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California's Health Care Safety Net: Evolving to Meet Future Needs

Safety net providers share a mission to deliver preventive and primary care, along with a variety of other services, to patients regardless of their ability to pay. It is estimated that more than one in four nonelderly Californians rely on safety net providers for their regular care.¹ These patients are typically uninsured or enrolled in a public program such as Medi-Cal or Healthy Families, and earn less than 300% of the federal poverty level (FPL).^{2,3} The potential demand for safety net services at any given time in California is tremendous, as the state currently has the highest number of uninsured in the United States, with 7.2 million (approximately 22 percent of its population) and approximately 7.5 million enrolled in Medi-Cal. While not all of these individuals will seek care in any given year, these figures show that nearly half the state's residents are potential users of the health care safety net.

Safety Net Providers, Patients, and Programs

The composition of safety net providers varies across communities. Typically included are community health centers and clinics, public hospitals and health systems, local health departments, and other organizations or clinicians that provide free or discounted care. Services are often tailored to meet community needs and to meet federal and state requirements, and may include primary and specialty care, dental, pharmacy, optometry, and mental health/substance abuse, along with

other enabling services such as transportation, translation services, and insurance eligibility/enrollment assistance.

In California, two core types of safety net providers are community clinics, many of which are designated as federally qualified health centers (FQHCs), and public hospitals. The number and utilization of California's community clinics has grown over the past few years. In 2009, about 1,000 clinic sites provided almost 15 million visits to 4.8 million patients.⁴ About 55% of clinic patients were Hispanic, and 45% had a primary language other than English.⁵ In 2009, 44% of visits were by uninsured patients and 39% by Medi-Cal enrollees (see Figure 1). The 100 public hospital facilities in California deliver 10 million outpatient visits per year.⁶ More than two-thirds of these outpatient visits are provided to uninsured individuals or Medi-Cal enrollees. It is challenging to paint a comprehensive picture of the safety net because some safety net providers such as private clinicians do not report data on utilization and costs to the state.

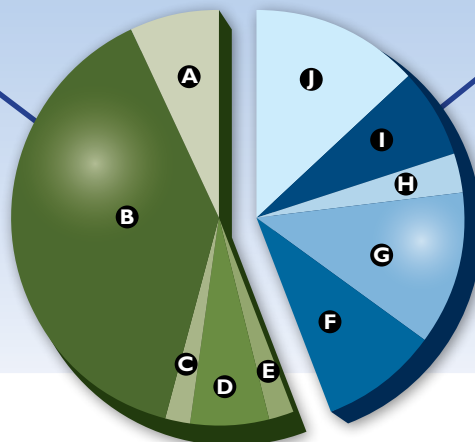
Sources of Funding

Safety net providers rely on a diverse and evolving set of funding sources, including federal and state programs such as Medicare and Medi-Cal, federal and state grants for specific programs, foundation grants, donations, and patient fees. The five-year 1115 Medi-Cal waiver approved in 2010 expands California's commitment to the safety net by providing

Figure 1: 2009 Patient Visits to Community Clinics by Insurance Source

Insured 56%

- A. Medicare 7%
- B. Medi-Cal 39%
- C. Healthy Families 2%
- D. Private Coverage 6%
- E. Other 2%



Uninsured 44%

- F. County 9%
- G. Self-Pay 12%
- H. Non-pay 3%
- I. Other episodic care programs* 7%
- J. Family Planning, Access, Care, and Treatment (PACT) program 13%

Source: Insure the Uninsured Project, November 2010

*Programs include Breast and Cervical Cancer Treatment, Child Health and Disability Prevention, and Expanded Access to Primary Care

substantial financial support. Key components of the waiver are:

- \$2.9 billion for expanded coverage prior to 2014 for up to 500,000 low-income individuals through the Low Income Health Program (LIHP),
- \$3.9 billion for the Safety Net Care Pool (SNCP) that covers uncompensated care costs in public hospitals, and
- \$3.3 billion for a Delivery System Reform Incentive Pool to support infrastructure development, innovation and redesign, population-focused improvement, and urgent improvement in care in public hospital systems.⁷

Moving Forward: The Future Safety Net

With implementation of the Affordable Care Act (ACA) underway, safety net providers may see an influx of new federal and state funds and will have the potential to attract newly insured patients. To meet the needs of current and future patients, providers will increasingly need to measure the quality of care provided and patient satisfaction with care, re-engineer practices to improve quality, and develop new partnerships to enhance care delivery. Safety net providers face ongoing risks to financial stability because of efforts to repeal ACA, as well as potential funding cuts resulting from state and county budget deficits. Other concerns include: 1) the payment rates for newly covered patients and whether these payments will cover needed services, 2) ability to effectively reach out to potential patients and successfully compete in the state's emerging health insurance exchange, and 3) ability to continue providing care for the remaining uninsured (e.g., the homeless, those with mental health or substance abuse disorders, undocumented individuals).

Becoming “Providers of Choice”

When ACA is fully implemented in 2014, approximately 4 million currently uninsured Californians may obtain coverage: about 2.1 million will likely be enrolled in Medi-Cal and another 2.0 million will be eligible for premium subsidies to purchase insurance through the state's health insurance exchange.⁸

Many newly insured individuals and families will have an expanded set of providers from whom to choose. Some safety net providers, often referred to as “providers of last resort,” are beginning to see their future identities as “providers of choice” who are able to attract and serve newly eligible individuals and families. Because many safety net providers currently offer a wide spectrum of health care and enabling

Figure 2: Joint Principles of the Patient Centered Medical Home⁹

- Each patient has a personal physician.
- The personal physician leads a team.
- There is a whole person orientation.
- Care is coordinated and integrated across health care settings.
- There is an emphasis on quality and safety.
- Patient access to care is enhanced.
- The payment structure recognizes services and value.

services, they serve as a natural “medical home” where patients can receive regular care and have a care team that comprehensively addresses their needs. Although the definition of a patient-centered medical home (PCMH) is evolving, its core features are listed in Figure 2.

Evidence is growing that PCMHs, which have been implemented in a variety of settings, organized by various sponsors (e.g., public and private payers), and located in diverse geographic locations, are resulting in improved quality of care and patient experience, as well as cost savings.¹⁰ A recent two-year evaluation of the PCMH implemented by Group Health Cooperative in Seattle found improvements in several dimensions of patients' experiences, quality of care, provider burnout, and total costs, as well as a 1.5:1 return on investment.¹¹ To date, medical home initiatives have focused primarily on patients with chronic illnesses and multiple health conditions. Increasingly, the concept is evolving to one of a “health home” that could be beneficial to all consumers, includes an emphasis on community supports that can improve health, and focuses on health throughout one's lifespan.

Embracing Payment and Delivery System Changes

Health care delivery system and payment changes are major tenets of federal health reform. There is evolving interest in Accountable Care Organizations (ACOs), which “bring together groups of providers to coordinate care for defined populations of patients, are rewarded for the efficient use of resources, and can report meaningful data on their clinical, financial, and quality performance.”¹² There is limited experience with the creation and operation of ACOs

References

- 1 UCLA Health Policy Fact Sheet, September 2007.
- 2 *California's Health Care Safety Net: Facts and Figures*, California HealthCare Foundation, October 2010.
- 3 For 2010, 300% of the FPL means gross income less than \$32,490 for a single person, \$43,710 for a family of 2, and \$66,150 for a family of 4.
- 4 *2006-2009 Overview of California's Uninsured*, Insure the Uninsured Project, November 2010.
- 5 *California: Profile of Community Clinics and Health Centers*, California Primary Care Association.
- 6 *California Public Hospitals' Outpatient Care: Value for Patients – and Our State's Health Care System*, CAPH Issues Brief, November 2008.
- 7 California Bridge to Reform: A Section 1115 Waiver Fact Sheet, California Department of Health Care Services, November 2010, and notes from Webinar: “California's Bridge to Reform: Our 1115 Demonstration Waiver”, November 4, 2010.
- 8 *California: Health Coverage, Utilization and Funding Trends*, Insure the Uninsured Project, October 28, 2010.
- 9 The American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), and American Osteopathic Association (AOA), representing approximately 333,000 physicians, developed these joint principles to describe the characteristics of the PCMH.

overall, and particularly within the safety net. The following issues will need to be addressed to allow for the successful implementation of ACOs within the safety net:¹³

- Moving from a fragmented set of providers to a “system of care” (e.g., through PCMHs)
- Increasing collaboration among safety net organizations to allow for contracts that tie payment to attainment of specific cost and quality outcomes
- Increasing care coordination and integration of services across safety net providers, to both improve patient outcomes and encourage efficient use of limited resources
- Improving access to specialty care and diagnostics to allow for more effective use of resources
- Increasing funds for infrastructure investments, including health information technology (IT)
- Enhancing efforts to collect, analyze, and report utilization, quality, and cost data

Under California's new 1115 waiver, Medi-Cal managed care plans have the opportunity to lead efforts to improve quality and integrate care for their enrollees by contracting with various safety net providers to serve as medical homes for seniors and persons with disabilities (SPDs), who are newly mandated to enroll in managed care. To effectively serve these patient populations, the state anticipates that “safety net providers will have developed integrated, coordinated, and sustainable delivery systems that will be ready to serve the newly eligible Medi-Cal population in 2014.”¹⁴ The exact configuration of these future delivery systems is unknown; there is a need to address the issues identified above and overcome any barriers that may limit the ability of safety net providers and health plans to develop ACOs. Even so, a “focus on the core principles of ACOs... will benefit the safety net institutions and all of its patient populations, whether ultimately covered by health reform or not, or whether the adoption of these principles results in the formation of an ACO or not.”¹⁵

Policy Recommendations

As California's health care delivery system is transformed over the next several years, safety net providers have the opportunity to evolve by building on their core strengths and developing new partnerships. Several policy approaches can help support this transformation, to ensure that the safety net remains intact and effectively serves a potentially larger patient population.

Integrating Care through Treatment for Late Life Depression

LifeLong Medical Care traces its roots to the Gray Panthers, a senior citizen advocacy group whose mission embraces the importance of consumers' involvement in their own health care. This mission was the basis of the model of care developed at LifeLong's Over 60 Health Center, which brings health and social service/mental health caregivers together to provide patient-centered primary care. LifeLong serves 22,000 predominantly low-income patients annually, 40% of whom are elders or people with physical and/or mental disabilities, and 19% of whom have a diagnosis of depression or other mental illness.

LifeLong uses the Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) model of chronic care management for depression,¹⁷ which has demonstrated effectiveness in the general adult population, with older adults, and with minority consumers. In comparison to standard treatment for depression, the IMPACT model features two key processes: 1) systematic diagnosis and tracking of depression outcomes, and 2) “stepped care” that changes if the patient is not improving. Two additional team members, a care manager and a consulting psychiatrist, assist the primary care provider.

Building on weekly meetings between primary care physicians and social service providers, LifeLong's Over 60 has added a Consumer Review Team (CRT) that further improves coordination of depression care among primary care, social service, and specialty mental health providers. The CRT includes primary care providers, a licensed clinical psychologist, a psychiatrist, and depression care manager(s). Once per month, a psychiatrist attends all-provider meetings to review difficult cases, give consultation regarding medication, and discuss potential referrals. A designated sub-team of the larger staff that focuses so closely on the mental health needs of enrolled patients has been beneficial for both patients and staff, leading to the following positive outcomes:

- Reduced depression and improved quality of life for patients;
- Increased consumer satisfaction with services;
- Increased availability of depression services for more low-income elders and people with disabilities;
- Increased coordination of care between primary care and mental health providers, consumers, and families; and
- Increased staff skills in therapy and management of depression.

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10 Kevin Grumbach and Paul Grundy, “Outcomes of Implementing Patient-Centered Medical Home Interventions: A Review of the Evidence from Prospective Evaluation Studies in the United States,” November 16, 2010, UCSF Center for Excellence in Primary Care/Patient-Centered Primary Care Collaborative.

11 Robert J. Reid et al. (2010). “The Group Health Medical Home at Year Two: Cost Savings, Higher Patient Satisfaction, and Less Burnout For Providers,” *Health Affairs*, 29(5):835-843.

12 James C. Robinson and Emma L. Dolan. “Accountable Care Organizations in California: Lessons for the National Debate on Delivery System Reform,” Integrated Healthcare Association, 2010.

13 Terry Conway and Pat Terrell. “Accountable Care in the Safety Net,” paper prepared for the Blue Shield of California Foundation, November 2010.

14 “California Section 1115 Comprehensive Demonstration Project Waiver: A Bridge to Reform, Vision for 2014,” California Department of Health Care Services, July, 2010.

15 “Accountable Care in the Safety Net.”

16 Kelly Pfeifer, MD presentation “Safety Net Innovations: The Road to Healthcare Reform”, California Health Policy Forum, December 2, 2010.

17 <http://impact-uw.org/>

1. Support investment in primary care as a mechanism for creating the safety net of the future. To transform the safety net, investment is needed in three major areas – workforce, health IT, and practice redesign. To build and sustain a multi-disciplinary primary care workforce that can meet patients' needs, additional incentives (e.g., scholarships, loan forgiveness) should be provided to encourage students in a wide array of health professions to commit to being primary care safety net providers. To allow for measurement and reporting of quality, cost, and utilization data, ACA funds should be tapped and leveraged to bring health IT systems to safety net providers. To support more effective use of resources and improved patient care, systems should be designed to allow for transfer of data across safety net providers. 1115 waiver and additional funds should be made available to clinics that want to redesign their practices to improve patient care and manage costs, for example, by integrating care across safety net providers, improving patient experience of care, increasing access to primary and specialty care, integrating primary and behavioral health care, or using technology as a tool for access and quality.¹⁶

2. Encourage safety net providers to be or become patient-centered medical homes through increased, appropriate reimbursement. PCMHs that feature more access to prevention and primary care, better care coordination and chronic disease management, and improved access to specialty care have the potential to improve quality and lower costs for patients in the safety net. Because there will be additional costs to create medical homes, payers may need to change payment methods to provide incentives for safety net providers to embrace the medical home model. Ultimately, safety net providers can be held accountable for the care they deliver, with payments tied to results.

3. Provide incentives for safety net providers to engage in innovative delivery system and payment reform. For the safety net to effectively meet the needs of future patients and more efficiently use available resources, enhanced partnerships will be required between public and private entities, including community clinics, hospitals, medical groups/physician offices, foundations, and state and local government agencies. Providing incentives for such partnerships (e.g., by removing legal or policy barriers to the formation of entities such as ACOs, supporting health IT investments to support data collection and exchange) should enable safety net organizations to compete on cost and quality in venues such as California's health insurance exchange.

4. Ensure that there is a “no wrong door” eligibility and enrollment system for public health insurance programs. Under health reform, it is expected that many individuals will move in and out of eligibility for various public health insurance programs, potentially jeopardizing their access to care. To address this issue, the ACA requires that eligibility and enrollment systems be available online and use a single, streamlined application for all health subsidy programs. Substantial investments in health IT systems will be required so that California's various statewide and county eligibility systems are able to communicate with one another; eligibility determination and enrollment processes are seamless, and coverage transitions are facilitated to the greatest extent possible. A “no wrong door” system will improve coverage continuity by a) requiring only one application that will be used to identify any programs (e.g., Medicaid, Healthy Families, subsidies for private coverage through the health insurance exchange) for which individuals and families are eligible, and b) processing enrollment applications. Because a large portion of their patients are currently eligible or will be eligible for these programs, safety net providers can play a key role in establishing eligibility and helping patients enroll.



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