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Abstract

This paper describes options for expanding access to care for California's Medi-Cal population. Recent federal policy initiatives and an expanding set of research reports have begun to focus considerable attention on developing new models for the organization of primary care services. Initial results suggest that these innovative delivery models can both decrease the overall cost of care while improving the quality of care. This conclusion is especially relevant for those who provide care to Medi-Cal recipients with chronic medical conditions—the population that contributes by far the most to the cost of Medi-Cal. The exigencies of containing both federal and state health care expenditures for all covered populations make consideration of alternative modes of health care delivery an essential part of any analysis of the potential impacts of ACA, both in California and throughout the country.

Keywords: medical care, Affordable Care Act, Medi-Cal, Medicaid

The California Challenge: Ensuring Primary Care Access for Medi-Cal Recipients under the Affordable Care Act

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Upon signing the Affordable Care Act (ACA), President Obama described for the American public the policy implications of what he had just done: “Today, after almost a century of trying . . . health insurance reform becomes law in the United States of America. . . . We have now just enshrined the core principle that everybody should have some basic security when it comes to their health care” (Obama 2010).

The “basic security” President Obama was referring to encompasses two core elements of ACA—an expansion of private, market-based health insurance through newly created, state administered Health Benefit Exchanges (HBE); and an expansion of Medicaid eligibility to all citizens and to permanent residents who had lived in the U.S. for five years or more, whose income falls below 133% of the federal poverty line (FPL).

The Congressional Budget Office has predicted that by 2016, 32 million Americans who otherwise would have been uninsured will have gained coverage as a result of ACA. The expansion of private health insurance through HBEs will add coverage for 16 million people who otherwise would have been uninsured. In parallel, the expansion of Medicaid to all people below 133% of FPL will provide coverage for an additional 16 million people (Elmendorf 2011).

Of the 16 million people newly eligible for Medicaid, between 2 million and 3 million will be in California (Pourat et al. 2011; Holohan and Headen 2001). Already the state with the largest Medicaid population, this influx of new beneficiaries will represent an increase of 20–30% in California’s Medi-Cal program. Fortunately for California, most of the cost of this expansion will be borne by the federal government. The challenge California faces is assuring that, once covered by Medi-Cal, these millions of new Medi-Cal recipients will actually have access to high quality primary care services, supplemented by specialty and referral services when appropriate.

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This paper describes options for expanding access to care for California's Medi-Cal population. Recent federal policy initiatives and an expanding set of research reports have begun to focus considerable attention on developing new models for the organization of primary care services. Initial results suggest that these innovative delivery models can both decrease the overall cost of care while improving the quality of care. This conclusion is especially relevant for those who provide care to Medi-Cal recipients with chronic medical conditions—the population that contributes by far the most to the cost of Medi-Cal. The exigencies of containing both federal and state health care expenditures for all covered populations make consideration of alternative modes of health care delivery an essential part of any analysis of the potential impacts of ACA, both in California and throughout the country.

Medicaid—History and Current Problems

As part of Lyndon Johnson's "Great Society" initiative, Congress passed the Social Security Act of 1965. The act had two central components: expansion of health insurance for seniors under the Medicare program (Title XVIII of the Social Security Act), and expansion of health insurance to poor individuals and families under the Medicaid program (Title XIX of the Social Security Act). The two programs shared the goal of expanding health insurance to the most vulnerable populations—the elderly and the poor—yet differed substantially in the manner in which they pursued this goal.

Medicare was essentially a system of universal, federally financed, and federally administered health insurance for all seniors (i.e., those 65 years of age or older) who qualify for Social Security benefits. While not technically a single-payer system, it nevertheless shares a number of characteristics with Canada's Medicare, a single-payer, universal insurance system enacted in 1968. By contrast, Medicaid was designed as a substantially more limited program, targeting only certain categorical groups of the poor. These initially included the elderly poor, the blind or disabled poor, and poor families with children who qualify for federal cash welfare assistance.

Another central difference between Medicaid and Medicare lies in the way the programs are financed and administered. While Medicare is solely the responsibility of the federal government, Medicaid is a joint federal/state program. Each state is responsible for developing and administering its own program. So long as the state program adheres to established federal guidelines for eligibility and service provision, states automatically receive partial reimbursement from the federal government for program costs.

The rate of reimbursement varies among the states, and is based on average per capita income in the state. In fiscal year 2008, the rate of federal reimbursement

ranged from a low of 50% in states such as California and New York, to a high of 76% in Mississippi and 74% in West Virginia. (As part of the American Recovery and Reinvestment Act passed in 2009, these reimbursement rates were temporarily increased to a low of 62% and a high of 85%.)

While designed and administered as a single program within each of the states, Medicaid is functionally made up of two different programs: one for children and adults without disability, and one for seniors and disabled adults. The difference comes in the types of services covered for these populations. For the majority of children and adults without disability, Medicaid expenditures go principally for direct medical care, including physicians' services, hospital care, and prescription drugs. While the elderly and the disabled also receive these covered services, a substantial portion of Medicaid funds goes to pay for long-term care, provided either in a nursing home or in the client's home.

As a result of this bifurcation of services and needs, there is a striking difference between the distribution of Medicaid enrollment for the two groups of eligible beneficiaries and the distribution of spending for them. Nationally, elderly or disabled individuals make up 25% of the Medicaid population, but account for 67% of Medicaid spending. The sickest 5% of Medicaid beneficiaries accounts for 54% of all spending (Kaiser Family Foundation 2011). In California, elderly or disabled individuals make up 18% of Medi-Cal enrollees, but account for 69% of Medi-Cal spending. This leaves only 31% of all Medi-Cal funding to provide care for the 82% of enrollees who are neither elderly nor disabled (Kaiser Family Foundation 2001b). In fiscal year 2007, Medi-Cal per enrollee spending averaged \$1,445 for children and \$969 per nondisabled adult, as compared to national averages of \$2,135 for children and \$2,541 per nondisabled adult. California has the lowest per enrollee Medicaid expenditure for nondisabled adults of all the states, and one of the lowest expenditures per child enrollee (Kaiser Family Foundation 2007).

Given California's low level of spending per enrollee, it is not surprising that California also has one of the lowest levels of payment to providers of all the states. Nationally, the rate of payment by state Medicaid programs to primary care physicians averages 66% of the rate paid to primary care physicians by the national Medicare program (Kaiser Family Foundation 2008). Medi-Cal's rate of payment to primary care physicians is 47% that of Medicare, giving California the fourth lowest payment rate of all the states. In addition to constraining costs by reducing payment rates to physicians, Medi-Cal also constrains costs by covering 52% of its enrollees—principally children and nondisabled adults—in managed care plans, in which payments to providers are based on a flat, per-capita rate.

With the relatively low rates of payment to providers—especially primary care providers—relatively few physicians and medical groups are willing to accept Medi-Cal enrollees as patients. As a consequence, Medi-Cal enrollees must often rely

on a network of publicly operated clinics and private, nonprofit clinics that collectively make up what is referred to as the “safety net.”

California’s safety net clinics (SNC), “are defined not by any specific legal terms or by their organizational structure or scope of practice but by their common mission: to provide health care services to individuals and their families regardless of a patient’s ability to pay” (Saviano 2009, p. 3). Most of the clinics that make up the safety net are operated either by public agencies such as public hospitals and health systems, or by private, nonprofit organizations.

Many of the clinics receive direct financial support either from the federal or state programs that target specific medically underserved populations, defined either by geographic location or by the demographics of the targeted population. The Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services administers the largest of these grant programs.

SNCs that meet certain structural requirements and that qualify for targeted grant funding under Section 330 of the Public Health Service Act are referred to as “federally qualified health centers” (FQHC). Clinics that met the HRSA structural requirements but have not yet obtained Section 330 funding are referred to as FQHC Look-Alikes (FQHCLA). In 2009 California had 113 FQHCs and an additional 26 FQHCLAs (Saviano 2009). Compared to private, fee-for-service providers, FQHCs have been shown to reduce both the number of emergency room visits and the frequency of hospitalization for patients on Medicaid (Rothkopf 2011). A parallel type of clinic that receives federal funding is the Rural Health Clinic (RHC). As the name implies, RHCs target specific rural areas that have a documented shortage of health manpower. The structural requirements for RHCs are somewhat less strict than FQHCs. In 2009 California had 261 RHCs.

In addition to these federally supported clinics, there is a range of SNCs that target low-income and uninsured populations yet do not receive direct federal or state support. Among these are licensed primary care clinics and free clinics. There is no good source of information as to the exact number of these clinics operating in California, yet they make up an important component of the safety net in many areas of the state.

The largest source of funding for SNCs in California is Medi-Cal, which accounts for approximately half of all clinic revenue. An additional 10% of that revenue comes from the federal Medicare program. Under federal regulations, FQHCs, FQHCLAs, and RHCs receive a higher rate of reimbursement from Medi-Cal than either other safety net providers or private providers not within the safety net. Nonetheless, given the patient population served, SNCs face continuing financial difficulties, especially in times of broader economic difficulties.

In 2006 nearly 7.6 million Californians, representing about one-fourth of the state’s nonelderly population, received regular care from the state’s safety net of

clinics and public hospitals (Gatchel and Lavarreda 2007). Of these, 28% were covered by either by Medi-Cal or by Healthy Families, California's program of health insurance for children in low-income families that do not qualify for Medi-Cal. An additional 24% of patients accessing safety net care were uninsured for all or part of the year.

Looking specifically at SNCs (as distinguished from safety net hospitals), we see that nearly 3.7 million Californians obtained care in 2006, representing more than 11.4 million patient encounters (Saviano 2009). Eighty-four percent of these patients had family incomes that were at or below 200% of FPL. Of those patients going to FQHCs or FQHCLAs, 45% were uninsured and 38% were covered by Medi-Cal. Given California's demographics, we find that 62% of patients obtaining care at these clinics were Hispanic or Latino.

The Impact of the Economic Downturn of SNCs

As the principal source of primary care services for both Medi-Cal enrollees and those who are uninsured, SNCs are particularly sensitive to the impact of economic downturn. There are few places where this fact is more relevant than in California. As a result of the severe budget shortfalls both state and county governments have experienced in the last few years, many sources of direct funding for SNCs have been reduced or eliminated. The impact in many areas has been profound. In 2009 this author was working as a primary care physician at a FQHC in the San Francisco Bay Area that targets urban homeless and uninsured adults. As a direct consequence of cuts in state funding, the clinic was forced to shut down its services one day per week and lay off staff (including me).

Beyond cuts in direct funding, SNCs have also had to deal with rapidly rising numbers of uninsured patients. In 2007–2008, an average of 6.9 million people in California were uninsured for all or part of the year (U.S. Census Bureau 2009). By 2009 that number had risen to 8.4 million people, representing 24.3% of all those under the age of 65 (Lavarreda et al. 2010). Given that SNCs provide medical care without limitations related to a patient's ability to pay for care, a rising number of uninsured individuals has meant increasing demand for the services provided by SNCs without a corresponding increase in funding for those services.

As a consequence of the rapidly increasing demand for their services coupled with substantial reductions in state and local financial support, SNCs throughout the state have experienced considerable strain as a result of the economic downturn. A recent study of the issues facing SNCs nationally concluded that, "safety-net institutions are very vulnerable, especially in the current economy. . . . Additional, focused effort and resources will be needed to ensure adequate capacity to serve Medicaid beneficiaries and the uninsured" (Kaiser Family Foundation 2011c).

Changes in the Affordable Care Act That Will Affect SNCs

As described above, between two million and three million Californians will obtain Medi-Cal coverage as a result of ACA. This expansion of coverage will begin in 2014. The expansion will take place primarily among poor and low-income adults younger than 65 who are not disabled, as this is the largest group of poor and low-income individuals who currently are not eligible for Medi-Cal coverage. A recent study estimated that approximately two-thirds of those newly eligible will be between the ages of 18–44 (Pourat et al. 2011). Twenty to thirty percent of those newly eligible will have one or more chronic medical condition and will be in either fair or poor health. Based on their previous lack of health insurance, about half will have no established source of care, while an additional 25–30% will already have been using a SNC as their usual source of care.

As the principal provider of primary care for Medi-Cal enrollees, SNCs can expect to have a large influx of new patients as a direct result of the 2014 expansion in Medi-Cal eligibility resulting from ACA. Already strained in their capacity to provide care to current patients, the added strain resulting from the Medi-Cal expansion will be substantial. Fortunately the Medi-Cal expansion will bring with it substantial new funding, especially for those SNCs eligible for enhanced federal reimbursement. Additionally, the federal government initially will pay 100% of the cost of the Medi-Cal expansion, dropping over time to 90% of the added cost, thus relieving the state government of substantial increases in funding its share of Medi-Cal.

Even with the added Medi-Cal funding, the challenge facing SNCs is how to expand access to care, given very real constraints on manpower and funding. One of the biggest challenges will be recruiting new primary care physicians willing to practice in the SNC context. The number of young physicians coming out of their training who are willing to practice primary care (typically defined as general internal medicine, general pediatrics, or family medicine) has been decreasing steadily over a period of several years (Bodenheim 2010). The number of those willing to practice primary care in a SNC has also been decreasing. Even with added funding, SNCs will have difficulty attracting sufficient numbers of physicians to meet the expected increase in demand.

Those who developed the ACA legislation were aware of this issue and included in the act a potential solution. Over a period of several years, a new model has evolved for the organization and delivery of primary care, referred to as the patient-centered medical home (PCMH) (Kilo and Wasson, 2010). ACA places great emphasis on the PCMH as a central element of enhanced primary care delivery by safety net providers.

The Patient-Centered Medical Home as a New Organizational Model for the Delivery of Primary Care

In February 2007, four national groups representing primary care physicians jointly adopted a policy statement describing the PCMH as a new model of care delivery (American Academy of Family Physicians 2007). As stated in the introduction to that document, “The PCMH is an approach to providing comprehensive primary care for children, youth, and adults. The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient’s family.” The statement identifies several core characteristics of the PCMH:

- “Personal physician—each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
- “Physician directed medical practice—the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- “Whole person orientation—the personal physician is responsible for providing for all the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals.
- “Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community (e.g., family, public and private community-based services).
- “Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.
- “Quality and safety are hallmarks of the medical home.
- “Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.”

The National Committee for Quality Assurance (NCQA) is a private, nonprofit organization that monitors quality of medical care on a national basis. In 2008, NCQA developed an initial set of guidelines to assess the quality of care provided under the PCMH model. Updated in 2011, NCQA suggests that these guidelines have become “the primary standardized method for evaluating a practice’s capability of performing as a patient-centered medical home” (National Committee for Quality Assurance 2011). NCQA recognizes three levels of quality attainment by

PCMH delivery systems, based on the extent to which they meet six core standards of care:

1. Enhance Access and Continuity
2. Identify and Manage Patient Populations
3. Plan and Manage Care
4. Provide Self-Care and Community Support
5. Track and Coordinate Care
6. Measure and Improve Performance

ACA identifies the PCMH as the care delivery model best suited to addressing the needs of patients, especially low-income patients with chronic medical conditions. ACA includes substantial new funding opportunities for developing and expanding PCMH delivery organizations, both within the context of SNCs and more generally in the health care system. The expectation is that by switching from a traditional delivery model centered on physicians and other practitioners acting as somewhat independent providers to the team-based model central to the PCMH, both the efficiency and the quality of the care provided by SNCs will be substantially enhanced.

Evidence of the Effectiveness of the PCMH in Providing High Quality Primary Care to Low-Income Populations

Since the PCMH model began to receive national attention, the results of a number of research studies have been published measuring their quality and their effectiveness. Takach has reported on recently launched PCMH initiatives in 17 states. These initiatives adopted increased payments to physicians for care provided to Medicaid patients based on those physicians attaining published PCMH quality standards. The study concluded that, “Modest increases in payment to physicians, aligned with quality improvement standards, have not only resulted in promising trends for costs and quality, but have also greatly improved access to care. . . . These early results give states good reason to continue developing patient-centered medical homes as part of their Medicaid programs” (Takach 2011, p. 1325). Felland, Ginsburg, and Kishbauch reported their study of a collaboration between a large, nonprofit health system and several established SNCs to improve the provision of care to low-income patients. The study followed the service capacity of providers, the use of services by patients, the coordination of services, and the cost of services. While specific outcomes varied among the specific sites studied, the authors were able to conclude “that collaboration among private and public health care providers, agencies, and other organizations has been valuable in improving coverage and access to care for low-income people” (Felland et al. 2011, p. 1296). The authors went on to recommend enhanced collaboration among private and public providers

of care as a principal means of expanding access to care for low-income patient populations.

Bodenheimer reported on the success of a large SNC in Denver that provides care to 40,000 patients at four different sites (2011). Over a period of several years the organization moved from a model based on the individual physician as the principal provider of care to a team-based model, with care “pods” comprised of three physicians, three medical assistants, a nurse, a behavioral health professional, and supporting staff. A key component of the reorganization was the adoption of an electronic health record that allowed closer monitoring of care and coordination of care. The organization was able to improve the quality of its care as well as access to care. Its next outcome priority will be a reduction in the cost of care for patients with complex health problems—a principal driver of costs.

Casey and colleagues also focused their study on reorganizing the provision of care to Medicaid enrollees with chronic health problems—in this case outpatient care for children with complex medical conditions (2011). The study took place at a tertiary care children’s hospital that provides ongoing care for what they referred to as medically complex children (MCC)—those children with the most complex and chronic conditions, all with special health care needs. The study created a team of providers for each child that included the staff of the hospital as well as the child’s community-based primary care provider.

Each child was assigned a nurse-coordinator who got to know the child and the family, was available to the family by phone, was present at each clinic visit, and coordinated care between the subspecialists and the primary care providers. The study found that the team-based, medical-home care model resulted in increased outpatient utilization and coordination, with decreased hospital and emergency room utilization, at an average cost savings to Medicaid of \$1,179 per child per month. The study did not track changes in health status or quality of life measures. The authors suggested that future research is needed to address these issues.

Looking at the provision of care to low-income adults, Katz and Brigham reported the outcomes of the ongoing effort in San Francisco to develop a coordinated, comprehensive care program for uninsured adults (2001). Labeled Healthy San Francisco (HSF), the program involves improving coordination of care among safety net providers—both clinics and hospitals —by establishing a primary care medical home for all previously uninsured enrollees. Investment in computerized enrollment systems and a web-based health record has enabled improved coordination of care among providers and continuity of care for enrollees. The program has resulted in fewer unnecessary emergency room visits and higher client satisfaction with care, leading the authors to recommend, “that other safety-net systems would do well to invest in information technology, establish primary care homes, increase

coordination of care, and improve customer service as provisions of the national health care reform law phase in” (Katz and Brigham 2001, p. 237).

While those SNCs that have adopted the PCMH model and similar approaches to the coordination of care have been able to demonstrate increased access and reduced costs, not all SNCs are in a position fully to adopt the PCMH model. Coleman and Phillips surveyed more than 500 SNCs nationally as part of a larger initiative to support the expansion of the PCMH model (2010). They asked participating centers to report on their current capabilities of meeting the PCMH certification requirements set by NCQA. They found that nearly half of the health centers lacked the capacity to schedule patients with a personal provider, and two-thirds did not have a process to schedule same-day appointments for patients calling with urgent needs. They did find that those health centers that had adopted team-based care had higher quality patient access and communications processes as compared to those without team-based care, suggesting that adopting a team-based care model is an essential first step in developing a fully effective PCMH.

Planning for Care for Medi-Cal Enrollees under ACA

California can expect to enroll two to three million new individuals in Medi-Cal as a consequence of the national expansion of Medicaid eligibility under ACA. While most of the cost of paying for these previously uninsured enrollees will be borne by the federal government, California’s safety net system of hospitals and clinics will experience a substantial and relatively rapid influx of patients seeking care, beginning in 2014. Many of these individuals will have chronic medical conditions that will make their care more complex, necessitating the involvement of specialists and hospitals.

Historically, low reimbursement rates to physicians and other providers who treat Medi-Cal patients have resulted in a disproportionate reliance on SNCs to provide primary care services for Medi-Cal enrollees. Nearly four million individuals seek care from California’s SNCs each year. As a consequence of the recent economic downturn, SNCs in California have had to operate under a growing financial strain.

While many of the two to three million new Medi-Cal enrollees will have obtained some level of care previously from a SNC, many will be new to the safety net system, having previously avoided obtaining care due to lack of health insurance and inability to pay. Experience from states such as Oregon that have expanded Medicaid enrollment to those who previously were uninsured has shown that these new enrollees initially have substantially higher utilization rates of both primary care and specialty care services than when they were uninsured (Finkelstein et al. 2011).

The PCMH model provides an alternative organizational structure for SNCs with the potential to enhance both the quality and the efficiency of primary care. If adopted on a widespread basis, SNCs operating as PCMHs could improve access to care that could meet the substantial increase in demand for services expected after the expansion of Medi-Cal eligibility takes place. However, many if not most SNCs currently lack certain capacities necessary to shift to the PCMH model. Thus, one of the principal tasks of policymakers in California over the next two years will be to work with SNCs as well as safety net hospitals and other providers to facilitate a widespread shift to the PCMH model.

Fortunately ACA contains a number of provisions that anticipate the added strain that will be placed on safety net providers as a consequence of the expansion of health insurance coverage nationally. A number of these provisions focus specifically on SNCs and provide potential resources to expand and improve the services they are able to offer. A recent study by Takach and Buxbaum has summarized the new programs and resources available to SNCs under ACA (2011). These include:

- \$11 billion in new funding for fiscal years 2011–2015 to “to support expansion of the operations and infrastructure of community health centers”;
- \$1.5 billion in expanded funding for the National Health Service Corps to assist in recruiting primary care physicians and other providers to serve in SNCs;
- creation of a new “community health team program” to assist SNCs to shift to a team-based delivery model;
- creation of a “Community-Based Collaborative Care Network Program” to assist SNCs to form collaborative delivery networks with hospitals and other specialty care providers;
- additional federal Medicaid funding for medical home programs that target current or future Medicaid enrollees with chronic illness.

In addition to these specifically targeted programs, ACA also creates and provides new funding for a Center for Medicare and Medicaid Innovation (CMMI). As described on its website, CMMI is, “a new engine for revitalizing and sustaining Medicare, Medicaid, and the Children’s Health Insurance Program . . . [that] has the resources and flexibility to rapidly test innovative care and payment models and encourage widespread adoption of practices that deliver better health care at lower cost” (U.S. Center for Medicare and Medicaid Services 2011). CMMI will provide grants to community-based providers to develop and test new delivery models, with wide dissemination of the results of the studies it supports. The intent of CMMI is to use evidence-based research to define optimal modes of care delivery, and then to work to shift the delivery system more generally to these proven models.

The challenge for California is to use the short time available to access many of these new resources provided by ACA, and to develop an effective working relationship among state and local governments, safety net hospitals, and SNCs so as to be able to invest these resources in ways that assure that the needed expansion of care will be available by January 2014. The question arises as to where the leadership for this effort will come from. Especially in the context of the recent budgetary crisis confronting California state government, it is not clear whether state leaders will be fully capable of organizing and leading this effort. Nonprofit advocacy organizations such as the California Primary Care Association (CPCA) may be able to play an essential role in leading the effort to strengthen California's safety net. CPCA is the state affiliate of the National Association of Community Health Centers, a national advocacy organization that promotes the provision of high quality health care to underserved communities. CPAC has focused its annual meeting for 2011 on the topic of "Community Clinics and Health Centers: Transforming the Future of Health Care" (California Primary Care Association 2011).

Academic medical centers (AMC) form an additional core component of California's health care system with the potential to contribute to the expansion and improvement of the state's safety net system. AMCs traditionally focus their efforts and their resources on highly specialized care, with the provision of primary care to low-income populations receiving lower priority. Rieselbach and Kellerman have suggested that AHCs could develop innovative collaborations with SNCs by forming what they refer to as "Community Health Center and Academic Medical Partnerships, or CHAMPs" (Rieselbach et al. 2011).

These organizations would be community based and would combine the roles of teaching, research, and patient care. Teaching would focus on training primary care practitioners, with administrative responsibility for the training program vested in the SNC. Research would focus on identifying optimal models for the organization and delivery of care. Patient care would be team-based and would emphasize primary care, with backup specialty care provided by the AHC. The authors suggest that, "CHAMPs could strengthen our country's Medicaid safety net, pioneer new approaches to health care delivery, and build a well-trained and highly motivated primary care workforce for the future" (Rieselbach et al. 2011, p. 2478). Whether the AHCs in California are willing to invest in these types of partnerships remains to be seen. However, state and federal policymakers have the potential to encourage the development of CHAMPs by linking other sources of funding to efforts to support SNCs and other safety net providers.

Conclusion

Millions of low-income, uninsured adults in California, many with chronic medical conditions, will gain access to health insurance once ACA takes effect in 2014. Many if not most of these will gain coverage through enrollment in Medi-Cal. However, providing access to high quality care for these new enrollees will be difficult. With the history of low rates of reimbursement to physicians and other providers, Medi-Cal enrollees have traditionally relied on a network of SNCs and other safety net providers for care. Especially in the context of the recent economic downturn, these providers are facing severe strain, and have limited capacity to expand the provision of care to the extent necessary to meet the expanded demand for services that will result from the implementation of ACA.

The PCMH model offers an alternative means of organizing the delivery of primary care with the potential to meet the expected need for care through enhancement of the coordination, efficiency, and quality of care. Research has shown that, compared to traditional provider systems, PCMHs are able to reduce costs, improve access, and increase quality. However, a substantial and sustained policy effort will be needed to fully implement the PCMH model, as many SNCs lack resources or capabilities essential to attaining the standards set for PCMH certification.

In December 2010 the Kaiser Family Foundation convened a roundtable discussion that focused on the need to ensure expanded access to care for Medicaid enrollees as part of national health reform efforts. The discussion involved federal and state government officials as well as academic researchers and policy experts, and arrived at an important conclusion.

Major ACA investments in the safety-net and in the health care workforce, and support for service delivery models that emphasize primary care and care coordination lay the groundwork for a system better-gearred to meet the needs of the population generally, and the needs of low-income Medicaid beneficiaries, in particular (Kaiser Family Foundation. 2011c, p. 10).

Whether we will be able to realize this potential is one of the greatest health policy challenges facing California in the years leading up to the full enactment of ACA.

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