Health and Human Services
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County of Sacramento

Divisions
Behavioral Health Services
Child Protective Services
Departmental Administration
Primary Health Services
Public Health
Senior and Adult Services

Memorandum

Date: May 28, 2015

To: Members, Board of Supervisors

From: Sherri Z. Heller, Director
Department of Health and Human Services

Subject: ***Status of Development of County Healthcare Services for Undocumented Immigrants***

This memorandum will be on the June 9th Board agenda as Communication Received and Filed, but we are providing you with this advance copy today.

On March 18, 2015 the Board held a workshop on healthcare services for undocumented immigrants. During the course of the hearing, the Department presented an overview of materials related to this topic, including a staff report and a briefing paper that had an associated matrix with potential options and cost estimates authored by Stan Rosenstein. The range of information provided was extensive and included background, State or other coverage, history of County medically indigent, status of State full scope coverage, other counties' coverage of undocumented immigrants, and potential options for serving this population along with cost estimates for each option.

In addition to staff reports, testimony from stakeholder groups and individuals was extensive and supported the need for health services to this population. See Board materials dated 03/18/15 for County and stakeholder documents.

At the conclusion of the hearing, the Board requested staff complete additional work, obtain stakeholder feedback, and report back.

Since the Board Workshop (03/18/15), the following actions have been taken:

1. Review of Fresno County materials and conference call with Fresno County.
2. Creation of additional documents for stakeholder groups:
   a) Relationship between Specialty Care, Hospital Services and Pharmacy by Health Management Associates dated March 24, 2015;
   b) Healthcare Services Proposed by Fresno County dated March 26, 2015;
   c) Prescription Options for Uninsured Residents dated April 10, 2014.

3. Stakeholder Meetings – covered in the next section.
4. Continued tracking of new information.

As described in the March 18th staff report, healthcare services to undocumented immigrants is not a county mandate. The County has discretion in providing services. Stakeholders have been actively engaged because they are compassionate about this population and they are also providing services or advocacy. Each stakeholder group represents a different perspective. Their input has been valuable.

STAKEHOLDER DISCUSSIONS

Stakeholder Process (7 meetings through May 7th – individual groups; large group)
Initial meetings were convened representing five stakeholder groups:

- Advocates – Building Healthy Communities (BHC), Sacramento Covered, Sacramento Area Congregations Together (Sac ACT), Legal Services of Northern California (LSNC), Health Education;
- Medical Societies – Sierra Sacramento Valley Medical Society (SSVMC), Sacramento Latino Medical Association (SaLMA);
- Capitol Health Network (CHN)/Federally Qualified Health Centers (FQHC);
- Hospital Council/Hospital Systems (Dignity Health, Kaiser, Sutter Health, UCD);
- UCD TEACH (Transforming Education and Community Health) - faculty/residents/students.

During each initial stakeholder meeting, information was briefly reviewed on potential options, Fresno County's program was described and feedback was solicited in two main areas:

1) What are Sacramento's perceived service gaps; and
2) What services / efforts can your organization contribute if a program is implemented?

Each group validated notes during and after the meeting. A Stakeholder Groups Summary document captured key themes across the groups:

General Themes

- All embrace providing health care coverage or services to the population of undocumented immigrants.
- There are needs for primary care, specialty care, non-emergency hospital based services, medication, labs, and diagnostic testing.

Perceived Service Gaps (*number of groups that endorsed the item / total of five stakeholder groups*)

- Primary care medical homes: access and capacity (5/5).
- Specialty care, particularly outpatient specialty follow-up (5/5).

- Pharmaceuticals (5/5).
- FQHCs sliding fee scale charges present a barrier (4/5).
- FQHCs do not have adequate capacity to meet current demands (4/5).
- FQHCs are not financially strong or robust compared with many other counties (3/5).
- FQHC accountability (3/5).
- Behavioral Health, Substance Abuse Services, Dental (3/5).

Special Needs

- Linguistically and culturally appropriate health services.
- Education and assistance – eligibility & enrollment, healthy living, chronic disease management, how to navigate services.
- Education and reassurance to decrease fears and increase comfort when seeking health services.
- Transportation.

Sacramento differs from Fresno in the following ways:

Sacramento

- Lacks a robust FQHC network.
- Access to primary care and specialty care is very impacted.

Fresno

- Has an agreement with a major hospital system and specialty network.
- Specialty network appears more involved and has better access in safety net services (Medi-Cal, uninsured).
- They have been serving undocumented immigrants and have better data on population estimates and needs.
- They have special funding for this program. They received a deferral to repay road funds ($5.5 million) and have targeted this for specialty services. Additionally, Fresno chose the health realignment option which utilizes a complex formula based on expenditures. Because they had historically provided services to the undocumented, they are able to include those expenditures in their realignment calculation.
- Robust FQHC system.
- Fresno contracts for Medi-Cal rates (specialty; hospital). Unclear at this time if Sacramento can contract for these rates.

Potential Options

- A coverage program (Options 1 – 3) is preferred to meeting a service gap (Option 5 – Fresno like model).
- Some groups preferred a program with the County Integrated Behavioral Health (IBH) TEACH Medical Home at the Primary Care Center (PCC) as the hub. Also suggested placing a specialty clinic at the PCC in partnership with Sacramento

Physicians' Initiative to Reach Out, Innovate and Teach (SPIRIT), hospital systems, and TEACH.
- Geographic access would be ideal.
- Hospital Partners noted services would be a step in the right direction but stressed need for organizational structures, clinic with capacity (such as County IBH TEACH).
- Hospital Partners strongly advocated for a workable program size for quality control.
- FQHCs acknowledged an obligation to see all individuals regardless of ability to pay but presented a document regarding a payment methodology for their services.

What services / efforts could organizations contribute?
- Enhance SPIRIT. SPIRIT worked best with County Clinic due to organizational structure and volumes.
- Medical Society and Hospital Systems expressed need for strong structure with SPIRIT and primary care/specialty services.
- Hospitals could donate more specialty if there was follow-up and continuity.
- Enhance UCD TEACH/County partnership (primary care, subspecialties, other teaching programs such as Family Nurse Practitioner (FNP) or Pharmacy Residents).

Draft Program Concept
Following the individual group meetings, the next meetings convened all groups together to review themes and to discuss a document containing an initial draft program concept. The program concept was drafted based on the individual group stakeholder feedback, use of the consultant's documents, consultation with the consultant, and an estimated $6 million budget (cost of the "Fresno model"). Key features are described below:

Assumptions
- This is a community issue.
- Sacramento County is substantially different than Fresno County. This means that direct application of their program will not work.
- There are many unknowns, including numbers of undocumented immigrants who would take advantage of a program. Fresno and Sacramento populations are likely very different.
- Primary care and specialty care access are impacted locally due to Affordable Care Act.
- Maximizing key existing partnerships is critical – SPIRIT, Hospitals, UCD TEACH.

General Concepts - This is a multi-pronged approach based on community needs and stakeholder feedback. Stakeholder meetings are still in process. Next meeting will review these in greater detail.

- **Primary Care** – Will be provided by County IBH TEACH with options for other points of access. Preventative care will be emphasized. *FQHCs wanted participation of all FQHCs. Hospital systems recommended utilization of County IBH TEACH and issuing an RFP for 1 – 2 clinics.*
- **Specialty Care** – Will define specialty care covered and exclusions. Leveraged services would be used prior to contracted services.
- **Leveraged Services** – Program partners will also be asked to donate, leverage and/or expand volunteer services. *This includes key partnerships such as SPIRIT, hospital systems and TEACH. One suggestion included a specialty clinic located at the Primary Care Center utilizing SPIRIT physicians with support from county staff. This was effective in the past.*
- **Pharmacy** – Outpatient pharmacy will be limited and take advantage of existing low cost retail options.
- **Administration** – Will need to determine a means to authorize services, pay claims, hold the network, track and monitor utilization and provide reports.
- **Patient Assistance** – Includes key patient assistance in the following areas: eligibility process, education (about use of healthcare services), navigation, assistance for scheduled appointments, and follow-up.

This program concept is not a comprehensive healthcare coverage program. It will cover some essential services. However, it <u>will not</u> cover any services provided by any State or Federal program. It will also not include dental, mental health, or alcohol and drug treatment. While these are important services, there are insufficient funds.

Eligibility

- Adults (19 – 64 years of age) up to 138% of the Federal Poverty Level (FPL); may need to set a threshold lower depending on funding;
- Sacramento County resident;
- Last resort program – does not cover any services provided by any State health or Federal programs. Utilizes Medi-Cal application process. This means enrollees do not meet requirements for full-scope Medi-Cal or other full scope coverage programs. Must have emergency Medi-Cal; may initially have hospital presumptive eligibility.

Cost Estimates

There are many unknowns so it is difficult to accurately project enrollment or expenditures.

- Total costs = $7 million. This will be inclusive of health services, administration, eligibility and navigation). *For this figure, estimate an enrollment of 4,000 – 6,000 adults. If less funding is available, will need to restrict eligibility, benefits, or access points.*

- Since this is a new program, it is better to start slowly and to monitor process and costs. It is also likely that initial enrollees will have pent up medical demands.
- Note: the smaller the program, the more difficult it is for cost containment and need for additional containment strategies.

Cost containment strategies

- Last resort program – maximizes use of other State or Federal programs.
- Limit access points initially, potentially increase later after monitoring service utilization and costs.
- Specific referral paths for enrollees and authorization processes.
- Prior authorization for specified services.
- Monitor service utilization and expenditures.
- Pause enrollment prior to reaching potential enrollment for monitoring purposes.
- Set an expenditure threshold and expenditure maximum. Once the threshold is achieved for the year, all program parties will be notified that the program will run out of funds and may not be able to pay for further services. Expenditures will stop when the maximum is reached and providers will be liable for the cost of any services provided above the maximum.

Stakeholder Feedback on Draft Program Concept

Stakeholders have been appreciative to be involved in the process. They have been very active and engaged in the meetings. *All stakeholders have been very vocal about the service needs and would prefer a comprehensive healthcare coverage program, but know that may not be realistic given the costs.* Stakeholders are in agreement that a "Fresno-like" program will not work for the local community.

Advocates focused on the beneficiary perspective and did not limit enrollment, clinic locations, eligibility, etc. Their ideas were supported by many of the stakeholders, but may be cost prohibitive. They also focused on patient assistance and navigation for a program of any design. All supported this concept.

FQHC stakeholders prefer participation at all sites, an allocation methodology, and FQHC determination of eligibility. They also did not see the need for a competitive selection process and want to claim for all services they provide beyond the scope of what may be offered in a limited benefits program. Other involved stakeholders expressed concerns about FQHC accountability, capacity and costs.

Hospital system representatives are very cognizant of the fiscal reality of program costs. They recommend utilizing the County IBH TEACH Clinic plus contracting through a competitive process for 1 – 2 clinics in different geographic areas. They also expressed great interest in collaborating with the County and with the Medical Society to "right size" the SPIRIT program. They are willing to recruit specialists for this component and would like a specialty clinic which may be based at the Primary Care Center. Additional comments of note from hospital system partners include a focus on quality, metrics and

demonstrating this as a pilot program for one year. One year may be too short for any measurement. Two years may be better for a pilot.

UCD TEACH stakeholders also focused on quality and maintaining low costs. They were willing to invest, which would include leveraging their resources. Their idea of a pilot was based on geography and the County IBH TEACH Clinic.

Stakeholders found the County eligibility process cumbersome and did not want to use the Medi-Cal application. However, this is required for the remaining CMISP residual program and it is also needed to ensure that patients do not meet requirements for other services. Patient assistance could be crafted to help with this piece. Eligibility will be determined by the Department of Human Assistance (DHA) staff. DHA staff will also provide information about other State and Federal programs.

Some stakeholders had difficulty planning and advocating for a model that is less than a full coverage program. *The cost range of a full scope Medi-Cal program was $42 to $52 million for the initial year. It also did not include mental health or alcohol and drug services.*

GOVERNOR'S BUDGET / OTHER UPDATES

Governor's May Revise – The May revise acknowledged longstanding State policy of inclusion of full-scope Medi-Cal benefits for Persons Residing Permanently Under Color of the Law (PRUCOL). The Governor's proposal assumes implementation of the Federal executive order with $62 million budgeted for a partial year and $200 million annually. The budget also includes $5 million for grants to nonprofit organizations to help provide application assistance to Californians seeking deferred action status under the President's order.

Implementation of the Federal executive order and application for full scope Medi-Cal benefits under PRUCOL may assist approximately half of the undocumented immigrant population Statewide and perhaps more in Sacramento.

Legislative – SB 4 (Lara) was amended in the Senate 04/28/15. The intent of the bill is to extend full-scope Medi-Cal to residents who are currently ineligible due to their citizenship status and to allow all residents to utilize the health exchange known as Covered California. As of May 4th, the bill was placed in the suspense file pending further review about the State's budget situation. Recently it was reported in the media that the Governor said he would veto SB 4 if it reached his desk.

Fresno – As of April 7, 2015, County Board of Supervisors approved an agreement to reimburse specialty medical care for Fresno County residents that are not eligible for their county medically indigent program or any other healthcare service. Fresno recently received approval for a five-year deferral to repay road funds that would have been due to the State in 2015. Allocated funds total $5.5 million, and will be used to

cover specialty care provided to undocumented individuals. As of April 22, Assemblymember Perea is seeking full forgiveness from the State for the $5.5 million.

Data - A recent policy brief was released by UC Berkeley/UCLA Center for Health Policy Research entitled, "Health Insurance and Demographics of California Immigrants Eligible for Deferred Action," March 2015. If the Court order blocking implementation of the Executive Order is resolved, approximately half of California's undocumented immigrants could be eligible for deferred action. However, timelines remain unclear. Individuals would need to complete required paperwork and apply for deferred action at a cost of $465 per application, and then would need to apply for full-scope Medi-Cal under PRUCOL (Persons Residing Under Color of Law). Immigration concerns or fears may limit the application for deferred action and/or application for Medi-Cal coverage. The average processing time for a DACA (Deferred Action for Childhood Arrivals) application is about six months. Processing time for DAPA (Deferred Action for Parents of U.S. Citizens and Lawful Residents) is not known.

Services to Children – The Board workshop Board letter and consultant paper mentioned the Child Health and Disability Prevention (CHDP) and California Children's Services (CCS), but staff recently learned of a program offered by Kaiser. The "Kaiser Child Health Program" provides health care coverage to children under the age of 19 who reside in a Kaiser service area, have a household income up to 300% of the Federal Poverty Level (for example: $59,370 for a family of three, $71,550 for a family of four per 2014 guidelines). U.S. Citizenship is not required. They serve approximately 5,260 enrolled in Sacramento County. 41,396 are children enrolled in Northern California.

STATUS OF PROGRAM DESIGN FOR SACRAMENTO COUNTY

After review of the workshop materials, stakeholder feedback and recent developments, such as the Governor's May revise budget, the County Executive Officer (CEO) will outline recommendations which are responsive to several stakeholder recommendations.

- Eligibility and Assistance – The Department of Human Assistance (DHA) staff will be re-deployed to assist with eligibility, education, and assistance about available services. This will be a last resort service. This program will not cover any services provided by any State or Federal programs and will utilize the Medi-Cal application process. This means enrollees do not meet requirements for full-scope Medi-Cal or other full scope coverage programs and must have emergency Medi-Cal.

- Primary Care - During the initial year, primary care will likely be provided by the County Integrated Behavioral Health (IBH) TEACH Medical Home based at the Primary Care Center (PCC). Anticipated enrollment will be approximately 3,000 enrollees which will be monitored based on specialty costs and may be adjusted.

Funding includes $1million for TEACH and support staff expansion. It does not fund additional points of access this year. As noted in the Consultant Stan Rosenstein's briefing paper, Federally Qualified Health Centers (FQHCs) and hospitals have respective obligations to serve this population and do so currently.

- Specialty Care - County funding will be targeted for specialty care provision at approximately $2.5 million, including $1.5 million in General Fund, and $1 million in Health Realignment budgeted for the County Medically Indigent Services Program (CMISP). Additionally, hospital systems currently partner with the Medical Society to provide some medical surgeries to this population. Staff will continue working with these groups to see if they can increase donated services. The value of these services may increase to a projected $1.5 million. The County will also support a partnership with hospital systems and the Medical Society for a specialty outpatient clinic at the PCC (donated physicians/County support staff) as noted below.

- Reallocated Services and PCC Space – Approximately $1 million of existing DHHS budget will be targeted toward this initiative. This includes donated space at the PCC and reallocated staff to support a specialty clinic. Support staff needs may vary depending on the number of physicians and type of scheduling. Staff will be trained to assist with navigation. Outpatient pharmacy will be limited and will take advantage of existing low cost retail options. Some pharmaceuticals will be provided by the County pharmacy for critical medications that are not available through low cost retail options.

- Administration – County funding will include $200,000 for administration.

Overall, the projected value of the combined and partner resources is approximately $6.5 million as shown below. The total new General Fund cost would be $1.7 million.

Service	Cost (rounded)	County Funding	In-Kind	Funding Source
ELIGIBILITY				
Eligibility & Assistance	$270,000	$270,000		Existing DHA staff; reallocated
PRIMARY CARE				
Primary Care – TEACH expansion	$1,000,000	$1,000,000		IGT
SPECIALTY				
Specialty Care provided by County through contracted services	$2,500,000	$2,500,000		Existing Health Realignment / CMISP budget
Specialty Care provided by hospital systems, Medical Society	$1,500,000		$1,500,000	In-kind contributions from private sector (estimated)
PCC Specialty Clinic space, staff, pharmaceuticals	$1,000,000	$1,000,000		Existing budget, reallocated staff
Administration	$200,000	$200,000		
TOTAL	$6,470,000	4,970,000	$1,500,000	

Additional work is needed to work out the details of the program and better determine our partners' contributions to this community problem.

Respectfully submitted,

SHERRI Z. HELLER, Director
Department of Health and Human Services

Attachments:

- Attachment 1 Relationship between Specialty Care, Hospital Services and Pharmacy by Health Management Associates dated March 24, 2015
- Attachment 2 Healthcare Services Proposed by Fresno County dated March 26, 2015
- Attachment 3 Prescription Options for Uninsured Residents dated April 10, 2014

c: Bradley J. Hudson-County Executive
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Relationship between Specialty Care, Hospital Services and Pharmacy

Health Management Associates

March 24, 2015

Non-insured individuals in California are able to access emergency services when needed and may qualify for presumptive eligibility if pregnant and otherwise not eligible for public insurance or temporarily when presenting to participating hospitals. Additionally the state Family PACT, the Every Woman Counts, and the Breast and Cervical Cancer Treatment (BCCTP) programs cover family planning, and sexually transmitted disease testing and treatment for both men and women and breast cancer screening treatment for women and men and cervical cancer treatment for women. Individuals without an emergent or one of the categorical needs, however, have limited options for access to primary and specialty care. For individuals who are prohibited from participating in the insurance exchange market, fewer options exist. Many of these individuals may afford to receive primary care at a Federally Qualified Health Center (FQHC) on a sliding scale, but this does not guarantee access to specialty care. This lack of access to specialists may lead to significant disease burden, affect quality of life and ability to function and limit employment potential. Over time the cost of non-treatment can be significant, especially when lost work days are added to the sum.

Therefore although access to primary care is important and foundational, access to non-emergent specialists, especially those in surgical or interventional specialties is also of importance and requires equal focus. Even non-surgical medical specialties that require advanced diagnostic tests can be cost prohibitive to access for individuals who are not insured. Sadly, the consequences of not having this level of comprehensive care can lead to significant personal burden and financial burden to the system.

Examples of common ailments or diseases that would be gaps in coverage in a system that solely provides primary care include the following:

1. Simple Hernia: Hernias result from a variety of factors and can grow in size, become painful, and the person's intestine may become incarcerated (blocked)—leading to a medical emergency. Repair of a hernia is a low risk surgical procedure that can be performed by a general surgeon and rarely requires inpatient hospitalization. The cost of the surgery may be prohibitive for an individual without insurance and will include a facility charge, anesthesist fee, and surgeon fee, at minimum.
2. Gallbladder Stones (Cholecystitis): Gallbladder stones lead to irritation of the gallbladder that in turn causes significant abdominal pain, nausea, vomiting and inability to eat. Stones can eventually block the gallbladder outlet and lead to liver irritation and an irritated gallbladder can also become infected requiring open drainage or removal.

Patients suffering from cholecystitis may have several hospital emergency department (ED) visits due to pain but unless the gallbladder is infected or about to rupture, surgeons prefer to remove it when the inflammation goes down. Therefore, surgical removal is considered best when done in a non-emergent manner and considered low risk. F or individuals without insurance this cost can be prohibitive.

3. Gastrointestinal (GI) endoscopies (colonoscopy, upper endoscopy, stomach/esophageal biopsies): I ndividuals may require a GI tract endoscopy or biopsy for a variety on non-emergent reasons like screening for colon or esophageal cancer, diagnosing particular types of stomach ulcers, diagnosing autoimmune diseases like Chron's or Ulcerative Colitis. Failure to screen or accurately diagnose these issues can lead to significant morbidity and mortality---at a time when treatment options are well established. For example, individuals with a family history of colon cancer can prevent developing cancer by monitoring colon polyps on a regular basis. This can only be done by a gastroenterologist of general surgeon trained in endoscopy and may require anesthesia---rarely are these able to be performed in the primary care setting.
4. Cancers: Diagnosing and treating cancers frequently requires advanced diagnostic equipment, surgical intervention and hospital based treatments. In California breast and cervical cancers are covered through the BCCTP program however no specific coverage exists for any other form of cancer. Common cancers like skin, colon, and prostate require biopsies, advanced diagnostic tests like CT and PET Scans and may require surgical removal or surgical open biopsy to confirm a diagnosis. These problems rarely present as medical emergencies and therefore non-insured individuals have limited options for obtaining a diagnosis in a timely fashion. Patients may also present with a definitive diagnosis but then have to face limitations in treatment. Radiation Oncology is a treatment option only available in hospital based settings or self-standing specially licensed centers. Chemotherapy treatment may be provided either in a hospital infusion center or physician office, but although physicians are willing to waive their professional fee, the cost of chemotherapy agents is prohibitive for a non-insured individual.
5. Complex Medical Issues: Certain complex medical issues require specialty intervention that may only be provided in a hospital based setting or may require advanced diagnostic support. Complex and/or new seizures or onset of new headaches, for example, may not be initially seen via an emergency room but may present at the primary care office. In order to ensure there is no brain mass or other issue causing the new seizure, CT and/or MRI scans may be required. If a mass is found a biopsy is warranted and on occasion ablation of the lesion will be required----these can only be performed by a neurosurgeon in a hospital based setting. Some lesions are not

cancerous and patients are able to live full lives once they are removed or minimized. Common examples of these lesions are pituitary adenomas.

When considering coverage options for the residually uninsured it is therefore important for systems to take into account the importance of primary care as a foundation but also the need to have specialists, advanced diagnostic and hospital based services available, albeit with limitations. Failure to do so may end up costing more as patients will eventually seek ED care, may have more advanced disease or be higher risk patients.

As Sacramento County considers expanding access to primary and specialty care to the residually uninsured, it is important to understand the potential barriers and issues that may arise. In our experience working with free clinics, FQHC's and faith based clinics, common themes have emerged in include:

1. Limited access to diagnostic services can hinder a specialist's ability to provide care that meets community standards. Thoughtful consideration of what those services are and establishment of evidence based guidelines on their use is critical.
2. Individuals need to have a stable medical home that is capable of managing their care across the delivery system in order to have the best outcomes and contain costs. Tying coverage to the medical home is important. For example, individuals will get a specialty service covered only when referred to the service by their medical home.
3. Specialists and hospital based providers are able to efficiently communicate with the patient's medical home. This can be done both by phone or secure electronic communication.
4. Assistance with prescriptions is highly advised at the provider level to ensure use of generics and evidence-based practices are maximized. A pharmacist who can help guide prescribers from expensive "new" medications that have no proven record of improved outcomes and have a lower cost alternative is critical. Additionally, when a generic option is not available a system that utilizes the Pharmaceutical Assistance Programs when appropriate can help keep costs down.

The following table highlights common hospital based or higher cost diagnostic services that may be required in order to appropriately support the specialist in providing equal high quality care to all patients. Associated high cost medications that may not have a generic alternative are also noted.

SPECIALTY CARE AND ASSOCIATED HIGH COST TREATMENTS AND SERVICES	
Specialty Service (Non-Surgical)	**Associated Hospital Based or High Cost Diagnostic Service**
Neurology	CT, MRI, EEG
Gastroenterology	Endoscopy, Colonoscopy,
Cardiology	ECHO, Cath Lab, Nuclear Stress Tests
Pulmonary	CT, Pulmonary Function Testing, Sleep Apnea Diagnostics
Oncology	CT, MRI, PET Scans, Infusion Services, Radiation Services, Surgical/Open biopsy Services
ASSOCIATED HIGH COST MEDICATIONS	
Specialty Service	**Associated Potential High Cost Pharmaceuticals**
Neurology	New generation anti-seizure medications
Gastroenterology	New generation Hepatitis C treatment
Cardiology	Anti-platelet
Pulmonary	Asthma and COPD inhalers
Oncology	Chemotherapy
Rheumatology	Biologics (e.g. Enbrel)
Endocrine	New generation Insulin

Healthcare Services Proposed by Fresno County
Undocumented Immigrants
March 26, 2015

Eligibility

- Adults
- Up to 138% Federal Poverty Level (FPL)
- Last resort services, have applied and denied full-scope Medi-Cal and must use all other healthcare options first

Gap Coverage Program - Specialty services and limited hospital services

- Referrals through FQHCs for patients meeting eligibility requirements, medical necessity, exhausted possible healthcare options as noted above
- There is not a FQHC contract however FQHCs must complete a referral protocol in alignment with program requirements
- Program pays for a wide range of specialists and hospital related services including testing and surgeries
- Program does not pay for primary care or emergency care

Contract

- Agreement with a vendor for authorization and claims payment
- Compensation capped at $5.5 million
- Five percent administrative fee for all claims processed
- Denies referral authorizations that are incomplete/inaccurate
- Pays specialty providers and hospital at Medi-Cal rates
- Submits invoices to county every 30 days
- Notifies County at an expenditure threshold (85%); wind down services for the year (pay pro-rated rate for the 30 day period)

What does this require to make it work?

<u>FQHCS</u>

- Serve individuals regardless of citizenship and ability to pay per their federal obligation
- Provides primary care, basic lab and radiology, case management and are eligible to participate in 340(b) pricing
- Submit referrals for specialty per referral protocol
- Under Fresno model, is not contracted for specialty services or receives any reimbursement for primary care services

<u>HOSPITALS</u>

- Emergency care via restricted scope Medi-Cal, hospital presumptive eligibility, other programs

- Fresno has one major hospital system – contracts for specialty services and inpatient services at Medi-Cal rates for services not reimbursable under Medi-Cal

SPECIALITY PROVIDERS

- Provide services at Medi-Cal rates

Financing

- $5.5 million is the amount of money the County has available due to the State deferring for 5 years County repayment of transportation funding. This amount is not representative of the cost of care rather it is the amount available because of this deferral.
- County has an agreement with State DHCS that any payments made under this program can offset payments the County makes to the state under AB 85 making this program operate at no new cost to the County. *Given this feature, the County may increase funding in the future at no cost to the County.*

Prescription Options for Uninsured Residents

April 10, 2015

Sacramento County uninsured residents with prescription needs have access to a few options that will give them a good value for their prescription needs. It is likely that many have discovered these available options, but would like to review them if they have not already been made aware. ***This table does not include those obtaining medications from FQHCs under 340(b) pricing.*** In the following table, some of the pros and cons are outlined. These are generally 1st line pharmaceuticals, advanced therapies or trade name products will generally not be available. Links for these programs are provided below.

Prescription Source	Advantages	Disadvantages
Walmart ($4/$10) - Offers a 30 day supply of selected medications for $4 and a 90 day supply for $10. The program offers an adequate supply of medications for most disease conditions for at least the 1st line of therapy.	Offers first line therapy for antibiotics, allergies, cholesterol and high blood pressure, gastrointestinal health, heart medications, depression, skin conditions, thyroid and women's health. If medication needs are simple, this option is a good value. A variety of pediatric prescription items are offered.	Therapy options in each class represent first line therapies. If failure occurs with these agents, options in the plan are missing. Most second line agents are not available. - **Diabetic supplies do not include testing strips and supplies or insulin.** - No inhalers are included in the plan for asthma patients who require them. - Medications for Mental Health are very limited and primarily include antidepressants. - Pain medications are limited and the plan does not include any controlled substances. - There are no medications for seizure disorders or prostate conditions. - Blood Pressure medications do not include Angiotensin Receptor Blockers.
Target ($4/$10) - Similar to Walmart's but contains less of an overall spectrum of medications.	They will match Wal*Mart pricing when asked. Their list does change frequently and now excludes thyroid medication.	See above – very similar disadvantages.
Sac Best Rx - Discount prescription savings card that is endorsed by Sacramento County since August of 2011. It can offer savings in some circumstances. Savings can be widely varied depending on the medication.	There is no cost to the user and is available at many pharmacy locations and some county offices as well as on-line. Worth checking discount possibilities when nothing else is available.	Pharmacies usual and customary charges vary widely. ***Discounts are not predictable or consistent.*** There are over 60,000 medications with some degree of discount and cover some of the medications absent from other options mentioned.
Patient Assistant Programs - Companies vary considerably on their programs. Some provide services to undocumented and some do not. Consider for expensive trade name pharmaceuticals.	Prescriptions can often be free if criteria are met. Manufacturer's websites often provide the necessary information on what is available and how to apply.	Medications from these programs are limited and applications may require separate forms and criteria validation from the patients.

Walmart: http://i.walmart.com/i/if/hmp/fusion/four_dollar_drug_list.pdf
Target: http://static.targetimg1.com/pharmacy/pdf/030115_RxGenerics_Condition.pdf
Sac Best Rx Card: http://www.sacbestrx.com/en/index.aspx