Healthcare Services for Undocumented Immigrants
Draft Program Concept – *Exercise Notes*
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Stakeholder Participants: Advocates – Nenick Vue, David Ramirez, Amy Williams, Kelly Bennett-Wofford, Kim Williams; FQHCs – Jim Ellsworth, Chuck Wiesen, Jonathan Porteus, Jennifer Stork, Miguel Suarez, Britta Guerro Hospitals/Medical Society – Brian Jensen, Rosemary Younts, Ashley Brand, Holly Harper, Ellen Brown, Bob Waste; Kris Wallach; UCD TEACH – Tonya Fancher, Craig Keenan, Fred Meyers, Ian Kim, Melody Le Tran, Ariya Chau
Facilitator: Sandy Damiano; **Small Group Scribes**: Karen Giordano, Steve Golka, Marcia Jo, Amelia Schendel

Exercise: Participants broke into small groups and reviewed a document outlining Draft Program Concepts. Staff explained this was a starting point to assist the conversation and the feedback process. This document contains the notes from that exercise. Groups are in alphabetical order. At the end of the exercise, each group gave a brief verbal summary report. Later each group validated typed notes for their respective sections.

ADVOCATES

A. GENERAL CONCEPTS

- Avoid using Fresno-frame and create a Sacramento program. Fresno and Sacramento are more dis-similar than similar
- Coordination of primary and specialty – has to be an entity to take on the role that is linguistically/culturally appropriate
- Funding to bolster primary care
- Primary care is not sufficient currently to take on new enrollees
- Change work "donated" to "leveraged" or "grantees with contractual obligations"
- Simple and coordinated program to ensure utilization
- Add to general concepts: #4 Coordination and Navigation
- Have a couple (2+) front doors/portals that are community-based
- Maintain an ongoing stakeholder process while operating the program to work out challenges

B. ELIGIBILITY AND SERVICES

- Coordination between adult services and wherever the adult patient's children receive services. Kaiser provides care for undocumented children currently and Kaiser may not be an option to provide care for adults in this model.
- If Kaiser caps undocumented children enrollment, then expand population from 19 -64 to include children
- Expand age range from 19 – 64 years to include adults older than 64. Immigrant adults 65+ not eligible for Medicare
- Strike Medi-Cal application denial requirement

- Utilize a simplified, fast-tracked application process
- Provide services during the pending application process so that services are not delayed
- Care and services provided consistent with the treatment plan and utilize Medi-Cal Managed Care timely access standards
- Affirmative application without a need to show medical need/or referral
- Encourage preventative care

C. PROVIDERS AND COSTS

- Stakeholders need to be aware of what specialties that are excluded in order to comment
- Since behavioral health is excluded in this model, needs to be included in the County Mental Health Expansion
- Coordinate behavioral health care with patients primary health care
- Vender payments and coordination of patient care needs to happen - focus on both
- Not capping 138% FPL and have a share of cost for individuals who have higher incomes
- Need to know what medications are excluded / need to see formulary
- Geographic access to pharmacies
- Continue to offer enrollment on a case-by-case basis when reaching funding/enrollment cap
- Establish a wait-list process
- Cost estimates section – change wording on 1st bullet from "stopped" at 4,000 to "paused"
- Strike prior authorization for specified services
- $6 million is not enough money
- Don't want a cap enrollment and funding
- Want to mirror a Medi-Cal program

D. OTHER

- Fresno more dissimilar than similar to Sacramento
- Assumption level - #4th assumption should not be involved in creating a Sacramento program because Fresno and County are completely different
- Fresno's infrastructure is very different from Sacramento's
- Take Fresno-like out of the language: build a Sacramento program
- Ensure cultural competencies on how providers/program engages with patients (access, get in, denied)
- Fresno-like is not preferred model

FQHCS

A. GENERAL CONCEPTS

- What defines "county clinic?" TEACH? County Employees?
- Who is included in "authorized community clinics?" What is this? By who? How?
- If dental – MH – substance abuse is not included - how / who will these be provided? These services are part of comprehensive primary care.
- What are donated (FQHCs already do this) services? Patients deserve to know what they can get, not intermitted unpredictable "lottery."

- What about hospitalization? What is the vision for this benefit?
- Put community clinics first before county clinic.
- Donated beyond 1:2 not exclusively donated.
- Where is specialty network coming from?
- Propose narrow specialty network as the reality.

B. ELIGIBILITY AND SERVICES

- Seems like County eligibility required which may be a step backward or duplicative of FQHC sliding fee.
- Also – not eligible – a barrier – do not want a litmus test through Medi-Cal. No Emergency Medi-Cal requirement.
- Propose that FQHCs manage eligibility via their sliding fee.
- Need a process that does not discriminate.
- Cannot violate Federal requirements which are to see everyone "regardless" of ability to pay.
- Cover what is in scope of service which may include dental, etc., and, other.
- Use FQHC network for all within scope services.
- Sidebar with specialty network or make referral to TPA with this bureaucracy – competitive bid.
- County put up block of money for specialty.
- What would procurement process look like at each level of care and TPA? Propose all licensed clinics.
- Lab – procurement? Propose separate process. Maybe system that will donate. Clinics have a sliding fee scale for labs.
- Pharmacy – need 340B discussion – What if no 340B?
- Define "last resort" program to indicate other available programs will be used first.
- Dental – MH – AOD – etc. will all be sliding fee.

C. PROVIDERS AND COSTS

- What is county clinic? County employees? TEACH?
- Paying sliding fee for enrollee will discourage provider participation.
- Potential compliance issue with this.
- Prefer - strongly prefer bundled "EAPC" rate for sliding fee, primary care, lab, etc. – average costs $88.
- County clinic: do not recommend county employees due to costs.
- Uncompensated care payment methodology not useful in utilization analysis due to ACA
- Pharmacy stipend
- Use established formulary – maybe FFS Medi-Cal/Walmart
- Approach Walmart? Donation?
- 340B thorny – for specialty, non FQHC, hospital
- HRSA allows 40 meds on site. Potentially limit formulary to these.
- No need for enrollment or limitations with EAPC model proposed by clinics. No cost containment issue with block grant to clinics for Primary Care / Specialty.
- No prior authorization, expenditure monitoring needed.
- TPA and clinics will monitor enrollment?

HOSPITALS / MEDICAL SOCIETY NOTES

A. GENERAL CONCEPTS

- Whole program - one year pilot
- Legislature part of reason for one year pilot; need to evaluate effectiveness is another
- Primary Care
    - County best to organize
    - County Clinic/ TEACH (to help staff)
    - RFP – 1 to 2 other clinics via a very stringent process
    - Geographic distribution for contracted clinics
    - Measurable outcomes; stringent outcomes TBD
- Specialty care
    - "Right size" SPIRIT program and build upon it
    - "Formalize" SPIRIT Program
    - Hospitals to find volunteer physicians/surgeons
    - County to find or fund ambulatory surgery center
    - Radiological services – county (independent)

B. ELIGIBILITY AND SERVICES

- 19 years of age and up because of Medi-Cal eligibility
- Need verification / checks and balances (advocates to lead. Navigator at clinic) in this context Advocate/Navigator is one and same person
- Scratch list of bullet on page 2 (to be eligible, applications must be accompanied by a referral from the county clinic or authorized clinics)
- Limited scope – change radiology. See above
- Services not covered – limited dental and mental health covered
- Donated services – specialty care – "range to be determined"

C. PROVIDERS AND COSTS

- Participating providers – as is.
- Need specialty care coordinator – county /SPIRIT
- Primary care – county to determine appropriate cost sharing with input from Advocates.
- Pharmacy – as is
- Cost estimates – one year pilot from launch
- Navigator involvement – to brief patient on any costs (i.e. sliding scale fees), coverage
- Rest of cost estimate strategies – ok
- Cost containment – leave as is

D. OTHER – N/A

UCD TEACH

A. GENERAL CONCEPTS

- Once threshold met, do services end? Not practical / not ethical. Patient / doctor relationship cannot cease. M.D. obligated to continue to see the patient.
- Can dual providers provide mental health and primary care services?
- Is "undocumented" covered under mental health (prop 63)?
- Are there options for providing mental health?
- Not consistent with UCD principle of providing "comprehensive care"
    - "comprehensive care" → geographic coverage
    - i.e., No one group → shared responsibility
- Defining responsibility and total care by geographic area
- IT – coordination
- Centralized navigators
- Population health
- Outcomes and program evaluation

B. ELIGIBILITY AND SERVICES

- <18 thru >65 covered?
- If <18 won't get care, families less likely to come
- UCD "responsible" for zip codes: 95820, 95817. Zip code responsibility for this population - **TBD**

C. PROVIDERS AND COSTS

- Comprehensive team-based care including learners; non-M.D. learners, physician learners, and PAs, NPs, Pharmacists, etc.
- "ACO Model" to manage a defined population in contrast to paying the sliding fee scale
- Bring specialists to the Primary Care Clinic
- Provide e-consults and phone consults
- Use a technology-enabled environment
- ACO model for providing pharmaceuticals
- Prescribe generics when available
- High value care (ACO) - High quality and low cost = faculty and student development
- Pull in "student clinics" to provide high quality and low cost care
- Include cultural and linguistic care

D. OTHER

- Community navigators helpful
- Navigating the "system" is challenging; should be "seamless" to the patient. The HCPs should be expert at this (not students). Stable cadre of HCPs and support staff
- Communication across systems vital