

## Health Care Services Master Plan Task Force

### Impact of Federal Health Care Reform + 1115 Waiver on Patient Demand and Facility Capacity

*Consistent with the HCSMP Task Force role, this briefing paper does not provide a comprehensive review of Health Reform and California's 1115 Waiver, but rather focuses on how the projected impact of these policies may affect access to care for San Francisco's low-income and vulnerable populations.*

#### OVERVIEW OF HEALTH REFORM

On March 23, 2010, President Obama signed H.R. 3590, the Patient Protection and Affordable Care Act, and H.R. 4872, the Health Care and Education Reconciliation Act of 2010. These bills make historic changes to the US health care system and are referred to collectively here as "Health Reform." Health Reform requires most US citizens and legal residents to have health insurance. To help individuals meet that requirement, Health Reform expands eligibility for Medicaid, creates new online health insurance marketplaces called Health Benefit Exchanges, and creates new requirements for private health insurance providers to make health insurance more accessible and affordable. Health Reform also makes investments in public health, including prevention and wellness programs, and the healthcare workforce. The most significant provisions of Health Reform – those that extend health insurance coverage to the currently uninsured – become effective on January 1, 2014.

On November 2, 2010, the federal Center for Medicare and Medicaid Services (CMS) approved California's current 1115 Medicaid waiver. Viewed as "A Bridge to Reform," the waiver makes available approximately \$10 billion in federal funds over the five-year period from November 1, 2010 through October 31, 2015 to:

- Provide health care coverage for low-income individuals who will become eligible for Medi-Cal (California's Medicaid program) or subsidies under the California Health Benefit Exchange when those provisions of Health Reform are implemented in 2014;
- Provide for the mandatory transition of some seniors and persons with disabilities from fee-for-service to managed care Medi-Cal;
- Provide funding for California's public hospital safety net;
- Fund uncompensated care costs; and
- Provide for other program enhancements.

### **64,000 – 117,000**

#### **Current Number of Uninsured Nonelderly San Franciscans (Ages 0-64)**

The San Francisco Department of Public Health (SFDPH) relies on the California Health Interview Survey (CHIS) to estimate its number of uninsured residents.<sup>i</sup> CHIS' most recent survey, from 2009, indicates that 9% of nonelderly San Franciscans (ages 0-64) were uninsured at the time of the survey and 16.4% of nonelderly San Franciscans were uninsured for all or part of 2009.<sup>ii</sup> This translates to 64,000 and 117,000 nonelderly uninsured San Franciscans, respectively. While measuring the number of persons uninsured for all or part of a given year may overestimate the size of San Francisco's uninsured population, this figure provides a useful upper bound of need when considering San Francisco's capacity to meet increased health care demand following the implementation of Health Reform. Therefore, this briefing paper will rely on the "uninsured for all or part of the year" estimate in its analysis.

## KEY LEGISLATIVE COMPONENTS OF HEALTH REFORM

### Individual Mandate

Beginning January 1, 2014, most US citizens and legal residents will be required to have baseline health insurance.<sup>iii</sup> To help people meet this requirement, Health Reform enacted a series of policies to expand access to health insurance. These include expanding eligibility for Medicaid, creating subsidies for low-income individuals purchasing health insurance on the private market, and enacting health insurance reforms to ensure increased or continued access to private and employer-sponsored health insurance.

#### Is the individual mandate constitutional?

The fate of the individual mandate is unclear. In August, the 11<sup>th</sup> Circuit Court of Appeals deemed the individual mandate unconstitutional; however, the 9<sup>th</sup> Circuit Court upheld the law. More recently, the 4<sup>th</sup> Circuit Court of Appeals dismissed cases brought by the State of Virginia and Liberty University. The mandate's constitutionality remains in question and is expected to come before the US Supreme Court in Federal Fiscal Year 11/12.

### Health Benefit Exchanges

#### Health Insurance Marketplace for US Citizens and Legal Immigrants

Health Reform requires states to create health benefit exchanges through which individuals or small businesses may purchase health insurance. Citizens and legal immigrants and employers with up to 100 employees may purchase coverage through an exchange. All plans offered in the exchanges will be required to offer benefits that meet a minimum set of standards. Insurers will offer four levels of coverage that vary by premiums, out-of-pocket costs, and benefits beyond the minimum requirements plus a catastrophic coverage plan. California's health benefit exchange is likely to be the largest exchange operated by a single state, with as many as 8.3 million residents expected to be eligible for coverage. The exchange also will provide resources to connect low-income Californians to federal subsidies for health coverage or government programs such as Medicaid.

#### Subsidies for Low Income Individuals and Families

Premium credits will be provided to individuals and families with incomes between 133 percent and 400 percent of FPL to help them purchase insurance through exchanges. These subsidies will be offered on a sliding scale basis and will limit the cost of the insurance premiums to between 2 percent of income for people with incomes up to 133 percent of FPL and 9 percent of income for people with incomes between 300 and 400 percent of FPL. Cost-sharing subsidies will also be available to people with incomes between 133 and 400 percent of FPL to limit out-of-pocket spending.

#### Contracts Required with Safety Net Providers

Full participation by safety net providers will be required for health plans operating in the health benefit exchanges. Safety net providers are defined in the new law as those eligible to participate in the 340B drug discount program.

## Medicaid Expansion

Medicaid currently covers 40 million Americans, 7 million of those Californians. The federal Medicaid eligibility expansion is expected to increase enrollment by 16 million nationwide and by approximately 1.8 million in California (about 1.4 million newly eligible persons + approximately 412,000 who are eligible now but not enrolled). Once the expansion becomes effective, Medi-Cal is expected to cover nearly one-quarter of the state population.

**30,000**

Estimated number of **new Medi-Cal beneficiaries in San Francisco** following Health Reform implementation. This estimate is based on San Francisco's current General Assistance, food stamp, and Healthy Families recipients compared against new Medi-Cal eligibility criteria.

*Source: San Francisco Human Services Agency*

### Expansion of Medicaid to Those with Incomes up to 133% FPL

Beginning January 1, 2014, Health Reform will expand Medicaid to all individuals under age 65 (including children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL (currently, approximately \$14,480 for an individual and \$24,640 for a family of three). Under the current law, FPL limits for Medicaid eligibility vary by state, and adults under age 65

without dependent children are not currently eligible for the program.

### Changes to Income and Asset Determination

Health Reform implements a new methodology for calculating income called Modified Adjusted Gross Income (MAGI), which is intended to be a single standard used by Medicaid, the State Children's Health Insurance Program (SCHIP), and the health benefit exchanges. Beginning in 2014, the asset test will be eliminated, and a single, streamlined application form for Medicaid, SCHIP, and subsidies through the exchange must also be in place.

### Medicaid Coverage up to Age 26 for Former Foster Children in Foster Care at Age 18

As of January 1, 2014, children aging out of foster care will be eligible for Medicaid coverage up to age 26. Though there are not yet specifics on the implementation of this provision, this would presumably apply to former foster children with incomes higher than 133% FPL, as those with incomes below that level would otherwise already be eligible for Medicaid under the expansion.

## Basic Health Plan

Health Reform provides states the option to create a Basic Health Plan for uninsured individuals with incomes between 134 and 200 percent of FPL who would otherwise be eligible to receive premium subsidies in the exchange. States opting to provide this coverage must ensure that the Basic Health Plan provides at least the essential health benefits and that the plan is less costly to individuals than insurance accessed through the exchange. Individuals with incomes between 134 and 200 percent of FPL in states creating Basic Health Plans will not be eligible for subsidies in the Exchanges.

Legislation has been introduced in California (SB 703) to create a Basic Health Plan, though it has not yet passed the Legislature. Supporters of the bill believe that the Basic Health Plan will lower costs for

consumers, create savings for the state, and provide better reimbursement for providers. Opponents, however, believe that moving the Basic Health Plan population out of the exchange would weaken the legitimacy of the exchange, negatively affect the exchange's risk pool, and add an additional layer of complexity to the state's health care system.

### **What should the California Health Benefit Exchange look like?**

On September 30, 2010, California became the first state to pass legislation creating a health insurance exchange. Since that time, California has convened a five-member governing body that, as of April 2011, began meeting monthly to design the exchange and plan for its implementation.<sup>iv</sup> Among the state's challenges is the decision of how to model the California Health Benefit Exchange (CHBE). Should California establish a Basic Health Plan? Should the state create a "public-partner" exchange of which Medi-Cal would be part? These questions are especially important for low-income individuals, many of whom are likely to alternate – because of income fluctuations – between Medi-Cal and the CHBE after Health Reform implementation, begging the question of how their continuity of care could be affected. For example, a recent national study suggests that half of all adults with household incomes below 200% FPL "will experience a shift in eligibility from Medicaid to an insurance exchange, or the reverse, within a year."<sup>v</sup> Once decided, the design of the CHBE may pose special health care access issues to individuals, providers, and policymakers.

### **Private Insurance Reforms**

Health Reform requires the following private insurance reforms, many of which have already been enacted:

- High-risk insurance pools for persons with pre-existing conditions
- Dependent coverage up to age 26
- Elimination of cost-sharing for prevention
- No limits on essential benefits for group health plans
- Re-insurance program for retirees under age 65 (ends 2014)
- Elimination of certain coverage restrictions:
  - Guarantee issue (requirement that health plans may not deny coverage based on age, sex, and/or health status),
  - Ban on lifetime coverage limits,
  - Prohibition on policy rescissions, and
  - Elimination of pre-existing condition coverage restrictions

### **Employer Requirements**

#### Employer Penalties When Employees Access Benefit Exchange Premium Credits

There is no mandate that employers offer health insurance. However, beginning in 2014, employers with more than 50 employees that have at least one employee who accesses a premium credit – credits

that allow persons with incomes between 133 – 400% of the Federal Poverty Level (FPL) to purchase insurance through a health benefit exchange – will be required to pay a fee. Those employers that do not offer coverage will be assessed a fee of \$2,000 per full-time employee. Those that do offer coverage will pay the lesser of the following: \$3,000 for each employee receiving the premium credit or \$2,000 for each full-time employee, excluding the first 30 employees from the assessment.

## KEY COMPONENTS OF CALIFORNIA'S 1115 WAIVER<sup>vi</sup>

Effective November 2010, California's 1115 Waiver adds another dimension to San Francisco's implementation of Health Reform. California's current 1115 Waiver provides funding to the safety-net hospitals, implements Medicaid reforms, and creates the Health Care Coverage Initiative (HCCI). Deemed a "Bridge to Reform," the primary aims of the current 1115 Waiver include:

- Expanding coverage to more uninsured adults,
- Preserving the county-based safety net,
- Improving care coordination for vulnerable populations, and
- Promoting public hospital delivery system transformation.

Significant funding under the waiver is not guaranteed, and portions of the funding are at-risk if certain milestones are not achieved. Please see below for more information on the 1115 Waiver's key elements related to the charge of the HCSMP Task Force.

### Medi-Cal Managed Care for Seniors and Persons with Disabilities

Seniors and persons with disabilities (SPD) constitute a small share of the Medi-Cal population – 16,000 to 20,000 in San Francisco – but a large portion of Medi-Cal spending. Previously part of the fee-for-service system, the current 1115 Waiver requires the enrollment of SPDs into managed care to achieve better care coordination and management of chronic conditions. Managed care enrollment for San Francisco's SPDs began in June 2010 and will continue through June 2011 and is mandatory for all Medi-Cal eligible SPDs with the exception of individuals who are dually eligible for both Medi-Cal and Medicare.

#### **What is an 1115 Waiver?**

A Section 1115 Waiver gives a state the authority to waive many federal requirements that typically apply when a state accepts federal funding for Medicaid, or "Medi-Cal" in California. 1115 Waiver funding must be "budget neutral," meaning that the waiver cannot cost the federal government more than what it would have spent without the waiver. California's current waiver is effective November 1, 2010 – October 31, 2015.

Low-Income Health Program

**15,000**

Anticipated number of SF PATH enrollees.

The 1115 Waiver creates the Low-Income Health Program (LIHP), which allows counties to expand access to care and coverage to low-income persons who will become eligible for Medi-Cal or subsidies in the California Health Benefit Exchange in 2014 under Health Reform. SF PATH, San Francisco’s LIHP:

- Serves new enrollees with incomes between 0 – 25% FPL; SF PATH also serves certain former Healthy San Francisco enrollees with incomes up to 200% FPL.
- Outlines a range of benefits and provides all enrollees with a medical home within the SFDPH network of care.
- Imposes managed care provider network requirements and clinical access standards.
- Increases County costs (both service and administrative costs) above and beyond costs currently incurred by the county to provide services to these populations.

**LIHP and San Francisco’s HIV/AIDS Population**

The federal Health Resources and Services Administration (HRSA) determined that HIV+ persons receiving care supported by the Ryan White CARE Act – but who are eligible for LIHP – must be enrolled in LIHP, as Ryan White CARE funds are designated the “payer of last resort.” As a result, LIHP programs such as SF PATH must assume financial responsibility for the health care of HIV+ LIHP-eligible persons who formerly received care through Ryan White – a mandate not originally envisioned as part of LIHP’s design and budget. In an effort to respond to HRSA’s mandate while containing program costs, SF PATH has had to set the income eligibility limit for new enrollees at 25% FPL.

**IMPACT OF HEALTH REFORM ON SAN FRANCISCO’S UNINSURED**

**Eligibility for Medi-Cal and Subsidies on the Exchange**

CHIS estimates that, after Health Reform implementation, just over two-thirds of the uninsured will qualify for Medi-Cal or subsidized health care coverage under the exchange.<sup>vii</sup> Applying, as CHIS does, this percentage to the number of San Franciscans who were uninsured at any time in the year prior to the 2009 survey, an estimated 76,600 San Franciscans will be eligible for health insurance through Medi-Cal or through subsidized coverage on the exchange. It is important to note, however, that these data represent only the potential impact of Health Reform on San Francisco. These figures represent eligibility, which does not necessarily equate to

**Potential Impact of Health Reform on Currently Uninsured San Franciscans between the Ages of 0 and 64**

CHIS estimates suggest that Health Reform will impact the estimated 117,000 uninsured nonelderly San Franciscans as follows:

- 49,800 (42.6%) will be eligible for Medi-Cal.
- 28,800 (24.6%) will be eligible for subsidized coverage on the California Health Benefit Exchange (CHBE).
- 19,900 (17%) will be eligible for *unsubsidized* coverage on the CHBE.
- 18,600 (15.9%) will be ineligible for the expansions due to their citizenship status.

enrollment. This can be seen even in the current health care system where, as an example, 65 percent of uninsured children are estimated to be eligible for Medicaid or the State Children’s Health Insurance Program.<sup>viii</sup> As a result, though CHS estimates that approximately 18,600 nonelderly San Franciscans will be ineligible for the health insurance options created under Health Reform, it is expected that far more San Franciscans will remain uninsured.

### The Remaining Uninsured

Early estimates suggest that approximately 64,400 San Franciscans (comprising not only the 18,600

**64,400**

The Congressional Budget Office estimates that 92% of US residents will be insured by 2016. Extending this estimate to San Francisco, 8% (**64,400**)\* of **all San Franciscans (regardless of age) would remain uninsured as of 2016.**

*\* Percentage estimate applied to San Francisco population data from the 2010 US Census.*

nonelderly described above, but all children, adults, and elderly) will remain uninsured after Health Reform’s implementation in 2014. A report by the Urban Institute finds that Individuals will remain uninsured after Health Reform for a variety of reasons (e.g., failure to enroll in Medicaid, immigration status, affordability, religious objections) and that the composition of those who remain uninsured will vary by state.<sup>ix</sup> Eighty-two percent of those who will remain uninsured in California after Health Reform will be nonelderly adults. Among California’s uninsured non-elderly adults:

- 31.3% will be eligible for Medi-Cal, but not enrolled. These are mostly singles without dependents and relatively young.
- 34.3% will be undocumented immigrants and therefore not subject to the individual mandate or eligible for Medicaid or health insurance purchased through the exchange.
- 15.1% will be exempt from the individual mandate because they would not have an affordable insurance option. These persons would generally be older with relatively low incomes.
- 6.3% will be eligible for affordable subsidized coverage in the exchange. These would be mostly younger singles without dependents.
- 12.9% will have an affordable private insurance option, despite not qualifying for a subsidy, and will not enroll for other reasons. These have relatively high incomes and are mostly in families with dependents.

### POSSIBLE IMPLICATIONS FOR SAN FRANCISCO: PATIENT DEMAND VS. FACILITY CAPACITY

#### Many of San Francisco’s Uninsured Already Access Care through a Medical Home

San Francisco is likely better positioned than many other places to advance Health Reform because of the Healthy San Francisco (HSF) program, San Francisco’s comprehensive health care program accessed through a primary care medical home.

Health Reform and California’s 1115 Waiver collectively emphasize the importance of primary medical care access. Both support the Patient-Centered Medical Home (“Medical Home”) model, which is founded on the idea that a high-functioning primary care system can improve health care quality – and the patient experience – while lowering costs. The Medical Home model:

- Is *patient-centered*, meaning that care is relationship-based and that the patient and his/her family are seen as partners in care.
- Offers *comprehensive care* from a team of providers such as physicians, nurse practitioners, pharmacists, and more.
- Emphasizes *care coordination*, driven by the primary care provider, across the continuum of care.
- Facilitates *access to care* while responding to each patient’s preferences and needs.
- Is *committed to quality and safety*, relying on evidence-based practices and regularly evaluating performance.

The ongoing patient-provider relationship is key to the Medical Home model, allowing each patient’s designated primary care provider to take a more comprehensive, holistic approach to patient care.

Health Reform – through state 1115 Medicaid Waivers and other initiatives – has promoted the Medical Home by establishing programs intended to implement and test the model. Through California’s 1115 Waiver, for example, all Medi-Cal eligible SPDs must be connected to a Medical Home to ensure better care coordination. The same is true for members of the LIHP established by the 1115 Waiver. Given this emphasis on the primary care-driven Medical Home, the primary care lens serves as a starting point for examining possible gaps in San Francisco’s provider supply in the face of Health Reform.

Similarly, HSF has:

- Created a single, streamlined electronic eligibility determination and enrollment system for multiple health programs, which will be useful in directing eligible persons to Medi-Cal or the California Health Benefit Exchange, as appropriate;
- Expanded the network of providers (including private) serving the uninsured,
- Promoted the use of primary care medical homes to ensure continuity of care, and
- Collected data identifying an unduplicated count of uninsured adults that are potentially eligible for Medi-Cal or the California Health Benefit Exchange.

A continued supply of insured persons may translate to a growing need for clinicians in San Francisco, particularly primary care providers. Furthermore, San Francisco’s growing Medi-Cal population may face barriers to care due to existing burdens that discourage some providers from program participation.

**Nearly Half of San Francisco’s Nonelderly Uninsured Being Served by Existing Capacity**

Many of San Francisco’s uninsured adults are already being served by San Francisco’s safety net through HSF. Thus, their care is being provided within current system capacity. Additional capacity will be needed for the “net new” population – those that are not yet being cared for by San Francisco’s providers (safety net and non-safety net).

<p><b>Anticipated Impacts of Health Reform and 1115 Waiver on Healthy San Francisco</b></p> <p>As of July 1, 2011, Healthy San Francisco (HSF) had 54,350 participants. HSF has estimated that, if all participants were still enrolled in the program in 2014, 60% (32,600) would disenroll from HSF and enroll in health insurance options created by Health Reform. This transition has already begun, with more than 10,000 HSF participants transitioning to SF Path on July 1, 2011. These SF Path participants will be eligible for Medi-Cal or subsidized insurance through the exchange beginning in 2014.</p>
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Recent enrollment figures indicate that of the 117,000 nonelderly San Franciscans (0-64) who were uninsured at any time in the past year, approximately 55,000 nonelderly adults (18-64) are currently receiving services through HSF or SF Path. It is important to note that 55,000 represents a point in time (current) number of uninsured who are enrolled in these programs, while the 117,000 estimate for the uninsured includes not only those uninsured at a point in time (time of survey), but also anyone who was uninsured at any time in the prior year. However, it would be safe to say that the current HSF and SF Path enrollment suggests that capacity already exists to care for at least 55,000 enrollees. This leaves up to 62,000 uninsured who may be accessing as-needed services, but do not have a regular source of care provided within existing capacity.

### San Francisco Currently Exceeds Benchmarks of Primary Care Supply Despite National and State Shortage Projections

The recently released [County Health Rankings](#), a project resulting from a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, indicates that San Francisco exceeds the national primary care benchmark relative to the size of its population.<sup>x</sup> Specifically, San Francisco’s population to primary

#### Ratio of Population to Primary Care Physicians

Source: 2009 Health Resources Administration Area (HRSA) Resource File

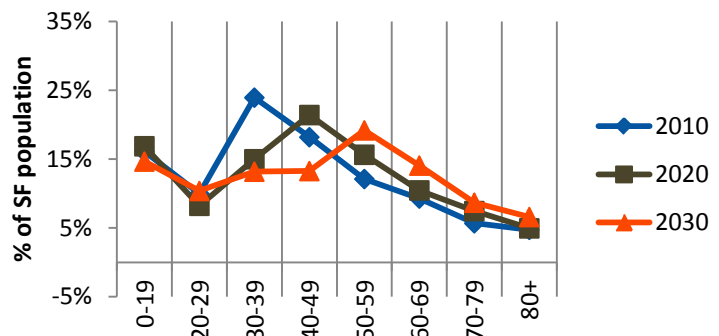
San Francisco County	National Benchmark*	California
401:1	631:1	847:1

\* 90<sup>th</sup> percentile

care physician ratio out performs the national benchmark, 631:1, suggesting that the city is well positioned to meet existing patient demands – and, potentially, increased patient demand under Health Reform.

Please note that the HRSA data source used to calculate San Francisco’s population to primary care physician ratio defines “primary care physicians” as “practicing physicians specializing in general practice medicine, family medicine, internal medicine, pediatrics, and obstetrics/gynecology.” Not included in this definition are nurse practitioners (NP) and physician assistants (PA), which constitute approximately 25% of the primary care workforce nationwide.<sup>xi</sup> (Though the PA/NP primary care workforce is difficult to quantify, research indicates that reliance on these professions for primary care services is growing in California – particularly among PAs.

**Projected Age of San Franciscans**  
Source: California Department of Finance, July 2007



By 2030, nearly half of San Francisco’s population could be over 50 compared to 29% statewide.

For example, a recent study found that approximately 22% of Federally Qualified Health Centers (FQHC) and “FQHC look-alike clinics” rely on NPs and PAs as their main providers of primary care services.)<sup>xii</sup>

While the current state of San Francisco’s provider supply seems bright, several sources predict a growing shortage of primary care providers nationally and at the state level. For example, the Association of American Medical Colleges estimated that the US could face a shortage of 21,000 primary care physicians by 2015.<sup>xiii</sup> In addition, state data indicate that many of California’s physicians are nearing retirement. According to the California Health Care Foundation’s California Healthcare Almanac,<sup>xiv</sup> nearly 30% of physicians are over 60 years old and nearing retirement, higher than any other state. This projection, coupled with San Francisco’s growing, aging population<sup>xv</sup> could create issues for San Francisco’s provider supply in the face of Health Reform. By 2030, for example, nearly half of San Francisco’s population will be age 50 or older. In addition, not all providers accept new patients – especially those on Medi-Cal.

### **Despite High Number of Primary Care Physicians, San Francisco May Lack Sufficient Primary Care Providers to Serve Expanded Medi-Cal Population in Timely Manner**

#### Expanded Medi-Cal Population Likely to Have Difficulty Finding Primary Care Provider

Health Reform is expected to expand San Francisco’s Medi-Cal population by an estimated 30,000 individuals. Research suggests, however, that Medi-Cal’s expansion may outpace any corresponding increase in the number of providers who serve Medi-Cal recipients. For example, a recent study indicated that:<sup>xvi</sup>

- California physicians are less likely to serve Medi-Cal patients (68%) compared to patients with private insurance (92%) or Medicare (78%). This trend follows among primary care providers.
- Ninety percent (90%) of survey respondents – all California physicians – were accepting new patients when the survey was administered; however, only 57% reported accepting new Medi-Cal patients.
- Twenty-five percent (25%) of physicians provide care to 80% of Medi-Cal patients.

Most physicians cite low reimbursement rates as the driver of their reluctance to enroll Medi-Cal patients. Through Health Reform, the federal government hopes to ameliorate such concerns by increasing Medi-Cal primary care physician reimbursement rates to match those provided through Medicare – but only for two years (2013 and 2014). While an important first step in shortening the Medi-Cal provider gap, whether this reimbursement increase is sufficient to attract new Medi-Cal providers to San Francisco in a timely manner has yet to be seen.

#### San Francisco Risks Financial Loss if Timely Access Standards Not Met

The issue of increased patient demand vs. a relatively fixed provider workforce poses unique challenges in California given timely access standards imposed by the state’s current 1115 Waiver and the California Department of Managed Health Care (DMHC).<sup>xvii</sup> Specifically:

- Under SF PATH, SFDPH’s network of care must be compliant with federally mandated timely access standards for primary, urgent, and specialty care and sets financial penalties for non-compliance.

- The 1115 Waiver expands San Francisco’s Medi-Cal managed care population for SPDs, subjecting more providers to DMHC timely access standards that impact a range of services. In addition, new Medi-Cal eligibles will also be subject to this standard.

To complicate matters, DMHC and Federal 1115 timely access standards do not always agree, as indicated in the table below.

**Timely Access Standards: State DMHC + Federal 1115 Waiver**

Clinical Service	DMHC Standard*	Federal 1115 Standard^
Urgent Care: No Authorization	48 Hours	48 Hours
Urgent Care: Prior Authorization	96 Hours	96 Hours
Primary Care (Non-Urgent)	10 Business Days	30 Business Days (through 6/30/12); then 20 days (7/1/12 – 12/31/13)
Specialty Care	15 Business Days	30 Business Days
Mental Health	10 Business Days	No Access Standards
Ancillary	15 Business Days	No Access Standards
Nurse Advice	Provision of 24/7 Phone Triage or Screening Services	Services Made Available 25/7 When Medically Necessary

\* Impacts Medi-Cal, Healthy Families, Healthy Kids, Healthy Workers, and Private Insurance

^ Standards for LIHP enrollees

While the issue of provider supply is primarily one of meeting the health care needs of all San Franciscans, timely access standards illustrate the potential financial burden posed to providers and the state if San Francisco’s provider supply is insufficient to meet patient demand.

Federal Response to Provider Gap

In response to the nation’s projected primary care provider shortage, the federal government has taken steps to build the primary care workforce in advance of Health Reform.<sup>xviii</sup> For example, the federal Prevention and Public Health Fund will create additional primary care residency slots, support primary care training for nurse practitioners and physician assistants, and more. In addition, Health Reform will expand the National Health Service Corps to pay the educational loans of primary care providers who practice in underserved areas. While a positive investment in the nation’s health, it is unclear to what extent such efforts will realize growth in the primary care workforce – and in what timeframe. The

**San Francisco’s Health Professional Shortage Areas**

Health Professional Shortage Areas (HPSAs) are designated by HRSA because they have shortages of primary medical care, dental providers, and/or mental health providers. HPSAs may be geographic, demographic, or institutional (e.g., FQHCs). San Francisco has 13 institutional HPSAs:

- Friendship House
- Mission Area Health
- Mission Neighborhood Health Center (2)
- Northeast Medical Services (3)
- SF Community Clinic Consortium (3)
- South of Market Health Center (3)

HPSA designation allows clinics to qualify for National Health Service Corps personnel as well as the ability to hire physicians with J-1 visas (non-immigrant exchange visas). Primary care and mental health HPSAs also qualify for Medicare incentive payments.

impact of such programs in San Francisco is also unclear.

### State Response to Provider Gap

In response to Health Reform and projected workforce shortages, California has taken steps to assess the state's current and projected healthcare workforce needs and to develop strategies to address those needs. For example:

- The [California Workforce Investment Board](#) (CWIB), in partnership with the [Office of Statewide Health Planning and Development](#) (OSHPD), received \$150,000 from HRSA to support the development of coherent and comprehensive health workforce development plan for California.
- With support from the HRSA Health Care Workforce Planning Grant, CWIB established the [Health Workforce Development Council \(HWDC\)](#) in August 2010. Comprised of wide-reaching representation, the HWDC seeks to expand the state's health workforce to ensure access to quality healthcare for all Californians. In tune with Health Reform's focus on primary care, HWDC also hopes to expand California's full-time primary care workforce by 10 – 25% over the next 10 years.
- The state has engaged in data collection to determine the direction health care workforce development efforts should take. For example, CWIB and OSHPD commissioned regional focus groups to assess the state's health care workforce development needs. Through this effort, focus group respondents identified certain categories of primary care and other health workers that will be needed immediately to respond to increased patient demand created by Health Reform: Alternative Medicine Practitioners, Behavioral/Mental Health Specialists, Clinical Laboratory Scientists, Community Health Workers, Family Nurse Practitioners, Geriatric Nurse Practitioners, Nurse Practitioners, Physician Assistants, and Registered Nurses.<sup>xix</sup> Respondents also projected needs for other health care workers within the next two years and within the next three to five years.

Through these and other efforts, California plans to identify and create statewide and regional partnerships and priorities to shorten its provider gap and meet current and future demands on the health care delivery system.

### The Health Care Future of San Francisco's Medically Underserved and Uninsured

San Francisco's primary care provider supply may not solely be a question of whether the city contains enough providers generally; rather, it could be a question of whether the city's primary care provider population contains enough clinicians willing and able to serve a diverse patient base regardless of ability to pay. For example, HRSA designates at least portions of the following San Francisco neighborhoods as Medically Underserved Areas (MUA):<sup>xx</sup>

- Bayview
- Chinatown
- Downtown/Civic Center
- Excelsior
- Financial District
- Golden Gate Park
- Lakeshore
- Mission
- Mission Bay
- Nob Hill
- North Beach
- Parkside
- Potrero Hill
- Russian Hill

- South of Market
- Sunset
- Treasure Island/Yerba Buena Island
- Visitacion Valley
- West of Twin Peak

Determined by calculating and weighting four variables – ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the poverty level, and percentage of the population age 65 and over – MUA designation suggests that residents of certain areas face barriers to care. While Health Reform will likely increase access to care among at least some MUA residents, the extent to which this is true is unclear, suggesting the importance of sustaining – and potentially increasing – San Francisco’s safety net provider pool.

Estimates also suggest that more than 64,000 San Franciscans will remain uninsured after Health Reform implementation. Though smaller than the City’s current uninsured population, those who remain uninsured will continue to rely on San Francisco’s safety net comprising public and private non-profit organizations that disproportionately provide health care services to low-income, uninsured, vulnerable populations. The reduction of San Francisco’s uninsured population does not pose immediate challenges regarding primary care demand; however, to ensure the provision of health care services for all, San Francisco must remain diligent in maintaining the Healthy San Francisco provider network and partnering with non-profit hospitals to ensure the provision of charity care.

**Specialty Care Access Likely to Remain an Issue for Uninsured and Those on Medi-Cal**

The Medical Home model emphasizes the importance of access to care and coordination of care across the health care continuum – including specialty care. Despite the fact that the Greater Bay Area exceeds national standards for number of specialists per population<sup>xxi, xxii</sup> -- and despite timely access standards

**Active Specialists per 100,000 Population**  
 Source: California HealthCare Foundation, Health Care Almanac, 2010

Greater Bay Area	Benchmark*
155	80-105

\* Established by the Council on Graduate Medical Education, part of the US Department of Health and Human Services.

imposed by the DMHC and California’s 1115 Waiver – access to specialty care may pose a challenge in California, particularly for the expanded Medi-Cal population and those who remain uninsured after Health Reform implementation.

Research conducted before Health Reform’s passage suggests that California’s uninsured and Medi-Cal populations already face specialty care access challenges because:

- Not enough specialists will accept referrals from safety net providers, leading to longer wait times and, potentially, poorer health outcomes for the referred, and
- Existing referral systems are inefficient, resulting in long wait times, the exchange of incomplete information, and poor patient-provider interactions.

For example, one study of California’s safety net providers found that:<sup>xxiii</sup>

- For 2/3 of the types of specialty services referred out, patients referred by community clinics and health centers waited between one and three months to see specialists.

- Among patients with complex medical needs, those referred by public hospitals for dermatology services – an identified difficult-to-access specialty – typically waited six months or more for an appointment.

In response to such findings, many clinics across the state have piloted various strategies – such as ensuring appropriate referrals, expanding primary care site expertise, increasing non-visit tools to support consult needs, bringing specialty care services on-site, building institutional relationships, and expanding the use of telemedicine – to improve patient access to specialty care.<sup>xxiv</sup> San Francisco has served as a national model in this regard through San Francisco General Hospital’s (SFGH) use of the eReferral system throughout its network of safety net clinics.

Developed by San Francisco General Hospital and the University of California, San Francisco, the eReferral system allows SFGH primary care providers and specialists to exchange free text messages through a referral program embedded in each patient’s electronic medical record. A specialty clinic’s designated “reviewer” must respond to referrals within three days, and the message exchange will result in scheduling an approved specialty care appointment, requesting more information (if needed), providing consultation, or direct scheduling of other needed services. A one-year pilot of the eReferral system in SFGH’s gastroenterology clinic found that wait times for appointments fell from 11 months to four months after the system’s implementation.<sup>xxv</sup>

#### **California’s Most Difficult-to-Access Specialties**

In 2007, Kaiser Permanente Community Benefit and the California HealthCare Foundation offered local safety net coalitions the chance to implement strategies to improve specialty care access for their patients. Selected coalitions most often focused on the following specialty areas for improved access:

- Orthopedics
- Gastroenterology
- Neurology
- Dermatology
- Cardiology
- Endocrinology
- Ophthalmology
- Rheumatology

While San Francisco’s innovations promise to improve vulnerable populations’ access to specialty care, such efforts may still not meet the timely access standards set forth by the DMHC and California’s 1115 Waiver. (State performance along 1115 Waiver timely access standards is not anticipated until 2012/2013.) In addition, these innovations expand access *within the existing safety care network* and do not encourage an expansion of the specialty care workforce itself – of particular concern in more difficult-to-access specialties. In short, San Francisco may still lack the right number – and the right mix – of specialists sufficient to meet the demand and often complex needs of San Francisco’s Medi-Cal and uninsured populations.

## PRELIMINARY POLICY CONSIDERATIONS FOR TASK FORCE DISCUSSION

The HCSMP Task Force is an advisory body charged with developing possible HCSMP recommendations informed by data and community feedback. SFDPH will consider these possible recommendations for inclusion in the final HCSMP. However, given the collective expertise of the Task Force – and given that Task Force discussions will likely yield ideas beyond the scope of the HCSMP – SFDPH presents below a series of policy considerations that may inform both the HCSMP’s development as well as San Francisco’s broader health planning efforts.

## HCSMP-SPECIFIC POLICY CONSIDERATIONS

The Task Force may wish to recommend that SFDPH consider including the following in the final HCSMP:

- Explore the possible impact of incentivizing the development of primary care health facilities that accept Medi-Cal and/or serve the uninsured.
- Explore the possible impact of incentivizing the development of specialty care facilities at which providers accept Medi-Cal and/or serve the uninsured.

## POLICY CONSIDERATIONS RELEVANT TO SAN FRANCISCO’S BROADER HEALTH PLANNING EFFORTS

The Task Force may wish to recommend that SFDPH consider the following in its broader health planning efforts:

### Federal Level

- Extend mandated increased primary care physician reimbursement rate beyond 2014.

### State Level

- Increase provider participation in Medi-Cal and the California Health Benefit exchange.
- Increase flexibility between primary care and specialty care provider roles.
- To expand San Francisco’s primary care capacity, use nurse practitioners and physician assistants to the fullest extent of their education and training.

### Local Level

- Preserve the Healthy San Francisco program and maintain the program’s provider network.

## LISTED ACRONYMS

Acronym	Definition
CHIS	California Health Interview Survey
CWIB	California Workforce Investment Board
CHBE	California Health Benefit Exchange
CMS	Centers for Medicare and Medicaid Services
DMHC	Department of Managed Health Care
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
HCCI	Health Care Coverage Initiative
HPSA	Health Provider Shortage Area
HRSA	Health Resources and Services Administration
HSF	Healthy San Francisco
HWDC	Health Workforce Development Council
LIHP	Low Income Health Program
MAGI	Modified Adjusted Gross Income
MUA	Medically Underserved Area
OSHPD	Office of Statewide Health Planning and Development
NP	Nurse Practitioner
PA	Physician Assistant
PPACA, or "ACA"	Patient Protection and Affordable Care Act, "Affordable Care Act"
SCHIP	State Children's Health Insurance Program
SFDPH	San Francisco Department of Public Health
SFGH	San Francisco General Hospital
SF PATH	"San Francisco Provides Access to Healthcare," San Francisco's LIHP
SPD	Seniors and Persons with Disabilities

<sup>i</sup> The University of California at Los Angeles' Center for Health Policy Studies has conducted the California Health Interview Survey (CHIS) since 2001. Conducted every two years, CHIS released findings from its 2009 survey in February 2011. Because the City and County of San Francisco does not conduct a separate survey to estimate the number of estimate the number of uninsured residents, SFDPH relies on CHIS data to quantify the size of its uninsured population.

<sup>ii</sup> Lavarreda, S.A., Cabezas, L. "Two-Thirds of California's Seven Million Uninsured May Obtain Coverage Under Health Care Reform." UCLA Center for Health Policy Research. February 2011.  
<http://www.healthpolicy.ucla.edu/pubs/files/SHIC%202009%20PB%20REVISED%204-4-11.pdf>.

<sup>iii</sup> There are exceptions to the individual mandate requirement for: undocumented immigrants, financial hardship, religious objections, American Indians, people who have been uninsured for less than three months, incarcerated individuals, those for whom the lowest cost plan option exceeds eight percent of their income, and those with incomes below the tax filing threshold.

<sup>iv</sup> Henry J. Kaiser Family Foundation. "Implement Health Insurance Exchanges: California." August 25, 2011.  
<http://www.kff.org/healthreform/upload/Implementing-Health-Insurance-Exchanges-California.pdf>.

<sup>v</sup> California HealthCare Foundation. "Public Partner: The California Health Benefit Exchange Aligned with Medi-Cal." October 2011.  
<http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/C/PDF%20CAExchangePublicPartner.pdf>.



- <sup>vi</sup> Henry J. Kaiser Family Foundation. "Policy Brief: California's 'Bridge to Reform' Medicaid Demonstration Waiver." June 2011. <http://kff.org/medicaid/upload/8197-R.pdf>.
- <sup>vii</sup> Lavarreda, S.A., Cabezas, L. "Two-Thirds of California's Seven Million Uninsured May Obtain Coverage Under Health Care Reform." UCLA Center for Health Policy Research. February 2011. <http://www.healthpolicy.ucla.edu/pubs/files/SHIC%202009%20PB%20REVISED%204-4-11.pdf>.
- <sup>viii</sup> Kenney G., Lynch V., Cook A., Phong S. "Who And Where Are The Children Yet To Enroll In Medicaid And The Children's Health Insurance Program?" Health Aff October 2010 vol. 29 no. 10 1920-1929.
- <sup>ix</sup> Urban Institute, "Who Will Be Uninsured After Health Insurance Reform," March 10, 2011. <http://www.rwjf.org/files/research/71998.pdf>
- <sup>x</sup> County Health Rankings (<http://www.countyhealthrankings.org/>)
- <sup>xi</sup> Dower C., O'Neil, E. *Primary Care Health Workforce in the United States*. Robert Wood Johnson Research Synthesis Report No. 22. July 2011. <http://www.rwjf.org/files/research/070811.policysynthesis.workforce.rpt.pdf> .
- <sup>xii</sup> Bates T., Chapman S. "Physician Assistant and Nurse Practitioner Staffing Patterns in California's Licensed Community Clinics." Center for Health Professions at the University of California, San Francisco, 2010. [http://www.futurehealth.ucsf.edu/Content/8866/2010-06\\_Physician\\_Assistant\\_and\\_Nurse\\_Practitioner\\_Staffing\\_Patterns\\_in\\_Californias\\_Licensed\\_Community\\_Clinics\\_2005-2008.pdf](http://www.futurehealth.ucsf.edu/Content/8866/2010-06_Physician_Assistant_and_Nurse_Practitioner_Staffing_Patterns_in_Californias_Licensed_Community_Clinics_2005-2008.pdf) .
- <sup>xiii</sup> HealthCare.gov. Fact Sheet: "Creating Jobs and Increasing the Number of Primary Care Providers." [http://www.healthcare.gov/news/factsheets/creating\\_jobs\\_and\\_increasing\\_primary\\_care\\_providers.html](http://www.healthcare.gov/news/factsheets/creating_jobs_and_increasing_primary_care_providers.html).
- <sup>xiv</sup> "California Physician Facts and Figures." California Health Care Almanac. California HealthCare Foundation. July 2010. <http://www.chcf.org/publications/2010/07/california-physician-facts-and-figures>.
- <sup>xv</sup> State of California, Department of Finance. *Population Projections for California and Its Counties 2000 – 2050, by Age, Gender, and Race/Ethnicity*. Sacramento, California, July 2007.
- <sup>xvi</sup> Bindman, A, Chu P, Grumbach K. Physician Participation in Medi-Cal, 2008. Prepared for the California Health Care Foundation. July 2010. <http://www.chcf.org/resources/download.aspx?id=%7b90D98D9D-C4A8-4BB5-B1EA-856B8FB7575B%7d> .
- <sup>xvii</sup> The California Department of Managed Health Care, a first-in the-nation HMO consumer rights organization, helps California consumers resolve problems with their health plan and works to provide a more stable and financially solvent managed care system.
- <sup>xviii</sup> HealthCare.gov. Fact Sheet: "Creating Jobs and Increasing the Number of Primary Care Providers."
- <sup>xix</sup> Sacramento State College of Continuing Education Applied Research Services. Healthcare Workforce Development Regional Focus Groups and Follow-Up Survey: Final Report. June 22, 2011. [http://www.cwib.ca.gov/res/docs/special\\_committees/hwdc/meeting\\_materials/2011/July%202011/Comprehensive%20Regional%20Focus%20Group%20Report.pdf](http://www.cwib.ca.gov/res/docs/special_committees/hwdc/meeting_materials/2011/July%202011/Comprehensive%20Regional%20Focus%20Group%20Report.pdf).
- <sup>xx</sup> Health Resources and Services Administration. Shortage Designation: Health Professional Shortage Areas and Medically Underserved Areas/Populations. <http://bhpr.hrsa.gov/shortage/>.
- <sup>xxi</sup> "Greater Bay Area" includes Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano, and Sonoma Counties.
- <sup>xxii</sup> California HealthCare Foundation. "California Health Care Almanac: California Physician Facts and Figures." July 2010. <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/C/PDF%20CaliforniaPhysicianFactsFigures2010.pdf>.
- <sup>xxiii</sup> Canin L., Wunsch B. "Specialty Care in the Safety Net: Efforts to Expand Timely Access." Prepared for the California HealthCare Foundation and Kaiser Permanente Community Benefit Programs. May 2009. <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/S/PDF%20SpecialtyCareOverview.pdf>.
- <sup>xxiv</sup> Soloman, N. "Understanding Common Reasons for Patient Referrals in Difficult-to-Access Specialties." Prepared for the California HealthCare Foundation. May 2009. <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/U/PDF%20UnderstandingSpecialtyReferralsInTheSafetyNet.pdf>.

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<sup>xxv</sup> Agency for Healthcare Research and Quality. Innovation Profile: Electronic Referrals and Communications Reduce Wait Times for Specialty Appointments and Improve Clinician Communication and Quality of Care.”  
<http://www.innovations.ahrq.gov/content.aspx?id=2759>.