

**An In-Depth Analysis of Federally Qualified Health Centers in Los Angeles County and the Implementation of the Patient Protection and Affordable Care Act**

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April 2013

Urban and Environmental Policy Senior Comprehensive Project

## **Acknowledgements**

First off, I would like to thank my professors for their support throughout this process. Thank you to Professor Robert Gottlieb and Professor Bhavna Shamasunder for your feedback and support along the way. I would also like to thank, my advisor, Professor Martha Matsuoka and Professor Peter Dreier from the Urban and Environmental Policy Department. The four of them collectively are by far the most supportive and inspirational department at Occidental College.

I would also like to thank Heng Lam Foong, my supervisor as the Student Assistant for the Community Health Engagement Project at Occidental. Her support and wisdom throughout the last two years at Oxy has greatly shaped my path and my way of thinking, without her much of what I have accomplished would not have been possible.

Thank you to all of my interviewees and participants, this project would not have been possible without your time and support. I appreciate all of the people who went out of their way to make time to speak with me to help with this project.

Finally, I would like to thank my friends and family, especially, my sister, Caitlin Welty, and my friends, Margeau Valteau, Irene Li, Elena Satten-Lopez, Avanica Khosla, and Francisco Hernandez. Without their support and love over the last nine months, and four years before that, I would not be where I am today and this project would not have been possible.

## **Executive Summary**

This paper is an examination of the effects of the Medicaid expansion in California, Medi-Cal as it is known within the state, on Federally Qualified Health Centers, or safety net clinics in Los Angeles County. To begin with there is a history of health care reform within the United States, starting with the passage of the most recent legislation, the Patient Protection and Affordable Care Act. This is specifically looking at the expansion of Medicaid and increased funding to community clinics. Additionally, the case of health care reform in Massachusetts is framed as a model for expansion to help understand how health care reform will effect the population. The research is then situated through looking at the role of Community Clinics more broadly, and specifically within Los Angeles County, where the bulk of the paper is focused.

Through an examination of State and County policy, as well as an in-depth analysis of Federally Qualified Health Centers in Los Angeles County, I look to examine the preparedness of these organizations moving forward towards 2014 and their ability to adequately serve an increased patient population. The findings from this research has been broken down into five key categories that show how clinics are moving forward, and what additional steps need to be taken to ensure that they are properly prepared for the Medi-Cal expansion of 2014. These categories are key concerns focused on health care reform, steps taken towards expansion, the role of technology, HealthyWay LA as Los Angeles County's LIHP Transition Program, and the Relationship with Los Angeles County.

Based upon the findings from the State, the County and the Clinics, I was able to create a series of recommendations to help ensure that Los Angeles County and California are able to transition well from the current system, to the expansion of 2014. On the state level there is the necessity to pass comprehensive reform legislation that not only benefits the county and clinics,

but patients as well. The county must play a role in increasing education, enhancing the role of technology, and reevaluating their role within specialty care. Finally, Federally Qualified Health Centers must continue with key steps to reform as well as taking additional steps to ensure patient education, as well as increasing the quality of their health care delivery and ensuring that their patients receive the best care possible from both their clinics and their partner organizations.

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## **Introduction**

The passage of the Patient Protection and Affordable Care Act is a landmark moment in American history, with the desire for universal health coverage dating back to the 1960s and with the beginning of Medicaid and Medicare. As the United States moves forward, it is becoming more apparent that old ways of understanding healthcare and the lack of focus on the patient as a whole, but on profits instead are becoming increasingly outdated and need to be refocused. Most nations that are comparable to the United States in population, economic status, and political ideology, offer some type of universal health coverage for its citizens. Such countries include Canada, Sweden, France, and the United Kingdom, providing examples of more functional health care systems, with lower costs. Despite the fear within the United States of moving towards a “socialized” society, it has become increasingly necessary to redevelop the ways in which health care delivery and insurance is dealt with in the US.<sup>1</sup>

With the election of President Barack Obama in 2008, the right moment, both politically and socially, had come to move forward with comprehensive health care reform. The Patient Protection and Affordable Care Act, or the Affordable Care Act, ACA, is the lasting piece of legislation to come out of this push. There have been attempts within the legislative and judicial branches to overturn this piece of legislation; however, despite the changes made by the Supreme Court, these attempts have been largely unsuccessful, leaving the Patient Protection and Affordable Care Act as the standing legislation detailing health care reform in America. Despite its many critics, both for and against universal health coverage, this act represents the future of health care in America, with major implementation beginning in 2014 and continuing into 2019.

I first became interested in health care reform in the summer after my first year at Occidental College. Two important things happened that summer to spark my interest, first I was

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<sup>1</sup> Reid, T.R. "5 Myths About Health Care Around the World". *Washington Post* 23 Aug 2009.

interning at the University of Arizona, College of Medicine, Office of Multicultural Affairs. Through this internship, I worked on a variety of projects, one of which was to conduct preliminary research examining how other schools of medicine had reworked their curricula to represent more accurately the population of the United States, and the patient population that they serve. Much of the medical knowledge today is based upon the anatomy of a white male. This is problematic in that it has become there is growing evidence that different diseases and chronic conditions present differently based upon gender and race. The physician I was working with was a female oncologist, so she was specifically interested in this issue focusing on how women present with different symptoms. Women's health is historically focused on obstetrics, gynecology, and breast health, because these are what make women anatomically different from men. However, what many people do not realize is that despite this focus, heart disease is the leading killer of women in the United States.<sup>2</sup> Through this research, I became increasingly interested in how different populations are affected by disease, and how these discrepancies in disease are not reflected in our health education or health care system. This was during the summer of 2009, when the federal debate about health care reform reached a critical point as bills were being drafted and reviewed. I began following the media coverage closely, wanting to understand better what the proposed reform would look like, who it would and would not affect. I continued to follow the coverage through the passage of the Patient Protection and Affordable Care Act the following March. After that summer, I knew that public health and health policy were my passions.

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<sup>2</sup> Centers for Disease Control, "Women's Health: Leading Causes of Death in Females United States, 2009 (current listing)." Last modified January 3, 2013. Accessed April 17, 2013. This is a statistical average for all women across the United States. If it is analyzed by race, economic status, age, or geographic location the statistics change, and heart disease is not the leading cause of death in all these subgroups.



Through my senior comprehensive project, I focus on the implementation of the Patient Protection and Affordable Care Act, specifically looking at the expansion of Medicaid, or Medi-Cal in California, which will go into effect on January 1, 2014 and the increased funding for community health centers, which began in 2010. I examine how safety net clinics are preparing for the expansion of Medi-Cal, looking at key steps being taken to ensure that they are equipped to serve their current and expanded patient population. Additionally, I look at the relationship between clinics and Los Angeles County, primarily the Department of Health Services, which administers HealthyWay LA, a health program for low-income individuals, and the Department of Public Social Services, which administers Medi-Cal on the county level.

The state of California has yet to pass legislation stating what the expansion of Medi-Cal will look like. Currently the legislature and the governor are at odds in determining what it will entail. However, there has been a commitment made by both Democratic controlled bodies for that the expansion to happen. With this expansion less than a year away, safety net clinics have begun to take steps to ensure that they are prepared. However, until the state passes guidelines as to what this expansion will look like, both clinics and the county can only take so many steps moving forward. Each clinic has taken its own steps to begin preparations, and the county has begun to move forward under the assumption that the Medi-Cal expansion will mirror the federal Medicaid expansion guidelines. It is necessary for the state government to determine the guidelines for the Medi-Cal expansion so that clinics and Los Angeles County may move forward with their preparation plans, the keys to which are patient education and outreach, the use of technology, and a need to streamlining processes to decrease paperwork and overlap, and ultimately, increase the quality of patient care.

## **Health Care Reform in the United States**

### ***Passage of the Patient Protection and Affordable Care Act***

As the American health care system has come under public scrutiny, it has become clear that our system is fractured and dysfunctional, providing a lower standard of patient care at a much higher cost than should be considered acceptable. The current health care delivery system is largely focused on profit as opposed to patient care and health. Due to the growing scrutiny, health care reform was one of the key topics in the 2008 presidential election, with John McCain advocating for a lower cost system, while Barack Obama wanted to implement universal health coverage, giving all Americans access to health care. Ultimately, Barack Obama won the 2008 election and began his push for universal health coverage. However, American politics have become increasingly tense and bipartisan, with many politicians only voting along party lines.

President Obama originally gave Congress a deadline of August 2009, to pass health care reform. However, this was not successful for multiple reasons. The first was the strength of the Tea Party that had grown over this summer, as Tea Party members spoke out against health care reform at town hall meetings across the country. The Tea Party was a social movement that arose in 2009 after the election and inauguration of President Obama, calling for his resignation based upon the claim that he is not a citizen. They are also admittedly opposed to progressive politics focused on a more libertarian America. They were able to sway public opinion, in some areas, against health care reform. Additionally, Republicans were refusing to agree to health care reform that included a public option, a government run insurance plan as an alternative to private insurers.<sup>3</sup> On November 7, 2009, the House of Representatives was finally able to pass health care reform legislation, Affordable Health Care for America Act, including a public option, and

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<sup>3</sup> Dunham, Will. "Timeline: Milestones in Obama's quest for healthcare reform." *Reuters*, March 22, 2010. <http://www.reuters.com/article/2010/03/22/us-usa-healthcare-timeline-idUSTRE62L0JA20100322> (accessed April 17, 2013).

on December 24, 2009, the Senate was able to pass their bill, the Patient Protection and Affordable Care Act, which did not include a public option, with 60 votes, the two-thirds needed to avoid a filibuster.<sup>4</sup> These two bills needed to be merged into one, approved by Congress and then signed by President Obama. However, on January 19, 2010, Scott Brown, a Republican, won the Senate special election, filling Ted Kennedy's seat; Kennedy, a Democrat, had died in 2009 and was a true champion of health care reform. With this election, the Democrats lost their super majority in the Senate, and the ability to prevent a filibuster.<sup>5</sup>

As opposed to reconciling the two bills that had been previously passed, the easiest solution became the House passing the Senate's bill, which they agreed to, on the grounds of being able to make amendments through the reconciliation process, which was not subject to filibuster.<sup>6</sup> On March 21, 2010, the House passed the Patient Protection and Affordable Care Act, and on March 23, 2010, President Obama signed it into law. The amendment bill, the Health Care and Education Reconciliation Act, was passed the following week, and signed by President Obama, on March 30, 2010. This amendment bill made numerous changes to the ACA; however, for the purposes of this paper, only two are notable. First, it increased the Medicaid payment rates to primary care doctors to match Medicare payment rates, which are higher in 2013 and 2014. Second, it outlined the federal government responsibility in the cost of the expansion. The federal government will cover the entire cost until 2016, 95% in 2017, 94% in 2018, 93% in 2019, and 90% after that, which left the states with a maximum of 10% of the cost of the

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<sup>4</sup> Ibid.

<sup>5</sup> Jacobs, Lawrence R., and Theda Skocpol. *Health Care Reform and American Politics: What Everyone Needs to Know*. (New York City, NY: Oxford University Press, 2010). 101-120

<sup>6</sup> Ibid, 183.

Medicaid expansion.<sup>7</sup> While the President Obama's goal of universal health coverage was not reached, it became a step in that direction.

Many states and insurance companies challenged the passing of the Affordable Care Act. One of those challenges, *National Federation of Independent Business v. Sebelius*, eventually reached the Supreme Court. On June 28, 2012, the Supreme Court upheld the ACA, 5 to 4. There are two major components to this ruling, one addressing the individual mandate, and one addressing Medicaid. The Justices voted to uphold individual mandate as a tax, thus requiring people to purchase health insurance or pay a penalty. In the case of Medicaid, the expansion was upheld; however, the justices ruled that the federal government could not take away Medicaid funding from states that refuse to expand coverage, instead states that refuse to expand coverage will not receive any additional funds from the federal government.<sup>8</sup> In terms of the future of health care, the ruling means that states that chose not to expand their Medicaid coverage will not be penalized, as originally intended in the law.

### ***Impact and Implementation***

The Patient Protection and Affordable Care Act will expand coverage to millions of Americans by expanding Medicaid eligibility, continuing funding for the Children's Health Insurance Program (CHIP), and subsidizing private insurance premiums and cost sharing for some lower-income individuals enrolled in exchange plans, among others.<sup>9</sup> While the act is expected to extend coverage to over 30 million Americans, it is also believed that by the final

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<sup>7</sup> Hossain, Farhana. "Proposed Changes in the Final Health Care Bill." *The New York Times*, sec. US Politics, last updated March 22, 2010. <http://www.nytimes.com/interactive/2010/03/19/us/politics/20100319-health-care-reconciliation.html> (accessed December 8, 2012).

<sup>8</sup> Parlapiano, Alicia. "How the Justices ruled on the Health Care Law." *The New York Times*, sec U.S., June 28, 2012. <http://www.nytimes.com/interactive/2012/06/28/us/how-the-justices-ruled-on-health-care.html?ref=us> (accessed December 7, 2012).

<sup>9</sup> Chaikind, Hinda, Curtis W Copeland, C. Stephen Redhead, and Jennifer Staman. "PPACA: A Brief Overview of the Law, Implementation, and Legal Challenges." (March 2, 2011). <http://www.nationalaglawcenter.org/assets/crs/R41664.pdf> (accessed December 8, 2012).

stages of implementation in 2019, there will still be 18 million Americans without health insurance.<sup>10</sup> These residually uninsured include undocumented immigrants, who because of their lack of status in the United States do not qualify for government benefits; those who are eligible for Medicaid under the expanded coverage, but do not enroll; those who opt out of coverage, and will be forced to pay a penalty fee of \$695 or 2.5 percent of yearly income; and those who opt out because health insurance is unaffordable, in cases where health insurance would cost more than 8 percent of household income, individuals/families would not be subject to the penalty fee.<sup>11</sup>

Since the law was upheld by the federal government, state governments, and employers, who are all responsible for the implementation, must start to think strategically about next steps for 2014. The federal government, specifically the Department of Health and Human Services, is responsible for the federal health exchange, which states may participate in if they chose not to create their own exchange. They must also work with insurance companies to prepare for reform, and create the regulations and regulatory committees. States are largely responsible for creating their own health insurance exchanges, in addition to the expansion of Medicaid, much of which is possible through federal funds.<sup>12</sup> The PPACA makes change to the employer-based system and employers, both large and small, must decide what next steps they will be taking in regards to insuring their employees.

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<sup>10</sup> “Health Care Reform: Overview.” *The New York Times*. Sec Times Topics. Last updated November 8, 2012. [http://topics.nytimes.com/top/news/health/diseasesconditionsandhealthtopics/health\\_insurance\\_and\\_managed\\_care/health\\_care\\_reform/index.html](http://topics.nytimes.com/top/news/health/diseasesconditionsandhealthtopics/health_insurance_and_managed_care/health_care_reform/index.html) (accessed December 8, 2012).

<sup>11</sup> Trumbull, Mark. “Obama signs health care bill: Who won’t be covered?” *The Christian Science Monitor*. March 23, 2010. <http://www.csmonitor.com/USA/2010/0323/Obama-signs-health-care-bill-Who-won-t-be-covered> (accessed December 8, 2012).

<sup>12</sup> Chaikind, Hinda, Curtis W Copeland, C. Stephen Redhead, and Jennifer Staman. “PPACA: A Brief Overview of the Law, Implementation, and Legal Challenges.” (March 2, 2011). <http://www.nationalaglawcenter.org/assets/crs/R41664.pdf> (accessed December 8, 2012).

The PPACA is a very long and complicated piece of legislation, which is evident by the four-year time gap from when the law was passed to when implementation begins, as well as the necessity for a five-year implementation period. This research focuses two aspects of the PPACA, the expansion of Medicaid, and the role of Community Clinics in health care delivery.

### ***Expansion of Medicaid***

Medicaid is one of the areas that are predicted to see the greatest growth from health care reform, largely due to a dramatic increase in government funds directed to the Medicaid program, as well as changes in the eligibility guidelines, allowing more low-income families and persons to enroll in the program. This is especially important for the state of California where there are currently 7 million people uninsured. It is estimated that by 2016, 1.7 of those 7 million will be enrolled in Medi-Cal.<sup>13</sup> Other sources have estimated that approximately 3 million people in California will be eligible for Medi-Cal in 2014; however, many of those many not enroll.<sup>14</sup> This is a dramatic increase in numbers from previous years. Due to this dramatic increase, the United States Department of Health and Human Services granted California a Section 1115 Medicaid Demonstration Waiver, “California’s Bridge to Reform”. This waiver granted California approximately \$8 billion in federal funds over a five-year period to help California complete enrollment over time as opposed to all at once. It has three major components, Low-Income Health Program (LIHP) Coverage Expansion, Delivery System Reform Incentive Pool (DSRIP), which increased funding to hospital systems, and mandatory enrollment of seniors and people

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<sup>13</sup> Long, Peter, and Jonathan Gruber, “Projecting the Impact of the Affordable Care Act on California,” *Health Affairs*, 30, no. 1. (2011): 63.

<sup>14</sup> Lavarreda, Shana Alex, and Livier Cabezas. “Two-Thirds of California’s Seven Million Uninsured May Obtain Coverage under Health Care Reform.” *UCLA Center for Health Policy Research: Health Policy Research Brief*. (February 2011).

with disabilities into managed care plans.<sup>15</sup> All three of these components are intended to help make the transition into health care reform easier.

The responsibility of providing health care to the lower income childless adults between the ages of 19 and 64 has largely been left up to the counties at this point. With the help of this waiver, coverage is expanded to them through two programs, Medicaid Coverage Expansion (MCE) and Health Care Coverage Initiative (HCCI). MCE is targeted at childless adults between ages 19 and 64 who are not enrolled in Medicaid and have family incomes at or below 133% FPL (\$14,484 for an individual in 2011).<sup>16</sup> HCCI is targeted at childless adults between ages 19 and 64 with family incomes between 133% FPL (\$14,484 for an individual in 2011) and 200% FPL (\$21,780 for an individual in 2011).<sup>17</sup> Both of these programs are run at the county level in the state of California and meant as “bridges” into reform to allow patients to start receiving health coverage before 2014. Once the coverage expansion begins in 2014, participants in MCE and HCCI will be transitioned into one of the reform programs, Medi-Cal, and health insurance exchanges, respectively.

#### *HealthyWay LA*

Currently, the county of Los Angeles is running both a MCE and a HCCI program, called HealthyWay LA, HWLA. This program is a “bridge” into health care reform, helping to enroll people as well as educating them about their rights as health care consumers. HWLA, which is administered by the Department of Health Services, unlike Medi-Cal, which is administered by the Department of Public Social Services, must meet certain guidelines, such as assignment of enrollees to a medical home, network adequacy, locations must be geographically accessible, and

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<sup>15</sup> The Henry J. Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured. “California’s ‘Bridge to Reform’ Medicaid Demonstration Waiver” (October 2011).

<sup>16</sup> Ibid.

<sup>17</sup> Ibid.

providers, as well as educational materials, must be culturally competent.<sup>18</sup> As of September 2012, there were 219,604 people in Los Angeles County enrolled in LIHP, 219,419 in MCE and 185 in HCCI.<sup>19</sup> This enrollment in MCE is up from the previous month, August 2012, which was 204, 878, an increase of 14,726 people in one month.<sup>20</sup>

The HWLA program is unique in that it divides its participants into two categories, matched and unmatched. Patients who are enrolled in matched, meet the Medi-Cal expansion guidelines and will be enrolled in Medi-Cal starting in 2014. They are called matched because the funding from the federal government is matching the county's cost for providing them with health coverage. Patients who are enrolled in unmatched are those patients who will one day qualify for Medi-Cal; however, they will not be enrolled starting in 2014 because they currently do not meet all the qualifications. Many of the unmatched patients are recent immigrants who will not qualify until they have been in the country for five years. These patients are referred to as unmatched because the federal government is not reimbursing the county for the cost of providing them with health insurance. These patients will continue to be covered in some form after 2014, when the rest of HWLA is enrolled into either Medi-Cal or the insurance exchanges, which is a very small percentage. The Department of Health Services is still working to decide how these patients will be covered and what that coverage will look like.<sup>21</sup>

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<sup>18</sup> The Henry J. Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured. "California's 'Bridge to Reform' Medicaid Demonstration Waiver" (October 2011).

<sup>19</sup> California Department of Health Care Services. "Low Income Health Program September 2012 Monthly Enrollment." (November 2012). [http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/Reports/DY8-M03\\_Enrl\\_Rpt.pdf](http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/Reports/DY8-M03_Enrl_Rpt.pdf) (accessed December 7, 2012).

<sup>20</sup> California Department of Health Care Services. "Low Income Health Program August 2012 Monthly Enrollment." (October 2012) [http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/Reports/DY8-M02\\_Enrl\\_Rpt.pdf](http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/Reports/DY8-M02_Enrl_Rpt.pdf) (accessed December 7, 2012).

<sup>21</sup> <http://file.lacounty.gov/bos/supdocs/69118.pdf>



According to a study conducted in 2011, approximately half of newly insured people in the state of California by 2016 will be residents of Los Angeles County.<sup>22</sup> While there is still a large uninsured population in Los Angeles, this program is helping to transition patients into a health care system by providing them with coverage and directing them to specific clinics to receive health care, thus helping to give them a medical home. However, this is increasing patient numbers for clinics and forcing them to come up with tactics as to how they will deal with an increased patient population, but still maintain the same standard of care.

### *Health Benefits Exchange*

The health benefits exchange in California is known as Covered California, which is governed by the California Health Benefit Exchange Board. Their mission is to "...increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value".<sup>23</sup>

The current HCCI enrollees in HealthyWay LA will be transitioned into the exchange, once it becomes available on January 1, 2014; however, open enrollment is expected to begin in October. The exchange is a virtual marketplace where uninsured Californians can go to purchase health insurance. Under the ACA, the federal government will provide subsidies for those earning between 138 percent and 400 percent of the federal poverty level. It is estimated that more than 3 million Californians will purchase health insurance subsidized by the federal

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22 Long, Peter, and Jonathan Gruber, "Projecting the Impact of the Affordable Care Act on California," *Health Affairs*, 30, no. 1. (2011): 67.

23 California Health Benefits Exchange, "California Health Benefit Exchange Vision, Mission and Values". Last modified October 21, 2011. Accessed April 17, 2013.  
<http://www.healthexchange.ca.gov/Pages/HBEXVisionMissionValues.aspx>.

government, and another 2 million will purchase unsubsidized insurance plans.<sup>24</sup> There will be enrollers throughout the state to help guide individuals through this process, both at clinics, stand-alone organizations, and over the phone. It is also important to note that those who are eligible for Medi-Cal will not be able to enroll in the health insurance exchanges.

### ***Increased funding to Community Clinics***

Another aspect of the Patient Protection and Affordable Care Act is increased funding to community clinics. While the number of patients with health coverage will dramatically increase starting in 2014, there is still a need to preserve community clinics and prompt a strong safety net, as can be seen in the case of Massachusetts. Many of the patients who were previously uninsured, but utilized community clinics will continue to visit these clinics out of a sense of familiarity. Patients newly insured under Medi-Cal will be assigned a medical home, those previously insured through HWLA ideally will keep the same medical home, and those who were previously uninsured will need to acquire a medical home. In many cases, these patients will want to be assigned to a clinic they are previously familiar with or to a community clinic close to where they live and work. Finally, the residually uninsured will continue to seek out care in the same way, which in many cases is at community clinics, because of their proximity to home or work, and their ability to offer the uninsured free services or on a sliding payment scale.

The Affordable Care Act provides approximately \$11 billion to support community clinics, \$1.5 billion of that is to support major construction and renovation projects, with the other \$9.5 billion allocated to create community health centers in medically underserved areas

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<sup>24</sup> Colliver, Victoria. "Health care exchange will offer policies." *San Francisco Gate*, November 12, 2012. <http://www.sfgate.com/health/article/Health-care-exchange-will-offer-policies-3675063.php> (accessed April 18, 2013).

and to increase preventative and primary care services.<sup>25</sup> The National Association of Community Health Centers estimates that this funding will allow clinics to double their current capacity, serving upwards of 40 million patients by 2015.<sup>26</sup> Even within the language of the PPACA, the necessity of a strong safety net is recognized and the funding to support this is provided. Through this expansion of sites and services, more people will be able to access health care, even if they remain uninsured. In some ways, community health clinics are the ideal model, because of their focus on coordination and comprehensive care to address multiple health issues when working with communities that are typically underserved, while being respectful of cultural and linguistic barriers. Additionally, they are able to provide high quality care for a fraction of the cost of emergency rooms or hospitals.

#### ***Key Provisions related to the ACA***

Additionally, there are two key provisions highlighted and reaffirmed by the ACA, meaningful use of technology and the concept of Patient Centered Medical Homes, or Primary Care Medical Homes, PCMH. Meaningful use was part of a law that was previously passed in 2009, Health Information Technology for Economic and Clinical Health (HITECH) Act. This law was passed as a way to push America forward by encouraging all health care providers to transition to using electronic health records, EHR. Meaningful use has five key pillars: improving quality, safety, efficiency, and reducing health disparities; engaging patients and families in their health; improving care coordination; improving population and public health; and ensuring

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<sup>25</sup> Health care.gov, "Community Health Centers and the Affordable Care Act: Increasing Access to Affordable, Cost Effective, High Quality Care." Last modified Sept 21, 2011. <http://www.healthcare.gov/news/factsheets/2010/08/increasing-access.html>. (accessed December 8, 2012).

<sup>26</sup> National Association of Community Health Centers, Robert Graham Center, George Washington University. "Expanding Health Centers Under Health Care Reform: Doubling Patient Capacity and Bringing Down Costs," (June 2010) [http://www.nachc.com/client/HCR\\_New\\_Patients\\_Final.pdf](http://www.nachc.com/client/HCR_New_Patients_Final.pdf) (Accessed December 9, 2012)

adequate privacy and security protection for personal health information.<sup>27</sup> The implementation was divided up into three phases, data capture and sharing (2011), advanced clinical processes (2013), and improved outcomes (2015).<sup>28</sup> While participation in this is not mandatory, it is highly encouraged. There are incentive payments given out to those who do chose to adopt the use of electronic medical records, and those who chose not to adopt will be penalized with a reduction in their Medicare/Medicaid fees starting in 2015. Additionally, there will be incentive payments made to those providers using electronic health records who can show improved outcomes within their patient population.

The concept of Patient Centered Medical Homes, also known as Primary Care Medical Homes, was expanded and mandated by the ACA. The ACA created the Center for Medicare and Medicaid Innovation, which is, currently evaluating innovative payment and health delivery systems to determine what systems will reduce Medicare or Medicaid spending, but also increase patient care. One of the systems that this center has evaluated is Patient Centered Medical Homes, ultimately showing that these medical homes do create the best overall experience for the patient. With that, there has been a push by the Department of Health and Human Services to have all FQHC meet the accreditation requirements to be a patient centered medical home.<sup>29</sup> The goal is to create a medical home that focuses on the patient as a whole as opposed to individual symptoms. Within this model, one lead clinician oversees care and ensures that the patient is receiving the best treatment possible. This is something that is particularly applicable to FQHC as they move forward, as the program is particularly focused on meeting the health care needs of

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<sup>27</sup> Ferris, Nancy. "'Meaningful Use' of Electronic Health Records," Health Affairs, August 24, 2010.

<sup>28</sup> Centers for Disease Control, "Meaningful Use". Last modified October 11 , 2012. Accessed April 18, 2013. <http://www.cdc.gov/ehrmeaningfuluse/introduction.html>.

<sup>29</sup> US Department of Health and Human Services. "Affordable Care Act to support quality improvement and access to primary care for more Americans." HHS Press Release. (September 29, 2011).

low-income patients who are generally covered by Medicaid.<sup>30</sup> This also allows FQHCs to move away from the image of being a safety net clinic, a concept that tends to have a negative connotation. The idea of a safety net is seen as a place of last resort for health care, conjuring up an image of a less than desirable setting. While this image does not accurately represent the majority of FQHCs in the United States, it is an image that they are constantly working to overcome. By embracing the concept of a Patient Centered Medical Home and its ideals, FQHCs can work to redefine what it means to be a safety net provider, showing that the health care they provide is not subpar, but instead patient focused and the quality that all communities deserved.

### ***Massachusetts as a Model***

In 2006, Massachusetts passed the first major health care overhaul law in the United States, known as Chapter 58. The Massachusetts law helped to create a framework to be used for future health care reform, a framework that was used by the ACA. Both laws are focused on making health care coverage more affordable, thus being able to expand coverage to more people. There many key similarities that can be used to show how Chapter 58 functioned as a framework for the ACA, however, due to the focus of this paper, only the effects on the state's safety net services by health care reform will be examined.<sup>31</sup>

There are lessons to be learned from health care reform in Massachusetts. First off, due to the restructuring of funds for safety net clinics and a decrease in federal funds, there were some gaps left within Massachusetts's health care delivery to patients using safety net clinics, specifically the uninsured. While community health centers are receiving some of the largest benefits out of the ACA, it is important to make sure that access is still ensured when making

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<sup>30</sup> Cassidy, Amanda. "Patient-Centered Medical Homes," *Health Affairs*. (September 14, 2010).

<sup>31</sup> Patel, Kavita, and John McDonough. "From Massachusetts to 1600 Pennsylvania Avenue: Aboard the Health Reform Express." *Health Affairs*. 29. no. 6 (2010): 1106 - 1111.

financial modifications.<sup>32</sup> In addition, within the first 10 weeks of the act being signed into law, Massachusetts removed the enrollment cap on one Medicaid program, and the income eligibility was raised on two others, thus allowing for tens of thousands of people to be enrolled effective immediately.<sup>33</sup> However, this also meant that almost immediately, safety net providers and community health centers saw an increase in burden because of the much-expanded patient population. Another issue that faced Massachusetts, which has already been seen in California, is a lack of primary care providers. There is already a shortage of primary care providers in the country, and the current providers will continue to see an increase in their patient population moving forward. To combat this shortage, there was an increase in funding for primary care training programs. This allowed community clinics to hire upwards of 92 new primary care clinicians, thus being able to serve 100,000 newly insured patients.<sup>34</sup>

In the years following the passage of healthcare reform, Massachusetts saw a dramatic increase in the number of patients trying to see doctors for the first time, from patients who were newly insured trying to access coverage for the first time and patients with new benefits, coverage for new types of providers and specialties, trying to access these benefits.<sup>35</sup>

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<sup>32</sup> Ibid.

<sup>33</sup> Kingsdale, Jon. "Implementing Health Care Reform in Massachusetts: Strategic Lessons Learned." *Health Affairs*. 28, no. 3/4. (2009): w591.

<sup>34</sup> Kingsdale. "Implementing Health Care Reform." w592.

<sup>35</sup> Long, Sharon K., and Paul B. Masi. "Access and Affordability: An Update on Health Reform in Massachusetts, Fall 2008." *Health Affairs*. 28, no. 3/4. (2009): w581.

**Access To And Use Of Health Care Under Health Reform In Massachusetts For Adults Ages 18-64: All Adults And By Family Income, 2006-2008**

All adults (N = 9,669)	Fall 2006	Fall 2007	Fall 2008
Has a usual source of care (excluding ED)	86.4%	88.7%*	92.1%***#
Any doctor visit in past 12 months	80.0	81.5	84.5***##
Preventive care	70.2	73.5*	76.8***
Multiple visits	65.7	64.2	69.4***##
Any visit to a specialist in past 12 months	50.6	48.4	53.4
Any dental care visit in past 12 months	67.8	72.0**	76.3***
Took any Rx drugs in past 12 months	55.2	54.3	59.5*
Did not get needed care for any reason in past 12 months	25.4	21.0**	21.5
Doctor care	8.1	5.8	6.4*
Specialist care	7.1	4.0***	7.2##
Medical tests, treatment, follow-up care	9.4	6.2***	7.7#
Preventive care screening	6.9	5.5	5.5**
Rx drugs	8.1	5.7*	6.3**
Dental care	12.7	9.3**	11.1
Any ED visits in past 12 months	34.2	35.1	33.4
Most recent ED visit was for nonemergency <sup>a</sup>	15.9	15.6	14.6
<b>Adults with family income less than 300% of poverty (n = 4,638)</b>			
Has a usual source of care (excluding ED)	79.3	83.2	87.3***
Any doctor visit in past 12 months	75.2	76.6	79.8**
Preventive care	64.7	70.3*	72.4**
Multiple visits	61.8	59.9	66.4*
Any visit to a specialist in past 12 months	46.2	42.2	49.6
Any dental care visit in past 12 months	48.9	58.5***	64.4***
Took any Rx drugs in past 12 months	55.5	54.0	59.7
Did not get needed care for any reason in past 12 months	35.3	29.5	31.8
Doctor care	13.6	9.5	11.6*
Specialist care	11.2	6.9**	12.6##
Medical tests, treatment, follow-up care	14.4	9.7**	12.8
Preventive care screening	8.3	6.2	9.3
Rx drugs	12.5	9.5	10.2**
Dental care	20.8	13.6***	17.4
Any ED visits in past 12 months	46.0	49.4	46.9*
Most recent ED visit was for nonemergency <sup>a</sup>	23.2	24.0	22.3

**SOURCE:** Massachusetts Health Reform Surveys, 2006, 2007, and 2008.

**NOTES:** See Appendix Exhibit 1 for information on the regression model (available online at <http://content.healthaffairs.org/cgi/content/full/hlthaff.28.4.w578/DC2>). ED is emergency department.

<sup>a</sup> A condition that the respondent thought could have been treated by a regular doctor if one had been available.

\* (\*\*) (\*\*\*) Regression-adjusted estimate of difference from fall 2006 was significantly different from zero at the 0.10 (0.05) (0.01) level, two-tailed test.

# (##) Regression-adjusted estimate of difference from fall 2007 was significantly different from zero at the 0.10 (0.05) level, two-tailed test.

In Massachusetts, lower income patients also had a harder time accessing services than those who had a high income; the same was true for patients with public benefits as opposed to private benefits.<sup>36</sup> This illustrates the need for a strong safety net because the lower income, public benefits patients were the ones being turned away from the private practice and other primary care providers. After being turned away from these providers, patients turn to safety net clinics to meet their healthcare needs. Safety net providers have also reported a significant volume increase of patients post-reform. Between 2009 and 2010, community health centers had 50,000 more visits than previous years.<sup>37</sup> In previous years, there was a significant increase in patients as well between 2005 and 2009; community health centers experienced a 31% increase in the total

<sup>36</sup> Long. "Access and Affordability." w582-w583.

<sup>37</sup> The Henry J. Kaiser Family Foundation. "Massachusetts Health Care Reform: Six Years Later." (May 2012.) <http://www.kff.org/healthreform/upload/8311.pdf>. (accessed Dec 06, 2012).

number of patients served.<sup>38</sup> Additionally, as expected, community health centers saw a drop in uninsured patients seeking care between 2005 and 2009 due to expanded coverage under Chapter 58. However, despite this drop, community health centers saw a dramatic increase in patients due to more patients being covered and those who remain uninsured still needing a clinic where they are able to receive services at a low cost.

In many ways, the case of Massachusetts will be repeated all over the country in 2014. As seen with patients in Massachusetts, newly insured patients do not leave the clinic setting that they are comfortable with, but instead return to it with their new public benefits. The residually uninsured continue to rely on safety net clinics, as their only option for health care coverage, beyond the emergency room, in addition to those who are newly insured and seeking health care for the first time. It is necessary that safety net clinics are prepared for this reality and receive the necessary funding and support to accommodate their broadening patient base.

## **The Role of Community Clinics in Health Care Delivery**

### ***Structure and Role of Community Clinics***

Community Clinics, as they function today, were created in the 1960s as part of President Lyndon B. Johnson's War on Poverty. At the time, they were called neighborhood health centers, unique in that health care was provided by a multidisciplinary team that provided not only necessary medical services, but also prevention, social and environmental services.<sup>39</sup> In 1989, the Medicaid and Medicare federally qualified health center (FQHCs) program was initiated due to concern within the Department of Health and Human Services that clinics were not using the funds from their Section 330 grants properly. Under the new system, clinics are paid the cost of

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<sup>38</sup> Ku, Leighton, Emily Jones, Peter Shin, Fraser Rothenberg Byrne, and Sharon K. Long. "Safety-Net Providers After Health Care Reform: Lessons From Massachusetts". *Archive of Internal Medicine* 171, no. 15 (2011).

<sup>39</sup> Dievier, Anne, and Terence Giovannini. "Community Health Centers: Promise and Performance." *Medical Care: Research and Review*. 55, no. 4 (December 1998): 407.



the services they provide, not the established Medicare or Medicaid cost of the service.<sup>40</sup> This allowed designated clinics to serve better their patient population. FQHCs also receive grant funds from Section 330 of the Public Health Service Act; these funds are not available to health centers that have not been given the FQHC designation. Historically, this is where FQHCs received most of their funding from; however, they also receive funding from state and local grants, reimbursements from Medicaid, Medicare, and private insurance, as well as uninsured patient fees.<sup>41</sup> It is possible for clinics to be designated a FQHC look alike, meaning they meet the same qualifications as a FQHC, but they do not receive the same government funding. However, they are eligible for similar benefits.

There are certain criteria that FQHCs must meet to receive this designation; each clinic must be located in or serve a high need community, governed by a community board, provide comprehensive primary health care, provide services to all no matter status or ability to pay, and meet other standards regarding administrative, clinical, and financial operations.<sup>42</sup> One of the most important criteria that a clinic must meet to receive the designation of FQHC is being located in a MUA, medically underserved area. These areas are designated by the Index of Medical Underservice, IMU, which takes into consideration existing primary care capacity, economic and health status of the community, infant mortality rate, percentage of the population 65 or over, and demand for care.<sup>43</sup> A clinic must have a score of 62 or lower to be considered located in a MUA. Community Health Centers (CHCs) are unique in that they are required by law to have a patient-majority governing board, what this means is that the people who are

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<sup>40</sup> Taylor, Jessamy. "The Fundamentals of Community Health Centers." *National Health Policy Forum*. (August 31, 2004), 5-6.

<sup>41</sup> Dievier, "Community Health Centers.", 408.

<sup>42</sup> United States Department of Health and Human Services, Health Resources and Services Administration, "What is a Health Center?." <http://bphc.hrsa.gov/about/index.html>. (accessed December 8, 2012).

<sup>43</sup> Taylor. "The Fundamentals of Community Health Centers.", 7.

responsible for making many of the large decisions for the clinic are patients who are affected by the decisions they make.<sup>44</sup> It is important for CHCs to have consistency within their clinicians, so limiting high turnover and ensuring that patients see the same clinician every time; it makes the clinic more efficient and gives their patients a consistency to their health care.

Safety net clinics play a strong role in the community, not only through providing health services to underserved populations, but also through their work with other organizations to bring additional resources into the community. They are focused not only on meeting the medical needs of their patients, but also the social needs of their patients. Due to their work with low income, at risk populations, clinics understand that meeting medical needs is not always enough and that in many cases a prescription for medicine is not enough. This focus and understanding is one of the many reasons that it is important to protect and examine the role of safety net clinics; it is about more than health care, it is about the comprehensive needs of a patient. Based upon previous research, many believe that the safety net was in crisis up until recently. With limited funds and a large patient population to serve, it is the focus of the safety net to make the most out of its funds, but also to provide the best care possible. As safety nets were beginning to fade in the minds of some, the ACA was introduced with a distinct focus on FQHCs and their ability to serve the underserved.

### ***Recommendations for Reform***

The Patient Protection and Affordable Care Act is an important piece of legislation in recognizing the importance and priority of safety net clinics, specifically FQHCs. Due to their population served and unique payment structure, government funding and support is important in maintaining these clinics. In a study done in 2011, conducted by The Commonwealth Fund,

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<sup>44</sup> Dievier, "Community Health Centers." 410.

*Modern Healthcare Health Care Opinion Leaders Survey*, nearly seven out of 10 respondents believe that health care reform will improve access and financial protection for vulnerable populations.<sup>45</sup> Without a strong safety net, these protections cannot be guaranteed, as shown by the 98 percent of respondents who believe that the traditional safety net will still play an important role after 2014.<sup>46</sup> When clinics are examining their role within the health care delivery system, they must consider many issues when planning and addressing their patients' needs. There must be a balance struck between serving the residually uninsured, while changing their image from the last resort to the ideal health care environment to maintain and attract new patients.

It is necessary for clinics to work with their patients to ensure that they are aware of their health care rights. While the PPACA provides provisions for limited English proficient or non-English speaking patients, clinics must help support this role through effective outreach. The PPACA provides funding for navigators, whose purpose is to ensure that outreach and education on health insurance exchanges and public benefits enrollment processes are culturally and linguistically appropriate.<sup>47</sup> Clinic staff will also need to be educated on the health care reform changes to ensure that they are able to help patients navigate the decision between Medicaid and health insurance exchanges, based upon income level. Additionally, there are provisions within the PPACA providing incentive for clinics to develop innovative delivery and payment systems. This is especially important for clinics that are looking to meet the needs of the newly insured who may consider seeking care elsewhere. Clinics must be staying up to date with the use of health information technology; coordinate and deliver patient centered care; support customer

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<sup>45</sup> Stremikis, Kristof, Julia Berenson, Anthony Shih, and Pamela Riley. "Health Care Opinion Leaders' Views on Vulnerable Populations in the U.S. Health System." *The Commonwealth Fund, Data Brief*. (August 2011), 2.

<sup>46</sup> *Ibid*, 2.

<sup>47</sup> Andrulis, Dennis P., and Nadia J. Siddiqui. "Health Reform holds both risks and rewards for Safety-Net Providers and Racially and Ethnically Diverse Patients." *Health Affairs*. 30, no. 10 (2011): 1831.

services; and assess and pay clinicians based on outcomes and quality of care.<sup>48</sup> However, when looking to do this, specifically looking at clinician payment, it is important for a uniform set of qualification to be maintained across the board, thus not having discrepancies from clinic to clinic. Such discrepancies could cause clinicians to question their role within the clinic and lead to higher turnover. In order to serve the increased patient population, it is estimated that FQHCs across the country will need close to 16,000 additional primary care providers and 14,000 additional nurses.<sup>49</sup>

In order to maintain old patients and attract new patients who are newly insured through the health exchanges, it is necessary for clinics to receive the designation of “essential community providers”. This means that they will be listed as providers on “qualified health plans”, these plans will be highly subsidized by the government and encourage patients to use community clinics as their primary provider, if they receive this designation.<sup>50</sup> It will also be important for safety net clinics to participate in networks, if they are not already doing so to help link patients to specialists and other expanded services.

Moving forward clinics have a lot to think about when addressing the needs of their patients. While some provisions are built into the PPACA for how they will be expected to do so, gaps do exist in these provisions and it is up to the clinics to define their own recommendations and steps forward.

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<sup>48</sup> Ibid, 1832-1833.

<sup>49</sup> National Association of Community Health Centers, Robert Graham Center, George Washington University. “School of Public Health and Health Services. Access transformed: building a primary care workforce for the 21<sup>st</sup> century.” (August 2008). <http://www.nachc.org/client/documents/ACCESS%20Transformed%20full%20report.pdf>. (Accessed December 7, 2012).

<sup>50</sup> Summer, Laura. “The Impact of the Affordable Care Act on the Safety Net.” *AcademyHealth*. (April 2011). [http://www.academyhealth.org/files/FileDownloads/AHPolicybrief\\_Safetynet.pdf](http://www.academyhealth.org/files/FileDownloads/AHPolicybrief_Safetynet.pdf) (accessed December 5, 2012)

## **The Future of Los Angeles County Safety Net Clinics**

Due to Los Angeles County's diverse, lower income, population there is an increased need for safety net providers. Counties in California have an obligation under law to provide healthcare services to the economically disadvantaged; however, how they choose to provide these services is up to the county. While the county does provide safety net facilities, these are not always enough and operate very differently from FQHCs, which are separate public or private entities. With the closure of the Martin Luther King Jr.- Harbor Hospital in 2007, many patients have begun to rely on local FQHCs to meet their health care needs.<sup>51</sup> This increased patient population is just one of many stressors affecting the Los Angeles safety net, particularly FQHCs. Moving forward it is necessary for county services and FQHCs to work together to ensure that patients receive the highest standard of care possible with the least amount of overlap and unnecessary work on the part of the county and the clinics. Even before health care reform there were numerous issues facing Los Angeles safety net clinics. One of the largest issues involved the state and local budget crisis, which led to a drastic decrease in state provided Medi-Cal funds. Other issues included an increasing growing uninsured population, particularly due to the economic recession, lack of public awareness, and difficulty with keeping up with the latest healthcare technology.<sup>52</sup>

As clinics are moving forward with the implementation of the PPACA, there are many factors to consider. It is estimated that community clinics in California regularly serve four million patients, with one million of those (17 percent) currently uninsured Californians.<sup>53</sup>

California's FQHCs (121 clinics had this designation as of 2011) stand to gain the most from

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<sup>51</sup> California Healthcare Foundation. "Los Angeles: Have and Have-Nots Lead to a Divide System." *California Health Care Almanac: Regional Markets*. (July 2009), 7.

<sup>52</sup> Saviano, Elizabeth C. "California's Safety-Net Clinics: A Primer." *California Healthcare Foundation*. (March 2009), 26-28.

<sup>53</sup> Dutton, Melinda, and Alice Lam. "Implementing National Health Reform in California: Opportunities for Improved Access to Care." *California Healthcare Foundation*. (March 2011), 11.

health care reform with increased funding, giving them the opportunity to not only expand their current services, but build new sites to increase capacity.<sup>54</sup> As the uninsured population in California has continued to grow, this growth has somewhat offset the increase in funding. In the state of California, health centers receive an average of \$181 per uninsured individual from the federal government. This is significantly less than the national average of \$270, or other large states, Texas at \$229, and New York at \$276.<sup>55</sup>

With the implementation of the Section 1115 waiver, Los Angeles FQHCs have been able to work with the county to create a health plan that enrolls qualified patients now to help them transition into healthcare reform and start receiving health services earlier. This plan mentioned above, is known as HealthyWay LA. It has allowed Angelenos to transition into health plans, while allowing clinics to prepare for increased patient population over time. While there is still expected to be a boost in patient population in 2014, this program has helped to pave the way and make the transition less jarring for both clinics and patients.<sup>56</sup>

### ***Health Status in Los Angeles County***

Los Angeles County is sprawling, with a population of 9,866,194 people, as of 2011.<sup>57</sup> This is the ninth largest population in the country, meaning that Los Angeles County is larger than 42 states. The necessity for health care reform to work in Los Angeles County is not only important for the state of California, but for the country as well. Below are tables and statistics related to health status in Los Angeles County, specifically focused on access and insurance

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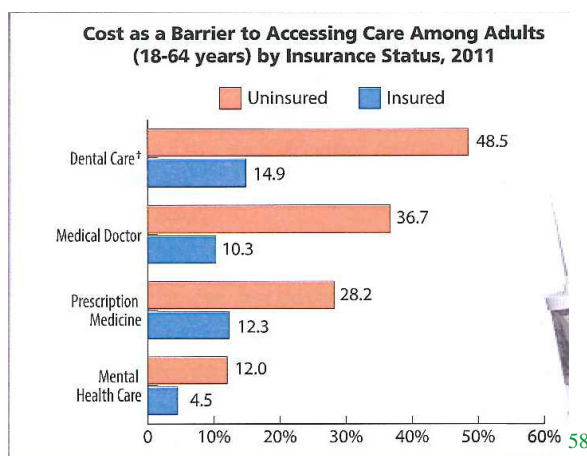
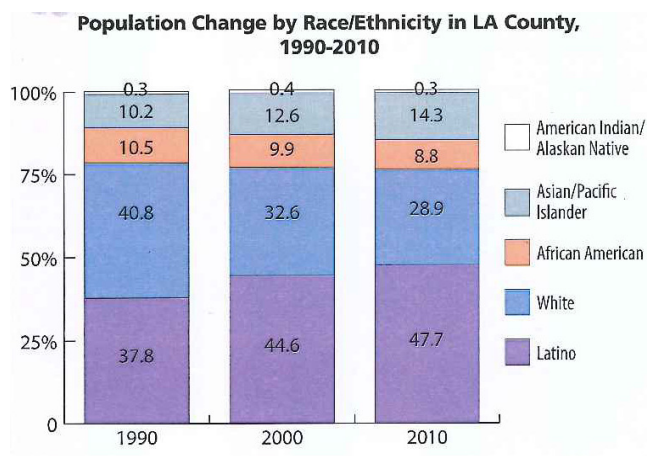
<sup>54</sup> Ibid, 11.

<sup>55</sup> Ibid, 12.

<sup>56</sup> Pourat, Nadereh, Anna C. Davis, Erin Salce, Diana Hilberman, Dylan H. Roby and, Gerald F. Kominski. "In Ten California Counties, Notable Progress in System Integration within the Safety Net, Although Challenges Remain." *Health Affairs*. 31. no. 8 (2012): 1720-1724.

<sup>57</sup> Los Angeles County Department of Public Health. "Key Indicators of Health by Service Planning Area" (2013) Accessed April 18, 2013 [http://publichealth.lacounty.gov/ha/docs/2011%20LACHS/KIR2011/KIR\\_2011FinalS.pdf](http://publichealth.lacounty.gov/ha/docs/2011%20LACHS/KIR2011/KIR_2011FinalS.pdf)

coverage. This data will help to illustrate the necessity for a strong safety net, when dealing with a large population.



Due to the large population in Los Angeles County, as well as the high immigrant and low-income population, it is important to have a strong safety net. Part of understanding this safety net is analyzing the ways in which the county and clinics are working together to create the strongest safety net possible moving forward towards 2014, to ensure coverage for other covered by Medi-Cal, both new and old, as well as the residually uninsured.

### Methodology

To ascertain how prepared safety net clinics in Los Angeles County are to deal with the impending implementation of the PPACA, I conducted a series of interviews on the state level, county level, and with four safety net clinics. I will be examine not only what these four clinics are doing, but also how current state and county policies affect their decisions. The four clinics examine are Federally Qualified Health Centers, FQHCs. These health centers are public or private non-profit health care organizations that meet certain criteria within the Medicare and Medicaid programs and because of this receive Section 330 grants under the Public Health

<sup>58</sup> Los Angeles County Department of Public Health. “Key Indicators of Health by Service Planning Area” (2013) Accessed April 18, 2013 [http://publichealth.lacounty.gov/ha/docs/2011%20LACHS/KIR2011/KIR\\_2011FinalS.pdf](http://publichealth.lacounty.gov/ha/docs/2011%20LACHS/KIR2011/KIR_2011FinalS.pdf)

Service Act.<sup>59</sup> I have chosen to work with two smaller clinics and two larger clinics. Originally, I was planning to compare my clinics in sets of two, thinking that it would not be fair to compare the smaller clinics to the larger clinics, due to their smaller budget, size of staff, and size of patient population. However, after conducting my initial research, I realized that clinic size and budget should not be a factor in this comparison, because they all operated under the same guidelines and regulations, since they are designated as FQHCs. Therefore, I will not be comparing the clinics based upon size, but instead will be doing a comparison across the four. The smaller clinics I will be examining are the Community Health Alliance of Pasadena, ChapCare, and T.H.E., To Help Everyone, Clinic, Inc. For my larger clinics, I will be examining St John's Well Child and Family Center, St John's, and QueensCare Family Clinics, QFC.

During each of my interviews with the clinics, I asked a series of open-ended questions related to the clinics current objectives focused on the expansion of Medi-Cal and other aspects of the ACA. Originally, I had planned to conduct a wide series of interviews focused at different levels of the clinics. Once I started to reach out to my clinic sites and conduct my interviews, I discovered that not only was the information repetitive from multiple interviews, but additionally, my sites were not as willing to give me open access to their sites and their staff. Due to this change, at three of my clinics, I was only able to interview upper management, and at the fourth, I was directed to middle management staff. I was not given open access to any of the clinics, and some of my interviews were conducted over the phone as the management staff was too busy to meet in person. Perhaps my findings would have been different had I been given different access, but due to my position as a student researcher, they were willing to have upper management meet with me, but not other staff members. At ChapCare I interviewed Margaret Martinez, CEO;

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<sup>59</sup> United States Department of Health Services, Health Resources and Services Administration, "What is a Health Center?." <http://bphc.hrsa.gov/about/index.html>. (accessed December 8, 2012).



at THE Clinic, Inc, Itohan Oyamenden, COO; at St John's, Regina Clemente, Campaigns Coordinator, and Nomsa Khalfani, Chief of Policy and Support Services; at QFC, Barbara Hines, President and CEO, and Alex Armstrong, COO. The only clinic where I met with middle management was St John's Well Child and Family Center; however, I was unable to meet with the CEO. St John's is very much an enigma within my research, as will be shown later.

The results of my interview have been broken down into five categories: key concerns focused on health care reform, steps to prepare for expansion, the role of technology within health care reform, the role of HealthyWay LA as Los Angeles County's LIHP transition program, and their relationship with Los Angeles County moving forward towards 2014. These categories help to provide information as to what the clinics are doing, but also how they are working together with each other and the county to move forward.

I have also used each clinic's I-990 tax documents, annual reports, demographic data from the federal government, and maps of geographic locations, to provide background information and situate the clinics within their communities and in relation to each other.<sup>60</sup>

In addition, to my clinic interviews and analysis, I interviewed policy makers and advocates on the state and county level. I interviewed Jamie Robertson, Program Officer, Health Reform and Public Programs from the California Health care Foundation. Much of their research as an organization in the last few years has focused on the ACA, the ramifications for Californians, and their recommendations for preparation. She works in Sacramento, helping to establish state health policy. She has been working with the California legislature to help determine what health care reform will look like in California. I also spoke with Kimberly Lewis,

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<sup>60</sup> Since all of the clinics are 501(c)(3) tax exempt they are required to file an I-990 with the IRS. These documents are available online ([www.guidestar.org](http://www.guidestar.org)) because as charitable organizations, they are required to make their tax documents available for public inspection. Only St John's and QFC publish annual reports, I asked the other two and they do not publish one. I asked why, but was not given a distinct reason. I believe that it might be related to the size discrepancy between the four clinics.

Managing Attorney, National Health Law Program - Los Angeles Office. The National Health Law Program works across the country to help educate legal advocacy groups about health care legislation, because they have a California office, they also work closely with the state government, and are helping to decide what health care reform will look like in California. On the county level, I spoke with Amy Luftig-Viste who splits her time between the Los Angeles County Chief Executive Office, as Principal Analyst, Health Care Reform, and the Department of Health Services, working on implementation of health care reform, through the HealthyWay LA program.

Ultimately, all other these interviews have come together to help me look at the interaction between these organizations and how everyone is working together to move forward with the implementation of the ACA.

### **Background Information on Clinics**

Below is basic background information about each of the clinics, history, services provided, locations, budget, and demographics. This information has been compiled from a series of sources including I-990 tax documents, annual reports, and organizational websites. Additionally, each Federally Qualified Health Center is required to file an annual report with the Health Resources and Service Administration, part of the Department of Health and Human Services, detailing the demographics of their patient population (race/ethnicity, insurance type, income, services accessed, age, income), as well as some basic health status statistics. To ensure consistency all demographic statistics reported will be based upon this data. Appendixes 2-5 provide maps of each clinic locations in relationship to their administrative offices, and a copy of the demographic report mentioned above.

### ***Community Health Alliance of Pasadena***

The Community Health Alliance of Pasadena, ChapCare, was founded in 1995 after a community coalition made up of residents, social service agencies and city governmental officials came together to find a way to increase access to affordable and culturally-sensitive medical and dental services. In 1998, ChapCare opened its first medical clinic, and in 2001, they opened their dental clinic. In 2004, they were designated a Federally Qualified Health Center, FQHC, and in 2007, they became one of the first health centers within Los Angeles County to implement electronic health records, EHR. Today, ChapCare is currently operating three sites, all of which offer medical services, with their flagship site offering dental and behavioral health services as well.<sup>61</sup> Their mission is to, "...to provide high quality, accessible and culturally sensitive health care and related services in an environment of care and mutual respect".<sup>62</sup>

ChapCare has three locations, Fair Oak Health Center, Lake Health Center, and Del Mar Health Center, as well as a mobile clinic. (See Appendix 2.1) While their primary service area is in the San Gabriel Valley, they will accept any patient from Los Angeles County, regardless of ability to pay. The Fair Oak Health Center is their largest site offering medical, dental and behavioral health services, while the other two sites only offer medical services.<sup>63</sup> In addition, they also offer case management services to their patients, helping patients gain access to other health and social services, including referrals, transportation, interpretive services for languages not available on staff (English, Spanish, Armenian), and health education and lifestyle review.<sup>64</sup>

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<sup>61</sup> CHAP: Community Health Alliance of Pasadena, "About CHAP." Accessed April 18, 2013. <http://chapcare.org/about-2/chap/>.

<sup>62</sup> Guidestar.org, "990 Form filed for ChapCare" (2011) <http://www.guidestar.org/organizations/95-4536824/community-health-alliance-pasadena.aspx>

<sup>63</sup> CHAP: Community Health Alliance of Pasadena, "About CHAP." Accessed April 18, 2013. <http://chapcare.org/about-2/chap/>.

<sup>64</sup> CHAP: Community Health Alliance of Pasadena, "Medical Services". Accessed April 18, 2013. <http://chapcare.org/medical/>.

There is not a lot of readily available information about ChapCare as an organization; their website is out of date, with not much useful information beyond a timeline of their history. Additionally, they do not publish an annual report, like many other clinics, providing demographic information about their patient population, as well as funding sources, current programs, and plans for the future. Due to this lack of information, it is hard to paint a picture of ChapCare as an organization.

Based upon their I-990 from 2011, ChapCare functions on a budget of approximately \$6 million; their revenue comes from a combination of government grants, patient service fees, fundraising and investment income.<sup>65</sup> Surprisingly, patient fees account for more of their revenue than any other source of income. This is in contrast to the common misconception that FQHCs are solely funded by government grants.<sup>66</sup> They have 16 uncompensated voting members on their board of directors, and 110 staff members.<sup>67</sup>

In the 2011, ChapCare served 14,214 patients, with 72.37% uninsured, 24.05% covered by Medicaid/CHIP, 2.43% covered by Medicare, and 1.15% covered by a third party. 82.53% of their patients identify as a racial or ethnic minority (meaning not Caucasian), 57.43% Hispanic/Latino, 22.17% African American, 2.50% Asian, 0.16% American Indian/Alaska Native, and 0.22% Native Hawaiian/Other Pacific Islander. Additionally, 30.75% of their patients reported being best served in a language other than English.<sup>68</sup> (See Appendix 2.2 for additional statistics)

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<sup>65</sup> Guidestar.org. "990 Form filed for ChapCare" pg. 9. (2011) <http://www.guidestar.org/organizations/95-4536824/community-health-alliance-pasadena.aspx>

<sup>66</sup> It is important to note that throughout this section, when I refer to patient service fees, I am not only referring to what patients are paying out of pocket, but also the reimbursements that the clinics receive from HWLA, Medi-Cal, and Medicare.

<sup>67</sup> Guidestar.org. "990 Form filed for ChapCare" pg. 5-6. (2011) <http://www.guidestar.org/organizations/95-4536824/community-health-alliance-pasadena.aspx>

<sup>68</sup> United States Department of Health and Human Services, Health Resources and Services Administration. *UDS Summary Report Community Health Alliance of Pasadena*. (2011).

### ***THE Clinic, Inc***

THE (To Help Everyone) Clinic was established in 1974 by a group of eight medical volunteers. Their mission was to bring affordable, quality health care to uninsured women living in the underserved, economically challenged community of South Los Angeles. Since its inception in 1974, THE Clinic, Inc has expanded its service beyond women to include men, teens and children. Their mission statement "...is to provide high quality, customer-friendly primary care and related services to all residents of South Los Angeles, especially those who are underserved".<sup>69</sup> They provide health care services as well as preventative education on a low cost, or ability to pay, basis. Within this, they recognize that not only is it important to provide health care to this community, but to do it in a way that recognizes the cultural, social and economic factors that affect the community.<sup>70</sup> In 2011, THE Clinic was one of the first clinics in the country to be accredited as a Primary Care Medical Home, also known as Patient Centered Medical Home, PCMH, by The Joint Commission. This accreditation recognized them for their "...highest commitment to delivering primary health care in a comprehensive, coordinated and accessible model".<sup>71</sup>

THE Clinic is focused on providing health care to South Los Angeles. They have one main clinic site that is open 6 days a week serving the community. Additionally, they have three satellite sites that are associated with different community partners, Lennox School District, Community Development Institute Head Start, and HOPICS, and a mobile clinic that provides services at Susan Miller Dorsey High School, Crenshaw High School, and various locations

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<sup>69</sup> THE (To Help Everyone) Clinic, Inc. "Overview and Mission". Accessed April 18, 2013. [http://www.theclinicinc.org/about\\_us.php](http://www.theclinicinc.org/about_us.php)

<sup>70</sup> THE Clinic, Inc Fact Sheet. <http://www.theclinicinc.org/factsheet1.pdf>

<sup>71</sup> THE (To Help Everyone) Clinic, Inc. "History and Vision". Accessed April 18, 2013. <http://www.theclinicinc.org/history.php>

throughout Lennox.<sup>72</sup> (See Appendix 3.1) They provide a wide variety of services focused on the whole person, “body, mind, and spirit”.<sup>73</sup> Beyond basic medical services, they also offer services targeted specifically at women, men, teens and children, ensuring health care access for all. There is also a strong focus on preventative medicine and health education, as well as supportive services, such as resource referrals and counseling on an individual, family, or group basis.<sup>74</sup>

THE Clinic functions on a budget of approximately \$7 million a year according to their 2011 I-990; their revenue is a combination of government grants, patient services fees, investment income, gifts, noncash contributions, and nongovernmental grants.<sup>75</sup> Their board of directors is made up of nine uncompensated voting individuals, and they employ a staff of 102 persons.<sup>76</sup>

In the 2011, THE Clinic served 12,190 patients, including 60.95% uninsured, 33.48% covered by Medicaid/CHIP, 3.73% covered by Medicare, and 1.84% covered by a third party. 98.54% of their patients identify as a racial or ethnic minority, 85.99% African American, 32.10% Hispanic/Latino, 9.78% Asian, 0.19% American Indian/Alaska Native, and 0.98% Native Hawaiian/Other Pacific Islander. Additionally, 26.81% of their patients reported being best served in a language other than English.<sup>77</sup> (See Appendix 3.2 for additional statistics)

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<sup>72</sup> THE Clinic, Inc Fact Sheet. <http://www.theclinicinc.org/factsheet1.pdf>

<sup>73</sup> THE (To Help Everyone) Clinic, Inc. "Services". Accessed April 18, 2013. <http://www.theclinicinc.org/services.php>

<sup>74</sup> THE (To Help Everyone) Clinic, Inc. "Services". Accessed April 18, 2013. <http://www.theclinicinc.org/services.php>

<sup>75</sup> Guidestar.org. "990 Form filed for THE Clinic, Inc." (2011) pg. 9 <http://www.guidestar.org/organizations/23-7351622/t-h-e-clinic.aspx>

<sup>76</sup> Ibid. pg. 5-6

<sup>77</sup> United States Department of Health and Human Services, Health Resources and Services Administration. *UDS Summary Report THE Clinic, Inc.* (2011).

### *St John's Well Child and Family Center*

St John's Well Child and Family Center was founded in 1964, with the mission of "...eliminating health disparities and fostering community well-being by providing and promoting the highest quality care in South Los Angeles".<sup>78</sup> They recognize four core values, dignity, honoring, treating, and respecting every person who they encounter; excellence, the best standard of care, personal and professional growth, accountability, creativity, teamwork, and quality; well-being, health focused on the whole person, enabling people to participate in their own health improvement; and social justice, working together with others to advance equity and fairness in community resources, and empowering and addressing the needs of all community members.<sup>79</sup> Their annual report for 2012 is focused on the role that community partnerships play in advancing health care equity. They site 19 new partnerships that have developed to help them expand not only their health services, but also their social justice reach. These partnerships are also helping them to reach populations previously not served by St John's, such as the transgender community and expanding their children's services, as two examples.<sup>80</sup>

St John's is network of 10 clinics, six community health centers, Dr. Louis C. Frayser Health Center, S. Mark Taper Foundation Health Center, Magnolia Place Health Center, W.M. Keck Foundation Health Center, East Compton Health Center at Casa Dominguez, and Functional Assessment Center, and four school-based health centers located at Lincoln High School, Hyde Park Elementary School, Manual Arts High School, and Dominguez High School.<sup>81</sup> (See Appendix 4.1) They offer a wide variety of services, medical, dental, mental health, as well as focused services for children, teens, women, seniors, podiatry and HIV/AIDS.

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<sup>78</sup> St John's Well Child and Family Center. "Overview of St John's Programs and Services." Accessed April 18, 2013 <http://www.wellchild.org/about.html>

<sup>79</sup> St John's Well Child and Family Center. "Overview of St John's Programs and Services." Accessed April 18, 2013 <http://www.wellchild.org/about.html>

<sup>80</sup> St John's Well Child and Family Center. "The Partnership of Power: Annual Report 2012" (2012)

<sup>81</sup> Ibid.

They also have a strong focus on outreach, health education, child development and literacy education, case management, and insurance enrollment.<sup>82</sup>

This network functions on a budget of approximately \$22 million a year. These funds come from a combination of government grants, private grants, noncash contributions, fundraising, patient service fees, and other revenue streams.<sup>83</sup> They have a board of directors of 14 uncompensated, voting members, and they have a staff of 289 persons between the 10 sites.<sup>84</sup>

In the 2011, St John's served 36,774 patients, including 60.82% uninsured, 37.21% covered by Medicaid/CHIP, 0.97% covered by Medicare, and 1.00% covered by a third party. Of their patients, 98.77% identify as a racial or ethnic minority, 81.83% Hispanic/Latino, 17.55% African American, 0.52% Asian, 0.10% American Indian/Alaska Native, and 0.10% Native Hawaiian/Other Pacific Islander. Additionally, 84.23% of their patients reported being best served in a language other than English.<sup>85</sup> (See Appendix 4.2 for additional statistics)

### ***QueensCare Family Clinics***

QueensCare Family Clinics has been a health care institution since 1897, when the original clinic was founded to care for the abandoned and neglected children of Los Angeles. The clinic, controlled by the Franciscan Sisters of the Sacred Heart, was moved to its present location in Echo Park in the late 1980s. In 1994, the clinic was transferred to Queen of Angels-Hollywood Presbyterian Medical Center for financial reasons. When the medical center was bought in 1998, the name was changed to QueensCare, combining with other community clinics

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<sup>82</sup> St John's Well Child and Family Center. "Overview of St John's Programs and Services." Accessed April 18, 2013 <http://www.wellchild.org/about.html>

<sup>83</sup> Guidestar.org. "990 Form filed for St John's Well Child and Family Center" (2011) pg. 9 <http://www.guidestar.org/organizations/95-4067758/st-johns-well-child-family-center.aspx>

<sup>84</sup> Ibid. pg 5-6

<sup>85</sup> United States Department of Health and Human Services, Health Resources and Services Administration. *UDS Summary Report St John's Well Child and Family Center*. (2011).



under the name of QueensCare Family Clinics. Until 2002, the clinics were controlled by the medical center. At this point, control was transferred to an independent board so that the clinics would be eligible to qualify as FQHC. QueensCare and QueensCare Family Clinics, two separate organizations, continue to collaborate; however, they are no longer controlled by the same board.<sup>86</sup> Their mission is “...to provide quality primary health care that is accessible to any patient in need in the communities we serve, regardless of ability to pay”.<sup>87</sup> Their 2012 annual report highlights how they stand up to protect, unite and lead within the community; protecting their patient population through their skills and resources, uniting the communities in their service areas, as well as working with other community organizations, and leading the way through the HealthyWay LA transition, both for themselves and other organizations.<sup>88</sup>

QueensCare Family Clinics is made up of six clinics, Bresee, Eagle Rock, East Los Angeles, Eastside, Echo Park and Hollywood.<sup>89</sup> (See Appendix 5.1) Their clinics offer a wide variety of services focused on providing acute and preventive care to all, regardless of age, ethnicity, income, and health insurance status. These services include primary, pediatric, dental and vision care, obstetrics and gynecological services, disease management, pediatric asthma, and pediatric weight management and diabetes education. They offer interpretative services in the following languages throughout their sites, Arabic, Armenian, Cantonese, Korean, Mandarin Chinese, Russian, Spanish, Tagalog, and Vietnamese.<sup>90</sup>

Each year, QFC operates on a budget of approximately \$21 million.<sup>91</sup> They provide a specific breakdown in their annual report of where these funds come from: 53% from patient

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<sup>86</sup> Queenscare Family Clinics “History”. Accessed April 18, 2013 <http://www.QueensCarefamilyclinics.org/about/history>

<sup>87</sup> Queenscare Family Clinics “Standing Up: Queenscare Family Clinics 2012 Annual Report”. (2012) pg. 5

<sup>88</sup> Ibid.

<sup>89</sup> The East Los Angeles and Eastside clinics are located within minutes of each other.

<sup>90</sup> Queenscare Family Clinics “Clinic Services”. Accessed April 18, 2013

<http://www.QueensCarefamilyclinics.org/services>

<sup>91</sup> Guidestar.org. “990 Form filed for Queenscare Family Clinics” (2011) pg. 9

<http://www.guidestar.org/organizations/95-3702136/queenscare-family-clinics.aspx>

service fees, 21% from the QFC/QueensCare partnership, 14% from contributions and in-kind donations, and 12% from HRSA Section 330 grant.<sup>92</sup> They have a board of directors made up of 15 voting members, QFC is different from the other clinics in that all but one of their board members are compensated for their time. Currently, QFC employs 217 individuals between their six clinic sites and their administrative team.<sup>93</sup>

In 2011, QueensCare Family Clinics served 36,927 patients, including 57.34% uninsured, 38.44% covered by Medicaid/CHIP, 3.02% covered by Medicare, and 1.20% covered by a third party. Of their total patient population, 92.40% identify as a racial or ethnic minority, 77.20% Hispanic/Latino, 22.43% Asian, 4.12% African American, 0.20% American Indian/Alaska Native, and 0.06% Native Hawaiian/Other Pacific Islander. Additionally, 53.55% of their patients reported being best served in a language other than English.<sup>94</sup> (See Appendix 5.2 for additional statistics)

### **Health Reform: California Moving Forward**

The state of California's government must determine what health care reform is going to look like before any governmental agency or other organization can move forward. Steps have been taken to address parts of the ACA, the health benefits exchange has been established, and other reforms have been made. However, the Legislature and Governor Brown are having trouble agreeing on what the Medi-Cal expansion is going to entail and whom it will affect. The Legislature has proposed that individuals earning up to 138 percent of the federal poverty level would be eligible for Medi-Cal. They have also proposed reform for the enrollment process,

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<sup>92</sup> Queenscare Family Clinics "Standing Up: Queenscare Family Clinics 2012 Annual Report". (2012) pg. 16 They also provide a more specific breakdown of the patient service fees, 53% HWLA, 40% Medi-Cal, 3% Medicare, 4% Individual Patients.

<sup>93</sup> Guidestar.org. "990 Form filed for Queenscare Family Clinics" (2011) pg. 5-6.  
<http://www.guidestar.org/organizations/95-3702136/queenscare-family-clinics.aspx>

<sup>94</sup> United States Department of Health and Human Services, Health Resources and Services Administration. *UDS Summary Report Queenscare Family Clinics*. (2011).

streamlining the process and the paperwork.<sup>95</sup> The Governor is creating push back by proposing amendments to these bills requiring extra paperwork for Medi-Cal enrollees, to ensure the no one is able to cheat the system. By doing this, it is creating paperwork that is not required for the health benefits exchange, thus making it more difficult for the enrollees and the state, especially if there are people who are on the cusp and could potentially be eligible for either program. However, the Governor wants to scale back on costs by eliminating long-term care for the disabled as well as transferring certain groups that are now covered by Medi-Cal, some AIDS and cancer patients and recent immigrants, to the insurance exchanges, where they will only qualify for partial subsidies. Additionally, he wants to reduce the amount of money given to the counties to cover the uninsured, which is approximately \$2 billion a year. Additionally, Governor Brown has proposed an opt-out trigger that would stop the Medi-Cal expansion if the federal government stopped paying 90 percent of the cost, as it is obligated to do after 2020.<sup>96</sup>

One of the most significant points that the Legislature and the Governor have not been able to agree on is whether the state or the counties will administer the health care expansion. There are arguments for both models of expansion; however, the state option is the more feasible one, with the county option believed to be a stalling tactic by the Governor as he looks for ways to save on cost.<sup>97</sup> However, the excuse of wanting to save on cost is poor since the state is not responsible for any of the costs for the first three years, until 2017, when their responsibility is 5 percent, with a maximum responsibility being 10 percent of the cost in 2020.<sup>98</sup> In the scheme of

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<sup>95</sup> California Healthline "Gov. Brown, Democrats Disagree Over Medi-Cal Expansion Plans." *Medi-Cal* (March 11, 2013). Accessed April 16, 2013. <http://www.californiahealthline.org/articles/2013/3/11/gov-brown-democrats-disagree-over-medi-cal-expansion-plans.aspx>

<sup>96</sup> Misak, Michael J. "Democrats, Brown at odds over healthcare act". *Los Angeles Times*, March 9, 2013. <http://www.latimes.com/health/la-me-healthcare-brown-20130310,0,2899658.story> (accessed April 18, 2013).

<sup>97</sup> Lewis, Kimberly. (Managing Attorney, Los Angeles Office - National Health Law Program). Interviewed by author. Telephone Interview. March 27, 2013.

<sup>98</sup> Ibid.

things, this is a fraction of California's budget. Ultimately, this seems like a stall tactic, the Governor is hoping that the Legislature or the counties will give in to his demands that way he can move forward with balancing his budget without worrying about the complete cost of the Medi-Cal expansion. Despite the fact that the state of California is not liable for any of the costs for the first three years.

If the state handles the expansion, it will be less fragmented, and they have the ability to create uniform regulations across the state to ensure that the Medi-Cal expansion will be handled properly and as many people as possible will be enrolled into the system.<sup>99</sup> Currently, the counties have a mandate from the state that was put in place in 1906, Section 1700, stating that they are responsible for providing health care to the uninsured and cannot afford insurance. If the state handles the expansion, the counties want this mandate removed as it is out of their control, but instead it is dependent upon what the state decides and how much funding they are willing to give the counties.<sup>100</sup> There is the concern, though, that the state does not have enough time to properly handle the expansion, since it is eight months away at this point (April 2013).<sup>101</sup>

The county option is not viable for multiple reasons. The counties do not have the time, resources or personnel to handle the expansion if it falls on them. They are also concerned about funding, because if they handle the expansion, the counties are worried that they will lose the funding they currently receive for the uninsured.<sup>102</sup> Additionally, under the ACA it is a state expansion, not a county expansion, meaning that the state of California would require a waiver from the federal government to move forward with the county expansion plan, a waiver they will

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<sup>99</sup> Lewis, Kimberly. (Managing Attorney, Los Angeles Office - National Health Law Program). Interviewed by author. Telephone Interview. March 27, 2013.

<sup>100</sup> Robertson, Jamie. (Program Officer, Health Reform and Public Programs, California HealthCare Foundation) Interviewed by author. Telephone Interview. February 17, 2013.

<sup>101</sup> Ibid. This paper was written in April 2013.

<sup>102</sup> Ibid.

most likely not receive.<sup>103</sup> If they were able to get a federal waiver to move forward with the county expansion plan it would mean that in addition to the state Medi-Cal program that is already in place, there would be 58 counties, running 58 different programs, with different requirements. The amount of overlap and unnecessary paperwork would be unbelievable, people would bounce from county to state programs depending upon their eligibility and if a patient were to move, and their benefits would not carry over. Additionally, there is the problem of counties who are not currently running a LIHP, they have no idea how to set up such a program and do not have the expertise or the experience of the state Medi-Cal officials or the counties running a LIHP. Ultimately, the county option is not viable; it is “not even in the spirit of the ACA, which is creating a program that is seamless and easy to get into”.<sup>104</sup>

There is also a concern on the state level as to how primary care providers are going to be reimbursed under Medi-Cal. The Governor has already cut their reimbursement rate in recent years, causing many providers to drop their Medi-Cal patients, because the reimbursement rate is not equal to the services provided.<sup>105</sup> The ACA requires an increase in reimbursement payments, but Governor Brown wants to cut the reimbursement rate by an additional 10 percent to save on costs for the expansion.<sup>106</sup> While this will save money as the expansion moves forward, it will also dramatically decrease the amount of primary care providers available to those enrolled in Medi-Cal. All this will do is increase the necessity for a strong safety net, as those are the providers required to see patients no matter their ability to pay.

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<sup>103</sup> Lustig-Viste, Amy. (Principal Analyst, Health Care Reform, Los Angeles County Chief Executive Office) Interviewed by author. Los Angeles, CA. March 13, 2013.

<sup>104</sup> Lustig-Viste, Amy. (Principal Analyst, Health Care Reform, Los Angeles County Chief Executive Office) Interviewed by author. Los Angeles, CA. March 13, 2013.

<sup>105</sup> Misak. "Democrats, Brown at odds over healthcare act."

<sup>106</sup> Robertson, Jamie. (Program Officer, Health Reform and Public Programs, California HealthCare Foundation) Interviewed by author. Telephone Interview. February 17, 2013.

There is a necessity for the process to be as streamlined as possible. Eventually, either the Legislature or the Governor will have to give in on the proposed amendments to move forward with this process. The Governor is focused on balancing the state budget no matter what the cost, while the Legislature is looking to streamline the process for Medi-Cal enrollees, making these public benefits available to as many people as possible. The Legislature is hoping to pass legislation for a state run program by the end of May; however, the Governor wants to revisit the issue in May after he has time to revise his proposed budget plan.<sup>107</sup> While the state needs to make the ultimate decisions as to how this expansion will be handled, the counties have no choice but to take steps on their own as they wait for state officials to agree on a plan.

## **Health Reform: Los Angeles County Moving Forward**

### ***HealthyWay LA to Medi-Cal Transition***

Despite the lack of state guidance moving forward, Los Angeles County has started to move forward with planning how to handle the transition from HealthyWay LA to Medi-Cal.<sup>108</sup> Since this transition is eight months away, it has reached the point where it is necessary for the county to start implementing their own steps to prepare for health care reform , because it is unknown as to when the state will ultimately decide what Medi-Cal will look like. Currently, the county is working with clinics, Community Clinic Association of Los Angeles County, and LA Care Health Plan to try to figure out the operational aspects of this transition. They are looking at things such as, at what point do they stop enrolling patients in HWLA so they have a clean record to give to the state; how do they ensure that patients keep their medical homes; how do they notify patients about the changes to come, ensuring that they understand what this means,

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<sup>107</sup> Misak. "Democrats, Brown at odds over healthcare act."

<sup>108</sup> The county is focused on the transition into Medi-Cal because Covered CA only covered patients who are at 133% of the federal poverty level or above, 93% of DHS (Department of Health Services) patients are below this level, and thus not eligible for Covered CA.

and the overall importance of filling out the paperwork.<sup>109</sup> All of these components have to happen to ensure that patients are transitioned into Medi-Cal.

In many ways, the County of Los Angeles is ahead of other counties because of how they chose to structure their LIHP. The HWLA matched eligibility almost exactly matches the eligibility requirements of Medi-Cal. The county did this to ensure a smoother transition so that they could eliminate redeterminations, saving patients time and paperwork.<sup>110</sup> Additionally, about a year ago, the county transitioned to a different enrollment system for HWLA to help streamline the process in 2014. The county is currently using a combination of YBN, Your Benefits Now, for the enrollment, which connects to the Leader database. While this transition was a nightmare, it was for the benefit of the patients, since the Leader database is the same system used by the Department of Public Social Services, DPSS, which administers Medi-Cal. This will hopefully lead to a smooth transition of patient records, information, and medical homes in the coming months.<sup>111</sup>

### ***Patient and Staff Education***

The county is also very concerned with the necessity for patient outreach and staff education. While patients will not start receiving paperwork until October, it is important to start education now so they understand the paperwork.<sup>112</sup> Many patients do not understand what health care reform means to them. The county wants to ensure that these patients know their

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<sup>109</sup> Lustig-Viste, Amy. (Principal Analyst, Health Care Reform, Los Angeles County Chief Executive Office) Interviewed by author. Los Angeles, CA. March 13, 2013.

<sup>110</sup> Redeterminations are conducted every year to ensure that patients are still eligible for HWLA or Medi-Cal benefits. Up until 2013, HWLA redetermination paperwork had to be completed in person; this made it hard to retain patients because people were not willing to travel to their clinic site to fill out paperwork to keep their coverage. Beginning in January 2013, HWLA redeterminations can be done through the mail, as is standard practice for Medi-Cal redeterminations. With the one to one transition from HWLA matched to Medi-Cal, there should be no need for redeterminations to be completed again in January 2014.

<sup>111</sup> Lustig-Viste, Amy. (Principal Analyst, Health Care Reform, Los Angeles County Chief Executive Office) Interviewed by author. Los Angeles, CA. March 13, 2013.

<sup>112</sup> It is mandated within the Medi-Cal expansion that patients under the 1115 waiver must be notified within 90 days of their transition from the LIHP to Medi-Cal.

rights, and understand that the county will be handling the bulk of their transition; they just need to fill out the paperwork when it comes. Additionally, the county is working with the community partners to see if this messaging should be extended to partner's patients as well.<sup>113</sup> Staff education, especially for health providers, is also necessary because they are the ones who interact with patients on a daily basis. The county wants to ensure that all staff is giving and receiving the same message. They hope to have external and internal messaging developed to start sending out by mid-April.<sup>114</sup>

### *Access to Specialty Care*

Currently, under HWLA the county handles all specialty care, meaning that all HWLA partners must refer their patients to DHS for specialty care. In addition to there being a concern about patients retaining their medical home, the county is also working to ensure that patients retain their specialty care providers. To do so, the county must contract with the clinic's IPA to ensure that a referral to DHS specialty care is possible. The two main Medi-Cal IPAs in Los Angeles County are Healthcare LA and AltaMed. The county is in the process of creating contracts with these two IPAs to ensure that when HWLA patients are transitioned into Medi-Cal they will still be referred to and able to see their established specialty care providers.<sup>115</sup> However, this is not an easy process because in addition to rate setting, the IPAs have a different processing for billing and payment than what the county is used to. This means that the county has to change completely their billing and referral processes to ensure that the IPAs will contract

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<sup>113</sup> DHS in addition to administering HWLA, they also have their own HWLA patients who have chosen to have DHS clinics and sites as their medical home. This means that DHS must work with their community partners to determine what should be handled by DHS as the administrator of HWLA and what each clinic will do for their own patients.

<sup>114</sup> Lustig-Viste, Amy. Los Angeles, CA. March 13, 2013.

<sup>115</sup> Ibid.



with them. These contracts need to be finalized by January 2014 to ensure that HWLA patients will still be able to see their same specialty care provider.

### ***Restructuring of HealthyWay LA Unmatched Program***

The county is also very focused on how they will be restructuring the HWLA unmatched program. It is estimated that there will be 1 ½ to 2 ½ million residually uninsured by 2017 in Los Angeles county; 75% of these people will be eligible for a health plan. This issue is just about accessing them and helping them to become enrolled in Medi-Cal or Covered California.<sup>116</sup> The rest of these individuals are people who will not be eligible for Medi-Cal or Covered CA because of their citizenship status, either because they are undocumented or have not been in the county long enough. These are the patients who end up in the HWLA unmatched program, the patients that DHS wants to see in a primary care medical home as opposed to the emergency room.

Currently, those enrolled in HWLA unmatched who seek care at community clinics are funded solely by the county, with no state or federal match. This means that moving forward there is not an immediate threat to the funding for those who seek care at community partners because this comes from county funds, and there are no plans for the county to realign these funds. However, the county uses state and federal funds to cover the uninsured in their system, meaning DHS clinics and hospitals. This is the funding that has the potential to be limited moving forward since the federal fund decrease is written into the ACA. The state is threatening to cut funds for the residually uninsured now to compensate for their increased cost from the Medi-Cal expansion. However, this does not make sense because the state is not obligated to cover any of the cost until 2017. Therefore the county wants the state to want until then to

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<sup>116</sup> Ibid.

determine how their funds will be affected. At this point, there will be real numbers as to who the residually uninsured are as opposed to speculative statistics.<sup>117</sup>

The county is also looking to restructure the payment method and criteria for enrollment into HWLA unmatched moving forward. Currently, the community clinics are paid a fee for service rate, meaning for each visit with a HWLA unmatched patient they are paid \$94 per visit regardless of what that visit entails. They are looking to move to capitation, which means the county will pay the clinics a per-member-per-month fee as opposed to per visit, which supports better care management.<sup>118</sup> They will also be evaluating how they determine who is enrolled into the program, because they have a set number of funds and there are more uninsured people in Los Angeles County than the program can pay for. Under the current rules, patients are prioritized based upon where they live, low-income neighborhoods, and areas that have low insurance rates, but high rates of disease. For the new system, they will prioritize based upon the health needs of the patient, regardless of where they live. This will ensure that the sickest of the uninsured are cared for first.

The county hopes that through making these changes to the HealthyWay LA unmatched program, not only will they be able to better serve the residually uninsured patients of Los Angeles, but that the program will work to the benefit of the county's clinics and their community partners. By changing the payment structure, clinics will have more funds to care for these patients, funds that actually meet the cost of caring for them, as opposed to these funds having to come from the clinics budget. This will also allow clinics to better serve those residually uninsured who are not enrolled in the HWLA unmatched program. Their federal funding for serving the uninsured, while reduced, will be serving a smaller population.

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<sup>117</sup> Lustig-Viste, Amy. Los Angeles, CA. March 13, 2013.

<sup>118</sup> Ibid.

Ultimately, the goal is to not only better serve the residually uninsured, but also allow the clinics to function more efficiently on a limited budget.

### **An In-Depth Look into Four Federally Qualified Health Centers in Los Angeles County**

Federally Qualified Health Centers are a unique set of health care providers within the American health care system. With the implementation of the Affordable Care Act, there are numerous opportunities for growth and change within this clinic setting. However, due to the nature of the law and the sizable patient population increase that will be seen under the Medi-Cal expansion of 2014, there are many issues that FQHCs are being forced to think critically about as they move forward. I worked with four different clinics, Community Health Alliance of Pasadena (ChapCare), THE Clinic, Inc., St John's Child and Family Wellness Center (St John's), and QueensCare Family Clinics (QFC) to assess what FQHCs in Los Angeles County are doing to prepare for this expansion. As has been previously outlined, Los Angeles County is the largest county in the state of California and has a larger health care delivery system than most states. The county of Los Angeles and the state of California serve as examples for much of the country, leading the way in developing the new health care delivery system under the Affordable Care Act.

Based upon my interviews with these clinics, I have broken down my findings into five categories: key concerns focused on health care reform, steps to prepare for expansion, the role of technology within health care reform, the role of HealthyWay LA as Los Angeles County's LIHP transition program, and their relationship with Los Angeles County moving forward towards 2014. Within each of these categories, there are overarching themes that can be seen from clinic to clinic. However, each clinic has their own perspective on health care reform and what they should do moving forward to meet the needs of their patient population.

## ***Key Concerns focused on Health Care Reform***

### *Community Health Alliance of Pasadena*

ChapCare has four primary concerns as they look to addressing the requirements of the ACA: continued reimbursement for the uninsured, patient retention, capacity to serve the newly insured, and what a decrease in self-pay patients' means for their funding. Currently, they receive reimbursement from the federal government for seeing uninsured patients because of their mandate as a FQHC to care for anyone who comes into the clinic. However, with the changes to the health care system through the ACA leaves very few options for the residually uninsured, which will in most cases, be either undocumented immigrants, those who are here legally, but not eligible for coverage yet or those who are eligible for insurance, but have not enrolled yet or are consciously choosing not to seek insurance coverage. This reimbursement will most likely continue in the cases of undocumented immigrants and for those who are not eligible for coverage yet. However, if patients are eligible for Medi-Cal or the health insurance exchanges and choose not to apply, they will not be eligible to pay on a sliding scale fee, but instead will be charged for 100 percent of the cost of the visit. This rule only applies to FQHCs, "...federal money cannot be used on people who are insurable."<sup>119, 120</sup>

Patient retention and capacity are also a two key concerns for ChapCare. They are concerned about whether or not those who are currently uninsured will choose to select ChapCare as their health care provider once they are insured. To help ensure this, they are working to make sure that their current patients are receiving the best customer service and patient care possible.<sup>121</sup> This was also cited as important because of the reimbursement and monetary support that these patients bring to ChapCare. In addition to retaining old patients, they

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<sup>119</sup> Martinez, Margaret B. (CEO ChapCare). Interview by author. Pasadena, CA. March 4, 2013.

<sup>120</sup> Just to clarify, if patients are not insurable, meaning they do not qualify for Medi-Cal or Covered CA, these patients will still be able to pay on a sliding scale.

<sup>121</sup> Martinez, Margaret B. Pasadena, CA. March 4, 2013.

are focused on making sure that they have the capacity to attract and serve the newly insured patients.<sup>122</sup> It is seen as a necessity to bring in these patients, for their reimbursements and payment streams, and to make sure that ChapCare is not just left with the residually uninsured.

The final concern voiced by ChapCare is whether they will see a decrease in self-paid, cash, patients, and what this will do to their pool of funds. If this number is decreased, it is imperative that ChapCare maintains their same level of funding as a FQHC to make sure that they are best serving their patients. It is also making sure that when these patients do come that ChapCare's staff is helping them access coverage if they are eligible for it.

#### *THE Clinic, Inc*

THE Clinic, Inc, located in South Los Angeles, had two key concerns, patient retention and patient education. Like ChapCare, they are concerned "since patients who have been historically uninsured will now have insurance, we need to make sure that they will continue to utilize our services."<sup>123</sup> This again is about making sure that they retain their patients, and are giving them the best care possible. They are also concerned with patient education, there is a lot of information available about what is happening under health care reform, however, much of it is misinformation or not explained at a level that a low income, non-English speaking population will understand. Therefore, patient education is also seen as key to ensure that patients know their rights and their options.

#### *St John's Well Child and Family Center*

St John's Well Child and Family Center is self-described as an atypical health care provider.<sup>124</sup> While some of their concerns do reflect the concerns of the other clinics, they have a

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<sup>122</sup> Ibid.

<sup>123</sup> Oyamenden, Itohan. (COO, THE Clinic, Inc.). Interview by author. Telephone Interview. March 27, 2013.

<sup>124</sup> Clemente, Regina. (Campaigns Coordinator, St John's Well Child and Family Center). Interviewed by author. Los Angeles, CA. March 22, 2013.

very strong social justice focus, which changes the way they view their patient population and how they work with them. They are very focused on the lack of inclusion of the undocumented in the ACA, both the CEO, Jim Mangia, and the organization overall are pushing for immigration reform to have a piece about health care, hopefully allowing undocumented immigrants to be covered under the ACA in the future.<sup>125</sup>

Their biggest concern moving towards 2014 is how people will become enrolled into the new health care system. They are in the process of developing strategies, which will be discussed later, to target low income and hard to access communities to ensure that they are educated about the changes and to help them enroll into the system.<sup>126</sup> They are also worried about how to increase capacity and meet the needs of everyone coming into the clinic. It was described as an “exciting and stressful time,” as everyone is waiting to see what the state will decide to do based upon the federal guidelines, but also taking into consideration what is best for California as a whole.<sup>127</sup>

Concerns about payment reform were also expressed. If the amount that each clinic is reimbursed per patient is decreased because there are more patients to cover, they will have to figure out how to maximize care at a lower cost, while still meeting the demands of the ACA, integrated care, case management, and linking to service. This is also largely speculation because the California state government has yet to announce what the new reimbursement system will be; it could change or it could stay the same.<sup>128</sup> Depending upon what this reimbursement looks like, St John’s is also examining their current partnerships with hospitals and other clinics. If there is a

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<sup>125</sup> Clemente, Regina. Los Angeles, CA. March 22, 2013.

<sup>126</sup> Clemente, Regina. Los Angeles, CA. March 22, 2013.

<sup>127</sup> Khalfani, Nomsa (Chief of Policy and Support Services, St John’s Well Child and Family Center) Interviewed by author. Telephone Interview. March 25, 2013.

<sup>128</sup> Khalfani, Nomsa Telephone Interview. March 25, 2013.

drastic change in the payment system, there may be a need to rework their partnerships to better serve the needs of their patients.

### *QueensCare Family Clinics*

QueensCare Family Clinics expressed three key concerns: what the enrollment process will look like, patient retention and education, and the necessity for payment reform. Since there has been nothing handed down from the state yet, due to the disagreements between the legislature and the governor, there is no concept of what the enrollment process is going to look like. QFC is largely concerned with how people who are currently outside the health care system are going to be brought into it, as Alex Armstrong, COO, stated, “We are a safety net clinic, it isn’t like we advertise”.<sup>129</sup> They are waiting for guidelines to see how those outside will be brought in, as well as who will be handling the expansion, the state or the county (although as previously discussed, it seems as though the county option is not a real option). Without guidelines, it is simply waiting to see what will happen, people are expecting something to happen starting January 2, 2014; however, there is currently no system setup and there is supposed to be one by October. There was also concern expressed as to where Medi-Cal patients would be assigned, which was interesting. The other clinics spoke of it as if patients would have a choice in where they receive their care; however, at QFC the belief seems to be that patients will be assigned to different clinics based upon certain criteria, i.e. where they live, work, or which clinic they originally register with. Due to this assumption, there is a worry about a disruption of care if current patients are reassigned to a different clinic. This is when patients need to take some initiative to ensure that they are able to stay with the same provider or clinic, so when they

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<sup>129</sup> Armstrong, Alex. (COO, Queenscare Family Clinics). Interviewed by author. Los Angeles, CA. March 4, 2013.

are enrolling making sure that QFC is their assigned medical home.<sup>130</sup> They are also worried how under this system they find out which patients have been assigned to them, and what that patient population will look like. Depending upon what this population looks like, more needy, less needing, “the young and healthy”, very sick population which has never sought care, it could drastically change the ways in which QFC deals with patients.<sup>131</sup> Ultimately, until guidelines are handed down from the state, clinics can only speculate.

They also have concerns about patient retention and education. Similar, to THE Clinic, Inc, patients do not have all the facts about what the expansion is going to look like so they are expecting things in 2014, which may or may not happen.<sup>132</sup> This is also a patient population that has not been previously insured, which means in the past they have had no appeal for other health care providers. However, now they have a payer source attached to them, which means other providers may try to solicit them away from their traditional care providers, the safety net clinics.<sup>133</sup>

The final concern of QFC is what the payment structure is going to look like. It could be assumed that the payment structure will stay the same; however, based on recent history and the fact that Governor Brown tried to get rid of the PPS rate, prospective payment system rate, or how FQHCs are paid for Medi-Cal patients, recently there is expected to be a restructuring of the payment plans. QFC pointed out two things in particular that need to be considered when the state is restructuring the payment system, the concept of patient centered medical homes, and redefining what a visit means. Currently, FQHCs, are paid on a per visit rate, however, under the new structure of patient center medical homes, PCMH, there is a strong focus on comprehensive

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<sup>130</sup> Hines, Barbara. (President and CEO, Queenscare Family Clinics). Interviewed by author. Los Angeles, CA. March 4, 2013.

<sup>131</sup> Armstrong, Alex. Los Angeles, CA. March 4, 2013.

<sup>132</sup> Hines, Barbara. Los Angeles, CA. March 4, 2013.

<sup>133</sup> Ibid.



care, providing preventative services, the notion of keeping a patient well as a whole. Despite these new requirements, much of these services are not covered under reimbursement, FQHCs have to find the money in other places to cover preventative services and other programs.<sup>134</sup> This is where QFC pointed out the complete importance in redefining what a visit means so it does include these preventative services. As the system currently stands, a visit is only a face-to-face, one on one visit with a MD, Nurse Practitioner, Physician Assistant, Dentist, Optometrist, or a mental health professional.<sup>135</sup> If the notion was expanded to include Clinical Pharmacists and other practitioners who meet with patients to discuss medication and other health issues, this would increase reimbursement for clinics, alleviate access and capacity issues, and allow them to better serve their patients. Additionally, allowing for group visits would save time, and allow physicians to disperse basic health information to a larger group of patients, shortening individual visit times and keeping the physician from giving the same speech repeatedly.<sup>136</sup>

### *Common Themes*

The common themes that can be seen among the key concerns are payment reform, patient retention and education, and enrollment of new patients. Currently, each FQHC is paid a certain rate per visit, PPS rate; however, this reimbursement in most cases does not cover the total cost of the visit and what the clinic is expected to provide the patient with now.<sup>137</sup> The necessity for payment is clearly expressed by every clinic. Until there is more guidance given from the state, there is not much any of the clinics can do beyond speculate as to what this reform will look like, or if it will even happen. They all have their opinions about the best way to

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<sup>134</sup> Ibid.

<sup>135</sup> Armstrong, Alex. Los Angeles, CA. March 4, 2013.

<sup>136</sup> Armstrong, Alex. Los Angeles, CA. March 4, 2013.

<sup>137</sup> This is negotiated individually between each clinic and the state (California Department of Health Care Services), so I was not given access to this information because each clinic is reimbursed at a different PPS rate. I asked for the rates, but it was stated that because they are not all reimbursed the same, it could cause tension between clinics if disparities in rates were known.

reform the payment structure, however what is common throughout all these different opinions is not only the need for reform, but also that this reform needs to increase the reimbursement that is given to clinics. In the next four years, FQHCs are going to see a great numbers of changes due to the ACA. They are expected to provide patients with complete health care focused on the patient as a whole, not just the disease or symptoms present. Due to this push to focus on preventative care, clinics need to have the funding and the resources to provide this prevention. While, there are funds written into the ACA for preventative medicine, it is not enough to cover the complete change in care expected. This is perhaps where QFC idea of redefining what a “visit” means becomes key.

Patient retention and education was also a key concern. Many of the FQHCs patients have never had health coverage before, or do not even realize that they will soon be eligible for health coverage. It is important for patients to understand what their options are, and what the ACA is doing because currently there are many misstatements circulating that have been pushed forth by the media and other organizations. This is where patient education comes in; however, once again until better guidelines are given from the state it is hard to know what to patients need to be educated on.

Patient retention was also mentioned numerous times. However, it is interesting to note the different reasons that these FQHCs are focused on patient retention. Both St John’s Well Child and Family Center seem more focused on patient retention because they believe that they provide their patients with the best care available. Additionally, throughout these interviews the language used was more focused on the patient’s best interest. In the cases of ChapCare and QueensCare Family Clinics, they are concerned about what is in their patients’ best interest as well, but the business aspect of health care can be seen. Both talk about patient retention, not

only as a necessity for continuation of care, but also tying it back to the payment aspect, how if they lose these patients they will lose the money that comes along with them. This is not to imply that these two organizations care any less about their patients needs, because this is not true, it is merely to point out the concern within both clinics focused on the funding aspects. This once again brings the conversation back to the need for payment reform.

All of the clinics also pointed out how these newly insured patients will be targeted by other providers, outside the safety net system. Since they are newly covered, through either Medi-Cal or Covered CA, they will now come with a reimbursement payment, while before they were uninsured patients forced to use the safety net because no private physician was willing to see them. The fact that newly insured patients will have a wide variety of physicians to choose from is amazing, and a great accomplishment of the ACA. However, the potential that these patients will leave their traditional safety net providers in favor of a private doctor is of great concern to FQHCs. This is part of the reason FQHCs are focused on transforming care, not only because it is federally mandated, but also because without this transformation, they could lose much of their patient population. They are still the safety net and still there to serve the needs of low-income patients, regardless of insurance; however, if they are only left with the residually uninsured they stand to lose much of their federal funding stream.

Finally, there is the issue of patient enrollment. Once again, without guidelines from the state it is hard to know what the patient enrollment process is going to look like. Covered CA has been setup so there are educational materials around the exchange. However, most of the patients seen at FQHCs will be part of the Medi-Cal expansion, not the exchange, so the necessity for the state to decide how the expansion is being handled is imperative. However, one of the clinics, St John's Well Child and Family Center, is not waiting for the state; they have already started to

devise a plan on how to educate patients and how to enroll them into the system, which will be discussed in the next section. The speculation around what enrollment will look like is interesting in that no one has a real sense as to what is going to happen. Based upon the literature and the current HWLA program, where patients are able to choose their own medical homes, it does not seem likely that patients will be assigned a new medical home if they already have one. New enrollees will be assigned a medical home. However, if they have never sought medical care in a clinic setting before, being assigned a medical home could be beneficial because new enrollees are being directed to where to receive their care.

### ***Steps taken towards Expansion***

#### *Community Health Alliance of Pasadena*

ChapCare cited four key components that they are using to help prepare for an expanded patient population. First, they have applied for a grant from Covered California. This would allow them to educate in the clinics about the expanded options under the ACA that their patients may qualify for, and in the community, educating the neighboring population about ChapCare and the services that they provide. They have already been using an outreach worker in the community for the past three years; however, she is focused on prenatal care. She has been able to attract women to ChapCare for their prenatal services, which has led to women returning for their next pregnancy based upon the care they received.<sup>138</sup> They hope to be able to do the same for the ACA through community outreach. Additionally, through Covered California they have staff members who are becoming certified assisters for the health insurance exchange. By having certified assisters on staff, they will be able to help those patients who qualify to enroll in the insurance exchange. The hope is that by giving them this assistance, they will choose to come back to ChapCare once they have insurance coverage.

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<sup>138</sup> Martinez, Margaret B. Pasadena, CA. March 4, 2013.

Additionally, they are planning to increase their capacity, by both maximizing the space they currently have and opening a new site. They recently conducted a study to see how many patients were being seen on a daily basis at each site. A key finding from this was that on the days where they have the most providers available, some of their clinics are seeing the least amount of activity. Currently, they are looking to understand why this is, and what can be done to fix it, if it is shifting clinic hours, shifting provider days or hours, or encouraging people to come to the clinic on different days.<sup>139</sup> Understanding why this is happening will allow them to maximize their capacity at all of their sites, and increase access to services. Specifically, for their Fair Oaks Clinic, which is the largest clinic, they have just acquired the lease for the entire building from the city of Pasadena. By having the entire building, as opposed to sharing it with another non-profit as they do currently, they will be able to reconfigure the clinic in a way that gives providers more space and allows them to better serve patients. They are also opening a new clinic, hopefully this month (April 2013) in South El Monte. This site gives them an opportunity to provide access to health care to yet another traditionally underserved community, and hoping to attract the patients who will be eligible for Medi-Cal under the expansion, so they will choose the new ChapCare site as their medical home.

One of the key components to the ACA that is critical for FQHCs is becoming a certified Patient Centered Medical Home, PCMH. ChapCare will soon be using this certification as part of a marketing campaign to attract patients to their clinics.

Providers are “the key to ACA”, according to ChapCare’s CEO Margie Martinez; without quality providers to serve the patient population in the clinics, the rest of the strategies to deal with expansion are irrelevant. However, “it is getting harder and harder to hire the full time family practice doctor, so [they] are having to look at the newly graduated, mid- levels, [such as]

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<sup>139</sup> Ibid.

physician assistants, nurse practitioners to come in”.<sup>140</sup> All of these mid-levels function under the supervisor of a physician. This is becoming an increasingly common practice in FQHCs to dealing with the primary care physician shortage, a shortage that had been created not by a lack of physicians specializing in primary care, but instead by the increased demand for primary care providers. Additionally, it is becoming increasingly difficult for FQHCs, such as ChapCare, to attract physicians to work for them. Many providers are opting to work for private practices, or organizations such as Kaiser or AltaMed, who are able to provide higher compensation and hours that are more flexible.<sup>141</sup> One key opportunity that ChapCare is able to offer is the option to enroll in a loan repayment program from physicians, nurse practitioners, physician assistants, nurses, and other specialties.<sup>142</sup>

#### *THE Clinic, Inc*

THE Clinic, Inc has been a certified Patient Centered Medical Home since 2011, and was one of the first sites to receive this designation by The Joint Commission.<sup>143</sup> This has given them an advantage over many other clinics in Los Angeles; they started addressing the requirements of the ACA early on. They are currently focused on “...making sure that they are differentiated from the competition, letting patients know about the services they receive, and what makes us different from the private doctor across the street”.<sup>144</sup> By differentiating themselves from other clinics and private doctors, they hope to retain their current patient population as well as attracting new patients through their unique services. One of these services is that they have been using Patient Portal for approximately a year now. Patient Portal is an online service that allows

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<sup>140</sup> Martinez, Margaret B. Pasadena, CA. March 4, 2013.

<sup>141</sup> Martinez, Margaret B. Pasadena, CA. March 4, 2013.

<sup>142</sup> Loan Repayment programs for physicians (obstetrics and gynecology, family practice, internal medicine, pediatrics), nurse practitioners (family practice), physician assistants (family practice), nursing, psych, dentistry, social work

<sup>143</sup> Oyamenden, Itohan. Telephone Interview. March 27, 2013.

<sup>144</sup> Ibid.

patients to make appointments, view medical records, view labs, and communicate with their provider, in addition to other services.<sup>145</sup> This is one of the criteria all FQHCs must meet under meaningful use; however, it is not mandated until 2015. THE Clinic, Inc is using this early implementation as a strategy to both keep and attract patients. Currently, they are reaching out to all the patients who have been activated in the system to remind them of this feature. Once, this is complete, they plan to start reaching out to the rest of their patients to let them know that this feature is available to them and for those who are interested, they will help them set it up.<sup>146</sup>

Capacity is another key aspect that THE Clinic, Inc is dealing with. Two years ago, through ACA, they received funding to update their current facilities. Through this update, they were able to add dental services. Currently, they are doing outreach about their current services and the addition of dental to attract new patients. Their mobile clinic is also a resource that is being used in outreach efforts. In addition to this, they will be opening a new facility in July. They are still in negotiations to acquire the site, so the exact location could not be disclosed, but it will be located in the 90019 zip code, which is Central Los Angeles just north of I-10, meaning they are expanding outside of their traditional service area of South Los Angeles.<sup>147</sup>

#### *St John's Well Child and Family Center*

St John's has the most community outreach oriented approach to preparing for the expansion. Starting in May 2013 through December 2014 they will be launching their "Get Ready, Get Covered" campaign both in clinic lobbies, or waiting rooms and going door to door in the community. Through face-to-face conversations with current patients and prospective new patients they hope to increase education and understanding as to what the ACA is, what it is

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<sup>145</sup> Ibid.

<sup>146</sup> Oyamenden, Itohan. Telephone Interview. March 27, 2013.

<sup>147</sup> Ibid.

doing, and how they can benefit from the law. For this campaign, they plan to hire three new full time Outreach and Education workers.<sup>148</sup>

As previously mentioned, their biggest concern within health care reform is getting those from low income or hard to access communities to enroll in the system. In addition to the launching of the “Get Ready, Get Covered” campaign, they will also be utilizing their Right to Health Committees to access community members who do not already use St John’s as a health care provider. Right to Health Committees are made up of patients coming together once a month to discuss their rights within the health care community, as well as other social justice issues affecting the South Los Angeles community. St John’s will be asking the members of these committees to hold house meetings. At each house meeting, a committee member will invite 8 – 10 members of their community, family, friends, or neighbors, to their house to learn about the ACA, how the law will affect them, and what health coverage options may become available to them. The attendees will be provided with information to help them enroll, either in Medi-Cal or in the health insurance exchange; they will then be asked if they would like to hold a similar meeting, using a concept similar to a phone tree to disseminate information throughout the community.<sup>149</sup>

Additionally, St John’s is part of the Campaign for Health and Human Rights, a coalition of organizations and their members, focused on South Los Angeles working to increase access to healthcare, safe and affordable housing, increased green space, and healthy food, among other issues.<sup>150</sup> They will be working closely with two of the other members of this coalition,

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<sup>148</sup> Clemente, Regina. Los Angeles, CA. March 22, 2013.

<sup>149</sup> Clemente, Regina. Los Angeles, CA. March 22, 2013.

<sup>150</sup> <http://www.southlahealthandhumanrights.org/> Full membership includes SEIU UHW, Southside Coalition of Community Health Centers, Los Angeles Metropolitan Churches, LACAN, SAJE, Esperanza Community Housing Corporation, PNHP (Physicians for a National Health Program California), Community Health Councils, and St John’s Well Child and Family Centers



Esperanza Community Housing Corporation, and SAJE, Strategic Alliance for a Just Economy, to utilize each other's membership base for their own campaigns.<sup>151</sup> St John's will encourage their patients to attend these events and will be bringing their mobile clinic to different events sponsored by Esperanza and SAJE. At these events, they will provide health screenings as well as educational materials about the ACA, and provide people with information about their coverage options. St John's focus is on providing as much information as possible to a wide variety of people. While they hope that all these people will chose to be St John's patients, they seem to care more about educating a large population of people so they can make informed decisions regarding their own health.

Since St John's is very focused on social justice issues and equality for all, they are looking for an option to provide undocumented immigrants with health coverage. Currently they are pushing for something in immigration reform to provide the undocumented with health coverage, however until this happens, they as the residually uninsured will have no health coverage. St John's network of clinics sees more undocumented immigrants than any other clinic in the SPA 6 area.<sup>152</sup> They are currently working with LA Care to come up with a health insurance plan for the undocumented immigrants living in Los Angeles County. If and when this is developed, they would start publicizing it at their various outreach events as an option for those who are undocumented, therefore they do not qualify for Medi-Cal or the health insurance exchange. Since this plan is still in the works, it is hard to know what it will entail, it will most likely only work at St John's, which has the potential to drastically increase the amount of patients St John's sees.<sup>153</sup>

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<sup>151</sup> Esperanza is currently focused on an anti-fracking campaign near USC and SAJE is a tenant-organizing group.

<sup>152</sup> Clemente, Regina. Los Angeles, CA. March 22, 2013.

<sup>153</sup> Ibid.

In addition to this strong community outreach and education focus, St John's is also taking steps to prepare their clinics for an increased patient population. This year they will be opening up at an eleventh clinic site, their fifth school based site, at Washington High School. They are currently undergoing an efficiency audit, which is being completed by a consultant agency. This audit is looking at how to improve "operational efficiency to enhance care quality, patient and employee satisfaction and productivity".<sup>154</sup> They are looking at how to minimize patient wait times, while maximizing their time with clinicians. It is not only about maximizing the time with the clinicians, but a more conscious focus on coordinated care and delivery of quality care.<sup>155</sup> The audit is focused on helping them create a patient centered environment as St John's has yet to receive their certification as a Patient Centered Medical Home. Another aspect of this is the "warm welcome", making sure that each clinic is creating a patient supportive environment to ensure that the patients have a pleasant experience and want to return to St John's in the future.<sup>156</sup> They want to refocus their image away from the notion of a safety net clinic, being seen as a safety net implies the place of last resort, while in contrast, a patient centered medical home implies a clinic that is focused on the patient as a whole, where people can come for continuing care and preventative medicine.<sup>157</sup> The provider shortage was also mentioned, and again how competitors are able to pay at a higher rate with more benefits. For St John's, it is about finding providers who are excited and passionate about working with these communities.

### *QueensCare Family Clinics*

QueensCare Family Clinics is primarily focused on increasing and maximizing capacity, and patient enrollment and education moving towards 2014. As part of standard practice, they

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<sup>154</sup> Ibid.

<sup>155</sup> Khalfani, Nomsa Telephone Interview. March 25, 2013.

<sup>156</sup> Clemente, Regina. Los Angeles, CA. March 22, 2013.

<sup>157</sup> Khalfani, Nomsa Telephone Interview. March 25, 2013.

have health enrollers at every clinic site. A health enroller meets with every new patient to determine if the patient is eligible for any type of coverage, which currently means HealthyWay LA or Medi-Cal. Currently, health enrollers are able to help patients enroll in HWLA, but they are not able to help patients enroll in Medi-Cal; this is handled by the county, but they can help patients start the process. All of QFC's health enrollers will become health assisters for the health exchange so once the exchange is active they will be able to help eligible patients. They have been conducting patient education based upon the current HWLA program since there are no guidelines yet for what the expansion will look like from the state.<sup>158</sup>

As one measure to increase capacity, QFC is building a new clinic site in East Los Angeles, replacing the two current clinics in East Los Angeles. This site will be nearly twice the size of their largest clinic, approximately 25,000 square feet.<sup>159</sup> The initial proposal to construct this clinic was written as part of a strategic plan in 2010, after the ACA had passed and clinics were starting to think about how they would address the changes to come in 2014. Ultimately, this clinic is seen as a risk by QFC management, not only because of the drastic increase in size compared to all the other clinics, but also because they will not know if they are going to see the increased demand to fill the clinic until the clinic is operational and the expansion has begun.<sup>160</sup> The necessity to find quality providers was also mentioned, as more providers allow a clinic to see more patients and have the potential to extend hours and open sites on Saturdays. QFC has the capacity to grow beyond this; however, they are more concerned with maximizing their current capacity. Approximately 40 percent of their patients are no shows, meaning that their schedules may look full, but this is not actually the case. It is important to fill in these gaps

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<sup>158</sup> As Amy Lustig Viste mentioned in the County Policy portion, the HWLA matched program has the exact same eligibility requirements as those mandated by the federal Medicaid expansion. Despite the lack of guidelines from the state of California, educating based off the HWLA program is the best bet because of the 1 to 1 match.

<sup>159</sup> Armstrong, Alex. Los Angeles, CA. March 4, 2013.

<sup>160</sup> Hines, Barbara. Los Angeles, CA. March 4, 2013.

before looking to expand more, especially when they are not sure what their future patient population is going to look like.<sup>161</sup>

### *Common Themes*

Four common themes emerged when looking at the steps being taken by clinics to prepare for the Medi-Cal expansion of 2014.

### Expanding Clinic Capacity

Clinics are expanding their capacity, focusing on outreach and education, looking to hire more providers, and transforming the care that they provide. Three of the clinics are adding new sites to be opened within the next year, St John's being the exception to this. However, they are adding an additional school site and are in the process of completely remodeling their pediatric clinic site. In addition to adding new sites, all are looking to improve and expand their current facilities to ensure that they are ready to handle an increase in their patient population. Expanded site capacity allows the clinics to see more patients physically, and newer facilities can be a marketing point to attract new patients. An issue that goes hand in hand with this is the ability to attract and hire new providers. Without new providers, no new capacity matters, because they will have the space to serve the patients, but not the clinicians. Ultimately, finding new providers will be the key to the expansion. It seems as though it will be a combination of clinics hiring non-traditional primary care providers, nurse practitioners and physician assistants, to be overseen by physicians. As well as attracting providers with loan reimbursement plans that will help them pay off their student loans while serving the community. Clinics must also play an active role in lobbying the state to not cut reimbursement rates for Medi-Cal providers. While FQHCs are required to see all patients, if they are receiving a hire reimbursement rate for Medi-

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<sup>161</sup> Armstrong, Alex. Los Angeles, CA. March 4, 2013.

Cal patients it will ease some of their budgetary concerns and help attract providers by being able to offer them a competitive salary.

#### Increased Patient Outreach and Education

Increased patient outreach and education are also essential to not only attract new patients, but to also sustain the patient population that they currently serve. It is interesting to see the different approaches to patient outreach and education. ChapCare and THE Clinic are taking more traditional approaches, such as education in the waiting room, the use of outreach workers and mobile clinics that would be expected of a community clinic. QFC seems to be waiting until they have more information to start thinking realistically about what patient education will look like. They are very business oriented and until they have more information, it does not seem to make financial sense to invest in education without all the facts. They also seem slightly skeptical about whether or not their patient population will even understand the materials that are being given to them. This seems like an opportunity to work with the county or other clinics to develop materials that their patient population will understand. They have access to them every day in their waiting room, by utilizing the patients that they do see on a regular basis they could test what they know and evaluate the best ways to disseminate information.

St John's is by far taking the most unique strategy to patient outreach and education. This comes from their strong focus on social justice issues, in addition to their involvement in many other groups and causes beyond health care. While in some ways, St John's seems to be the ideal model for patient outreach and education, it is unrealistic to expect more traditional clinics to start using organizing tactics to educate their patient population. It seems as though some of St John's tactics, such as the waiting room educational sessions, could be applied across the board

and educational materials could be adapted from clinic to clinic. However, most of the clinics do not have the staff capacity or the time to lead home education sessions.

### Transforming Patient Care

All the clinics are also focused on transforming their patient care. They have previously focused care on the whole patient; however the new designation of Patient Centered Medical Home is important for multiple reasons. First, it nationally accredits clinics as a place that is focused on the whole patient; it also can be used to advertise to new patients. There are also incentive payments written into the ACA for PCMH, so this is yet another opportunity for clinics to increase their funds by reaching this designation. PCMH are also given special privileges within Covered CA, allowing them to attract more patients through the health benefits exchange. This will help to change their patient population, however it will also create challenges in that they will be dealing with more insurance plans that they have not traditionally dealt with. They must figure out how to bill these plans, in addition to determining how many private insurance plans they are willing to accept in addition to their Medi-Cal patients and the residually uninsured.

### **Emerging Issues**

The following three sections look more in depth at three key issues related to clinics concerns moving forward. These three sections have been identified because each is a common theme of great importance that was mentioned by each clinic sites. This will help to situate other pressing issues that clinics are concerned with, that are important for implementation, but do not directly come from the ACA or have a direct impact on patients.

## ***Role of Technology within the ACA***

### *Community Health Alliance of Pasadena*

ChapCare was the first site that I interviewed. They pointed out how the adoption and use of technology under the ACA is key especially for FQHCs. The use of electronic health records, EHR, is mandated through meaningful use; however, some clinics, like ChapCare have been using EHR for much longer. ChapCare adopted the system the use of EHR in 2007.<sup>162</sup> This is seen as an advantage because their clinical and administrative staff is well versed in the technology and have already adapted to using it on a daily basis. ChapCare also believes that they will be better able to manage growth because they have the data to help them make informed decisions because they have been using the EHR system longer.<sup>163</sup>

ChapCare is also creatively using technology to help them better serve their patient population. They have signed an agreement to implement a new software system, PointCarePA, which will help them evaluate their patients health coverage needs and determine which health program best suits them. ChapCare is the first community health center in Los Angeles to begin using this specific software. This system uses a five question, 90-second eligibility assessment to capture the necessary data to determine which health plan will best match with the patient. The system provides each patient with "...a personalized list of options, complete with program contact information, monthly costs, sign-up checklists of important documents needed to enroll, and applications."<sup>164</sup>

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<sup>162</sup> Murchinson, Julie V., Aaron Apodaca, Christine E. Sison, Christy Rosenberg, and Richard Swafford. "For the Record: EHR Adoption in the Safety Net." *California Healthcare Foundation*. (February 2009).

<sup>163</sup> Martinez, Margaret B. Pasadena, CA. March 4, 2013.

<sup>164</sup> Healthcare Information and Management Systems Society. "Community Health Alliance of Pasadena Signs with PointCare to Incorporate PointCarePA into its Patient Information Programs" Usability Press Release. (March 5, 2013).

*THE Clinic, Inc*

THE Clinic, Inc, began using EHR approximately two years ago, and activated their Patient Portal a year ago. Most clinics have not begun to activate their patient portals yet, because it is not mandated by meaningful use until 2015. However, THE Clinic, Inc, made the decision to activate early, as this is a critical tool for patients. Additionally, many clinics have implemented EHR, but not everyone has started to use patient portal, this distinguishes them from other clinics. This is key to the implementation of health care reform, and their early activation of patient portal is currently being used as a marketing point for current and new patients. They believe in contrast to ChapCare that their recent implementation is a strength over early adopters of EHR, because they have the most up to date technology and training.

*St John's Well Child and Family Center*

St John's is also a recent adopter of EHR, starting the transition in 2010.<sup>165</sup> They ultimately decided to adopt the use of EHR, not only because it was mandated by the ACA, but also because they serve a very large patient population between their ten different sites and the use of EHR is instrumental in population management especially when operating that many clinics. It will also allow them to identify high-risk patients, keeping better track of individual patients, as well as being able to map patterns of risk within their patient population across South Los Angeles.<sup>166</sup> Additionally, with the push towards coordinated care, EHR allows for better communication between clinicians about patients and can be seen through real time results. FQHCs are being expected to panel patients and have a plan for those patients; EHR will allow clinics to more easily do this than if they were using paper charts.<sup>167</sup>

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<sup>165</sup> St John's Well Child and Family Center. "Health Equals Freedom: St John's Well Child and Family Center Annual Report 2011". (2011)

<sup>166</sup> Khalfani, Nomsa Telephone Interview. March 25, 2013.

<sup>167</sup> Khalfani, Nomsa Telephone Interview. March 25, 2013.



### *QueensCare Family Clinics*

QFC was an early adopter of EHR, like ChapCare, with final implementation taking place in November 2007.<sup>168</sup> Since they were an early adopter, they have a wide data set to pull from, which allows them to report better and quicker. QFC was quick to point out that while EHR has many advantages, it does not make patient visits faster as many people believe, the visit time is actually lengthened after initial implementation, and eventually returns to normal because the physicians are still required to chart everything and take the steps mandated by the system with each patient. It ensures that nothing slips through the cracks because of the required checklists, and all the patient data is stored in an easily accessible format, but patient visits are not shortened.

While QFC does think that they have a competitive advantage as an early adopter, they do not think it will last long. Currently, many clinics are working through the same struggles QFC had about 5 years ago after they adopted their EHR system, according to them, in about 3 years that advantage will be gone, as most clinics will have worked through the initial problems. They also mentioned the high cost of the product and the continued cost of maintenance and staff training. EHR is not a one-time cost, but a continued expense every year once it has been adopted. QFC recognized two key issues in regards to the ACA and the use of EHR. First, the use of patient portal, which is required as a patient centered medical home, and they have already activated. They plan to place computer kiosks in the waiting room of every clinic so patients can be educated on how to go online and access the patient portal. The second, more wide reaching issue, was the necessity for there to be an interface built so that clinics can communicate with each other and with the county. This will cut down on duplication if patients go to multiple sites and different clinics, additionally the county handles all specialty care so the ability for the

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<sup>168</sup> Murchinson, Julie V. et al. "For the Record: EHR Adoption in the Safety Net." (February 2009).

primary care provider to communicate with the specialty care provider is key. Currently, there is no such interface, it is also complicated by the fact that not every clinic is running the same EHR software, and the county has its own system as well. For the ACA to be fully realized looking at technology and FQHCs, the whole system needs to be able to communicate, which is not possible at this time.<sup>169</sup>

### *Common Themes*

Technology is cited as important by all four clinics, not only because of their obligation through meaningful use, but because it allows them to provide the best patient care possible. There are two distinct arguments around the use of electronic health records, whether the advantage goes to those who were early adopters or those who are recent adopters. Ultimately, it seems as though the advantage goes to those who were early adopters as they have more experience with the system. With all the other changes taking place because of the ACA, it is one less thing that they must ask their providers to learn and understand. Additionally, they are able to provide detailed histories about long standing patients, and disease patterns in their service area. While, the recent adopters will have the most up to date technology, this advantage will disappear when the earlier adopters have to update their systems in a few years. They also have to work through the learning curve that the early adopters have already been forced to deal with.

Another aspect where technology becomes important is through incentive payments. Due to the HiTECH Act in 2009, providers that use EHR will be paid incentive payments through the state's Medi-Cal office. This is another way in which technology becomes important because it provides the opportunity for increased revenue. Clinics that also can demonstrate improved health outcomes will be provided with additional incentive payments. This is another avenue in

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<sup>169</sup> Armstrong, Alex. Los Angeles, CA. March 4, 2013.

which early adopters will have the upper hand over recent adopters, because they will be able to pull a larger data set to show the changes in their patient population's health.

### ***HealthyWay LA role as Los Angeles County's LIHP Transition***<sup>170</sup>

#### *Community Health Alliance of Pasadena*

ChapCare was fairly positive about the HealthyWay LA program. According to CEO Margie Martinez, they did not see a large change in their patient population due to the implementation of the HealthyWay LA program. She believes that this lack of change in their patients is because ChapCare had already been a participant in Public Private Partnership, or PPP, the county's precursor to HWLA. Many of the PPP patients were transferred into the HWLA program and continued to seek services at ChapCare. The main change that was seen by ChapCare was that HWLA created two categories of patients, matched and unmatched. Matched patients will be transferred into Medi-Cal as part of the expansion in 2014, while unmatched will not. Most unmatched patients are patients who will one day be eligible for coverage, but are not currently for a variety of reasons; many of them are legal immigrants, but have not been in the country long enough to qualify. While the matched program will be rolled into Medi-Cal, the unmatched will most likely still be covered by the county, as part of the residually uninsured, in some capacity, which has yet to be determined.<sup>171</sup>

#### *THE Clinic, Inc*

THE Clinic, Inc was very concerned about what the transition from HWLA to the state Medi-Cal program. Without any guidance currently, it is hard to know what the new program

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<sup>170</sup> There is no section on St John's within this subheading. After my initial interview, I followed up with them hoping to receive answers to some questions related to this section. My original contact did not have information related to this section because it is not the work that she does. I followed up with them multiple times, but unfortunately, I never received any concrete information. I still included this section despite this gap because it is important to note the clinics' opinions about the HWLA program.

<sup>171</sup> Martinez, Margaret B. Pasadena, CA. March 4, 2013.

will look like or how it is going to function. There is a lot of conversation around the new program, and the idea of open enrollment starting in October, however, until the state makes a decision, nothing is actually known. They are working with the county to ensure that the transition will be as smooth as possible and that past mistakes, from implementation and transference of the HWLA program, will be learned from. However, if the past is any indication, they do not believe that the transition will ultimately be smooth.<sup>172</sup>

### *QueensCare Family Clinics*

QFC also has reservation about the transition for the HWLA matched into Medi-Cal. They also cited the recent transition as a complete and total disaster. The electronic program did not work in the way the county thought it would, the network was continually crashing, and people were getting lost in the system, due to this clinic were not being reimbursed for visits.<sup>173</sup> Similarly, QFC does not believe that the transition will be smooth, the county and the state still need to work out a lot of details to determine what this all is going to look like. The number of patients currently enrolled in HWLA matched is equal to the number of patients enrolled in approximately 60% of the other LIHP programs in California.<sup>174</sup> Additionally, all of the patients who are currently enrolled in the HWLA program need to be informed about their transition into Medi-Cal and what it means, this is a patient population that has been routinely denied for Medi-Cal, but will now be eligible, something that might not be understood by all.<sup>175</sup> Regardless of all these concerns, whether the transition works or not, FQHCs are still required to see any patient who walks through their doors, no matter their status, health coverage, or ability to pay.<sup>176</sup>

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<sup>172</sup> Oyamenden, Itohan. Telephone Interview. March 27, 2013.

<sup>173</sup> Hines, Barbara. Los Angeles, CA. March 4, 2013.

<sup>174</sup> Armstrong, Alex. Los Angeles, CA. March 4, 2013.

<sup>175</sup> Ibid.

<sup>176</sup> Ibid.

### *Common Themes*

While all the clinics believe that HealthyWay LA was a useful transition program, there are also concerns as to how smooth this transition will be. The 1115 waiver provided the funding for the HealthyWay LA program; however, it provided limited guidelines beyond who was to be covered and funding requirements. Due to this lack of guidance, there has been struggle after struggle in determining how the program will function. When the program first began the guidelines in place did not function as promised, causing many issues for both the clinics and the county. Additionally, last year when the county transitioned to using the Leader system, in hopes of making the transition to Medi-Cal smoother, it was not smooth at all, and created issues for the county, clinics and patients. The hope within the county, that this transition will elevate any future problems, since they are using the same system now; however, the clinics are less than hopeful. The county has been working very hard to ensure that these same struggles do not appear in 2014, when HealthyWay LA is rolled into Medi-Cal. Until the state determines what the Medi-Cal expansion will look like and who is handling it, the state or the counties, it is hard to know what this transition will entail.

As outlined in the County section, there is some plan for what is to happen to the HWLA unmatched program. It does seem as though this plan as not been shared yet with the clinics, as the clinic administrators that I interviewed all expressed concern about what is going to happen to those in unmatched. They all plan to continue to see those enrolled in the unmatched program, they are just unsure as to what their reimbursement will look like and whom they will be serving through this program. This is an opportunity for the county to work with clinics in determining what the unmatched program will look like moving forward, since they are a key provider for the residually uninsured. Additionally, clinics need to voice their concerns to the county in a constructive way so that they may come together to determine how to best serve the residually

uninsured. A united voice for the state and federal officials is the best way to ensure continued funding for the residually uninsured.

### ***Relationship with Los Angeles County***<sup>177</sup>

#### *Community Health Alliance of Pasadena*

ChapCare has two main concerns about their relationship with Los Angeles County moving forward. The first is competition for patients from the county; the Department of Health Services has its own set of clinics and hospitals that provide an additional safety net for the uninsured and low-income patients. Right now, patients enrolled in Medi-Cal or HWLA can choose whether they would like their medical home under each program to be either a community partner clinic, like the ones discussed, or a county clinic. While there is a working relationship with the county, ultimately they are looking to serve the same patients.<sup>178</sup>

The other concern voiced by ChapCare was the necessity for the county to reform how patients access specialty care. The current system is overbooked and in many cases, patients do not show up for their appointments with a specialty care provider because the county assigns them appointment times without consulting them, or they do not even realize that they have been given an appointment. Starting in April 2013, ChapCare will be using a new program called E-Consult to help manage their specialty care patients. This program will allow the primary care providers at ChapCare to consult with county specialty care providers in real time. While it only applies to some specialties, dermatology and gastroenterology being two such specialties, it will allow for expedited appointments if necessary for these patients and ideally, it will break up some of the backlog through the county's specialty care system.<sup>179</sup>

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<sup>177</sup> See footnote 169 above

<sup>178</sup> Martinez, Margaret B. Pasadena, CA. March 4, 2013.

<sup>179</sup> Ibid.

*THE Clinic, Inc*

Itohan Oyamendan has been included in a county committee preparing for health care reform, called the Everyone on Board Committee. It is made up of different clinics, county partners, and governmental organizations, including Department of Health Services, 211, Department of Public Health, and Department of Social Services. They are working together to plan for health care reform, and the exchange. They want to ensure that future patients and the community do not receive varying information, making sure that all levels of involvement, from the smallest community organization to the county are on the same page.<sup>180</sup>

*QueensCare Family Clinics*

Currently, QFC is working with the county in a variety of capacities. They are one of Los Angeles County's largest community partners, therefore, the county comes to them for recommendations, "if a change works for QueensCare Family Clinics, it will work for the others".<sup>181</sup> Additionally, they work with a variety of non-profits, CPCA, California Primary Care Association, and CCALAC, Community Clinic Association of Los Angeles County. CCALAC is an association of the majority of clinics in Los Angeles County, they negotiate all contracts between clinics and the county, doing everything expect the rate setting, for HWLA unmatched, which is done on an individual basis, but everyone is reimbursed at the same rate.<sup>182</sup>

Additionally, QFC once again sited the need for technology and a system that is in full communication in respect to their relationship with the county. Since specialty care is handled by the county, it would be ideal if the different EHR systems could communicate about the same patient. This would decrease the change of patients being lost in the cracks. It would also stop

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<sup>180</sup> Oyamenden, Itohan. Telephone Interview. March 27, 2013.

<sup>181</sup> Hines, Barbara. Los Angeles, CA. March 4, 2013.

<sup>182</sup> Medi-Cal reimbursements come from the state and are determined on a clinic-by-clinic basis. HWLA matched reimbursements are the same as the Medi-Cal reimbursements, because of the one to one match, meaning that different clinics are reimbursed differently for seeing matched patients. HWLA unmatched reimbursements are determined by the county with each clinic, however, everyone is reimbursed the same, \$94 per visit.

the practice of duplicate tests and labs if different providers were able to see what had already been ordered, saving the county, clinics, and patients' time and money.

### *Common Themes*

As clinics move forward, continuing to foster a positive working relationship with the county is important. There is a concern about competition with the county, not only for patients, but for providers as well. While this is a legitimate concern, it seems as though it is necessary to see the county as a partner not a competitor. The provider shortage does proposed a legitimate problem, it is important to work with the county to ensure that providers are used to their maximum capacity. Currently, specialty care under HWLA is handled by the county through referrals, perhaps primary care should also be referred to the county or to another clinic, if a clinic does not have the providers to manage the amount of patients.<sup>183</sup> Additionally, how specialty care is handled does seem to need reform. Patients enrolled in HWLA have their specialty care handled by the county through a referral system. The county is working hard to ensure that these patients are able to keep their specialty care providers. However, due to the lack of patient autonomy within the current system, many new patients do not show up for their specialty care appointments because the appointment times are assigned to them. The belief is that if patients were able to schedule their own appointments, this would increase the rate of patients coming to their appointments. Ideally under a new system, patients would be able to schedule their appointments, thus be held accountable for missed appointments. This would help to decrease the rates of no shows within specialty care.

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<sup>183</sup> However, this does seem unlikely, as noted above in the Key Concerns about Health Care Reform, the no show rate for FQHCs is incredibly high, thus they have the available appointments, it is just about maximizing those appointments.



## **Recommendations**

Based upon my findings through my interviews with individuals working at the state and county levels, as well as an in depth look into Federally Qualified Health Centers in Los Angeles County. I will provide a series of recommendations as to how clinics, the county, and the state should move forward to ensure that they are best serving their patient population.

### ***Legislation and the State of California***

The first recommendation that I will offer is that the state needs to quickly decide how it will be moving forward. There is limited time before this expansion is expected to start and this is not the time for the legislature and the Governor to be arguing about spending that will not be taking place until 2017. Without guidelines from the state, no other organization can move forward in a real way. It is also essential that California drop this notion of a county controlled expansion, it is not feasible and is wasting time when tangible steps need to be taken moving forward.

As part of this legislation, the Medi-Cal enrollment regulations need to be changed, the goal is streamline and eliminate unnecessary paperwork, which is not clear in some of the current proposed legislation. An important part to ensuring streamlined processes is change the regulation that requires new Medi-Cal patients to enroll through DPSS. Currently, under HWLA enrollers at clinics are able to help patients enroll in the program; this will also be true at many clinics for Covered CA. These enrollees need to be able to present patients with all of their options and be able to help them access these options on the spot as opposed to sending them to an additional agency that they may never contact. The California Department of Health Care Services needs to make payment reform for how providers are reimbursed for Medi-Cal patients. Part of this is redefining what a visit means. A visit needs to extend beyond the traditional

providers to encompass all aspects of health care. If clinics are going to be expected to provide health care for the whole patient, they need to reimburse for providing all of these services.

***Los Angeles County: Education, Specialty Care and Technology***

The County of Los Angeles needs to take on the role of education throughout the county about what health care delivery in the county will look like after the Medi-Cal expansion and overall changes. They must be the ones to take on this role to ensure that uniform messages and educational materials are being used throughout the county. By doing this, more people will be educated, including those outside the safety net health system and everyone will receive the same information no matter where their medical home is. They should also be in charge of provider education. Additionally, the county must reform how specialty care is handled; they are already taking steps to do so. However, it is key to not only ensuring that current patients retain their specialty care providers, but also to make sure that specialty care by the county is streamlined and handled in an efficient manner. Patients need to have personal responsibility in their specialty care, which they do not currently have. If they are forced to make their own appointments, they will be accountable to the visit. There also needs to be more oversight to keep patients from slipping through the cracks.

Technology is also something that the county plays a sizeable role in. Not only should they include technology in their patient and provider education, but patients need to understand how technology plays a role in meeting their health needs and all providers need to be educated in how to use this technology, specifically EHR and online enrollment. Finally, the county must develop an interface that allows not only the clinics to share information with each other, but that also allows them to share this information with the county, and the state if necessary. Currently, all FQHCs are transitioning to the use of EHR; however, without a way to communicate with

each other, the county and the state about patients and their needs the role of EHR is very limited. Clinics need to be able to share patient information if a patient changes medical homes, as well as sharing disease trends and other data that comes from tracking patients through EHR. This will help to provide a better picture of who is utilizing the safety net, what their health needs are, and how these needs differ from clinic to clinic and neighborhoods.

While the county already has plans to revamp the HealthyWay LA unmatched program, it is important that this be a top priority as well. The safety net is responsible for the care and treatment of all individuals, not matter what their insurance status. The ACA makes great strides to improve coverage rates and provide patients with opportunities they would not have had previously, but it completely ignores those who will be residually uninsured for reasons beyond their own control. This program needs to be reprioritized to ensure that those need it the most are receiving the care that they need, prioritizing chronic conditions over place of residence. However, since this program has limited funding it is necessary to find additional revenue streams and for additional programs focusing on the residually uninsured to be implemented.

### ***Federally Qualified Health Centers***

While all four of the Federally Qualified Health Centers that I spoke with are moving forward with plans to serve, better their patient populations. These recommendations are applicable not only to the clinics that I worked with, but for all FQHCs in Los Angeles County, and to any health provider that works with a low-income population that will be affected by the Medi-Cal expansion.

The implementation of EHR needs to be top priority for any FQHC, not only because of the mandate under meaningful use, but because it allows them to better track their patient population and allows their patients access to their health records. It is also an opportunity for a

small, but important increase in funding through the incentive payments given to providers who have adopted the use of EHR. It also presents opportunity for increased funding in the future, if there are additional incentive payments from the federal government based upon outcomes. An EHR system allows clinics to more efficiently track patient outcomes and better prove how their treatment and programs are working to improve the health of a community. Along with this, all clinics need to activate their patient portals as soon as possible, it is not only a selling point to attract new patients, but it allows patients access to their records, ask providers questions, schedule appointments, as well as other tools to help increase their involvement in their own health care.

Clinics need to take the educational materials from the county and distribute them to their own patients to ensure that the information is being disbursed. If the state were to allow clinics to help patients enroll in Medi-Cal, all clinics must then have health educators/enrollers at every site that meet with each individual patient to talk about options and work with them to move forward. This needs to become standard practice at every clinic, for every patient, not just select patients. Clinics should also follow the model of St John's Well Child and Family Center, utilizing their access to a mobile clinic to educate throughout the community, as well as providing an opportunity for patients to meet with a health enroller. While policy change is important moving forward with the Medi-Cal expansion, education is what will ultimately create a change within the system. There can be a multitude of policy changes to allow patients to better access Medi-Cal benefits, but if they do not know that this option is, available to them it will not be utilized and the policy changes will be worth nothing. It is better to have an overeducated population as opposed to an undereducated one. This allows patients to make their own informed decisions with all the facts in front of them.

Additionally, all clinics must become Patient Centered Medical Homes. This certification gives them added benefits, stating that they provide the best patient care possible for the patient as a whole. If clinics want to move away from the image of being a safety net clinic, it is important for them to take steps to show how they are transforming the care they are delivering. While some sites may already operated through a patient centered model and will not need to make many of the changes that are necessary to receive this certification. However, this is an official seal showing their patients, the community and other organizations that they are recognized for their patient centered model, they are working to provide the best care possible to their patients. Being certified as a PCMH also allows clinics to apply for additional funding and allows them access to additional funding streams that they may not otherwise qualify for.

FQHCs also play a large role in providing coverage for the residually uninsured. In addition to the county's HealthyWay LA unmatched program, other steps need to be taken by clinics to help ensure that their patients without health insurance will still receive care, and that their care is reimbursed at a rate that is equal to the care they are provided with. St John's Well Child and Family Center is currently working with LA Care Health Plan to try to produce an insurance option for the residually uninsured in Los Angeles County. This will help to provide coverage for those who cannot be covered under HWLA due to limited funds. This plan needs to be fully developed and implemented not only at St John's, but also at all safety net clinics in Los Angeles County. It will provide the residually uninsured with more than one option for their health care, as well as providing them a way to have their visits covered beyond paying out of pocket, at a sliding scale fee. It could also be a pathway into health coverage, either Medi-Cal or the insurance exchanges, depending upon if health care is written into the immigration reform bill.

Federally Qualified Health Centers play a dual role moving forward towards the expansion of Medi-Cal. Not only do they working with their patient population, and must determine how to best serve them through all this change, but they also hold a great deal of power to influence policy, at least on the county level, and the state level through a organized mass as opposed to individual clinics. It is important for them to continually recognize this power and use it moving forward to advocate for both themselves and their patients.

### **Conclusion**

While there are some limitations within my study, overall I was able to survey a wide variety of individuals and decision makers involved in ensuring the expansion of Medi-Cal. One of my biggest gaps, is the lack of complete data from St John's Well Child and Family Center. They were able to provide me with a great deal of data, however, because of the lack of expertise of my contact, I was not able to receive complete answers to all my questions. In many categories they provide an interesting contrast to my more traditional clinics, it would have been interesting to see the ways in which they contrasted in their view of HealthyWay LA and St John's relationship with Los Angeles County. Additionally, access to other individuals within the county government would have provided a broader scope of data, however because of county restrictions I was not able to interview any other individuals. Finally, the ability to speak to a representative from Med-Cal, either in Los Angeles County or on the State level, would have provided additional depth to my research. Again, due to governmental restrictions, I was not able to contact anyone, I asked my interviewees for help in this, but none of them were willing or able to provide me with a contact.

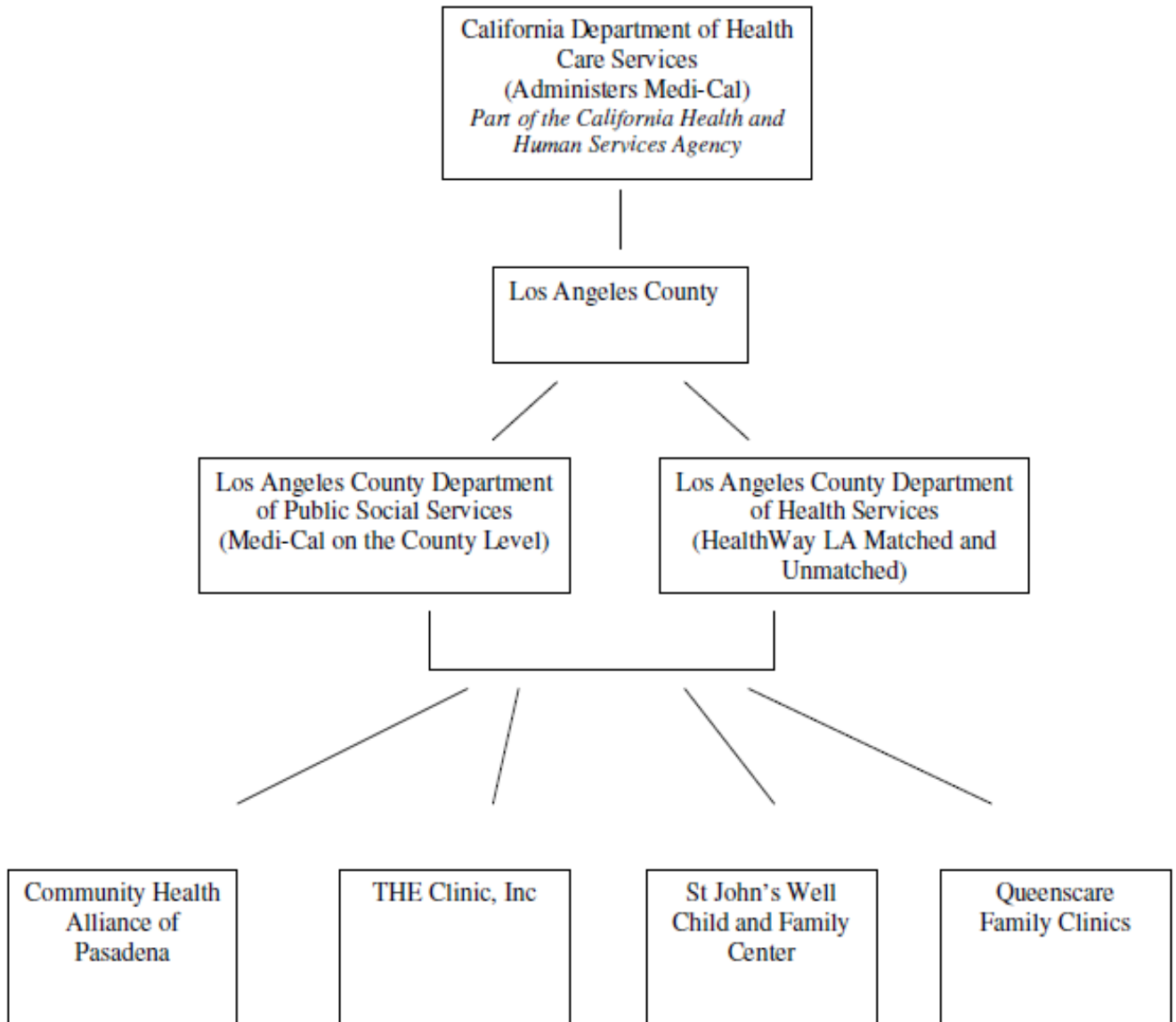
The Affordable Care Act created in 2010, to extend health care coverage to more Americans moving forward into the 21<sup>st</sup> Century. Despite setback from Supreme Court cases and

some states refusal to implement the act as it was originally envisioned, the act is largely intact and it seems like it will remain that way. Moving forward the Medicaid expansion is one of the ways in which large populations of people will be afforded health coverage for the first time. This is allowing a new population to access health care in a completely new way. California is on the forefront of this movement not only with the proposed expansion of Medi-Cal, but also by being the first state to setup, a health benefits exchange. The state is taking the implementation of this law very seriously, despite its slow pace in some respects.

California, and more specifically Los Angeles County is a model for the rest of the nation moving forward. The County has a larger population than many states, and will have one of the largest populations of residually uninsured individuals, therefore if health care reform works in Los Angeles County it will work in most other states. The state, the county, and Federally Qualified Health Centers must work together to ensure that the transition is not only smooth for them as organizations and governing bodies, but for their patients as well. While many exciting and successful steps have been taken to prepare for the Medi-Cal expansion in 2014, the overall effect of these steps and those to be taken in the next few months will not be realized until the expansion happens. Through methodical preparation clinics, the county, and the state can work to hopefully ensure a smooth transition and a successful program, but until implementation and enrollment begins the successes and failures have yet to be seen. Ultimately, the Affordable Care Act is not about political opinions and beliefs, but it is about extending a basic human right to as many individuals as possible to ensure that they are receiving the best care and to improve the health of the United States as a whole.

**Appendix**

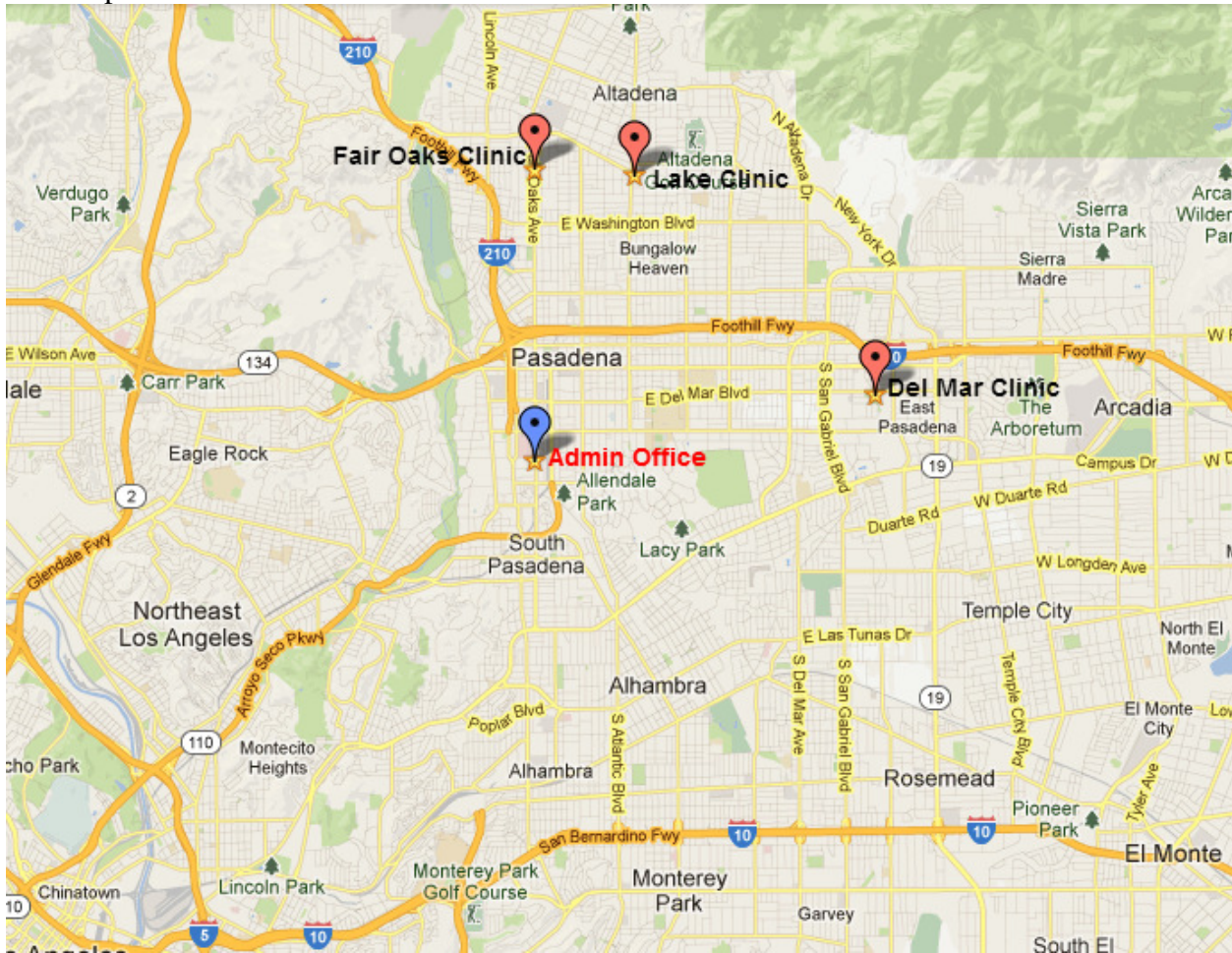
**Structure Chart (1)**





## Community Health Alliance of Pasadena (2)

### 2.1 ChapCare Locations



## 2.2

BHCMIS ID: 0910140  
 COMMUNITY HEALTH ALLIANCE OF PASADENA, Pasadena, CA

Date Requested: 8/29/2012  
 Data As Of: 05/14/2012

### UDS Summary Report - 2011 Grantee - Universal

GRANTEE	
<b>PATIENTS</b>	
Total Patients	14,214
<b>Number/Percent of Patients by Services Utilized</b>	
Medical Services	13,092/92.11%
Dental Services	2,251/15.84%
Mental Health Services	394/2.77%
Substance Abuse Services	0/0.00%
Vision Services	0/0.00%
Enabling Services	1,275/8.97%
<b>Number/Percent of Patients by Special Populations</b>	
Homeless Patients	1,855/13.05%
Farmworker Patients	75/0.53%
School Based Patients	0/0.00%
Veteran Patients	26/0.18%
<b>Number/Percent of Patients by Age</b>	
Children (< 18 years old)	2,475/17.41%
Adult (18 - 64)	11,249/79.14%
Geriatric (age 65 and over)	490/3.45%
<b>Number/Percent of Patients by Insurance Status</b>	
Uninsured	10,286/72.37%
Children Uninsured (age 0-19 years)	742/26.65%
Medicaid/CHIP <sup>1</sup>	3,418/24.05%
Medicare	346/2.43%
Other Third Party	164/1.15%
<b>Patients by Income Status (% Known)</b>	
Patients at or below 200% of poverty	99.15%
Patients at or below 100% of poverty (included in above)	85.56%
<b>Patients by Race &amp; Ethnicity (% Known)</b>	
% Racial and/or Ethnic Minority	82.53%
% Hispanic/Latino Identity	57.43%
% African American	22.17%
% Asian	2.50%
% American Indian/Alaska Native	0.16%
% Native Hawaiian/Other Pacific Islander	0.22%
% More than one race	0.51%
% Best Served in another language	30.75%

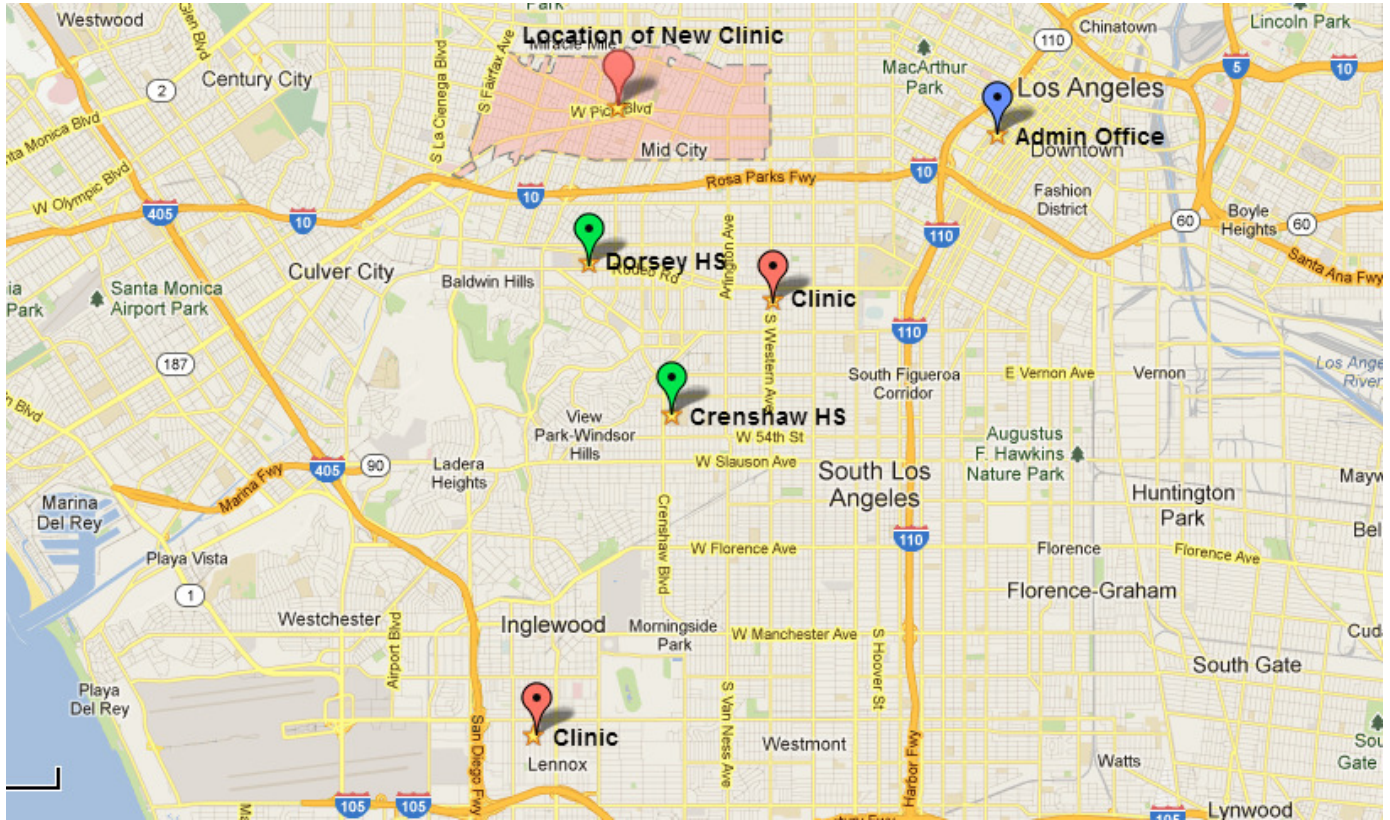
<sup>1</sup> - Data Cannot be Calculated

<sup>1</sup> Includes Medicaid, Medicaid CHIP, and Other Public Insurance CHIP

		GRANTEE
<b>PATIENTS</b>		
<b>Percent of Medical Patients with Specific Diagnoses</b>		
Hypertension <sup>2</sup>		21.79%
Diabetes <sup>3</sup>		13.69%
Asthma		3.06%
HIV		0.14%
<b>Prenatal</b>		
Number of Prenatal Patients		223
Number of Prenatal Patients who delivered		66
	GRANTEE	ADJUSTED QUARTILE RANKING <sup>5</sup>
<b>QUALITY OF CARE/HEALTH OUTCOMES</b>		
<b>Prenatal</b>		
% Having First Prenatal Visit in 1st Trimester	73.09%	1
% Low and Very Low Birth Weight	69.70%	4
<b>Preventive Screening &amp; Immunizations</b>		
% of Women with Pap Tests	55.75%	2
% of Children and Adolescents with BMI Percentile and Counseling on Nutrition and Physical Activity Documented	0.00%	4
% of Adults who Received Weight Screening and Follow up if Appropriate	28.68%	3
% of Adults Assessed for Tobacco Use	98.20%	1
% of Tobacco Users who Received Cessation Advice and/or Medication	7.86%	4
% of Asthmatics Treated with Appropriate Pharmacological Intervention	68.18%	3
% of Two year Olds Immunized <sup>4</sup>	10.34%	4
<b>Chronic Disease Management</b>		
% Hypertensive Patients with Blood Pressure < 140/90	65.08%	1
% Diabetic Patients with HbA1c <= 9	66.01%	2
<p><sup>1</sup> - Data Cannot be Calculated</p> <p><sup>2</sup> Hypertensive adults as a percent of estimated adult medical patients of ages 18-85.</p> <p><sup>3</sup> Diabetic adults as a percent of estimated adult medical patients of ages 18-75.</p> <p><sup>4</sup> Measure was revised in 2011 and is not comparable to calendar year 2010 and prior.</p> <p><sup>5</sup> Grantee adjusted quartile results from a statistical model adjusting for special populations, uninsured and minority patients, and EHR use. Clinical performance for each measure is ranked from Quartile 1, highest 25% of reporting grantees, to Quartile 4, lowest 25% of reporting grantees.</p>		

### THE Clinic, Inc (3)

#### 3.1 THE Clinic Inc Locations





3.2

BHCMIS ID: 092440  
 T.H.E. CLINIC, INC., Los Angeles, CA

Date Requested: 8/29/2012  
 Data As Of: 05/14/2012

UDS Summary Report - 2011  
 Grantee - Universal

GRANTEE	
<b>PATIENTS</b>	
Total Patients	12,190
<b>Number/Percent of Patients by Service Utilized</b>	
Medical Services	11,243/92.23%
Dental Services	0/0.00%
Mental Health Services	437/3.58%
Substance Abuse Services	0/0.00%
Vision Services	0/0.00%
Enabling Services	421/3.45%
<b>Number/Percent of Patients by Special Populations</b>	
Homeless Patients	7/0.06%
Farmworker Patients	0/0.00%
School Based Patients	0/0.00%
Veteran Patients	0/0.00%
<b>Number/Percent of Patients by Age</b>	
Children (< 18 years old)	2,796/22.94%
Adult (18 - 64)	8,978/73.65%
Geriatric (age 65 and over)	416/3.41%
<b>Number/Percent of Patients by Insurance Status</b>	
Uninsured	7,430/60.95%
Children Uninsured (age 0-19 years)	853/26.69%
Medicaid/CHIP <sup>1</sup>	4,081/33.48%
Medicare	455/3.73%
Other Third Party	224/1.84%
<b>Patients by Income Status (% Known)</b>	
Patients at or below 200% of poverty	98.67%
Patients at or below 100% of poverty (Included In above)	86.32%
<b>Patients by Race &amp; Ethnicity (% Known)</b>	
% Racial and/or Ethnic Minority	98.54%
% Hispanic/Latino Identity	32.10%
% African American	85.99%
% Asian	9.76%
% American Indian/Alaska Native	0.19%
% Native Hawaiian/Other Pacific Islander	0.98%
% More than one race	0.56%
% Best Served In another language	26.81%
<small>                     * - Data Cannot be Calculated  <sup>1</sup> Includes Medicaid, Medicaid CHIP, and Other Public Insurance CHIP                 </small>	

		GRANTEE
<b>PATIENTS</b>		
<b>Percent of Medical Patients with Specific Diagnoses</b>		
Hypertension <sup>2</sup>		30.48%
Diabetes <sup>3</sup>		14.86%
Asthma		2.65%
HIV		2.46%
<b>Prenatal</b>		
Number of Prenatal Patients		282
Number of Prenatal Patients who delivered		106

	GRANTEE	ADJUSTED QUARTILE RANKING <sup>5</sup>
<b>QUALITY OF CARE/HEALTH OUTCOMES</b>		
<b>Prenatal</b>		
% Having First Prenatal Visit In 1st Trimester	80.85%	1
% Low and Very Low Birth Weight	11.01%	4
<b>Preventive Screening &amp; Immunizations</b>		
% of Women with Pap Tests	85.71%	1
% of Children and Adolescents with BMI Percentile and Counseling on Nutrition and Physical Activity Documented	37.14%	3
% of Adults who Received Weight Screening and Follow up if Appropriate	70.00%	1
% of Adults Assessed for Tobacco Use	92.86%	2
% of Tobacco Users who Received Cessation Advice and/or Medication	55.71%	3
% of Asthmatics Treated with Appropriate Pharmacological Intervention	98.57%	1
% of Two year Olds Immunized <sup>4</sup>	70.00%	2
<b>Chronic Disease Management</b>		
% Hypertensive Patients with Blood Pressure < 140/90	67.14%	2
% Diabetic Patients with HbA1c <= 9	75.71%	1

<sup>1</sup> - Data Cannot be Calculated

<sup>2</sup> Hypertensive adults as a percent of estimated adult medical patients of ages 18-85.

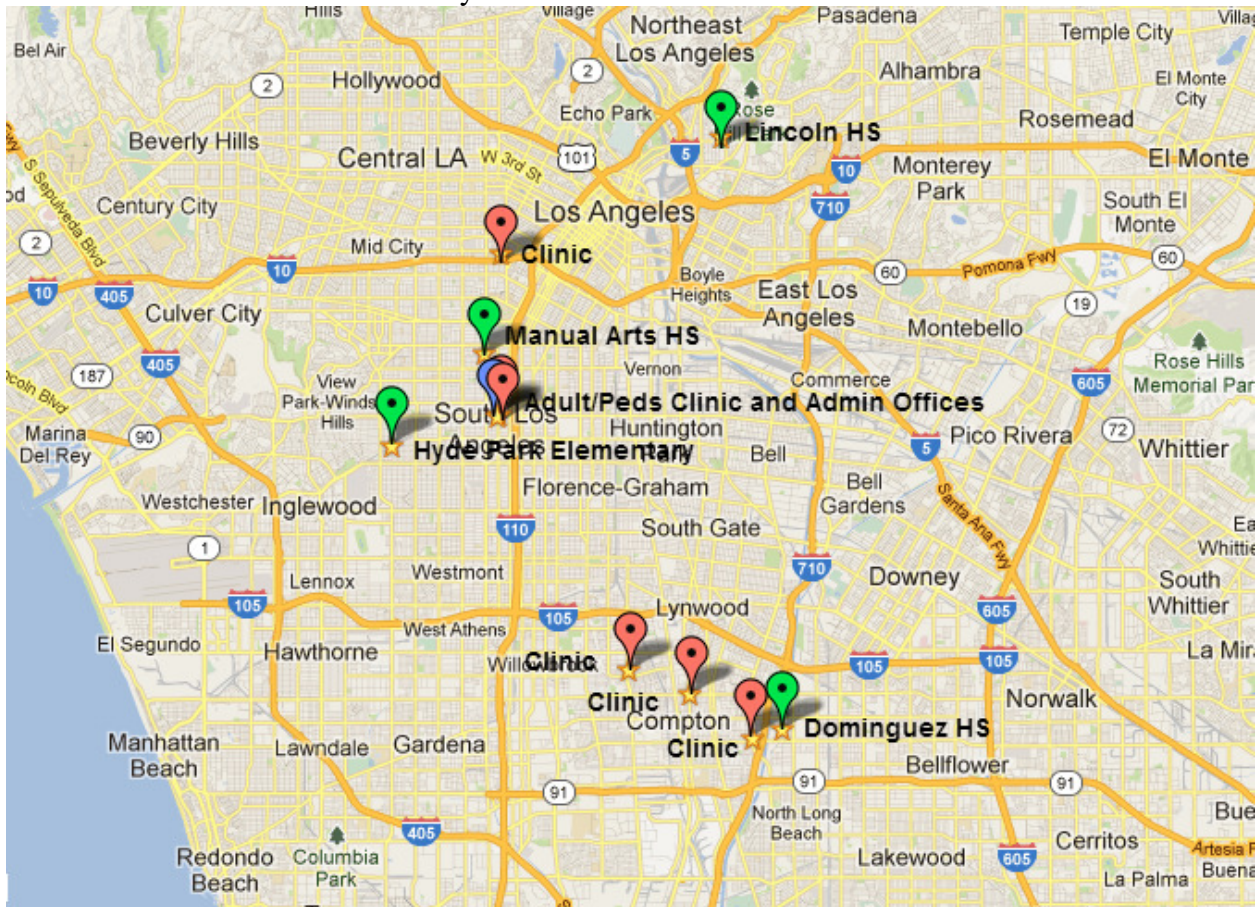
<sup>3</sup> Diabetic adults as a percent of estimated adult medical patients of ages 18-75.

<sup>4</sup> Measure was revised in 2011 and is not comparable to calendar year 2010 and prior.

<sup>5</sup> Grantee adjusted quartile results from a statistical model adjusting for special populations, uninsured and minority patients, and EHR use. Clinical performance for each measure is ranked from Quartile 1, highest 25% of reporting grantees, to Quartile 4, lowest 25% of reporting grantees.

## St John's Well Child and Family Center (4)

### 4.1 St John's Well Child and Family Center Locations



4.2

BHCMIS ID: 0910370  
 ST. JOHNS WELL CHILD & FAMILY CENTER, Los Angeles, CA

Date Requested: 8/29/2012  
 Data As Of: 05/14/2012

UDS Summary Report - 2011  
 Grantee - Universal

GRANTEE	
<b>PATIENTS</b>	
Total Patients	36,774
<b>Number/Percent of Patients by Services Utilized</b>	
Medical Services	32,745/89.04%
Dental Services	7,980/21.70%
Mental Health Services	938/2.55%
Substance Abuse Services	-
Vision Services	-
Enabling Services	19,934/54.21%
<b>Number/Percent of Patients by Special Populations</b>	
Homeless Patients	1,387/3.77%
Farmworker Patients	283/0.77%
School Based Patients	5,385/14.64%
Veteran Patients	424/1.15%
<b>Number/Percent of Patients by Age</b>	
Children (< 18 years old)	13,971/37.99%
Adult (18 - 64)	21,892/59.53%
Geriatric (age 65 and over)	911/2.48%
<b>Number/Percent of Patients by Insurance Status</b>	
Uninsured	22,367/60.82%
Children Uninsured (age 0-19 years)	3,903/25.55%
Medicaid/CHIP <sup>1</sup>	13,684/37.21%
Medicare	357/0.97%
Other Third Party	366/1.00%
<b>Patients by Income Status (% Known)</b>	
Patients at or below 200% of poverty	99.15%
Patients at or below 100% of poverty (Included In above)	89.46%
<b>Patients by Race &amp; Ethnicity (% Known)</b>	
% Racial and/or Ethnic Minority	98.77%
% Hispanic/Latino Identity	81.63%
% African American	17.55%
% Asian	0.52%
% American Indian/Alaska Native	0.10%
% Native Hawaiian/Other Pacific Islander	0.10%
% More than one race	0.02%
% Best Served In another language	84.23%
- Data Cannot be Calculated	
<sup>1</sup> Includes Medicaid, Medicaid CHIP, and Other Public Insurance CHIP	



GRANTEE	
<b>PATIENTS</b>	
<b>Percent of Medical Patients with Specific Diagnoses</b>	
Hypertension <sup>2</sup>	19.25%
Diabetes <sup>3</sup>	16.48%
Asthma	2.92%
HIV	0.02%
<b>Prenatal</b>	
Number of Prenatal Patients	485
Number of Prenatal Patients who delivered	200

	GRANTEE	ADJUSTED QUARTILE RANKING <sup>5</sup>
<b>QUALITY OF CARE/HEALTH OUTCOMES</b>		
<b>Prenatal</b>		
% Having First Prenatal Visit in 1st Trimester	72.16%	2
% Low and Very Low Birth Weight	4.00%	1
<b>Preventive Screening &amp; Immunizations</b>		
% of Women with Pap Tests	74.29%	1
% of Children and Adolescents with BMI Percentile and Counseling on Nutrition and Physical Activity Documented	57.14%	2
% of Adults who Received Weight Screening and Follow up if Appropriate	84.29%	1
% of Adults Assessed for Tobacco Use	95.71%	2
% of Tobacco Users who Received Cessation Advice and/or Medication	55.71%	3
% of Asthmatics Treated with Appropriate Pharmacological Intervention	91.43%	2
% of Two year Olds Immunized <sup>4</sup>	24.95%	4
<b>Chronic Disease Management</b>		
% Hypertensive Patients with Blood Pressure < 140/90	81.43%	1
% Diabetic Patients with HbA1c <= 9	71.43%	2

∨ - Data Cannot be Calculated

<sup>2</sup> Hypertensive adults as a percent of estimated adult medical patients of ages 18-85.

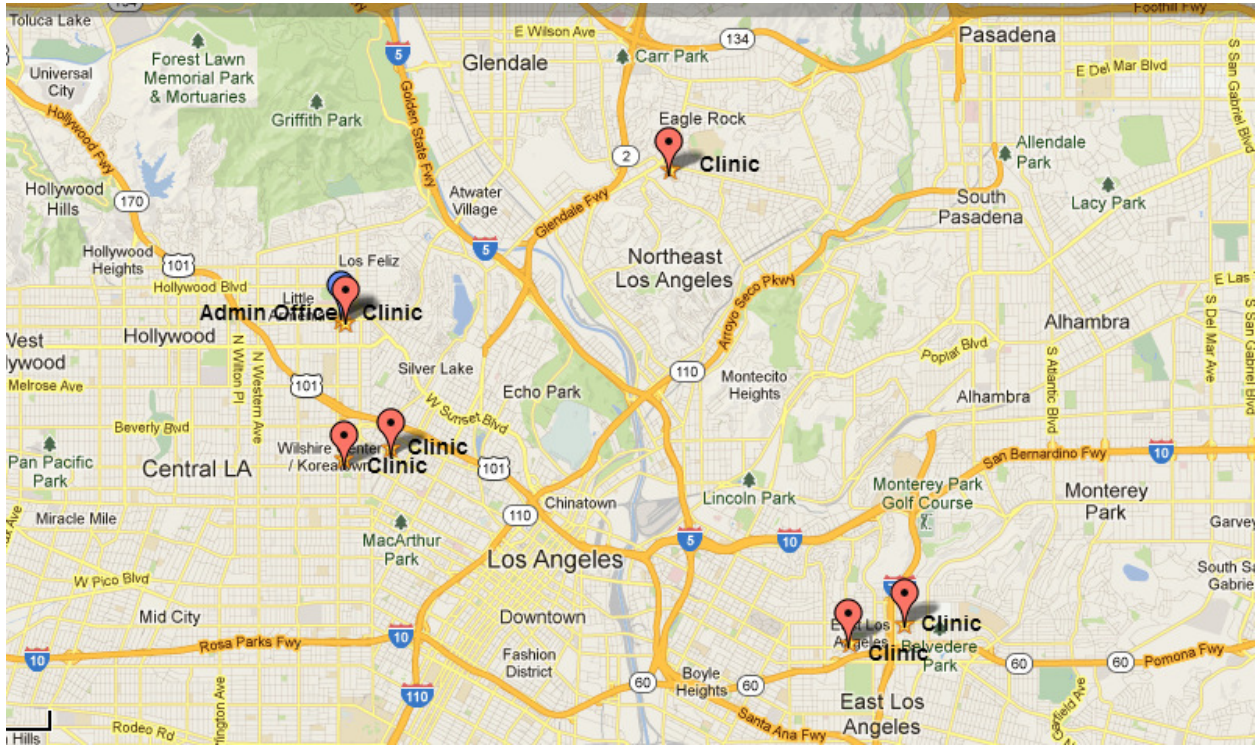
<sup>3</sup> Diabetic adults as a percent of estimated adult medical patients of ages 18-75.

<sup>4</sup> Measure was revised in 2011 and is not comparable to calendar year 2010 and prior.

<sup>5</sup> Grantee adjusted quartile results from a statistical model adjusting for special populations, uninsured and minority patients, and EHR use. Clinical performance for each measure is ranked from Quartile 1, highest 25% of reporting grantees, to Quartile 4, lowest 25% of reporting grantees.

# QueensCare Family Clinics (5)

## 5.1



5.2

BHCOMS ID: 0910340  
 QUEENSCARE FAMILY CLINICS, Los Angeles, CA

Date Requested: 8/29/2012  
 Data As Of: 05/14/2012

UDS Summary Report - 2011  
 Grantee - Universal

GRANTEE	
<b>PATIENTS</b>	
Total Patients	36,927
<b>Number/Percent of Patients by Services Utilized</b>	
Medical Services	30,484/82.55%
Dental Services	6,085/16.48%
Mental Health Services	00.00%
Substance Abuse Services	00.00%
Vision Services	6,353/17.20%
Enabling Services	2,551/6.91%
<b>Number/Percent of Patients by Special Populations</b>	
Homeless Patients	380.10%
Farmworker Patients	00.00%
School Based Patients	00.00%
Veteran Patients	60.02%
<b>Number/Percent of Patients by Age</b>	
Children (< 18 years old)	12,758/34.55%
Adult (18 - 64)	21,679/58.71%
Geriatric (age 65 and over)	2,490/6.74%
<b>Number/Percent of Patients by Insurance Status</b>	
Uninsured	21,174/57.34%
Children Uninsured (age 0-19 years)	4,799/13.12%
Medicaid/CHIP <sup>1</sup>	14,196/38.44%
Medicare	1,114/3.02%
Other Third Party	443/1.20%
<b>Patients by Income Status (% Known)</b>	
Patients at or below 200% of poverty	99.07%
Patients at or below 100% of poverty (Included in above)	82.98%
<b>Patients by Race &amp; Ethnicity (% Known)</b>	
% Racial and/or Ethnic Minority	92.40%
% Hispanic/Latino Identity	77.20%
% African American	4.12%
% Asian	22.43%
% American Indian/Alaska Native	0.20%
% Native Hawaiian/Other Pacific Islander	0.06%
% More than one race	0.00%
% Best Served in another language	53.55%
<sup>1</sup> - Data Cannot be Calculated	
<sup>1</sup> Includes Medicaid, Medicaid CHIP, and Other Public Insurance CHIP	

		GRANTEE
<b>PATIENTS</b>		
<b>Percent of Medical Patients with Specific Diagnoses</b>		
Hypertension <sup>2</sup>		34.16%
Diabetes <sup>3</sup>		29.14%
Asthma		4.05%
HIV		0.02%
<b>Prenatal</b>		
Number of Prenatal Patients		394
Number of Prenatal Patients who delivered		175
	GRANTEE	ADJUSTED QUARTILE RANKING <sup>4</sup>
<b>QUALITY OF CARE/HEALTH OUTCOMES</b>		
<b>Prenatal</b>		
% Having First Prenatal Visit in 1st Trimester	72.08%	2
% Low and Very Low Birth Weight	5.68%	1
<b>Preventive Screening &amp; Immunizations</b>		
% of Women with Pap Tests	64.29%	2
% of Children and Adolescents with BMI Percentile and Counseling on Nutrition and Physical Activity Documented	89.42%	1
% of Adults who Received Weight Screening and Follow up if Appropriate	63.00%	1
% of Adults Assessed for Tobacco Use	58.96%	4
% of Tobacco Users who Received Cessation Advice and/or Medication	16.70%	4
% of Asthmatics Treated with Appropriate Pharmacological Intervention	43.79%	4
% of Two year Olds Immunized <sup>4</sup>	34.29%	3
<b>Chronic Disease Management</b>		
% Hypertensive Patients with Blood Pressure < 140/90	61.43%	3
% Diabetic Patients with HbA1c <= 9	82.86%	1
<sup>1</sup> - Data Cannot be Calculated <sup>2</sup> Hypertensive adults as a percent of estimated adult medical patients of ages 18-85. <sup>3</sup> Diabetic adults as a percent of estimated adult medical patients of ages 18-75. <sup>4</sup> Measure was revised in 2011 and is not comparable to calendar year 2010 and prior. <sup>5</sup> Grantee adjusted quartile results from a statistical model adjusting for special populations, uninsured and minority patients, and EHR use. Clinical performance for each measure is ranked from Quartile 1, highest 25% of reporting grantees, to Quartile 4, lowest 25% of reporting grantees.		

## Glossary of Terms<sup>184</sup>

**AltaMed IPA:** AltaMed’s Independent Practice Association (IPA) contracts with community-based primary care physicians. The goal of AltaMed’s IPA is to expand access to a broader array of services to a greater number of independent physicians and offer additional services. AltaMed IPA is one of the largest in Los Angeles County working largely with community clinics serving low-income populations.

**Bundled Payments:** This is a system by which doctors and hospitals in an area are paid not at a fee for service rate, but on a capitation system linked to outcomes. It is seen as the middle ground between fee for service and a capitation system. The areas with the best patient outcomes are paid at a higher rate. This system makes providers focus more on activates that deliver real health benefits at a lower cost.

**Capitation:** This is a system in which individual providers or a group of providers, normally contracted with an independent practice association, are paid a set amount for each enrolled person assigned to them per a period of time, normally a year or a month. This payment is made regardless of where or not the person seeks treatment. Rates can be affected by numerous factors such as age, race, sex, employment, location, as well as the expected utilization of care and medical history.

**Children’s Health Insurance Program (CHIP):** Enacted in 1997, CHIP is a federal-state program that provides health care coverage for uninsured low-income children who are not eligible for Medicaid. States have the option of administering CHIP through their Medicaid programs or through a separate program (or a combination of both). The federal government matches state spending for CHIP but federal CHIP funds are capped.<sup>185</sup>

**Dual Eligibles:** A term used to describe an individual who is eligible for Medicare and for some level of Medicaid benefits. Most dual eligibles qualify for full Medicaid benefits including nursing home services, and Medicaid pays their Medicare premiums and cost sharing. For other duals Medicaid provides the “Medicare Savings Programs” through which enrollees receive assistance with Medicare premiums, deductibles, and other cost sharing requirements.<sup>186</sup>

**Electronic Health Records:** Computerized records of a patient’s health information including medical, demographic, and administrative data. This record can be created and stored within one health care organization or it can be shared across health care organizations and delivery sites.<sup>187</sup>

**Fee-for-Service:** A traditional method of paying for medical services under which doctors and hospitals are paid for each service they provide. Bills are either paid by the patient, who then

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<sup>184</sup> Unless otherwise noted definitions in this glossary are from the following sources.

Jacobs, Lawrence R., and Theda Skocpol. *Health Care Reform and American Politics: What Everyone Needs to Know*. (New York City, NY: Oxford University Press, 2010).

<sup>185</sup> The Henry J. Kaiser Family Foundation. “Focus on Health Reform: Glossary of Key Health Reform Terms” (2010) <http://www.kff.org/healthreform/upload/7909.pdf> (accessed April 18, 2013).

<sup>186</sup> Ibid.

<sup>187</sup> Ibid.

submits them to the insurance company, or are submitted by the provider to the patient's insurance carrier for reimbursement.<sup>188</sup>

**Health Care and Education Reconciliation Act of 2010:** This is the second piece of legislation that passed to make up the Affordable Care Act. This Act passed the House and received the majority of the vote in the Senate. It passed the Senate using the “reconciliation” process to make changes in the budget and taxes, it did not require sixty votes to clear a filibuster. This reconciled the differences between the House and Senate legislation, including larger tax credits and subsidies to make healthcare more affordable. It created new Medicare taxes on individuals earning more than \$200,000 or families making more than \$250,000. It also reformed the student loan process, increasing Pell Grants and paying down part of the budget deficit.

**Health Information Technology for Economic and Clinical Health Act:** This act was passed in 2009 as part of the American Recovery and Reinvestment Act of 2009, it is also known as the HITECH Act. The goal of this legislation is to promote and expand the use of health information technology, it is specifically focused on electronic health records and the implementation of meaningful use.

**Health Insurance Exchanges:** Health Insurance Exchanges allow consumers to shop for competing health plans that meet or exceed common standards. The exchanges will be administered by the states and will help arrange subsidies for small businesses and for low and middle-income individuals, in order to make insurance plans more affordable. For states that chose to opt out of the Health Insurance Exchanges, there will be a federally run exchange that individuals can use.

**Healthcare LA IPA:** This is another one of the large IPAs located in Los Angeles County. The Department of Health Services is currently working to contract with them to ensure a continuation of specialty care in 2014.

**Independent Practice Association:** This is an association of independent physicians, or other organization that contracts with independent physicians, and provides services to managed care organizations on a negotiated per capita rate, flat retainer fee, or negotiated [fee-for-service](#) basis.

**LA Care Health Plan:** This an independent, local public agency based in Los Angeles, California, that began operations as a licensed health plan in 1997. The organization serves low-income people in Los Angeles County through five health coverage programs including Medi-Cal, Healthy Families Program, L.A. Care's Healthy Kids, L.A. Care's Medicare Advantage Special Needs Plan, and PASC-SEIU Homecare Workers Health Care Plan. L.A. Care is the nation's largest public health plan, with more than one million enrolled members.<sup>189</sup>

**Meaningful Use:** Meaningful use has five key pillars: improving quality, safety, efficiency, and reducing health disparities; engaging patients and families in their health; improving care

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<sup>188</sup> The Henry J. Kaiser Family Foundation. “Focus on Health Reform: Glossary of Key Health Reform Terms” (2010) <http://www.kff.org/healthreform/upload/7909.pdf> (accessed April 18, 2013).

<sup>189</sup> LA Care Health Plan. “About LA Care” (February 2012) <http://www.lacare.org/aboutlacare> (accessed April 20, 2013)



coordination; improving population and public health; and ensuring adequate privacy and security protection for personal health information. The implementation was divided up into three phases, data capture and sharing (2011), advanced clinical processes (2013), and improved outcomes (2015).

**Medicaid:** Medicaid finances medical care for the very poor through federal funding that matches state expenditures. States administer the program and have some leeway in setting the rules; in the past, many excluded individuals with no children. The new healthcare reform extends Medicaid to cover all American citizens, including childless adults, with incomes up to 133% of the Federal Poverty Line.

**Medicare:** Medicare is the government health insurance program for those 65 or older as well as the disabled and those with end stage renal disease. Health reform expanded Medicare's prescription drug provision to close a gap in coverage known as the "doughnut hole". In addition, reform removed subsidies to private insurers involved in the Medicare Advantage program and increased Medicare taxes on individuals earning more than \$200,000 per year or families making more than \$250,000 annually.

**Medi-Cal:** This is the name of the California Medicaid welfare program serving low-income families, seniors, persons with disabilities, children in foster care, pregnant women, and certain low-income adults. It is jointly administered by the California Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS), which is the federal agency responsible for Medicare and Medicaid.

**ObamaCare:** Term commonly used by conservative critics to refer to the Patient Protection and Affordable Care Act. In reality, President Obama only outlined general principles to guide Congress and did not offer a particular legislative proposal.

**Public Option:** The public option was a policy promoted by progressives and many Democrats to create a government run health insurance plan that people and businesses could choose instead of a private plan. A national public option was not included in the final version of the 2010 healthcare reform legislation, though the new law makes it possible for states to choose to establish one or another variant of public options.

**Public-Private Partnership (PPP) Program:** This program was a partnership between the Los Angeles County Department of Health Services and private, community based partners. This partnership was based on the commitment to providing quality health services in a culturally and linguistically appropriate environment to low income and uninsured communities. This program was the predecessor to the HealthyWay LA program.

**Safety Net:** Health care providers who deliver health care services to patients regardless of their ability to pay. These providers may consist of public hospital systems, community health centers, local health departments, and other providers who serve a disproportionate share of uninsured and low-income patients.

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