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# HMA

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HEALTH MANAGEMENT ASSOCIATES

*A Plan for the Equitable, Organized and  
Integrated Delivery of Health Care Services for  
Underserved Residents of Orange County*

JANUARY 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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## *Introduction*

The most clinically-effective and cost-efficient approach to assure medically vulnerable populations and communities access to health care services is the topic of the hour in both Washington, DC and in Sacramento. While the details of what will become the final plan are still unclear, there are provisions in both the national reform proposals and in California's proposed Medi-Cal 1115 waiver that will, in all likelihood, be adopted and will significantly change both the funding and organization of health care delivery in communities across the State and country. The plan detailed in this report was initiated by providers and agencies that are determined to internally impact that re-organization of care delivery before change is imposed externally; to start now to prepare for a more rational, equitable and sustainable delivery system for the underserved in a way that makes the most sense for Orange County.

This document is meant to be a work plan. While it does describe what exists now, its primary focus is what could be in the relatively near future. It has been developed through a process that identifies and builds upon the extensive innovation already undertaken by individual providers and agencies, attempting to broaden the scope of existing efforts and consolidating parallel initiatives. It does not suggest changes that are dramatically outside of the political and cultural realities of the community or try to revise the institutional missions and areas of expertise of participants in this effort but, instead, builds within that framework while still challenging all of the participants in this effort to move beyond the current approaches. It draws from experiences and lessons in other communities and seeks to adapt them to the unique nature of Orange County, when applicable. It builds on the anticipated health care needs of the underserved population, not simply upon the goals of providers who deliver care. Finally, it is developed within the context of and consistent with the key tenets of both state and federal health care reform most likely to shape the health care industry over the coming years.

Described within this plan are recommendations calling for both immediate action and further exploration and debate. Moving beyond discussion to implementation will take a directed and coordinated effort with clear short- and long-term goals defined and with specific roles for all participants identified. Most of all, it will require leadership, tenacity and unified focus. There are some individual recommendations that may not be acceptable for all and there may be some institutions that contribute more than others to get this enormous effort underway. These issues are not as important as a firm understanding of and agreement by all participants on the following concepts:

- What is being attempted through this effort is extremely difficult and counter-intuitive to the way in which most health care providers have always related to each other. It calls upon individual providers and government agencies to act as “good citizens” and to agree to participate in building something that, while initial sacrifice may be required, will ultimately result in a change that will benefit all of those that participate. This process requires a commitment to continue to remain at the table, even when there is disagreement.

- What is being proposed is nothing less than a transformation of the current approach to caring for the most vulnerable members of our community. Delivery system capacity and infrastructure will need to be invested in up-front to minimize the current reliance on emergency departments and waiting until illness requires hospital admission. Highly complex patients will need to be sought out, not avoided, as this strategy will ultimately result in a more effective—and less costly—delivery of health care services. As a community, the currently segmented and siloed approach to delivery of care to different populations will need to be challenged and collaborative and integrated efforts that maximize all of the resources available will need to be insisted upon.
- Finally, the participants in this effort will not wait until change is imposed be as a result of a State waiver or a new national plan but, rather, will lead the way and will be emulated by other communities.

Health Management Associates (HMA) has been honored to be a part of this critical effort in Orange County, an initiative which, if implemented, could become a national model for a collaborative, population-based, equitable, cost-effective and sustainable delivery system that assures access and improves the health status of its community.

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## *Findings/Conclusions*

Over the course of the past four months, HMA has: reviewed utilization, financial and demographic data and past reports; explored potential synergies with State and national reform efforts; held individual discussions with leaders in Orange County (see list in Appendix A); and facilitated several group discussions about the future of health service delivery for vulnerable populations and communities. Among the conclusions and findings that shape the recommendations detailed in this plan are the following:

- The organization of health care services in Orange County is unlike most other communities in California and is also dissimilar to other counties in the US that have as large a population of uninsured and under-insured residents. It relies almost entirely on the private sector (physicians, hospitals, clinics) for the care of the uninsured and Medi-Cal populations. Thus, as a plan is developed, providers not generally considered as part of the “safety net” will need to be addressed and involved. The continued role of private providers in both maintenance of effort and in the management of populations is critical in the development of a network for the uninsured and underserved in Orange County. This is particularly true because of the relatively small number of Federally Qualified Health Centers (FQHCs) and the lack of a public hospital and health system.
- While there are a significant number of people in Orange County without health insurance (with estimates ranging from 385,000 to over half a million), the underserved population (despite some concentrated pockets of medical need) is spread over a large geographic area. Further, data documenting emergency room and inpatient admissions do not describe the level of uninsured utilization one would expect with such a large population of people without coverage. This dispersal of the impact of the uninsured offers the opportunity to bring all providers in the community to the table in the development of a collaborative network to address a problem that is truly community-wide, not one that is only impacting a few overwhelmed institutions.
- Because there is no county public hospital system in Orange County and because the current level of FQHC capacity to provide care to for the uninsured is limited, with the two largest networks providing a significantly lower proportion of care to the uninsured than State or national averages, the delivery system that serves the indigent population currently depends heavily on community clinics and private providers, including hospital emergency departments and physicians (who provide services for cash or at no charge). Although this lack of FQHC capacity for the uninsured has not been addressed in any coordinated way, it seems to be widely acknowledged that the major FQHCs (Alta Med and UCI) are not serving the number of uninsured that FQHCs would be expected to serve in other communities.

- CalOptima has traditionally relied heavily on private physicians to provide care for Medi-Cal patients and the County's MSI program also assigns many of its members to private practitioners. The willingness of private physicians to continue to deliver care to Medi-Cal patients (including those on MSI who will likely convert to Medi-Cal under health reform) may change as more residents are given the opportunity to buy health insurance through the exchanges anticipated under any new national plan and private physicians open their doors to these newly insured patients. The continued federal commitment to expansion of FQHCs over the next 2-3 years, as well as the potential inherent in new US Health Resource Service Administration guidance on specialty care provided within FQHCs, offers Orange County a unique opportunity. It would be a mistake not to take advantage of the federal commitment for expansion as well as the FQHC benefits of the discounts available through 340B drug pricing, tort coverage and a cost-based Medi-Cal rate that allows for support of increased uninsured capacity.
- While the local County tax subsidy of indigent care services is less per capita than some other California counties, it is more than others both within the State and certainly more compared with counties in states outside of California, where there is no Section 17000 requirement. In those communities around the country where local indigent health care subsidies are either holding steady or not declining significantly (very few, if any, are actually growing), the County is most often invested in operating its own hospitals and clinics and is committed to meet growing cost and demand (and preserving jobs). It is unlikely that the Orange County subsidy will increase, particularly in the current economic environment and particularly as the County is still in the process of coming out of bankruptcy. Thus, attention should be paid to maximizing the impact of that County subsidy, particularly to drawing down all potential federal match funding.
- Orange County made several notable attempts to address the deficits in the availability of health care services for uninsured that have been creative and innovative. These efforts include, but are certainly not limited to: the County's MSI program (particularly the information technology products that have been developed to connect the various providers delivering services to MSI patients); the development of community clinics, some subsidized by or connected to private hospitals; Kaiser's approach to the management of chronically ill patients; activities of the Health Funders Partnership of Orange County including the AccessOC program and its attempt to maximize private physician contribution to indigent care and the coordination of activities related to major health access and health status problems, and, of course; the creation of CalOptima, which was established by the community to assure access for Medi-Cal patients. These initiatives, each of which are valuable and should be preserved, currently operate largely in isolation from each other, not as components of one comprehensive and collaborative approach.
- Coordination of effort between the Orange County Health Care Agency (OCHCA) and CalOptima is critical to: 1) effectively use all available resources;

2) maximize federal matching opportunities, and; 3) assure a smooth transition of uninsured patients into Medi-Cal over the next several years (the extension of Medicaid coverage to all under 133% of the federal poverty level is supported by both the House and Senate reform proposals, and would move approximately 80% of the County's MSI program to Medi-Cal). Both programs independently address network development, claims processing, utilization review and care management—all functions that could be integrated. Further opportunities exist in possible collaborative approaches to behavioral health and coverage of IHHS workers. Leaders of both agencies appear to be open to such further collaboration and coordination.

- The contribution of the hospitals in Orange County—both not-for-profit and for-profit—to the care of the uninsured and Medi-Cal populations is significant and needs to be recognized and continued (and, in some systems, expanded). Several hospitals were negatively impacted when community clinics that had traditionally served as a resource for ED and inpatient discharges of “unattached” uninsured patients cut off that access and new connections for continuing care need to be forged. Other hospital systems have committed to the subsidization of community clinics and that commitment could be strengthened and developed into an integrated network. Still other hospitals have unique expertise (chronic illness care management, specialty services) that could be built upon as a collaborative delivery system is developed. The leadership role of Orange County hospitals will require proactive planning, however, not simply reaction to those who come into their EDs, and will demand that they view themselves as “citizens of the County,” a role well beyond considering only the well-being of their own individual institutions.
- The community clinics in Orange County offer access to medical homes for the uninsured; however, they currently only represent a fraction of the capacity that is needed to meet the demand of the uninsured in the County. The Coalition of Orange County Clinics provides a useful role in convening the clinics but has only a limited function in representing those networks that have the greatest potential for significantly expanding care for the uninsured (the large FQHCs) and has primarily been focused, to date, on advocacy for funding.
- Individual free-standing clinics and FQHCs are a critical resource (particularly those serving specific ethnic and special needs populations) that should be part of any delivery system focused on under-served populations. However, the hospital-subsidized clinics (CHOC's community sites, La Amistad, Camino, St. Jude, SOS) could be even more effective of as a coordinated network on which to build capacity.
- Given that there is a limited level of local tax subsidy for the uninsured, a priority for delivery system development should be the maximization of all available revenues and the assurance that no funding is left on the table unspent. There seem to be significant holes in the current approach to assuring that all of those

eligible for Medi-Cal or other coverage programs are enrolled and this failure must be aggressively addressed. In addition, there appear to be specific opportunities, particularly through cooperation between CalOptima and other public entities (i.e., the County and the University of California) to draw down additional federal dollars matching local dollars spent on indigent care. Finally, there are specific opportunities for gaining operational efficiencies by coordinating and/or consolidating administrative functions between the County and CalOptima and, even, AccessOC.

- It appears that neither business nor philanthropy play as significant a role in health care in Orange County as they do in other communities, even at the level of individual hospital support. However, the effort by the Health Funders Partnership of Orange County to consolidate and focus what is available is significant and needs to be considered as an asset in the establishment of a coordinated system of care, particularly in the building of infrastructure. Further, while there doesn't appear to be any organized interest from the business community now, the potential for the availability of an affordable "health coverage" plan for small businesses could have considerable attractiveness in the years to come.
- The various information technology initiatives underway related to the management of services for uninsured and Medi-Cal patients are both innovative and being developed in relatively isolated—even competitive--silos. Given the need to maximize all available resources and provider capacity, technologies like the MSI's *ER-connect*, *Clinic-connect* and *Community-connect* and AccessOC's *e-consult* should be consolidated as a part of this evolving delivery system and, in fact, should be assessed for further upgrading to include additional functions (assessment for eligibility into all possible coverage programs, availability of appointments in Medical Homes, etc.). Further initiatives, such as forays into telemedicine being developed at the corporate level in the St. Joseph Health System or the chronic disease registries being utilized in Kaiser have the potential for broader integration.
- The components of the Orange County Health Care Agency will be significant elements in any coordinated delivery system development. In addition to the leadership "honest broker" role that the County will need to play in moving this initiative forward, the contribution of innovations designed through its MSI program and the ongoing interaction with its behavioral health and public health activities will be vital to assure success of any restructured delivery system that is designed around the population that it is meant to serve. The County plays several critical roles: health care vendor (MSI, behavioral health) and assurer of the health of the public. It is that latter role that will need to be further developed and emphasized.
- The timing and the approach of this effort coincide well with national health care reform efforts (integrated delivery systems, Accountable Care Organizations, bundled payments, dollars for health information technology that facilitates multi-

provider networks, expansion of coverage requiring delivery systems) and efforts by the state to renew its Medicaid 1115 waiver.

## *Principles*

The plan is built upon several key principles, including:

- The delivery system network should be geographically accessible and culturally sensitive to all who need it and should be built upon a rationale that assures that care is delivered appropriately and effectively, and centered around a Medical Home for all targeted patients.
- All available resources need to be maximized (county, state, federal, philanthropic, hospital contributions) and utmost attention given to minimizing duplication of effort.
- There is not enough money in the system—even with maximizing all available dollars—to pay for a full complement of health care services for all of the uninsured immediately. Thus, the plan is built on the assumption that the delivery system will be expanded incrementally, likely focusing on 100,000 uninsured patients in the first phase, although infrastructure will need to be developed up-front and the final result will be an accessible system for all residents of Orange County.
- There will need to be objective standards established to assure equitability in the contribution of providers to this effort, with regular assessment to facilitate accountability and transparency. This contribution level will be achieved in a variety of ways (direct services, monetary support, etc.) and will be equally applied to the agreed upon standard.
- The plan must have all of the following components: identified target population; comprehensive delivery system; management infrastructure to assure patient and provider participation and compliance; financing strategies that support the delivery system, and; a formalized structure to assure accountability to all participants.
- This new delivery system should be viewed not as a transitory project but as a new way of operating as collaborators in Orange County, requiring commitment from all participants to formalize the initiative into a multi-provider network with community-wide (not institution-specific) objectives and goals.

- This effort must, whenever possible, incorporate the opportunities and directives inherent in State and national health reform efforts to assure maximum support and sustainability.

## *Model*

The recommendations and work plan that follow are specific activities that are all derived from a basic model of care that the new collaborative network will be striving for as it develops. This model for the proposed network delivery system is based upon the make-up and health status of the population of the under-served in Orange County, and the health interventions that are most likely to improve their health status and decrease overall costs. It assumes that better care, a population focus and management of those enrolled in such a comprehensive network will result in improved health at the lowest cost. It also requires and supports greater integration of its different healthcare providers.

The population to be served through this model of care can be divided into two groups in terms of health status and utilization: first, those with chronic illnesses who are likely to be repetitive users of health services, often in emergency department settings, and; second, those who are basically well and generally are lower utilizers of services but may have unrecognized health risks. The two-pronged approach recognizes that there are limited resources in the system and that focus needs to be directed to where those resources will be used most effectively. The “benefit package” for the chronically ill through the network will include a designated Patient Centered Medical Home (PCMH) for each patient as the center of the delivery system, access to a full range of diagnostics, specialty referrals, urgent care and medications. Case management is a key feature of this package. The “benefit package” for the second group of non-chronically ill will not include all the features of a full PCMH, nor medications, at least not without a more than nominal co-pay. It will include access to primary preventive measures such as immunizations, screening for infectious diseases and cancer and chronic illness as appropriate, and, perhaps, treatment of mild hypertension and intermittent asthma. Urgent care services at specific locations will also be available within this package but may include co-pays for medications or provision of certain services such as job physicals.

### The Patient Centered Medical Home

Providing a Patient Centered Medical Home has been shown to be associated with better outcomes and decreased emergency room use, hospitalization and overall costs. A primary care practice that meets the criteria of a PCMH must provide access to the patient at all times, and continuity of care with the same provider. All health problems or concerns should be brought to the PCMH first and the PCMH is expected to initiate and coordinate all referrals. The PCMH must receive results of specialty consultations, urgent care visits, emergency room visits, diagnostic tests and inpatient hospitalizations. The PCMH is usually the provider responsible for follow-up of specialty recommendations. Further, practices will be required, in time, to provide team-based care, meet standards

set by the network, participate in care management and work closely with system case management and disease management programs. Explicit quality improvement activities will be required of a PCMH.

The network may determine that some patients merit specially designated medical homes, such as those persons with special needs due to such conditions as serious mental illness, developmental disabilities, cancer, or HIV/AIDS

#### Call Center

A high quality, highly functioning after- hours nurse triage service--with documentation sent back to the PCMH--is one solution to more effectively address access and utilization issues. A Call Center may simply provide advice to patients, schedule a “next day appointment” in the patient’s medical home, or refer to an Urgent Care Center or ED within the network as appropriate. The Call Center sends documentation from triage to the medical home and activates a reminder call to reinforce importance of medical home follow up.

#### Urgent Care

Urgent care is a needed service for those with chronic illness as well as persons who are otherwise well. The best place for after hours care is within the practice that cares for all of the patient’s needs and much of the need can be met by assuring phone contact with the PCMH or the Call Center with follow-up during regular hours. However, health concerns may arise that must be seen directly by a health professional without delay and many of these problems do not require a full ED visit. Urgent care at designated centers should be a benefit available to all enrollees in the network. Patients should be seen at an urgent care center within 30 minutes of arrival. Staffing may be accomplished with primary care physicians, nurse practitioners or physician assistants, and with the use of telemedicine capabilities. A relationship with one or more EDs and hospitals is essential and transfer according to network protocols must be expeditious. Urgent care centers must also send information on diagnoses, results, and treatments back to the PCMH and be responsible for and have the ability to make follow-up appointments after the patient is treated.

#### Specialty Referral

Specialty consultation and management will be necessary for patients in the network and access to appropriate subspecialty appointments should be available in real time for patients with PCMHs. An electronic referral system should be used within the Network that provides for the following:

- is internet-based;
- has the ability to incorporate clinical and administrative rules that provide decision support and efficiently allow only appropriate referrals to be accepted;
- is easy to use;

- can schedule appointments once a referral has been approved;
- is able to route the consultation results back to the PCMH provider;
- provides the management tool of tracking individual referral requests; and
- reports on all aspects of specialty resource utilization (who is requesting referrals, for what, how many, where are they being referred to and whether consult results are being returned) to provide the network with important information about the effectiveness of the referral system.

Increased training for primary care practitioners may be required. Further, electronic consultation and telemedicine are appropriate alternatives for many types of consultation requests and can expand specialist resources, as well as allow co-management of a patient's condition between a specialist and primary care practitioner, decreasing follow-up appointments with a specialist.

### Care Management

The care of network patients with chronic or high resource-consuming conditions must be firmly and systematically managed. The uninsured with these conditions will otherwise consume the network's resources by utilizing the most expensive services. Care management, as conceptualized in this model, is not a stand-alone program but rather an approach that requires the participation, integration, and buy-in of all the network's health care providers. Investment in infrastructure and organization will be necessary if the network is to fully benefit from this approach. Important elements of the care management element of the model are:

- assessment of health conditions, stratified risk, and resource needs;
- development of a care plan that is accessible and used throughout the network;
- facilitation of the monitoring of utilization to assure use of needed care as well as to identify patients that are utilization outliers;
- assuring that a care team approach exists within the PCMH practice and includes care managers, pharmacists, and others;
- coordination of transition care from hospitals, EDs, and urgent care facilities back to the PCMH with care plan changes and patient self management support;
- the existence of clear, adequate and consistent communication between the PCMH, specialists, hospitals and case managers; and
- an emphasis on patient self-management that includes education, support and reminders, and goal setting.

### Information Technology

Adequate information technology support is necessary to support care management within the network. Fortunately, there are several systems in use within Orange County that can be expanded or applied in a care management program. A chronic disease registry is essential for planned care and the management of chronic conditions. It must be web-based to be accessible at multiple locations and able to receive data from other

databases. Several good registries are available commercially and Kaiser uses a registry in its disease management approach. ER-Connect allows efficient communication and transition between emergency departments and the Medical Home and could be used by hospitals at discharge of network patients.

A major focus of this model delivery system will be to continually test and refine new innovations (i.e., home monitoring) to assure that resources are always maximized and health care improves.

## *Recommendations*

The following are specific recommendations that are grouped as follows: 1) formalizing the network and governance; 2) defining the target population; 3) developing the components of a restructured delivery system; 4) approaches to manage the population; and 5) financing strategies to support the network. These recommendations will be integrated into a more specific work plan in the final section of this report.

### Formalizing the Network

In order to assure that the delivery system network developed through this effort is sustainable and not ultimately dependent upon the good will of the leaders currently around the table, it will need to be built upon sound governance and management structures and be supported by a clear financing plan. It is critical to understand that this governance will serve to coordinate and build upon what exists now, not to replicate systems and programs that have already proven to be effective. Financing is discussed in a section below. Recommendations for network governance include:

- A not-for-profit or semi-public organization (i.e., a public authority) should be established to facilitate the development and oversight of the delivery system for underserved populations in Orange County. In other communities, this oversight has been accomplished through both private organizations and governmental bodies. Whatever the organizational structure, the Board of the organization must be built on the commitment and active participation of decision-makers from the organizations making contributions to the effort, including, but not limited to, the Orange County Health Care Agency, CalOptima and hospitals. It will also be critical to have representation from the physician community, community clinics and FQHCs; with participation determined based on contribution criteria. Finally, the organization should have representation by both the patients served and the broader civic community.
- Name the new organization as soon as possible. It is important that this name reflect its role as a multi-institutional delivery system—not a project or an initiative, which implies that it is a temporary endeavor.

- The functions of the governing structure of the new body should include:
  - 1) identifying the populations and communities targeted by the network ( a fluid process as under-served populations change through both health reform and demographic shifts);
  - 2) assuring the seamless collaboration of multiple providers and monitoring the equity of contribution to the comprehensive network;
  - 3) determining gaps in the delivery system and collaborating on the building of new capacity;
  - 4) overseeing the coordination of effort between CalOptima and OCHCA (MSI, behavioral health, public health) programs related to this new delivery system;
  - 5) executing financing strategies to maximize all available resources (federal, state, philanthropic, institutional);
  - 6) organizing participating providers to serve as recruiter of new capacity into the network;
  - 7) assuring the effective management of the target patient populations;
  - 8) identifying system needs (IT, care management) and managing vendors and consultants to assure directed and coordinated efforts that function for the entire network, not in separate silos;
  - 9) setting quality benchmarks that address both effective utilization of services and, ultimately, improved individual and community-wide health status;
  - 10) seeking collaboration between the medical delivery system and other community-based programs and services (culturally-sensitive community-based organizations, transportation, housing, education, etc.) to assure a more comprehensive approach to assuring improved health;
  - 11) serving as a community-wide advocate for medically vulnerable residents;
  - 12) implementing a continuous process of monitoring, evaluation and change to assure ongoing clinical effectiveness and cost efficiency, and;
  - 13) planning for and responding to the financial and operational implications of health reform at both the federal and state levels.

- Although, in order to maintain the current momentum, consultants could be used to start the process moving, highly-skilled staff will need to be recruited by the organization's Board as soon as possible. This staff could be supplemented by those leading existing programs at OCHCA and CalOptima but will need, at least initially, to be significantly directed by an active Board and its committees (see "Work Plan" section below).
- Given the rapid health care changes being debated in Sacramento and Washington right now, this new organization should contemplate building a lobbying and public relations component that will not only stay abreast of all fast-breaking changes but will assure that the model being developed in Orange County is understood by and promoted to those who are making decisions about resource allocations.

### Target Population

Identifying the population(s) to be addressed by this effort is critical to assure the effectiveness of the network in addressing the real needs of the patients. The total number of uninsured is unclear and changeable (particularly due to the recently increased unemployment rate). Multiple tracks (focused attention on some, build capacity/network for broader group) are proposed in this plan. It is most feasible to bring populations into the network incrementally and, because of the geographic dispersal of the medically indigent throughout the County, we believe that it is preferable to target the following patient groups over the first several years of this effort:

- those with incomes under 133% of the federal poverty level who will likely move into Medi-Cal under health reform over the next several years (approximately 80% of the County's MSI program eligibility);
- the chronically ill, including those with both medical and behavioral health problems and high utilizers of services who would most benefit by significant management of their care; and
- those that are currently covered by Medi-Cal but still have difficulty accessing care and would benefit by being connected into an organized delivery system and whose inclusion could help provide support for those without any coverage.

The assumption inherent in this plan is that a target of 100,000-120,000 currently uninsured patients enrolled into this new delivery system (with some receiving more intensive services, as described in the model), is a rational goal.

## Delivery System Restructuring

In order to assure a comprehensive, geographically dispersed and high quality health care network for the medically vulnerable population for the residents of Orange County, we recommend attention to the following areas in further development of capacity for the uninsured and Medi-Cal population or the coordination of existing services:

### **Primary Care**

A major focus of this network development effort must be on the establishment of stable and expanded primary care capacity, particularly for Medical Homes for uninsured patients. Specifically, we recommend:

- Take on the issue of establishing community expectations for a proportion of uninsured patients to be cared for by FQHCs operating within Orange County, based on both State and national averages. FQHCs should be expected to provide a critical level of access for the uninsured in return for their cost-based Medicaid reimbursement, their tort coverage, access to 340B drug pricing and direct grants to support the delivery of care to those without means. In order to assist in making this transition more palatable, CalOptima should assign Medi-Cal lives to FQHCs and other community clinics based on a commitment to and demonstration of increasing capacity for the uninsured in these centers to documentable levels based on at minimum, state norms. This action will provide—particularly for FQHCs—a funding source to provide some support for expansion for uninsured patients. CalOptima is moving in this direction already but it is important to also understand that this will mean increasing the overall proportion of assignees to clinics.
- Take advantage of the federal commitment to expanding FQHC capacity to create new sites in Orange County. This focus on FQHC capacity can and likely will take several different forms and it is advisable to do a focused assessment (which can be done quickly) of which strategy or strategies will likely result in the greatest capacity expansion. All participants in this network development initiative should actively encourage current efforts to convert community clinics to FQHC status and pursue one or more of the following options to increase FQHC capacity in Orange County:
  - 1) Explore the restructuring of the UCI FQHC clinics, moving from the University management to a more community-based ownership and governance that would commit to greater capacity to care for under-served populations. The UCI Family Practice residency program could be accommodated in this restructured network and, perhaps, be seen as a focus of training FQHC physicians for the community.

- 2) Create a new FQHC, perhaps building on a restructured UCI FQHC described in #1, which would include, at minimum, the community clinics currently subsidized by St. Joseph's Health System (La Amistad, Camino, St. Jude), Hoag (SOS) and Children's Hospital of Orange County. This new FQHC would immediately have a significant Medi-Cal patient population (through the CHOC clinics) that would bring the entire FQHC network added revenue to support the full scope of adult and pediatric care. It may make sense to recruit one experienced management team to operate the new FQHC.
  - 3) Encourage another FQHC (perhaps from San Diego County with a focus on south Orange County) to take on one or more community clinics to expand capacity, an option particularly if #1 and #2 turn out not to be viable.
- In order to assure maintenance of effort from private physicians, practices should be recruited to participate in the network that currently deliver care to some significant level of CalOptima and MSI patients and that are willing to be participants in this network effort. These practices would be incentivized to serve as Medical Homes to the uninsured through new financial payments (described below). It is likely to make the most sense to first engage the major IPAs in discussion about their willingness to participate in this effort. The most likely mechanism for bringing those physicians to the table is through negotiation with and involvement of organized IPAs and CalOptima provider networks.
  - Build upon the aggressive and effective chronic care management in the Kaiser-Permanente system, perhaps by "partnering" Kaiser with the evolving new FQHC network) to utilize this expertise more broadly.
  - Create several pilot sites, pairing Orange County behavioral health staff/resources with FQHCs and community clinics that will serve as Medical Homes for identified patients with both mental health and chronic medical problems (see potential funding supplement in finance section below). This would foster better coordination between medical and behavioral health providers and would take advantage of 340 (B) discount drug pricing available through FQHCs.

### **Specialty Outpatient Care**

Access to and appropriate use of specialty care for medically indigent populations is a significant problem in Orange County, as it is across the country. To begin to rationalize the approach in Orange County, we recommend:

- Develop a network of specialty physician participants for the patients covered through this network by creating an equitable distribution and commitment from major physician groups and the current participants in CalOptima and MSI. The

UCI faculty and physicians should play a significant role in this network with clearly delineated areas of responsibility and agreement to be reimbursed at the same level as other specialty providers. The financial reimbursement rates will need to be augmented by a firm network commitment to a process that assures only those patients that truly need a specialty visit are referred and that facilitates a smooth transition back to the patient's primary care Medical Home.

- Institute *E-consult*, being developed for AccessOC, throughout the network (including CalOptima and MSI patients) to provide consultation access to primary care medical homes. Further, couple this effort with *E-referral*, being developed for the MSI program and build in "rules" to assure that the referral is appropriate, includes needed information (diagnostic test results, pharmacy, primary care notes), and that patients are returned to their Medical Homes with the advice of the specialty consultants.
- Maximize potential for specialty care provision within FQHCs, an opportunity now federally-allowed, within some limits (see Appendix B). The activity related to increasing FQHC Medical Home capacity expansion should keep in mind the potential for also increasing specialty care availability within the FQHC networks. If FQHCs are able to provide more specialty care to Medi-Cal patients and are reimbursed at FQHC rates, additional revenue could be generated to expand access for the uninsured
- Explore the use of telemedicine for some specialties.
- While it is unlikely that the specialty care needs of the uninsured will be met in any significant way through volunteer efforts, there should be a clear commitment to maintenance of current efforts like AccessOC and integration of those efforts into the network.

### **Emergency/Urgent Care Services**

In order to assure benefit to hospitals participating in the network, particularly those hospitals experiencing a disproportionately high level of emergency department (ED) use by uninsured patients, a significant commitment will need to be made by the new network to both manage patients into appropriate care settings (see section on patient management below) and to develop infrastructure to assure that redirection. A recent report compiled by OCHCA estimates that nearly half of ED visits in Orange County are for non-urgent and avoidable conditions (even more for infants and for children covered by Medi-Cal) and most often the reason given for the ED visit is the lack of access (real or perceived) to primary care services. Thus, addressing this issue is a critical component of building a new delivery system model. Specifically, we recommend:

- The network should commit to the initiation and financial support of the establishment of “urgent care centers” adjacent to high utilization hospital EDs. The centers could be collaborations with FQHCs that could receive preferential rates for both providing episodic care and, more importantly, aggressively managing patients back into their primary care Medical Homes. The establishment of these centers would be a key area for initial capital contributions from philanthropy and/or CalOptima, who would significantly benefit from redirection of patients, including its own assignees, from inappropriate ED use.
- The OCHCA’s MSI program’s *ER-connect* IT system should be further expanded to allow for easier identification of patient’s Medical Home and assistance in providing same-day appointments.
- Discussions should be initiated with the Emergency Medical System (EMS) in Orange County to determine the potential for diverting unnecessary transportation of patients to hospital EDs. In other communities, the EMS system has turned out to be an often over-looked and critical component of the safety net. Many of its “911” calls are simply seeking assistance in acquiring medical care that is not necessarily emergent. If the network could work with the EMS system, through OCHCA, to assure access to health care services—either through primary care providers or urgent care centers—there would be a significant cost-savings and greater potential for establishing a more established connection to a Medical Home for the patient.

## **Inpatient Care**

While most hospitals in Orange County experience some load of uninsured inpatient care, and some hospitals are impacted to a greater degree than others, it is not possible at this time for the costs of all services to be covered for all of the County’s uninsured through this network. Significant attention needs to be paid now to developing the outpatient capacity (particularly a primary care network) and management systems to assure that all resources are utilized most effectively. Over the next several years, it is likely that more of these patients will be covered (either through expanded Medi-Cal eligibility or through affordable plans offered by insurance exchanges) and it makes sense to spend this transition time developing a network that will provide a rational delivery system. Thus, we make the following recommendations related to inpatient care:

- Unless, by an objective measurement, a participating hospital can show significant financial distress, hospitals in Orange County should agree to forego reimbursement for uninsured patients (including those that currently qualify for MSI) for the next 2-3 years so scarce resources can be targeted to the development of primary, specialty and urgent care outpatient capacity, as well as management systems that will facilitate the most appropriate use of network services.

- The network should negotiate, devise and manage an equitable division of inpatient responsibilities, including elective and tertiary care. This network approach would take into account the geographic dispersal of patients, the expertise and investment already present in individual hospitals, the relative value of inpatient contributions being made, etc.
- Linkages should be formalized between participating hospitals and ambulatory providers (primary and specialty) to assure that inpatients are able to be effectively discharged into ongoing care, minimizing the likelihood of recurring and unnecessary ED visits.
- Hospital contributions would be monitored and applied to a calculation of their contribution to the overall network and to “community benefit.”

### Managing the Population

Population health management is the approach most likely to optimize the success of the network. The network’s potential members are all the medically indigent in Orange County. Unlike the strategy of conventional health plans and providers, the network should aggressively seek to identify and enroll the chronically ill and those with “high impact conditions” who are at risk of health declines and also high use of health resources. The network must stratify the enrolled by health status and utilize evidence-based interventions to meet the different needs, ranging from primary prevention, to monitored and supported medication management, to full care management by the primary care team, telephonic nurse and pharmacist case managers managing with standing orders and protocols, to a full court press of care management with telephonic and home support, involvement of multiple physicians at several sites.

The network will not simply await the patient to initiate needed care but will contact patients, remind them, and support them to meet their individualized plan. The Patient Centered Medical Home must remain as the center and single point of contact for most of this care but all sectors within the network must be able to communicate encounter, pharmacy and results data and share a common care plan. Attention should also be paid to reinforcing best life style and health seeking behavior. It is clear that in organizing, capitalizing and financing the Network, priority should be given to information technology, communications, care management, and self management support.

The network can build upon the resources of other providers in Orange County. CalOptima and MSI have initiated efforts in disease management and, to a lesser extent, population management. Kaiser Permanente has a robust population management system, although its closed population, employed staff and ownership of facilities may limit its

application within the network. An organized and focused approach should be initiated to facilitate the process through which these organizations may offer their experience and perhaps share resources with the network in the following areas:

- information technology, including monitoring pharmacy and managing real time utilization/inpatient census data, claims data, systems that support risk stratification, triage and medication management and those that support transition care from inpatient, ED, or Urgent Care back to the Medical Home;
- case management and care management organization, staffing, training and support;
- urgent care and convenient care standards, staffing, equipment and location;
- outpatient specialty and diagnostics referral technologies and criteria and the related management and operations of referral and reporting software, staffing and systems;
- setting and maintenance of evidence-based interventions and treatments for chronic illnesses;
- integration of different disciplines such as primary care, specialty or behavioral health;
- education and orientation programs for professionals and other staff; and
- best practices in program implementation.

### Financing the Network

Financing the evolving multi-provider network will need to optimize current resources, pairing—as much as possible—the approach to the uninsured and the Medi-Cal populations, being continually aggressive in taking advantage of new federal and state opportunities, supporting innovative integrated delivery models, coordinating institutional and philanthropic support of health care for under-served populations, and, finally, recognizing that the development of the network will be incremental and funding will need to be directed in ways that build the most rational and sustainable system possible. For example, management infrastructure to coordinate providers and assure patient compliance will be key up-front investments, as will filling current holes in the delivery system (primary care capacity, in particular). Financing will require smart people constantly assessing and re-assessing opportunities for the full network, not just individual sectors (i.e., hospitals, clinics, CalOptima). Finally, the financing strategy will have two major components: 1) how to maximize total dollars available to support the

network and the needs of the target populations and, 2) how to pay out that money to meet the goals set by the network. Specifically, our recommendations are:

- All participants should commit to an aggressive eligibility screening campaign to assure that all residents of the County—and particularly those that are chronically ill and currently using services within the system—are receiving all of the financial support to which they are entitled (see Appendix D for a more detailed discussion of this issue). Key areas for focused attention would be in the County’s behavioral health program (in which, it is estimated, only approximately 15,000 of its 42,000 patients are enrolled in Medi-Cal and 1100 in MSI) as well as in all community clinics that currently care for significant numbers of uninsured patients but which may not have the resources to pursue Medi-Cal eligibility. It is also recommended that CalOptima invest in the infrastructure—through *One-e-app*, *Auth-Med* or another product—and coordinate this effort throughout the County, as it will reap the greatest benefit in getting more people onto the Medi-Cal rolls. However, CalOptima should consult with OCHCA to be sure that its screening process also assures compatibility with current screens for eligibility into County benefit programs and full administrative match should be sought for its implementation.
- There are several significant opportunities available to draw down additional federal matching dollars through CalOptima in collaboration with both Orange County and the University of California-Irvine. Pursuing these opportunities represent the single most significant sources of new revenue to expand access to care for under-served populations. Specifically, attention should be paid to the following Intergovernmental Transfer Agreement (IGT) opportunities:
  - 1) Federal match of County MSI and tobacco settlement (TSR) dollars not currently matched. This initiative would require that the MSI—and, perhaps, the use of TSR money used to support primary care capacity—be funneled through CalOptima. CalOptima can then “pay out” the new dollars to Medi-Cal providers (clinics and private physicians) as “performance bonuses” in return for their also providing care to a set number of uninsured patients—thereby accomplishing the mission of the MSI program but with a near doubling of the current available dollars.
  - 2) An IGT for the County’s behavioral health program. California has established a vehicle that allows for a pilot program (see citation in Appendix C) to create a behavioral health IGT in two counties. Solano County is already implementing this initiative and receives much of its funding through its County Operated Health System. This allows for counties with administrative costs of less than 9% in their behavioral health programs to gain federal match of their county expenditures and move from a certified expense funded program that pays, in some cases, less than cost to an actuarial rate that would pay them at least cost plus 6% for margin. The IGT for Orange County (which appears, after initial review, to be eligible) would

run through CalOptima, which would, in turn, contract with the County—and/or others—for behavioral health services. This IGT, particularly if coupled with aggressive Medi-Cal screening of behavioral health patients, could bring significant new resources into the network and could help to fund both expansion and innovative efforts such as pilot behavioral/medical integration efforts and ED diversion management.

- 3) Federal match of UCI expenditures. There is the potential for an IGT to bring in additional federal matching dollars through collaboration between UCI and CalOptima that would allow UCI—or any providers contracting with UCI—more than cost for Medicaid services. This could create new funding to support providers within the network. In conversations with the senior financial leadership of the UC system, it was agreed that there would be University willingness to discuss this potential in a serious way.
  - 4) An IGT of some of CalOptima’s reserves. Although a match of some portion of CalOptima’s reserves would serve a one-time purpose, it could generate significant dollars that could be committed to infrastructure development or be held for transition payments over the anticipated 2-3 years before additional patients are moved into Medi-Cal under national health reform efforts. For example, acknowledging CalOptima’s need to maintain a prudent reserve, it is likely that reserve dollars could be matched to bring in new resources to be devoted to new capacity (FQHC’s urgent care centers) and paying for management infrastructure development (care management, call centers, etc.). It is estimated that up to about \$40 million could be certified for such a transfer.
- Hospitals participating in the network should agree upon an objective and accountable network contribution formula, perhaps based on gross revenues, to achieve an equitable approach to support a “pool” of funding for the network. Elements of that support could include, but not be limited to, any of the following forms:
    - 1) cash contributions;
    - 2) direct provision of services for a certain number of uninsured patients (i.e., Kaiser taking on a selected group of complex patients with chronic illnesses that would benefit from their management through their Medical Financial Assistance Program);
    - 3) agreeing to take an equitable number of uninsured patient admissions (including those previously covered by MSI) without reimbursement (currently about \$20 million annually);
    - 4) diverting some percentage of AB 1383 Hospital Fee Proposal dollars (if the plan is approved by CMS) into the network;

- 5) providing a level of diagnostic and/or procedural (i.e., “free surgery days”) support for the uninsured, organized and controlled by the network;
- 6) contributing areas of unique expertise (i.e., disease management, telemedicine) to the entire network.

The network governance would provide accountability and “credit” for community benefit for these contributions.

- It is clear that, despite aggressive attention to all of the revenue-generating activities described above, there will not now be enough money in the system to cover a comprehensive set of benefits for all of the uninsured in Orange County. It is recommended that, as described above, target populations are “taken on” incrementally, with priority given to those most likely to move onto the Medi-Cal rolls under health reform (the vast majority of the MSI patients) and those most disproportionately utilizing health care services now. It is further recommended that the network commit to a limited benefit plan which CalOptima would administer for the network. At least initially, this plan would not pay for inpatient facility or physician inpatient fees—with those costs contributed by the participating hospitals in exchange for the build-up of Medical Home and urgent care capacity and for a commitment to develop and implement a systematic approach to managing high priority uninsured patients. In similar plans in both Flint, Michigan and in San Francisco, the cost of coverage for all services except inpatient and behavioral health is remarkably similar—about \$140 per member per month. It is anticipated that, over the next several years, the benefit package will be expanded to include inpatient care. Deciding to target dollars toward the building of an effective delivery and management system now seems to be the most critical use of available dollars and it appears feasible that 100,000 patients could be initially covered under this plan.
- The network should look into the potential for uninsured residents to “buy into” this new coverage plan and to establishing sliding fee scales for patient contribution. (It should be noted that nearly \$3 million is generated annually from co-payments in the San Francisco coverage plan that covers approximately 48,000 people).
- Currently CalOptima has a 10-15% penetration in the dually eligible patient population in Orange County through their One Plus plan. This penetration currently yields a margin of \$7-8 million annually. If the community, particularly providers, worked together to increase this penetration to 50-60%, this margin could be increased to \$24-32 million. CalOptima should then be willing to reinvest part of this money into the health system for the underserved, either through direct payments or by using the money as IGTs to increase Medi-Cal capitation payments and rates to providers. Many patients with Medicaid and Medicare fear joining managed care plans, thinking that it will result in their

being restricted in their choice of providers or their access to services. The reality is, most dual eligibles would receive more services within a managed care model. In Orange County, where many private providers are caring for patients in the managed care system, hearing from their doctor that they could continue with their care and might be entitled to even more services in CalOptima's plan, would likely help convince them to join. Hospitals can help in educating their physicians about the long-term value in growing this plan in order to help subsidize care for the uninsured.

- If a partnership could be developed between the County and CalOptima, a unique opportunity exists to provide health insurance coverage to its IHHS workers who provide in-home care. As a federally claimable service that becomes part of the cost of delivering care to Medi-Cal patients, a 50% federal match could be generated to cover some of the 17,000 workers in the County, only about 2200 of who currently receive benefits through their union. As they are low-paid workers, this could further decrease the rolls of the uninsured and also maximize the opportunity to bring new dollars into the community.
- The network should aggressively pursue all federal funding available for expansion of care for the underserved through new FQHC starts and expansions. The value of incorporating the CHOC clinics into any new network—or one expanded through the UCI FQHC—is that such integration brings significant new Medi-Cal revenue to both enhance payment for specialty care and to expand access for those without payment.
- Focused attention should be paid, over the coming months, to federal dollars for model programs (Accountable Care Organizations, coordinated care networks, IT innovations) for which the network will likely be uniquely suited. In addition, as the California 1115 Waiver is up for renewal, attention should be paid to maximizing Coverage Initiative investment into Orange County, particularly as it doesn't have a public hospital system, which is the vehicle that other states use to maximize state and federal dollars. Coordinated efforts through the network should be employed to support the County in this advocacy.
- CalOptima has, in the past, sought State approval for entering into a waiver to facilitate a change in their approach to delivering long-term care services, moving away from institutionalization to building capacity in home- and community-based-care. As nursing home payments represent approximately \$300 million of the CalOptima budget, the network should work with CalOptima and the State to seek implementation of the County's inclusion in the waiver (as has been done in other California counties) and allow for more creative and cost-effective use of these funds.

- The Health Funders Partnership of Orange County should explore an even greater focus of its philanthropic capacity to seed this new network and assist in early implementation.

### *Work Plan: Next Steps*

It is important that there be a commitment by a critical mass of key stakeholders to move quickly toward implementation of this new approach to assuring an effective and equitable delivery system, building on the momentum generated by the planning process of the past several months. The fact that this effort falls in the midst of a national effort to dramatically change the paradigm for health care delivery, financing and organization—particularly for underserved populations—makes this imperative for quick action even more critical. The following are steps, grouped in three month intervals, to guide the development and implementation over the next year:

#### First Quarter (February-April)

The key activities for the first quarter will require heavy consultant assistance—and, perhaps, contribution of senior staff from participating agencies and providers—as the new organization is developed and staff is recruited. It is important, however, to commit to becoming a staff-run—not a consultant-run—entity as soon as it is possible to find the right staff. Also, during this initial implementation period (which will likely be a full year), the leaders of all participating entities will need to devote their own personal time and energy to lead the work in order to assure that it is moving in the direction that makes sense and is, ultimately, sustainable within the Orange County environment. Finally, while work groups and committees will need to be established, their charge should be clear and timelines should be strictly adhered to so they don't become ends in and of themselves. While it should be clearly noted that there are a significant number of individual recommendations included in this plan that could—and should-- be acted upon immediately, specific priority steps to be taken in the first quarter should include:

- 1) **Establish the new organization.** A 501(c)(3) organization should be established that will oversee and manage the development and implementation of the new collaborative delivery system. A working committee should address (and bring recommendations to all of the participating entities for approval) the following organizational issues:
  - Board membership, network name, charge/mission and structure (including standing committees);

- determination of representation of other key sectors (physicians, clinics, business/civic, patients/community);
- relationship to partners that will carry out functions of the collaborative system (CalOptima, individual providers, OCHCA);
- public relations and communication plan;
- initial start-up financing; and
- staffing and recruitment strategy.

It is recommended that this working committee include several hospital CEOs, philanthropy, the County and CalOptima. There will also need to be legal counsel provided to facilitate the organizational development—perhaps contributed by one or more of the hospital partners. The goal should be to have the new organization and Board of Directors in place by the end of the first quarter.

- 2) Create a finance committee and set priorities for generating resources for the organization.** The financing of this effort (as described in detail in the “Recommendations” section of this plan), will fall into several categories: 1) initial support and start-up (provider contributions, philanthropy, etc.); 2) potential for accessing federal dollars tied to health reform (for FQHC expansion, model development, IT infrastructure, etc.); 3) ongoing and major sources of revenue, primarily generated by public entities through Intergovernmental Transfer Agreements; 4) maximizing all potential areas of collaboration between CalOptima and OCHCA; and 5) establishing systems that will continuously assess utilization, spending and new opportunities within the new network.

During the first quarter, a standing finance committee should be created and should consist of, at minimum: CalOptima, OCHCA, philanthropy, a for-profit hospital system CEO and a not-for-profit hospital system CEO. This committee should establish a priority agenda, with determination made by the end of the first quarter on: start-up funding, IGT targets (particularly between CalOptima and OCHCA and CalOptima and UCI), and an equitable and transparent hospital contribution formula.

- 3) Commit to a comprehensive eligibility screening initiative to both identify people eligible for Medi-Cal and other entitlement programs as well as to identify those that would become the target of the new network.** The new organization should commit to a comprehensive process that assures that all efforts have been made to link vulnerable people to the benefits for which they may be eligible. CalOptima should take a lead in assuring that this effort is supported but must assure that OCHCA and all participating providers are active partners. The process should be implemented by the end of the first quarter. The

OCHCA enrollment operation currently utilizes more than 40 sites and these should be built upon.

4) **Initiate the establishment of a new FQHC network.** The centerpiece of the delivery system developed under this plan is the creation of a new FQHC network to significantly expand primary care capacity for the uninsured, particularly those in the target populations of the MSI-eligibles and the chronically ill. Acting quickly on the establishment of this new FQHC would also allow for maximum connection to new resources being made available through health reform efforts. The process should start immediately with an assessment of all available options for maximizing benefit and new uninsured capacity, including:

- thoroughly understanding all current federal opportunities for FQHC expansion (including meeting with the regional HRSA staff) and likely challenges that might be faced in Orange County (i.e., Medically Underserved Area status);
- exploring the potential for expanding on the current UCI FQHC network, under new governance and management, by incorporating other existing clinics (including the CHOC facilities and other clinics, particularly those that are currently hospital-subsidized);
- exploring other options if the UCI connection cannot be made, to either expand a current FQHC or to start a new one; and
- assessing all sites that would be included in the new FQHC network for compliance with clinical, financial and organizational requirements for designation.

This effort needs to be an intensive one and will require the assistance of experienced and skilled consultants working with, at minimum: UCI (if there is interest in restructuring their FQHC), CHOC, Hoag, St. Joseph Health System. There will, of course, also need to be the involvement of the participating clinic leadership and communication with CalOptima related to their willingness to guarantee some level of Medi-Cal assignees. The final recommendation related to the establishment of the new FQHC network should be presented to the newly established organizational Board by the end of the first quarter, along with a detailed plan that describes the work to be done in certification of the new FQHC network.

5) **Determine targets for the establishment of urgent care centers to assist in the diversion of patients inappropriately utilizing EDs.** There are clear hospital targets for the establishment of urgent care centers near or adjacent to EDs with high volumes of patients utilizing emergent care unnecessarily. Several “priority sites” should be determined as the first places for these models to be established

and plans developed that address: start-up financial support; potential relationships with FQHCs in the operation of the centers; financing strategies. It is recommended that the OCHCA lead this effort because of their role public health role and their experience in addressing ED utilization through the MSI program. A plan should be ready for approval for at least one center by the end of the first quarter.

- 6) **Begin intensive collaboration discussions between CalOptima and OCHCA and clearly define the roles of each in the new network.** The establishment of significant coordination between OCHCA and CalOptima is perhaps the most critical component in assuring the network’s long-term effectiveness. Ongoing meetings should commence to set the agenda for: the integration of the MSI program into the network (with administration and management functions merged with CalOptima); building consolidated systems based in part upon the OCHCA’s expertise in IT devoted to supporting provider networks; assuring comprehensive eligibility screening throughout the County; developing an IGT approach that will maximize federal match of County/State dollars (MSI, TSR, behavioral health, coverage of IHHS workers), and; other activities identified in this plan. As CalOptima takes on a greater responsibility for the management of patient care, OCHCA will be able to better define it role as “honest broker” for the network.

The leadership of the two organizations should commit to focused and regular meetings with key staff to establish priorities and timelines.

- 7) **Establish a set of priority areas for patient management.** In order to avoid a “standing committee” that doesn’t move quickly enough to set management system priorities, it is recommended that consultants be utilized and focused on identifying specific infrastructure targets—as well as potential collaborators among the network participants—that would have the most significant impact on the management of high risk and high cost patients. This set of priorities (IT investment and coordination, care management, call center, etc.) would be delivered to the Board of the new organization by the end of the first quarter.

## Second Quarter (May-July)

During the second quarter, priority work should be to:

- 1) **Announce the new organization.** The network should be introduced in an organized and public fashion as a conscious and determined effort by community stakeholders to be “good citizens” and to create an equitable and collaborative approach to assuring an effective delivery system for all of the residents of Orange County. This communication effort should be made locally (including to individual institutional boards), with key officials in Sacramento and in Washington, DC. Special attention should be paid to the potentially unique role that the network can play in structures (Accountable Care Organizations,

Coordinated Care Networks) emanating from national health reform efforts and also to the implications of the California Medicaid 1115 waiver related to increased Coverage Initiative funding that could be applied to the network.

- 2) **Officially seat the new Board (including representation from physicians, clinics and the broader civic community) as the organizational governance.** Board leadership should be determined, working committees established and search for staff leaders (CEO, COO, CMO, CFO, CIO) should be initiated.
- 3) **Recruit key staff leaders.** The CEO should be hired before the end of the second quarter; he/she will then participate in the selection of other staff leaders and in the coordination of consultants and staff from other agencies.
- 4) **Determine the benefit package for network “enrollees.”** By the end of the second quarter, the package of services—along with any financial contributions expected from the patients- should be clearly defined. It is anticipated that there will be at least two different levels of service (with a more comprehensive set of services directed toward the more complex and costly patients).
- 5) **Formalize hospital contributions.** An equitable, transparent and documentable “contribution formula” should be determined and agreed to by all of the participating hospitals in the network (see details in the “Financial Recommendations” section). This should be accomplished by the end of the second quarter.
- 6) **Initiate one or more IGT opportunities.** The process should commence with the State for one or more of the IGT options identified as the most viable during the first quarter. This will require significant involvement by CalOptima, OCHCA and, perhaps, UCI.
- 7) **Initiate a County-wide “campaign” to enroll all eligible residents into programs to which they are entitled.** Philanthropy should assist in the publicity of this effort.
- 8) **Begin the FQHC application process for either expansion sites for an existing (but restructured) FQHC or for a new start.** This process is exhaustive and will require a staff/consultant team to both draft the application and a plan for bringing the clinics into compliance with FQHC requirements. This is likely to be a 6-month process.
- 9) **Determine a pilot site for an integrated approach to patients with both medical and behavioral health problems.** OCHCA, CalOptima and one or more clinic sites should produce a plan for an integrated practice for network patients with both medical and behavioral health problems by the end of the second quarter.

- 10) **Develop an approach to involving private practices in the network as Medical Homes.** Determining the role of private practices and the criteria for their participation should be completed by the end of the second quarter.
- 11) **Define an equitable division of specialty care resources that will be components of the network.** Commitments should be acquired by major sources of specialty care (including UCI and major IPAs) related to specific specialties, volumes, financing, referral systems, etc. by the end of the second quarter.
- 12) **Establish a mechanism to assure equity among hospitals in the provision of inpatient and diagnostic services for network patients.** As it is proposed that, for at least the first several years, funding be focused on ambulatory care capacity and infrastructure development rather than inpatient care, it is critical that a plan is in place to assure that all hospitals take their “fair share” of the load. While some may contribute because of their geography, others may take on certain specialties, while others may contribute in other ways. The inpatient rationalization component of the network plan should be developed by the end of the second quarter.
- 13) **Finalize an IT plan.** The plan should coordinate all current network support efforts (MSI, CalOptima, AccessOC) and allow for expansion to support appointment generation, disease registries, referral “rules” to better assure appropriateness, connection to enrollment eligibility efforts. The plan should also identify sources of funding (including federal dollars) and be presented to the Board by the end of the second quarter.
- 14) **Set patient management priorities.** A set of patient management priorities and resources should be finalized and presented to the Board by the end of the second quarter for a determination on next steps.

### Third Quarter (August-October)

During the third quarter, priority work should be to:

- 1) **Have all senior staff in place and establish management systems for the network.** The COO, CMO, CIO and CFO should be in place early into the third quarter. Their employment will minimize the need for consultants, requiring “outside” assistance on only targeted and specialty areas (finance, FQHC, IT, care management, etc.).
- 2) **Complete FQHC application.** The final application should be able to be completed in the third quarter, although work will need to continue on clinic compliance, board development, etc.

- 3) **Determine network for target population.** The primary, specialty and inpatient network for the target population will be determined during the third quarter, as well as the process for adding to or subtracting from that network.
- 4) **Continue development of financing strategies.** Ongoing work should continue on strategies, including those detailed in this document.
- 5) **Start behavioral health/primary care integration pilot.** This pilot site (probably at an FQHC to maximize opportunities for reimbursement, favorable 340B drug pricing, etc.) should serve as the Medical Home for a targeted number of complex network patients.
- 6) **Identify target network enrollees through comprehensive screening process.** By the end of the third quarter, the first group of targeted enrollees should be identified, most through the conversions of MSI into the network.
- 7) **Implement first urgent care center.** By the end of the third quarter, the network's first urgent care center should be established at one of the hospitals with the most significant volume of unnecessary utilization from the target population.
- 8) **Implement infrastructure priorities.** Based on the priorities determined during the planning process over the first two quarters, patient management infrastructure (call center, care management in targeted populations, IT coordination, etc.) should begin to be implemented in the third quarter.

#### Fourth Quarter (November-January)

Although the specific work of the final quarter may change and evolve, in general, priority work should be to:

- 1) **Continue to grow enrollment of target population.**
- 2) **Continue to build financing strategies.**
- 3) **Continue to refine provider network, focusing on productivity and quality.**
- 4) **Continue to build patient management infrastructure, assuring effectiveness and efficiency.**
- 5) **Set quality and utilization goals for the next year and develop a tracking and data collection system by which to monitor network impact.**
- 6) **Assess the implications of federal and state reform initiatives on the developing network.**
- 7) **Utilize the public-private nature of the network to become a positive advocate for medically under-served populations and communities.**

## *Appendices*

Appendix A: Individual Interviews

Appendix B: Specialty Care Provision in FQHCs

Appendix C: Behavioral Health IGT Citation

Appendix D: Maximizing Enrollment into Coverage Programs

## **Appendix A: Individual Interviews**

HMA conducted interviews with the following people in the course of preparing this plan:

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

Barry Arbuckle, PhD, President and CEO, Memorial Care Medical Centers

Isabel Becerra, CEO, Coalition of Orange County Community Clinics

Terry Belmont, CEO, University of California-Irvine Medical Center

Michelle Blair, CEO, Orange County Medical Association

Greg Buchert, MD, COO, CalOptima

Richard Chambers, CEO, CalOptima

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

Ben Chu, MD, President, Kaiser-Permanente (Southern California Region)

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

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

Chris Crittenden, President, NetChemistry

Castulo de la Roche, CEO, AltaMed Health Systems

Jeffery Flocken, Regional President and CEO, Tenet Health Care

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

Ed Gerber, Board Chairman, Coalition of Orange County Community Clinics

John Gilwee, VP/Governmental Affairs, University of California-Irvine Medical Center

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

John Heydt, MD, President and CEO, University Physicians/Surgeons, UCI

Michael Hurwitz, MD, President, Orange County Medical Association

Ed Kacic, President, Irvine Health Foundation

Keith Matsutsuyu, Principal, NetChemistry

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

Pam Pimental, Executive Director, MOMS

Richard Pitts, MD, Incoming President, Orange County Medical Association

Deborah Proctor, President and CEO, St. Joseph Health System

Lex Reddy, CEO, Prime Healthcare Management, Inc.

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

David Riley, Agency Director, Orange County Health Care Agency

Elliot Sternberg, EVP Wellness and Health Improvement, St. Joseph Health System

Paul Van Dolah, President, Van Dolah & Associates

Kenneth Westbrook, President and CEO, Integrated Healthcare Holdings, Inc.

In addition, HMA had significant interaction with and assistance from Ruth Kurisu (Health Funders Partnership of Orange County), Curt Condon (Orange County Health Care Agency) and Ilia Rolan (CalOptima).

## **Appendix B: Specialty Care Provision in FQHCs**

HRSA released its current specialty care guidance in December of 2008. The guidance is applicable FQHCs that want to add specialty 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 Bureau would apply similar logic in considering change of scope requests for Look Alikes requesting to add specialty care.

Like most HRSA guidance, the new PIN is subject to a range of interpretations. In general, however, HRSA appears to be taking an approach that specialty care services may be included within a health center'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 Bureau will specifically look at the following factors:

1. 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.
2. 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.

3. 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.
4. Location. The service must be provided at a current FQHC site, a new site that is being incorporated into the FQHC's scope, or at a location "where in-scope services are provided but that does not meet the definition of a service site." If the service is provided at a location that is not a service site, the health center must document how referrals will be made and how arrangements will be made for appropriate follow-up care at the health center. 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.
5. 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 FTCA deeming process in order to ensure coverage. Certain staffing arrangements (e.g., group contracts) may not be eligible for FTCA coverage.

## Appendix C: Behavioral Health IGT Citation

### **W&I Section 5719.5**

5719.5. (a) Notwithstanding any other provision of state law, and to the extent permitted by federal law, the State Department of Mental Health may, in consultation with the State Department of Health Services, field test major components of a capitated, integrated service system of Medi-Cal mental health managed care in not less than two, and not more than five participating counties.

(b) County participation in the field test shall be at the counties' option.

(c) Counties eligible to participate in the field test described in subdivision (a) shall include either of the following:

(1) Any county with an existing county organized health system.

(2) Any county that has been designated for the development of a new county organized health system.

(d) The State Department of Mental Health, in consultation with the State Department of Health Services, the counties selected for field testing, and groups representing mental health clients, their families and advocates, county mental health directors, and public and private mental health professionals and providers, shall develop, for the purpose of the field test, major components for an integrated, capitated service system of Medi-Cal mental health managed care, including, but not limited to, all of the following:

(1) (A) A definition of medical necessity.

(B) The preliminary definition developed pursuant to this paragraph shall be submitted to the Legislature no later than February 1, 1994.

(2) Protocols for facilitating access and coordination of mental health, physical health, educational, vocational, and other supportive services for persons receiving services through the field test.

(3) Procedures for promoting quality assurance, performance monitoring measures and outcome evaluation, including measures of client satisfaction, and procedures for addressing beneficiary grievances concerning service denials, changes, or terminations.

(e) Counties participating in the field test shall report to the State Department of Mental Health as the department deems necessary.

(f) Counties participating in the field test shall do both of the following:

(1) (A) Explore, in consultation with the State Department of Mental Health, the State Department of Health Services, and the California Mental Health Directors Association, rates for capitated, integrated Medi-Cal mental health managed care systems, using an actuarially sound rate setting methodology.

(B) These rates shall be evaluated by the State Department of Mental Health and the State Department of Health Services to determine their fiscal impact, and shall result in no increase in cost to the General Fund, compared with the cost that would occur under the existing organization of Medi-Cal funded mental health services, except for caseload growth and price increases as included in the Medi-Cal estimates prepared by the State Department of Health Services and approved by the Department of Finance. In evaluating the fiscal impact of these rates, the departments shall take into account any shift in clients

between Medi-Cal programs in which the nonfederal match is funded by state funds and those in which the match is funded by local funds.

(2) Demonstrate the appropriate fiscal relationship between county organized health systems for the federal medicaid program and integrated, capitated Medi-Cal mental health managed care programs.

## **Appendix D: Maximizing Enrollment into Coverage Programs**

### **Goal:**

Increase the proportion of eligible Orange County residents who are enrolled in Medicaid (Medi-Cal) or Healthy Families so as to decrease burden on county safety net providers and provide a revenue source for Medicaid providers.

### **Problem:**

Across the country many eligible persons are not enrolled in Medi-Cal /Healthy Families. For example, a national survey found that 35.0% of adults without private coverage eligible for Medicaid under current criteria have not enrolled.<sup>114-Davidoff '01</sup> Even if a person qualifies for Medi-Cal at the time of hospitalization, lack of Medi-Cal before hospitalization results in fewer outpatient visits and more avoidable hospitalizations.<sup>1</sup>

### **Reasons:**

Fear of application, especially among immigrants  
Language barriers  
Administrative difficulties  
Stigma attached to Medi-Cal (welfare) program  
Lack of advocacy for denied SSI applications for disabled adults.<sup>2</sup>

### **Work Plan for Increasing Medicaid Enrollment in Orange County:**

Different strategies are needed for the two distinct populations that are eligible but not enrolled in Medi-Cal /Health Families:

- Categorical eligibles: Parents with dependent children, pregnant women, children
- Adults eligible on the basis of a permanent disabling disease

#### **A. To increase enrollment for those with categorical eligibility**

- 1) Determine the cost of creating an on-line enrollment application for adults entering MSI. At least, two products should be considered. *Auth-med*, which is currently being used for MSI can be extended so it can do full on-line eligibility. Another product used in other counties for adults to screen for Medi-cal and used

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<sup>1</sup> A. Davidoff, B. Garrett, and A. Yemane, "Medicaid-eligible Adults Who Are Not Enrolled: Who Are They and Do They Get The Care They Need" New Federalism Series A, No. A-48, (Washington, Urban Institute, October 2001) [http://www.urban.org/Uploadedpdf/310378\\_anf\\_a48.pdf](http://www.urban.org/Uploadedpdf/310378_anf_a48.pdf)

<sup>2</sup> Nationally, most of the 60% of SSI applications that are denied are not appealed. However, when applications are appealed with case management and legal advocacy, 85-95% are approved. SF did a two year pilot of SSI advocacy through partnership with a community-based group<sup>2</sup>: 86% award rate with average of 12 months of retroactive benefits. Return on investment: 5 to 1 hard dollars.

in Orange County for children is *One-e-app*. For clients eligible for Medi-Cal, an application can be submitted electronically to the State from One-e-app through Cal-Win (this could also be created through One-e-app). This process markedly shortens the time to Medi-Cal thereby hastening the time during which payment is available for medical services. Having an electronic system for enrolling clients onto Medi-Cal will be even more important if Medi-Cal is expanded under federal health reform efforts. Any on-line eligibility system should include the capability of scanning documents such as birth certificates. This will enable the county to store information that will help eligibilize patients in the future for federal health insurance expansions.

The electronic eligibility system should also be used as the system of record for the MSI. This will facilitate tracking of clients, decrease duplication of care, and improve accountability. Also, by maintaining lists of patients not currently eligible for Medicaid with their documentation scanned (birth certificates, income statements) it will be easier and faster to enroll them into Medicaid or direct them to a subsidized insurance product if federal health reform efforts result in coverage expansions.

- 2) Once the costs of an electronic eligibility/system of record are understood, look for philanthropic or federal economic stimulus dollars to fund since most of the costs are one-time and ultimately having the system will improve the financial viability of the safety net. San Francisco's one-time costs for establishment of One-e-app as a uniform eligibility system and system of record was \$500,000. Given that many of the features SF uses were developed specifically for SF (e.g., Cal-Win interface, system of record), it would seem it should be less expensive now that it has already been created. There is an ongoing maintenance expense for One-e-app (in the case of San Francisco, the on-going operating cost is \$200,000 a year). However, the existing providers are likely doing eligibility now and once the system is in place there should be savings from eliminating existing efforts.
- 3) Issue an RFP for community based agencies interested in enrolling clients into Medicaid. Community application assistors have been shown to increase the number of Latino and Asian immigrants who apply for Medicaid.<sup>3</sup> This is consistent with the demographics of OC. With a web-based electronic on-line application, it can be done without expensive IT equipment for connectivity.
- 4) Consider doing a media outreach campaign to increase Medical, especially for enrolling infants.
- 5) Arrange high level meeting with OC Department of Social Services on churn rate (patients losing Medi-Cal than regaining Medi-cal due to problems during

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<sup>3 3</sup> Aizser A, Currie J. The impact of outreach on Medi-cal enrollment and child health: Lessons from California. California Policy Research Center, September 2002.  
[www.econ.columbia.edu/currie/Papers/The\\_Impact\\_of\\_Outreach.pdf](http://www.econ.columbia.edu/currie/Papers/The_Impact_of_Outreach.pdf)

application procedure). Other counties have been able to improve process with the result that clients do not have months when they are not on Medi-cal.

**B. To increase enrollment for adults eligible on the basis of a permanent disabling disease**

- 1) Estimate size of opportunity
  - a) The largest group of clients eligible based on permanent disabling disease would likely be in county mental health system. Persons with diagnoses of schizophrenia, psychotic disease are very likely to be eligible. Persons with severe depression may also be eligible. Underlying substance use does not exclude them from eligibility if they have a primary medical illness. If diagnoses are not easily available, use of antipsychotic medication is a good proxy for eligibility along with recent acute hospitalization. Also, clients who are in residential placement would be eligible. However, clients who are in IMD's (institutions for mental diseases, generally defined as institutions with more than 16 beds or where more than 50% of the clients have a primary mental health disease) are not eligible to receive Medicaid or SSI payments while institutionalized.

Some proportion of the clients meeting the above criteria will already be on SSI/Medicaid. Persons who are undocumented will not be able to receive SSI/Medicaid. Based on size of the undocumented population (which may not be known), we would estimate that 70% of patients meeting the above criteria are eligible for SSI/Medicaid. The difference between the proportion already receiving it and 70% is an estimate of the opportunity for this population.
  - b) Second group that would be eligible for SSI/Medicaid would be persons currently being seen through the MSI who have disabling medical illnesses. The highest percent of potential eligibles would be persons with HIV/AIDS, chronic liver disease, congestive heart failure, diabetics with blindness or amputations or severe peripheral neuropathy of severe gastroparesis.
- 2) Arrange a high level meeting with Orange County social service department. They have a lot to gain by increasing the proportion of persons who have SSI because 1) the county will receive a retroactive check repaying the county for general assistance provided to the client dating back to the date of disability; 2) the client will no longer be eligible/need county general assistance; 3) SSI checks are larger than general assistance allowing the person to have a higher standard of living (spend more within county) and require less assistance.
- 3) Create an SSI unit either within OCHCA or within the county social service department to do the preliminary outreach work with clients to help them to apply for SSI. The cost of SSI can be partially reimbursed through California Services Black Grant, a state fund that assists counties in getting individuals onto Medi-

Cal. Clients can be given a preliminary application form to be completed by their providers at the time of a visit (e.g., at the time of a visit with psychiatrist).

- 4) Issue an RFP for a provider of SSI advocacy services. The provider should have access to legal help, as well as the ability to refer patients to specialists who can complete the paperwork. The RFP can be structured either as an hourly wage, a sum for each client who receives SSI or as a percentage of what the county gains in terms of retro payments.

In gauging the financial benefits of SSI advocacy it is important to consider whether many of these patients would obtain Medi-cal without SSI advocacy under federal health reform efforts. Current bills would expand Medicaid to up to 133% or 150% of poverty without any need to demonstrate a disabling illness. The fate of these bills is likely to be known in January.

Certainly, if a Medicaid expansion passes the financial opportunity for SSI advocacy decreases, but it does not go completely away. The reason is that it may be difficult to get some of these clients to enroll in Medicaid for the same reasons that people do not enroll now in Medicaid even when they are eligible. People who either fear eligibility determinations or do not perceive benefits from enrolling do not enroll. SSI, on the other hand, has a direct financial benefit to the client—a monthly income check. This check makes it easier for clients to house themselves, eliminates the need to provide them general assistance (which will still be required with an expansion of Medicaid), and brings increased federal dollars into the county. Most importantly, the promise of a monthly check often makes it easier to motivate clients to go through the eligibility process including finding forms such as birth certificates.

Overall, it is likely that SSI advocacy will still be a financial net benefit for the county even with a federal expansion of Medicaid eligibility.

### **Tapping into VA benefits for uninsured persons in Orange County**

An under appreciated source of benefits for uninsured persons is Veteran's Administration benefits. Although there are no VA hospitals in Orange County, there appear to be three VA outpatient clinics (Santa Ana, Anaheim and Laguna Hills) that are part of the VA Long Beach network.

The challenge is to aggressively determine Veterans who are currently relying on EDs or on over-stretched community clinics and redirect them into the VA clinics, so as to build a network for persons who do not have alternatives with the available scarce resources.

There are several reasons persons do not avail themselves of VA benefits. First, there is often a misunderstanding both among veterans and service providers that only people with service related injuries are eligible for benefits. This is not true. Low income veterans are also eligible. Second, some veterans perceive the quality of services at VA facilities as low based on historic problems that the VA has had. This is no longer the

case. Third, clients who are able to obtain services at a community clinic or through a hospital ED may not perceive any benefit from going to a VA facility. However, in certain areas, especially specialty care and behavioral health services, they may be able to obtain services through the VA that are not otherwise available to them, or with a much shorter wait.

Because each VA network is paid based on the number of veterans it cares for, VA facilities are very eager to increase their enrollments. Also, VA facilities are happy to provide specialty care, prescriptions or diagnostic tests to veterans even if the veteran receives their primary care elsewhere.

Work plan for increasing the proportion of uninsured persons who seek services at the VA.

1. For MSI eligibility screen, ask enrollees whether they are veterans.
2. Meet with local VA staff to determine easiest ways for veterans to seek services.
3. Put together a glossy pamphlet, in cooperation with the local VA, on what services veterans can receive that is specific to Orange County, including phone numbers, directions to facilities.
4. Encourage veterans at entry points into the system (ED eligibility, community-clinic eligibility) to seek services at the VA.

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