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A SLIPPERY SLOPE: FINANCING SPECIALTY SERVICES IN CALIFORNIA'S SAFETY NET

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Many California safety net providers from community clinics and health centers as well as public hospital systems (comprised of hospitals and outpatient clinics) are working to develop new approaches to the crisis in specialty care access. These efforts include, but are certainly not limited to, the development of new models, with either one or multiple primary care clinics providing some specialty services on site; referral centers with volunteer specialist providers; technology solutions to manage referrals more efficiently and effectively; and using telemedicine to expand access to specialty care.

Access to specialty care has long been a serious problem for safety net patients of California's nonprofit community clinics and health centers and public clinics operated by counties and public hospital systems. It remains so today. According to a 2004 report published by the California HealthCare Foundation, fully 85% of California federally qualified health center medical directors said that their patients "often" or "almost always" had trouble accessing care – and that these access problems were increasing.[1]

The Specialty Care Access Initiative (SCAI) is a partnership established in August 2006 between the California Association of Public Hospitals and Health Systems/California Health Care Safety Net Institute (CAPH/SNI), the California Primary Care Association (CPCA), and Kaiser Permanente Community Benefit North and South (KP).

The SCAI's goals are to:

- identify, test, document and reduce barriers to specialty care access and demand management;
- identify, test, document and implement solutions to increase access to specialty care access;
- document, disseminate and facilitate the utilization of knowledge about barriers and solutions; and
- design, sequence, and implement advocacy strategies for needed change.

As part of their activities, the SCAI partnership, sponsored a number of roundtables and discussion papers to expand the knowledge and approaches to improving specialty care

[1] Mathematica Policy Research, Inc., Examining Access to Specialty Care for California's Uninsured, June 2004.

access. In addition, Kaiser Permanente and the California HealthCare Foundation have provided funding for 26 county coalitions to undertake local collaborative planning aimed at expanding specialty care access to safety net patients. Central to each of these endeavors is the question of how to sustain these efforts financially. This discussion paper will explore some of the financing challenges that impact these types of efforts.

Current Financing of Specialty Services in Community Clinics and Health Centers and Public Hospital Systems

Safety net providers face a myriad of challenges in adequately financing the specialty care services their patients need and which they sometimes provide themselves. There is no dedicated ongoing funding for specialty care services for the uninsured, Medi-Cal rates for specialty care are inadequate, and Federally Qualified Health Centers (FQHCs) that want to use enhanced Medi-Cal funding for this purpose face many uncertainties. Establishing a clear picture of the financial landscape that impacts the delivery of specialty care services requires an understanding of key regulatory issues, payor mix, staffing support and productivity. In addition to addressing these issues, safety net providers interested in financing specialty care improvements must be cognizant of the need to leverage community resources, limited grant funding and patient revenues.

Payor mix issues require a continual balancing act for all safety net clinics. In every clinic, administrators struggle to manage their organizations' financial health and future. Many of the patients who come to the clinics require extensive medical care, yet have no insurance coverage and can only pay a small amount of the cost of their services. For those patients covered by Medi-Cal, the program does not currently reimburse for new and effective approaches to delivering primary care. Overall, reimbursement does not keep up with the cost of care California spends an average of $5,257 per Medi-Cal beneficiary annually, almost 30% less than the national average of $7,188. In fact, California ranks 47th out of 50 U.S. states in total Medicaid (Medi-Cal in California) spending per patient providing the lowest amount spent per beneficiary among the ten most populous states.[2] Medi-Cal managed care capitation rates in the state are the lowest in the nation. Many non-profit community health centers and public clinics have transitioned from a cost-based reimbursement system to a fixed price, per-visit prospective payment system (PPS) available to Federally Qualified Health Centers. The FQHC prospective payment system rewards clinics for efficiency but does not cover the full cost of care. To remain viable, clinics need to leverage their Medi-Cal funded patients to help cover the cost of care for those who are uninsured.

In 2006, California's 264 community clinic organizations served almost 3.7 million patients - representing approximately 10% of the total population of California in that year and 53% of individuals living at or below the federal poverty level. Community clinics and health centers are heavily dependent on Medi-Cal as their major source of revenue, comprising 68% of net patient revenues and 46% of total revenues. The

[2] Kaiser Family Foundation, State Health Facts, federal FY2005 expenditures and June 2005 enrollment (www.statehealthfacts.org).

second largest source of funding for community clinics and health centers comes from the federal government in the form of operating grants available to Federally Qualified Health Centers (FQHCs). In 2006, this funding source provided almost 14% of total clinic revenues though it is available to only about 38% of clinic corporations (Section 330 clinics).[3] Other funding comes from state and county health care programs in addition to private grant sources of operating support. The remainder of clinic funding comes from a combination of patient fees, generally paid on a sliding fee schedule based on patients' income levels, and community contributions.

Public hospital systems, similarly, have no designated funding that specifically supports provision or expansion of specialty care. Though they comprise only 6% of all hospitals statewide, public hospital systems operate in counties where 81% of the state's population reside, supplying roughly half of all the inpatient and outpatient hospital care to the state's 6.5 million uninsured. Pubic hospital systems provide care to 2.5 million Californians including nearly 10 million outpatient visits annually. Over two-thirds of the care provided by public hospital systems is to Medi-Cal beneficiaries or the uninsured. Therefore, public hospital systems are reliant on funding from the state's Medi-Cal program, the majority of which comes through the Medi-Cal Hospital/Uninsured Care Demonstration Project (Waiver). Finalized in September 2005, this five-year waiver established the funding mechanism for the inpatient Medi-Cal fee-for-service and uninsured care provided in public hospital systems. It represented the largest change in 15 years to the financing of California's public hospital systems. Under the Waiver, public hospital systems are able to access federal funding for Medi-Cal beneficiaries and uninsured patients, up to certain caps, based on the cost of the care they provide. However, for every dollar of eligible care provided, public hospital systems are only reimbursed fifty-cents. Consequently, California's public hospital systems expend $5 billion in costs under the waiver but receive only approximately $2.5 billion in federal reimbursement funding. This leaves public hospital systems with the responsibility of finding funding to close the gap between cost of care and actual reimbursement. Faced with their own budget crises, counties have been forced to make significant cuts to public hospitals. As a result, more than two-thirds of public hospitals currently face budget deficits. Under these conditions, hospitals are unable to increase funding for any single service line (for example, specialty care) without making budgetary cuts in another.

Financing Challenges Continue to Expand

Currently there is limited outside private funding for specialty services. Kaiser Permanente and California HealthCare Foundation have funded efforts to improve demand management, increase efficiencies on the supply side and increase access to the supply of specialty services, but safety net organizations are still largely dependent on traditional government funding sources to pay for specialty services. Kaiser Permanente and California HealthCare Foundation's upcoming 2009 implementation grants will assist county coalitions throughout the state in testing new models of providing and financing specialty care in the safety net.

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[3] Capital Link, California Community Clinics, A Financial Profile, October 2008 DRAFT.

Many communities are very committed to finding ways to fund these new approaches. Each approach brings its own financing challenges outlined briefly below:

- The "hub" models, in which specialists work at one or more safety net primary care clinics to deliver specialty services, have been successful over several years at some sites. Advantages of this approach include the fact that the clinics work with existing licensing, infrastructure and patch together third party payments with limited patient fees. Clinics have been able to add services to their federal scope of practice in order to receive enhanced Medi-Cal and Medicare rates. Careful attention must be given to the emerging and new interpretation of the federal Bureau of Primary Health Care polices as well as state policies. Issues include the scope of practice of an FQHC, malpractice insurance coverage through the Federal Tort Claims Act (FTCA), the "four walls"[4] issues and increasing concerns that private specialists will want to bypass state fee-for-service arrangements in order to receive higher reimbursement by contracting with FQHC clinics. Financial risk can be high, as either one or multiple clinics takes on additional uncompensated care for the uninsured. These issues are more fully described later in this paper.

  Staffing considerations and their cost are also key issues in the provision of specialty care. Careful planning is essential. Clinics that host specialty providers (as in the "hub" models described above) report needing nursing resources to support specialty care programs at a ratio of 2-3 hours per every hour of specialty clinic, while specialists vary tremendously in the number of patients they can see per hour. Specialist culture is very different from primary care culture, and clinic staff must be prepared accordingly. New specialists require significant assistance from clinic medical directors, who, in turn, often need additional administrative help. Often clinics do not have complete control over specialists' scheduling, and in general supervising and managing them is both time-consuming and expensive. Credentialing and malpractice insurance issues are also critical and are described later in this paper.

- Volunteer specialist programs have also been successfully implemented in several California communities. However, it is highly unlikely that volunteer efforts will meet more than a small percentage of demand. While there is little new about using volunteer providers to address the critical challenges in accessing specialty care, improvements in accessing and organizing charity care have been effective in leveraging the impact of this strategy. A centralized

[4] The Department Health Care Services (DHCS) so-called "Four Walls" policy refers to a series of interpretations by federal Medicaid regulators of the circumstances under which FQHC/RHC providers may be reimbursed at the all-inclusive FQHC rate for services provided to patients at off-site locations. While neither CMS nor DHCS have ever formally adopted this policy, DHCS has imposed the criteria for services furnished outside the clinic when seeking to disallow reimbursement for FQHC services provided in the offices of providers operating fee-for-service practices.

referral center with an affiliated volunteer network has many advantages. Recruitment of a critical mass of community specialists who volunteer their time not only changes the community norms around donating care, but also reduces the burden on individual providers. However, these organized volunteer programs often have limited ways to generate patient based or third party income. Their full cost often must be covered by grant sources and donations to fund ongoing operations; as such, they require significant and continual fundraising work. FTCA coverage for volunteers at FQHCs is currently not permitted, so FQHCs must obtain gap medical malpractice insurance for these providers or require that they come to the health center with their own malpractice policy.

- Web-based referral systems (e-Referrals) use electronic technologies to enhance the referral process for patients from emergency departments and/or community health centers to specialists for the referring provider, the patient and the program administrator. The advantage of this approach is improved allocation of scarce resources and reduced inefficiencies, though the lack of financial metrics to describe them makes documentation of cost-savings very difficult. Cost considerations include software licensing, subscription and maintenance; hardware; vendor implementation support; support and training for the system administrator; and rules development and maintenance. The set-up and training period requires intensive commitment of staff resources. An additional obstacle is that some private specialist offices may be unequipped to handle referrals or connect electronically to the referral system. Currently there is no on-going funding to support the maintenance and staffing of e-Referral systems.

- A number of California clinics, historically those in rural communities with a growing cohort in urban areas, use telemedicine to address the gap in specialty care access for their patients, particularly in specialty areas such as radiology, pathology, optometry, and mental health. Although California has been a pioneer in telemedicine policy, enacting one of the first state telemedicine laws in 1996 (and expanding it in 2005), reimbursement policies lag behind current practice. Medi-Cal does reimburse for telemedicine services, but does not adequately compensate for ancillary services, including setting up the equipment, coordinating and scheduling the visit, and telecommunications. Volume is key to reducing the cost per visit, though this can be a challenge in more isolated rural areas with relatively fewer patient visits. In addition, Medi-Cal reimburses for “store-and-forward” (versus real-time) technology only in the areas of teledermatology, teleophthalmology, and teleoptometry, despite the fact that in the past few years this approach has been demonstrated to be useful in other specialties, including oral health, cardiology, and pathology. As a result of these funding realities, it can be difficult for telemedicine providers to develop an attractive business case. Telemedicine in the California safety net remains uncomfortably dependent on grant funding.

FQHC Policies and Other Regulations Impacting Specialty Care

Enhanced Medi-Cal reimbursement has been, and will continue to be, the critical linchpin to financing specialty care services at safety net clinics. Thus, an important piece of the puzzle in improving access to specialty care services has been the ability of FQHCs to expand their scope of practice to include these services. This route is beset by complex legal, financial and organizational issues, centered primarily on federal FQHC rules. Emerging discussions in federal policies for specialty care are on the horizon and are likely to have significant impact; as such, these changes are described in some detail below.

Early in 2009, the Bureau of Primary Health Care (BPHC) of the Healthcare Resources and Services Administration (HRSA), DHHS, released Policy Information Notice (PIN) 2009-02, "Specialty Services and Health Centers' Scope of Project," which describes the criteria that HRSA and BPHC will use to evaluate requests from health centers seeking to add specialty services to their scope of project.[5]

PIN 2009-02 seeks to respond to the difficulties that health centers have faced in expanding their federal scope of project to include services offered by specialists, and the confusion that has ensued in the absence of clear direction from HRSA. Important guidance is also found in PIN 2008-01, "Defining Scope of Project and Policy for Requesting Changes," which describes HRSA's policy for an approved scope of project for section 330-funded health centers and the process for health centers seeking prior approval to make changes in the approved scope of project.[6] HRSA is considering another new PIN to delineate federal policies for health centers participating in telemedicine and telehealth programs, and does not consider these to be specialty services in their own right.

PIN 2009-02 offers the following general guidance:

- Adding a service not included in Form 5 – Part A of a health center's grant application – which defines "Services Provided" – is considered a *significant change* in scope of project and requires prior approval.
- If a health center has been providing a service via an informal referral arrangement and wants to provide the service directly or by formal agreement, this, also, constitutes a *significant* change.
- Once a service has been included in the Federal scope of project, it must be available to all clients on a sliding fee scale.
- No new requirements apply to primary care physicians operating within their normal scope of practice.

Specifically, the specialty PIN states that applications to expand the scope of project will be assessed according to whether the proposed new services (1) are necessary for the

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[5] Available at http://bphc.hrsa.gov/policy/pin0902/default.htm (visited January 14, 2009).

[6] Available at http://bphc.hrsa.gov/policy/pin0801/ (visited January 8, 2009).

adequate support of primary care and (2) meet the needs of the target population. Applications for expanded scope of project must carefully document compliance with these requirements, demonstrating the target population's need for the service "both in narrative format and with data."

The PIN offers several examples of specialty services that support primary care for a particular population and that "function as a logical extension to the required primary care services already provided by the health center and/or … complement the required primary health care services." These include: pulmonologist consultations and examinations, where the health center has a substantial population of patients with asthma or tuberculosis; cardiology screenings and diagnoses, where the health center serves a substantial number of patients at risk for heart disease or high blood pressure; and minor outpatient services or examinations performed by a podiatrist, where the health center serves a population with a high prevalence of diabetes. The PIN also cites specialty psychiatric and periodontic services, colonoscopies, and oncological care as other services potentially necessary for the support of primary care, depending on the clinic's patient population and their needs. Although the PIN acknowledges that the list of examples is not exhaustive, the focus is clearly on screening and diagnosis and not on treatment. In response to a question about treatment services posed during a conference call regarding the PIN on January 14, 2009, HRSA staff said that treatment services are potentially allowable, depending on other factors described in the PIN, including a lack of other accessible providers.

On the subject of funding, the specialty PIN emphasizes that the health center applying for an expanded scope of project must demonstrate that adding the new service will not jeopardize the health center's overall financial stability, and that it is "equipped in terms of technology, finances, and personnel" to provide the additional services *and* all required primary health services.

With regard to location, the specialty PIN states that any new service must be provided at either (1) at an approved site within the Federal scope of practice, (2) "a new site that will be proximate to available FQHC services," or (3) a location "where in-scope services are provided but that does not meet the definition of a service site." In this third case, the health center is required to document the procedures for referral and for follow-up care as part of its application. In all cases, health centers are required to document the availability of translation and transportation services.

PIN 2009-02 emphasizes that any specialty service included in the approved scope of project must be available equally to all patients regardless of ability to pay and made accessible to all through a sliding fee scale.

> Specifically, the discounted fee schedule must provide a full discount to individuals and families with annual incomes at or below the poverty guidelines (only nominal fees that do not impede access to care may be charged) and for those with incomes between 100 percent and 200 percent of poverty, fees must be charged in accordance with a sliding discount policy based on family size and

> income. No discounts may be provided to patients with incomes over 200 percent of the Federal poverty level.

In keeping with HRSA's focus on services and not on providers, the PIN does not include a list of professionals considered primary health care clinicians versus specialists. It does, however, require that the health center demonstrate that all providers associated with new specialty services are licensed by the state, and properly credentialed and privileged by the health center. The PIN does not dictate particular staffing structures, but cautions:

> Health centers are encouraged to carefully consider the benefits and risks associated with various staffing arrangements because each impacts health center costs and operations differently. When evaluating change in Federal scope requests, HRSA will examine the proposed staffing arrangement as part of a review of the impact of the proposed change on the total organization (e.g., whether the arrangement necessitates an affiliation agreement).

Finally, the specialty PIN emphasizes that any new service must be described in the health center's next funding application in order to ensure continuity of FTCA coverage, but warns that "inclusion of a service within the Federal scope of practice is, in and of itself, not enough to guarantee FTCA coverage." In particular, the PIN cautions that "the definition of 'provider'" under the Federal scope of project may not be consistent with the definition of provider under the relevant statutory FTCA provisions. It offers the examples of volunteer providers, physicians contracted under a professional corporation or employed by other corporations, and interns/residents/medical students not employed by the health center, who "may be included as part of the Federal scope of project, but are not covered under the FTCA." The PIN refers health centers to PAL 2008-05, "New Requirements for Deeming under the Federally Supported Health Centers Assistance Act for Calendar Year 2009."

One of BPHC's concerns in the expansion of specialty care in FQHCs is the potential for increased liability relating to the FTCA's coverage for specialist services which has historically provided coverage to "employees" of the health center, including board members, officers, and employees. Contractors are covered only if the individual (1) normally performs on average at least 32 1/2 hours of service per week; or (2) in the case of an individual who normally works less than 32 1/2 hours per week, is a licensed provider in the fields of family practice, general internal medicine, general pediatrics, or obstetrics and gynecology.

Thus, any health center contracting with specialist providers would need to obtain malpractice insurance policies, including tail coverage as applicable, for all specialist physicians delivering services as independent contractors, less than an average of 32 1/2 hours per week. Such policies should cover the health center, its staff, and the specialist physician.

State regulations on clinics' provision of specialty services are less complex and restrictive than Federal policies. While California law defines "primary care clinics" as

distinct from “specialty clinics,” licensure as a “primary care clinic” does not prohibit health centers from providing physician specialist services. Primary care clinics in California can directly provide medical, surgical, dental, optometric, or podiatric advice, services, or treatment to patients, though provision of certain services, for example ambulatory surgery, requires clinics to meet additional licensing and building code standards.

Finally, clinics contracting with each other and with specialist physicians need to ensure compliance with antitrust regulations, Bureau of Primary Health Care Affiliation Policies, the federal Stark Law, state and federal anti-kickback statutes, IRS Excess Benefits rules, and other legal requirements.

Collaboration - Key to Future Improvements

Key to future specialty care improvements and policy changes that support expanded specialty services in California’s safety net clinics is collaboration between non-profit community clinics and health centers and the public hospital health systems. Both groups are uniquely positioned to help California’s low-income residents achieve improved health status while reducing the cost of health care services and need each other to accomplish that.

Collaboration in the policy arena may be critical to sustaining improvements in access to specialty care. Efforts will be needed to secure clear guidance on funding for telemedicine and telehealth services, enhanced support for e-Referral systems if they can be demonstrated to improve the efficiency and effectiveness of care, improved Medi-Cal rates, and the clarification, understanding and compliance with emerging federal policies for FQHC funding.

Already stretched to the limit and beyond, California’s safety net providers require additional resources and protections to meet their current role and to grow effectively to meet the demand for future expansions in necessary care for vulnerable patients. The financial dilemmas outlined in this paper are intended to spur system collaboration so that the state’s safety net providers are able to continue to play a pivotal role in delivering quality health care to all Californians.

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