% federal funding of increased rates

Provides 10% bonus payment to Medicare Primary Care Physicians

Develops a national quality improvement strategy with priorities to improve delivery of care, patient outcomes and population health goals

Establishes the Community-based Collaborative Care Network Program – to support consortiums of health care providers to coordinate and integrate health care services for low-income uninsured and underinsured persons

Requires financial disclosure between health entities

Enhances requirements for data collection and reporting on race, ethnicity, sex, primary language, disability status and rural populations as well as access and treatment data for people with disabilities

Prevention/Wellness

Requires Medicare and Medicaid to cover only proven preventive services

Eliminates cost-sharing for Medicare and Medicaid preventive services, gives states 1% FMAP increase

Provides Medicare beneficiaries with comprehensive health risk assessment and personalized prevention plan

Requires Medicaid coverage of tobacco cessation services for pregnant women

Requires qualified health plans to provide certain preventive services without cost sharing

Provides small employer grants to establish wellness programs and provides technical assistance to evaluate employer-based wellness programs

Allows employers to reward employees with premium discounts or cost-sharing waivers for meeting certain health related goals and establishes a 10 state pilot program to apply similar employee rewards in individual market

Requires chain restaurants and vending machine food to disclose nutritional content

Long Term Care

Creates national voluntary insurance program for community living assistance services and supports (CLASS program) – with cash benefit of \$50 or more per day to buy non-medical services and supports to maintain community residence

Medicaid

- Extends the Medicaid Money Follows the Person Rebalancing Demonstration program
- Provides states with new options for HCBS services thorough state plan amendment rather than through waiver – for persons with income of 300% of maximum SSI (approximately 220% FPL) payment and a higher level of need
- Establishes Community First Choice Option for Medicaid – provides community based attendant supports and services to persons with disabilities who require institutional level of care – with 6% enhanced FMAP to states
- Creates the State Balancing Incentive Program – enhanced FMAP to states to increase proportion of community based long term care services

Requires Medicare and Medicaid nursing facilities to disclose ownership, accountability and expenditures and requires that collected information be published on website

Other Investments

Medicare

- Makes Part D doughnut hole changes
- Makes Part D cost sharing for full duals receiving HCBS services the same as full duals receiving institutional care
- Expands Medicare to individuals with certain health conditions who were exposed to environmental health hazards living in an emergency declaration area that was established prior to 6-17-09
- Provides 10% bonus payment to PCPs and general surgeons practicing in health professional shortage areas
- Provides funds for qualifying hospitals in counties with the lowest quartile Medicare spending
- Prohibits Medicare Advantage plans from setting cost-sharing higher than required under fee-for-service

Workforce

- Creates Workforce Advisory Committee to establish national workforce strategy
- Increases number of GME training positions by redistributing currently unused slots – priority given to primary care and general surgery and to states with lowest resident physician to population ratio
- Increases legal flexibility to allow GME training in outpatient settings
- Ensures availability of residency programs in rural/underserved areas
- Establishes Teaching Health Centers – community based ambulatory patient care centers, including FQHCs
- Increases scholarships and loans, supports primary care training and capacity building, provides state grants to providers in underserved areas, trains and recruits providers for rural areas, provides medical residents with preventive medicine, cultural competence, oral health and public health training, promotes training of diverse workforce
- Addresses nurse shortage by increasing capacity for education, providing loan repayment and grants, creating a nursing career ladder, providing grants to employ and train family nurse practitioners who provide primary care in FQHCs and nurse-managed clinics
- Supports development of training programs focusing on primary care models – medical homes, team management of chronic disease and integration of physical and mental health services

Community Health Centers and School Based Health Centers

- Increases community health centers funding by \$11 billion
- Establishes new program to support school-based health centers
- Establishes new program to support nurse-managed health clinics

Trauma care

- Creates a new trauma center program to strengthen ED and trauma center capacity
- Funds research on emergency medicine and develops demonstration programs to design, implement and evaluate innovative emergency care system models

Establishes Regular Corps and Ready Reserve Corps for public health service in time of national emergency

Non-Profit Hospitals

- Requires non-profit hospitals to conduct a community needs assessment every three years and adopt an implementation strategy for identified needs
- Requires non-profit hospitals to adopt and widely publicize financial assistance policies regarding availability of free or discounted care and how to apply
- Limits charges to patients who qualify for financial assistance to the amount generally billed to insured patients
- Requires non-profit hospitals to make reasonable attempts to determine financial assistance eligibility before starting extraordinary collection actions
- Imposes tax of \$50,000 per year for failure to meet these requirements

Appendix D – Individuals Interviewed for this Report

Richard Afable, MD, MPH, President and CEO, Hoag Hospital

Larry Ainsworth, CEO, St. Joseph Hospital

Nick Anas, MD, Medical Director of the CHOC Pediatric Intensive Care Unit and PSF Division Chief of Critical Care, Children’s Hospital of Orange County

Greg Buchert, MD, COO, CalOptima

Maria Calleros, Director, Business Development, CalOptima

Dan Castillo, Administrator, County of Orange, Medical Services Initiative

Richard Chambers, CEO, CalOptima

Joyce Cheung, Director of Care Management, Kaiser-Permanente (Orange County)

Ray Chicoine, COO, Monarch Health Care

Jay Cohen, MD, President and Chairman, Monarch Health Care

Kim Cripe, President and CEO, Children’s Hospital of Orange County

Chris Cruttenden, President, Safety Net Connect

Castulo de La Roche, President & CEO, AltaMed Health Services Corporation

Alan Edwards, MD, Medical Director of Behavioral Health, Orange County Health Care Agency

Jeffery Flocken, Regional President and CEO, Tenet Health Care

Charles Foster, Administrator, St. Joseph Heritage Medical Group

Robert Gates, Deputy Director for Medical Services, Orange County Health Care Agency

Jon Gilwee, Senior Director, Government Healthcare Programs, University of California Irvine Medical Center

Mary Hale, Chief, Behavioral Health Operations, Orange County Health Care Agency

Eric Handler, MD, Public Health Officer, Orange County Health Care Agency

John Heydt, MD, President & CEO, UC Irvine Physicians & Surgeons, University of California Irvine Medical Center

Janet Holcomb, Orange County Health Care Agency

Russ English, Integrated Healthcare Holding, Inc.

Garth Jorgensen, Operations Manager, Camino Health Center

Ed Kacic, President, Irvine Health Foundation

Kathy Kolodge, Executive Director of Ambulatory Care, Children's Hospital of Orange County

Ruth Kurisu, Managing Director, Health Funders Partnership

Keith Matsutsuyu, Principal, Safety Net Connect

Gloria Mayer, Executive Director, Friends of Children Clinic

Karen McGlinn, Executive Director, SOS Free Clinic

Julie Miller-Phipps, President and CEO, Kaiser-Permanente (Orange County)

Santiago Munoz, MD, Associate Vice President, UC Division of Clinical Services Development, University of California-Irvine

Tricia Nguyen, Executive Director, Vietnamese Community of Orange County Asian Health Center

Matt Niedzwiecki, VP Ancillary & Support Services, Children's Hospital of Orange County

Lee Penrose, CEO, St. Jude Medical Center

Cory Rayyes, Vice President, Administrator and COO, St. Joseph Hospital

Lex Reddy, CEO, Prime Healthcare Management, Inc.

Mark Refowitz, Behavioral Health Director, Orange County Health Care Agency

Dave Riley, Agency Director, Orange County Health Care Agency

Barry Ross, Executive Director, St. Jude Medical Center

Kerri Schiller, Senior VP & CFO, Children's Hospital of Orange County

Linda Simon, VP Mission Integration, St. Joseph Hospital

Kurt Stauder, MD, COO, UC Irvine Physicians & Surgeons, University of California Irvine Medical Center

Cathy Teschke, Executive Director, La Amistad Family Health Center

David Thiessen, Chief of Quality Management, Orange County Health Care Agency

Lori Weaver, Director of Managed Care Contracting, Hoag Hospital

Kenneth Westbrook, President & CEO, Integrated Healthcare Holding, Inc.