Capitol Health Network
Better access. Healthy communities.

March 31, 2015

Dr. Sandy Damiano, PhD
Deputy Director
Primary Health Services Division
Department of Health & Human Services
700-A East Parkway
Sacramento, CA 95823

Dear Dr. Damiano:

Capitol Health Network and its members appreciate the opportunity to work with you to further define and understand the options presented to the Sacramento County Board of Supervisors at the March 18, 2015 Workshop on Health Care Coverage for Undocumented Immigrants. The time and resources that the County has already devoted demonstrates its dedication to improving the lives of all our community's residents. Below you will find some initial thoughts on how we might create a program that meets the medical needs of one of our community's most vulnerable and isolated people. In the interests of collaboration and not by way of dictating any program parameters, we make the following observations and recommendations with a view to creating the most comprehensive, caring, efficient and accessible program possible.

Who We Are

Capitol Health Network (CHN) is a membership organization comprised of Federally Qualified Health Centers (FQHC), Rural Health Centers (RHC), Community Clinics, and other community service organizations. The mission of CHN is to support and strengthen the healthcare safety net and to advocate for vulnerable people in Sacramento and the surrounding region. CHN's members served over 200,000 people in 2014, including about 150,000 Medi-Cal insured people. Our Members operate over 25 primary care sites in all areas of Sacramento County; providing culturally competent primary medical care, primary behavioral health care, dental care, some specialty care and related services. At this time, all of our health center members have an interest in serving the County's medically indigent people.

What We Propose

CHN is a member of the Building Healthy Communities coalition (BHC) and has participated in the activities leading up to the current project to more deeply define the options presented to the Board of Supervisors on March 18, 2015.

All of us are strongly supportive of a full services care plan for undocumented people as presented in Options 3, 4 and 2 (in our order of preference). We are aware of the time that creating and implementing such expansive plans would entail. We are also aware of the tight fiscal constraints within which the County must operate. If the County chooses to adopt any of the options listed above, CHN's Members would eagerly participate in developing such a solution.

Accordingly and for the sake of economy and timeliness, CHN and BHC are focusing our responses on Option 5 as presented in the Matrix Options and Estimates of March 10, 2015. We believe that Option 5 is the simplest, most cost efficient and quickest solution to deploy. It provides broad geographical network of care, the highest likelihood of establishing culturally competent medical homes, and the best continuity of care for the people to be served.

An Option 5 Approach

From a starting point that the estimated cost to the County of an Option 5 solution would be about $6 million in the first year, we recommend that an amount should be separately spent on primary care and on specialty care. The optimal division should be calculable by an actuary. We would further recommend that the County contract with CHN's members to provide primary medical, behavioral and dental care to create a broadly accessible primary care network; and contract with one of the local medical groups/Independent Physician Associations to provide selected specialty medical care.

For primary care, we believe that the State operated Expanded Access Primary Care Program (EAPC) would be a good template from which to create a program for undocumented people in Sacramento County.

This program awarded funding to health centers once a year. Participating health centers billed qualified medical encounters against this award, once each month; with each qualifying medical encounter being identified. Eligibility, program policies, clinic standards, service requirements, and documentation under an EAPC-like program would all be fairly easily definable and would not require the County to invent new administrative functions or the health centers to create new workflows. Providing access under such a program would fall to the health centers and would not require any County supervision. Oversight and an audit trail through the health centers' records systems would be provided by the monthly billing reports. Allocation of the total funding among health centers could be achieved through a formula based on the relative numbers of uninsured served in the prior year relative to the total numbers of uninsured served by the participating health centers (per OSHPD reports). A base award with additional allocations for health centers serving large uninsured populations might be the most logical and acceptable way to arrive at contract award amounts. (Since health centers do not collect immigration status data, we would propose using uninsured people as a reasonable proxy for the relative number of undocumented people.)

EAPC was not a perfect program. In 2011, its last year of operation, participating health centers were reimbursed about $72.00 per medical encounter. This is substantially below the total cost of delivering

care in a medical home setting; which meant that health centers continued to directly subsidize patient care. In addition, EAPC required the health center to provide prescriptions, labs and other diagnostic services as a part of the per medical encounter reimbursement. Thus, as (if) the County develops an EAPC-like program, the community health centers would appreciate exploring ways that they could lessen their exposure to these costs

Specialty care and Hospitalizations

After very initial conversations with networks of specialty care providers, we believe it would be possible for the County to contract with such an agency to provide focused specialty services. Working from a fixed amount, we propose working with the BHC, willing health plans or Independent Physician Associations (IPA) and the County staff to identify requisite specialty services and cost estimates. All specialty services may not be available under such a scenario. Lack of access to hospital-based procedures, cost and other considerations may dissuade some specialists from participating. Nevertheless, a specialty network of essential services would greatly improve health outcomes for the people we serve.

Non-emergent hospital services would not be covered under this program. Emergency hospital services would continue to be covered by Medi-Cal. Participating health centers will need to assist patients to access hospital charity care programs for non-emergent hospital services. Since an EAPC-like program would have a relatively low income eligibility threshold (e.g. less than 200% of FPL), we would expect that the hospital systems will be able to provide some access for needy patients. Further, appropriate use of a primary medical home and available specialty care should, over time, drive down the need of patients to access care in a hospital setting. Even though a lack of a defined hospital benefit limits access, this EAPC-like program would be a vast improvement on our current situation.

Patient Navigation

CHN recommends that navigation and care coordination services be made available for the undocumented patient population to ensure culturally competent and linguistically appropriate patient access and utilization of County programs. Given that the undocumented population consists of first generation immigrants who are either limited or non-English speakers, navigation and translation services are essential to directing patients to appropriate providers and services. Further an Option 5 approach would likely provide a collection of services rather than a fully implemented enrollment and coverage program. This will create difficulties in centralizing information and access points for undocumented people. Navigation services, particularly with trusted community based partners, such as Health Education Council, La Familia Counseling Center, and Sacramento Covered, can mitigate access and utilization issues, particularly in regards to specialty care. Specialists are often harder to geographically access and are less likely to provide culturally competent and linguistically appropriate services and staff. Additionally, effective specialty care requires medically fluent interpreters to ensure proper communication between patients and doctors for consultation and diagnosis. For these reasons, CHN

recommends that community health navigators and care coordinators be included in the implementation of a County health access program for the undocumented.

In closing, we greatly value your leadership in creating this opportunity to better serve our vulnerable and unfranchised patients. We look forward to working with you toward program implementation and the commencement of services for all the medically indigent people of Sacramento County.

Respectfully Submitted,

James Ellsworth
Executive Director

CC: Board of Directors
FQHC/RHC Council
BHC Health Access Team