Notice of a Special Meeting of the
FINANCE COMMITTEE and/or CITY COUNCIL
2:00 p.m. – Monday, June 15, 2015
PASADENA CITY HALL - COUNCIL CHAMBERS ROOM S249

NOTICE IS HEREBY GIVEN that a special meeting of the Finance Committee and/or City Council will be held **Monday, June 15, 2015** at **2:00 p.m.** in the **COUNCIL CHAMBERS ROOM S249**, at City of Pasadena City Hall, 100 N. Garfield Ave., Pasadena, California.

A. CALL TO ORDER

B. NEW BUSINESS

1. Acceptance of $491,770 from the California Strategic Growth Council Grant Program, Authorization to Enter into a Contract with Rincon Consultants, Inc. for a Total not to Exceed $100,958 for the Preparation of a Climate Action Plan, and Appropriation of $91,780 from the Grant Funding

C. **PUBLIC HEARING: FISCAL YEAR 2016 RECOMMENDED OPERATING BUDGET**
Recommendation: It is recommended that the City Council:

1. Continue the public hearing to each subsequent regular meeting of the City Council at 7:00 p.m. , until June 22, 2015, or such other date as the City Council may determine, and, at which time, the City Council will be asked to close the public hearing and formally adopt the Fiscal Year 2016 Recommended Operating Budget

Discussion as part of the public hearing regarding Fiscal Year 2016 Recommended Operating Budget:

a) Fire
b) City Council
c) City Clerk
d) City Attorney
e) City Manager
f) Successor Agency to the PCDC
g) Finance
h) Human Resources
i) Public Health*
j) Decision Packages

D. ADJOURN SPECIAL MEETING

TERRY TORNEK, Mayor
Chair, Finance Committee

Veronica Jones, Recording Secretary
Finance Committee

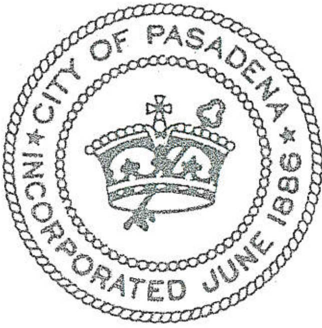
***<u>Note to the public:</u>* Public comment is limited to items on this agenda. An opportunity for public comment will be provided when the items are discussed. Please limit comments to no more than three minutes.**

This notice, in its entirety, was posted at City Hall and distributed as indicated below by 5:30 p.m. on Thursday, June 11th, 2015.

* Attachments

Distribution:

City Council	Los Angeles Times	City Manager
Star-News	City Attorney	Pasadena Weekly
City Clerk	La Opinion	Main Library
Pasadena Journal	Council Chambers Bulletin Board	City Hall Front Kiosk



Agenda Report

June 15, 2015

TO: Honorable Mayor and City Council

THROUGH: Finance Committee

FROM: Planning & Community Development Department

SUBJECT: ACCEPTANCE OF $491,770 FROM THE CALIFORNIA STRATEGIC GROWTH COUNCIL GRANT PROGRAM, AUTHORIZATION TO ENTER INTO A CONTRACT WITH RINCON CONSULTANTS, INC. FOR A TOTAL NOT TO EXCEED $100,958 FOR THE PREPARATION OF A CLIMATE ACTION PLAN, AND APPROPRIATION OF $91,780 FROM GRANT FUNDING

RECOMMENDATION:

It is recommended that the City Council:

1. Find that the recommended action is exempt from review pursuant to the California Environmental Quality Act (CEQA), pursuant to the State CEQA guidelines Section 15061(b)(3);

2. Accept a grant and recognize revenues in the amount of $491,770 to the Building Services Fund (204) awarded to the City through the California Strategic Growth Council Grant Program;

3. Appropriate $91,780 of the grant funding to the Planning and Community Development Fiscal Year 2015 operating budget, Account 8115-204-444200-91513 (Sustainability Growth Council Project) for the preparation of a Climate Action Plan;

4. Authorize the City Manager or his designee to enter into a contract, without competitive bidding pursuant to City Charter Section 1002(F), contracts for professional or unique services, with Rincon Consultants, Inc. for an amount not to exceed $100,958 for the preparation of a Climate Action Plan.

BACKGROUND:

The Strategic Growth Council (SGC) is a state cabinet level inter-agency committee that manages competitive grants to cities, counties, and designated regional agencies through the Sustainable Communities Planning Grants & Incentives Program. In

February 2014, the Planning and Community Development Department applied to SGC for a grant for $500,000 to develop a Climate Action Plan (CAP) and to augment the existing funding for background research and public outreach in developing the appropriate zoning tools to implement the 2035 General Plan vision and Citywide design guidelines.

In July 2014, SGC announced that the City had been awarded a Sustainable Communities Planning Grant totaling $491,770. The grant includes an environmental justice component requiring the City to implement a work program that has direct benefits to underserved communities in the City. The grant, which will be administered by the Planning and Community Development Department, consists of two components: 1) Preparation of a Climate Action Plan (CAP); and 2) Development of the appropriate zoning tools to implement the 2035 General Plan vision and Citywide design guidelines. Both components of the grant must be completed in order to receive funding from SGC.

Climate Action Plan: In response to global climate change, the State of California's Governor's Office and Legislature have created Greenhouse Gases (GHG) reduction targets for the state and local jurisdictions. A CAP is a document that outlines specific activities to reduce GHG emissions to help achieve GHG reduction targets. The proposed scope of work for preparation of the CAP includes:

- Updating the City's GHG emissions forecast;
- Establishing GHG emission reduction targets;
- Conducting public outreach;
- Developing and quantifying measures to reduce GHG emissions;
- Developing thresholds of significance for projects undergoing CEQA review;
- Preparing an implementation strategy; and
- Preparing the necessary CEQA compliance document (Negative Declaration or Mitigated Negative Declaration) that may be required to adopt a CAP.

A CAP will demonstrate that the City is assuming its responsibility for meeting State goals while also enabling the City to cost-effectively mitigate GHG emissions impacts. This would be a multi-departmental collaborative effort. The grant allocates $91,780 to be used toward preparation of a CAP.

After the City was awarded the grant, a Request for Proposals (RFP) to prepare a CAP was posted on the Purchasing Division's website on September 24, 2014. Planning and Community Development Department staff received two proposals from Rincon Consultant Inc. and Atkins Consulting. The proposals were evaluated based on the following criteria stated in the RFP:

a. Expertise, qualifications, feedback from references, and directly related experience of the consultant, including that of the individuals to be assigned to this engagement (50 percent)
b. Ability to communicate clearly with the public, commissions, and City Council (30 percent)

c. Cost of Services (10 percent)
d. Local Pasadena Businesses preference (5 percent)
e. Small and Micro-Businesses preference as certified by the State of California (5 percent)

Rincon Consultants Inc. scored 92.5 points and Atkins Consulting scored 75 points out of 100 points. While both firms were qualified, Rincon Consultants Inc. scored slightly higher in criterion (a) Expertise and Qualifications, because Rincon Consultants Inc. prepared the City's GHG Emission Inventory, which is typically a pre-cursor or the first step to preparing a CAP. Atkins Consulting scored lower in criterion (c) Cost of Services, because it's proposed budget would require additional funding from other sources to supplement grant funding, while Rincon Consultants Inc.'s proposed budget met the grant's allocation toward the CAP. Furthermore, Rincon Consultants Inc. has previously assisted the City of Pasadena in preparation of the Pasadena General Plan Noise Element, East Colorado Blvd Specific Plan Environmental Impact Report (EIR), and several other EIRs for Master Plans (Caltech Master Plan and All Saints Church Master Plan). Rincon Consultants Inc. also received a five percentage preference for being a small and micro-business. Neither firm is located in Pasadena.

Based on previous experience, Rincon Consultant Inc. has demonstrated their expertise and qualification in preparing CAPs, their ability to community clearly with staff, public, commissions, and City Council, and provided the lowest priced proposal which met the grant's allocation toward the CAP.

General Plan Implementation: The remainder of the grant ($391,990) will be used for background research and public outreach in developing the appropriate zoning tools to implement the 2035 General Plan vision and Citywide design guidelines. The funding to complete the work to update the City's Design Guidelines, Specific Plans and Zoning Ordinance will be provided through a $1.5 million grant awarded by Metropolitan Transportation Authority and the General Plan Maintenance Fee.

COUNCIL POLICY CONSIDERATION:

The City adopted the Urban Environmental Accords, which states that a jurisdiction will adopt a citywide greenhouse gas reduction plan that reduces the jurisdiction's emissions by 25 percent by 2030, including a system for accounting and auditing greenhouse gas emissions. Similarly, one of the implementation measures of the Open Space and Conservation Element adopted in January 2012 calls for the City to develop a CAP.

ENVIRONMENTAL ANALYSIS:

Acceptance, recognition and appropriation of grant funding, and entering into a contract are activities covered by the general rule that the California Environmental Quality Act (CEQA) applies only to projects that have the potential for causing a significant effect on the environment in accordance with Section 15061(b)(3) of the Guidelines. Where it can

be seen with certainty that there is no possibility that the activity in question may have a significant effect on the environment, the activities are not subject to the provisions of CEQA. The environmental impacts associated with the projects utilizing the grant will be evaluated at a later time through an appropriate environmental review process. Therefore, no additional environmental review is needed at this time.

FISCAL IMPACT:

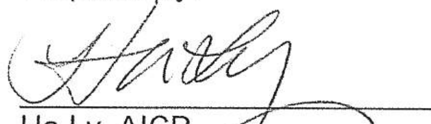
By recognizing the grant funding provided by SGC, the City will receive $491,770 in grant funding over three years. Grant funds will be disbursed on a reimbursement basis. Per the grant agreement, $91,780 is allocated for the CAP and the remaining $399,990 is allocated toward background research and public outreach in development of the appropriate zoning tools to implement the 2035 General Plan vision and Citywide design guidelines. Contingency, indirect and support costs are expected to be addressed by utilization of existing budget appropriations.

The total contract amount for Rincon Consultants, Inc. to prepare the CAP would not exceed $100,958, which consists of the $91,780 proposed amount and a 10 percent contingency of $9,178. It is requested to appropriate $91,780 of grant funding to Account 8115-204-444200-91513 (Sustainability Growth Council Project); $9,178 will be funded out of existing appropriations in account 8115-204-444200 Project 91178 (General Plan Maintenance Fee). The remaining balance of the grant will be appropriated via future budget appropriations.

Respectfully submitted,

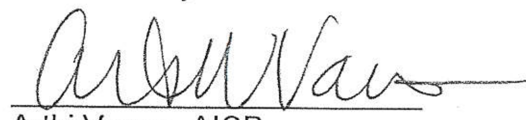
VINCENT P. BERTONI, AICP
Director of Planning & Community
Development Department

Prepared by:



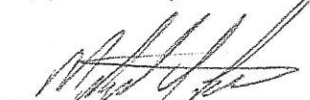
Ha Ly, AICP
Associate Planner

Concurred by:



Arthi Varma, AICP
Principal Planner

Approved by:



MICHAEL J. BECK
City Manager

Disclosure Pursuant to the
City of Pasadena Taxpayer Protection Amendment of 2000
Pasadena City Charter, Article XVII

Contractor/Organization hereby discloses its trustees, directors, partners, officers, and those with more than a 10% equity, participation, or revenue interest in Contractor/Organization, as follows:
(If printing, please print legibly. Use additional sheets as necessary.)

1. Contractor/Organization Name:

Rincon Consultants, Inc.

2. Name(s) of trustees, directors, partners, officers of Contractor/Organization:

Michael P. Gialketsis, CEO
Stephen Svete, COO North
Duane Vander Pluym, CFO
John Dreher, Jr., COO South
Richard Daulton, Secretary
Joe Power, Vice President/Sr. Principal
Walt Hamann, Vice President

3. Names of those with more than a 10% equity, participation or revenue interest in Contractor/Organization:

Michael P. Gialketsis
Stephen Svete
Duane Vander Pluym
Walt Hamann

Prepared by: Duane Vander Pluym

Title: CFO

Date: July 30, 2014

For office use only:
Contract/Transaction No. ____________________

If not a contract, type of transaction: ____________________

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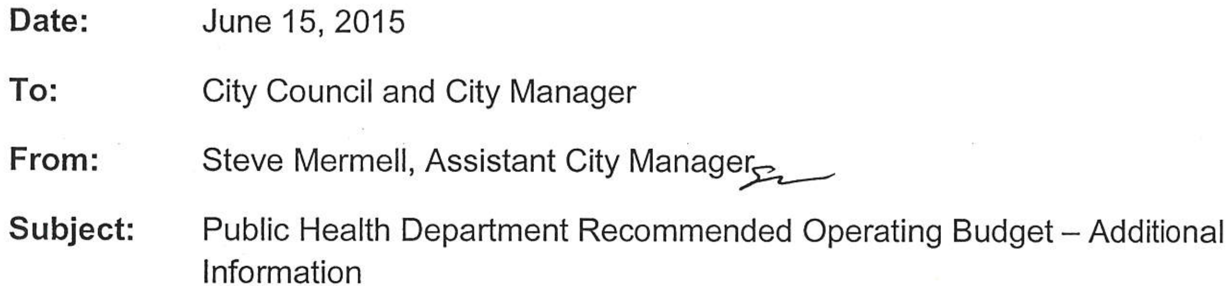
Memorandum



Date: June 15, 2015

To: City Council and City Manager

From: Steve Mermell, Assistant City Manager

Subject: Public Health Department Recommended Operating Budget – Additional Information

On June 8, staff presented a recommended operating budget for the Public Health Department which would result in the elimination of the Prenatal clinic, HIV services, Public Health Laboratory and the Driving Under the Influence (DUI) program in addition to other various minor program reductions. The purpose of these proposed changes is to better align available resources with expenditures and to position the Health Department for success following the implementation of the Patient Protection and Affordable Care Act by focusing on core public health services and away from the provision of specialty clinical care.

As part of the presentation, City Councilmembers asked several questions and requested additional information. This memorandum has been prepared in response.

Item 1: As part of the staff presentation, there was discussion in regard to CHAPcare, the local Federally Qualified Health Center (FQHC), partnering with the City to maintain HIV services in place; however, it was recognized that while there was conceptual understanding, a practical solution that sufficiently protects both parties and satisfies any requirements that Los Angeles County, the granting agency for the HIV services contracts the Pasadena Public Health Department currently maintains, may not be possible. Were this the case, there was discussion of bringing in another FQHC to provide these services were it determined that the City can no longer do so. The question that was asked is whether or not CHAPcare would have to approve/consent to the existence of another FQHC in its service area.

Response: The Health Resources and Services Administration (HRSA) is an agency of the U.S. Department of Health and Human Services. HRSA is the primary federal agency for improving access to health care services for people who are uninsured, isolated or medically vulnerable. In order for an agency to become an FQHC, HRSA's approval is required.

Based on conversations with HRSA representatives, in order for an FQHC to expand its scope of services or its geographic service area, approval by HRSA is required. Such a process would include an assessment of the need for services, in this case HIV services, in the area. While CHAPcare's approval/consent is not required, it could ask

HRSA to consider that it already meets area needs and/or is prepared to expand its scope to provide these services, thus establishment of another FQHC is unnecessary. To this point, in recent discussions with CHAPcare on June 11, representations were made that CHAPcare is prepared to expand its services and provide essentially the same services currently provided by the Public Health Department without the benefit of the Los Angeles County contracts. Staff has requested that CHAPcare provide the City a written proposal for consideration.

The prior concept, discussed with the Council on June 8th, that was being explored whereby the City retains the County contracts and enters into an agreement with CHAPcare for management services as well as reimbursement for any funding gaps, has been determined by CHAPcare to be cost-prohibitive given the City's cost structure. CHAPcare feels it would be significantly less expensive for it to establish its own 'Ryan White look-alike clinic'. It is expected that CHAPcare representatives will present their proposal during the Public Hearing on the Recommended Operating Budget.

Item 2: Staff was requested to provide more information regarding the difference between what revenues are available to be collected through grants/fee for service contracts and program expenses.

Response: Attachment A projects the estimated revenues and expenses for HIV services and the Prenatal clinic for the next three fiscal years. These projections assume the following:

A. The Department collects all funds available via LA County contracts
B. The Programs are fully-staffed for each fiscal year
C. The implementation of Electronic Health Records, with an estimated cost of $220,000 in FY16 and $50,000 in each subsequent fiscal year
D. Patient volumes remain at current levels
E. One additional Nurse Practitioner is added to the Ambulatory Outpatient Medical (AOM) Program to manage the clinical staff in the Andrew Escajeda Comprehensive Care Services Clinic

Item 3: Staff was asked to outline in greater detail the requirements to become a Federally Qualified Health Center (FQHC).

Response: As mentioned above HRSA is the agency that approves the establishment of FQHCs. In order to obtain designation as an FQHC a health center must demonstrate need and meet numerous requirements including but not limited to the following (additional requirements can be found at http://bphc.hrsa.gov/programrequirements/index.html):

- Provision of comprehensive primary care (directly and/or by contract), and assure that patients can access the care regardless of ability to pay, including:
  - Primary medical care;
  - Diagnostic laboratory and radiological services;

- Preventive services including: prenatal and perinatal, cancer and other disease screening, well child services, immunizations against vaccine preventable diseases, screening for elevated blood lead levels, communicable diseases and cholesterol;
- Eye, ear and dental screening for children;
- Voluntary family planning services;
- Preventive dental services;
- Emergency medical services including coverage for hours when the center is closed;
- Pharmaceutical services, as appropriate to the particular health center;
- Referrals to other providers of medical and health-related services including substance abuse and mental health services;
- Patient case management services including referral and follow-up and accessing eligibility for and gaining access to Federal, State, and local support and financial programs for medical, social, housing and other related services;
- Enabling services including outreach, transportation, interpreter services, and education about health services availability and appropriate use.

- Be governed by a community-based board that independently exercises key authorities including:

  - Hiring, evaluating and, if necessary, dismissing the chief executive;
  - Adopting policies and procedures;
  - Establishing services, hours of operations;
  - Fee schedules, discount schedules, and adopting the annual budget;
  - Conducting strategic planning, quality assessment, and oversight and stewardship functions.
  - The governing board must be representative of the community being served and at least 51% of board members must be regular consumers of the health center's services (i.e. use the health center for their regular source of health care).

- Utilize systems to maximize collections and reimbursement for its costs in providing health services, including written billing, credit and collection policies and procedures.

Once requirements are met, obtaining FQHC or FQHC Look-Alike status is a lengthy process that requires a significant allocation of resources. As part of the analysis prepared by The Camden Group, which was included as part of the June 8th memorandum, consideration of pursuing FQHC status was considered; Camden concluded:

> "Designation of FQHC status is another avenue through which PPHD could obtain enhanced reimbursement. In its current state, PPHD does not have the infrastructure in place to receive this designation. An FQHC needs to be governed by a Community-Board, which PPHD would need to implement. Substantial investments, particularly in information technology, reporting, and

clinical procedures, would need to be made to become an FQHC candidate. Furthermore, the application process is arduous and would require dedicated resources. The impact of ChapCare, a nearby FQHC, on the success of PPHD gaining a FQHC designation would need to be taken into consideration."

The Camden report continues,

> "If FQHC designation is a favorable route for PPHD, they will likely experience significant backlash and competition from ChapCare. Currently, HIV/AIDS care is a carve out benefit from ChapCare and referrals are made to PPHD for these services. If PPHD chooses to pursue an FQHC designation, they would be in direct competition with ChapCare and would alienate this referral source. ChapCare is a more sophisticated healthcare delivery system with an enhanced infrastructure and would argue that they could provide all services, including HIV/AIDS, thereby negating the need for PPHD to become an FQHC. Furthermore, as mentioned above, substantial investments would need to be made to obtain this designation and there is no guarantee that PPHD would be awarded this designation."

While perhaps not the best comparative, the attached article from the California HealthCare Foundation (Attachment B), which illustrates the experience of one community clinic seeking to obtain FQHC designation, is instructive in outlining the challenges associated with the process.

Item 4: What is the process for the City Council to make decisions in regard to the proposed actions?

Response: Staff is recommending that the City Council use the budget process as the vehicle by which to make decisions regarding the proposed service reductions. The proposed operating budget for the Public Health Department anticipates the following reductions and associated timelines.

- July 1*, Public Health Laboratory
- July 1*, Driving Under the Influence (DUI) program
- September 30, HIV services including dental
- December 31, Prenatal clinic

*Based on the Memorandums of Understanding between the City and the impacted employee bargaining groups, written notification of layoff is required at least two weeks before the effective date. Consequently, were the City Council to accept the staff recommendation and adopt the City's budget on June 22nd, notice to the employees in the Public Health Laboratory and the Alcohol Recovery Center which provides the DUI program, would occur on June 23rd, with an effective date of July 7th. Nonetheless, as noted in the June 8th memorandum, the Human Resources Department has held a number of meetings with potentially impacted employees and their respective bargaining groups and significant progress has been made to reduce the number of impacted personnel.

In any event, the City Council may take whatever action(s) it deems appropriate at whatever time it desires in regard to this matter, however, depending on the action/timing there may be additional fiscal impacts. Moreover, there are other key factors and decisions which may affect timing.

Under the City's current contracts with Los Angeles County for HIV services and the Health Care LA, IPA contract, the City is required to provide a 90 day transition plan for clients in the event they must be transferred to a new service provider, including notification to all current members. Consequently, the proposed September 30th date to cease operations of HIV services is contingent of City Council action by the end of June.

More importantly, a fundamental decision must be made as to whether to accept CHAPcare's proposal to establish its own HIV clinic, which it is free to do unilaterally, or invite another FQHC with existing HIV services into Pasadena to operate out of the Pasadena Community Health Center.

In addition to the responses to questions above, staff would like to provide the following additional information for the City Council's consideration.

Item 5: During Public Comment one speaker indicated that the City of Berkley had created its own FQHC. This is not accurate, according to the current Director and Health Officer of the Berkeley Department of Public Health. There is one FQHC in Berkeley, LifeLong Medical Care. It did not originate from the Berkeley City Department of Public Health. Although the Health Department does collaborate on many initiatives with the FQHC, it did not spin off any services to it. The Berkeley Department of Public Health currently does not, and in the past has not received any Ryan White Funds.

Item 6: Included in the June 8th memorandum was a table which compared the services provided by the Public Health Departments of Pasadena, Berkley and Long Beach. As was indicated, the City of Berkley provides HIV outreach, testing and counseling services as well as surveillance, but does not offer clinical programs.

The City of Long Beach does offer clinical programs similar to Pasadena, but does not offer Mental Health Psychotherapy, Psychiatry, Oral Health (Dental), Home-based Case Management or Food Services which Pasadena currently offers. Conversely, the Long Beach Public Health Department has a budget nearly three times the size of the Pasadena Public Health Department and has in place an effective electronic billing system and electronic health records system. By its estimation, Long Beach has about 400 clients, while Pasadena has nearly 300. Long Beach relies on other community partners including its local FQHC to provide services to HIV clients.

Item 7: The June 8th memorandum included a 'status quo' fund sheet. Attachment C is a fund sheet that incorporates the recommended budget reductions. The 'status quo' fund sheet is provided as Attachment D.

Item 8: The following table has been prepared to help the Council and public understand what services are being recommended to be retained by the Public Health Department.

Current Services offered by Pasadena Public Health Department	Services recommended to continue	Services Proposed to be Eliminated
Vital Records	●	
Communicable Disease Control Program	●	
Tuberculosis Clinic	●	
Communicable Disease Surveillance & Epidemiology	●	
Immunization program	●	
Immunization Clinic	●	
Travel Clinic		●
STD Clinic		●
Public Health Laboratory		●
Prenatal Clinic		●
Maternal, Child, and Adolescent Health (MCAH) program	●	
Child Health and Disability Program	●	
Nutrition programs (NEOP-funded)	●	
Tobacco programs	●	
Women, Infants, and Children (WIC) Program	●	
Emergency Preparedness and Bioterrorism Program	●	
Environmental Health Programs	●	
HIV/AIDS clinic and wrap-around services		●
HIV/STD outreach, testing, and counseling	●	
HIV/AIDS Psychiatry and Psychotherapy		●
HIV/AIDS Surveillance program	●	
HIV/AIDS Food pantry		●
Black Infant Health Program	●	
Dental Clinic		●
Mental Health Programs	●	
Substance Abuse Prevention program (Project Alert)	●	
Substance Abuse Outpatient Treatment program	●	
Diabetes/Chronic disease programs	●	
Substance Abuse- Driving Under the Influence (DUI)		●
Healthy Kids insurance enrollment grant	●	

ATTACHMENT A

FY16 Status Quo Budget with Max Revenue Collection

SOCIAL & MENTAL HEALTH PROGRAM REVENUE	FY16	FY17	FY18*
AIDS Drug Assistance Program (ADAP)	15,917	15,917	15,917
HIV/AIDS SPAS-2-8 Ambulatory Outpatient Services	142,612	142,612	142,612
HIV/AIDS Medical Care Coordination	526,490	526,490	526,490
HIV/AIDS MH Psychiatry	75,000	75,000	75,000
Medi-Cal Waiver	680,000	680,000	680,000
HIV/AIDS Oral Health	691,000	571,000	571,000
HIV/AIDS Home Based Case Management	728,743	728,743	728,743
HIV/AIDS MH Psychotherapy	279,594	279,594	279,594
HIV/AIDS Benefits Specialty Services	92,024	92,024	92,024
Alcohol DUI Program	150,000	150,000	150,000
Revenue Subtotal	**3,381,380**	**3,261,380**	**3,261,380**

SOCIAL & MENTAL HEALTH PROGRAM EXPENSES	FY16	FY17	FY18*
AIDS Drug Assistance Program (ADAP)	28,500	29,480	30,497
HIV/AIDS SPAS-2-8 Ambulatory Outpatient Services	815,840	846,366	878,143
HIV/AIDS Medical Care Coordination	643,548	665,072	687,383
HIV/AIDS MH Psychiatry	77,622	81,306	85,169
Medi-Cal Waiver	833,874	868,821	905,337
HIV/AIDS Oral Health	915,329	946,657	979,229
HIV/AIDS Home Based Case Management	823,582	852,490	882,501
HIV/AIDS MH Psychotherapy	283,012	292,876	303,119
HIV/AIDS Benefits Specialty Services	133,796	138,403	143,185
Alcohol DUI Program	265,851	275,496	285,534
Expenses Subtotal	**4,820,954**	**4,996,967**	**5,180,096**
Variance / (Shortfall)	**$ (1,439,574)**	**$ (1,735,587)**	**$ (1,918,716)**

COMMUNITY HEALTH SERVICES PROGRAM REVENUE	FY16	FY17	FY18*
Prenatal Clinic	806,121	806,121	806,121
Public Health Laboratory	29,462	29,462	29,462
Revenue Subtotal	**835,583**	**835,583**	**835,583**

COMMUNITY HEALTH SERVICES PROGRAM EXPENSES	FY16	FY17	FY18*
Prenatal Clinic	955,655	989,559	1,024,790
Public Health Laboratory	333,566	351,551	364,684
Expenses Subtotal	**1,289,221**	**1,341,110**	**1,389,474**
Variance / (Shortfall)	**$ (453,638)**	**$ (505,527)**	**$ (553,891)**

ADDITIONAL COSTS	FY16	FY17	FY18*
Electronic Health Records implementation and maintenance (5 year period)	200,000	50,000	50,000
Medical billing system maintenance (5 year period)	20,000	20,000	20,000
Subtotal	**$ (220,000)**	**$ (70,000)**	**$ (70,000)**
TOTAL VARIANCE / (SHORTFALL)	**$ (2,113,212)**	**$ (2,311,114)**	**$ (2,542,607)**

Assumptions

PPHD collects every last dollar available via LA County contracts
PPHD is fully staffed 100% of the program year
Patient volumes stay at current levels
Additional Nurse Practitioner position added to AOM to manage clinical programs at a cost of approximately $145,000
3% increase in personnel costs in FY17 and FY18
5% increase in services and supplies costs in FY17 and FY18
5% increase in internal service charges in FY17 and FY18

*LA County HIV/AIDS program grants expire in March 2017 so this analysis assumes they are renewed by the County at the same contract value
**Medicare offers an incentive program providing a subsidy for the implementation of an electronic health record system but the incentive amount is dependent on demonstration of meaningful use which makes it difficult to determine if PPHD would qualify and for how much.

ATTACHMENT B

The Clinic's Tale:
Chasing FQHC Status Not for the Faint-Hearted

California HealthCare Foundation

IN 1967, A YOUNG, CALIFORNIA-TRAINED physician from Jamaica threw himself into saving a struggling health clinic operating out of an old furniture store near the edge of Watts in Los Angeles. Dr. Bassett Brown's hard work and determination in the aftermath of the riots that swept the area — and through the intervening years — helped ensure basic health care services for generations of working poor and dispossessed in a 71-square-mile area of Los Angeles County.

The Central Neighborhood Health Foundation today remains an essential cord in the health care safety net of the county. And its future appears secure, despite the precarious nature of funding for the uninsured and the unrelenting needs of the clinic's target population. Yet the organization's survival until recently was very much in doubt.

Ironically, it was a federal program designed to ensure the financial health of community centers like Central Neighborhood that nearly triggered the clinic's demise. Known as the Federally Qualified Health Center program (FQHC), the initiative channels state and federal dollars to health care entities that provide a disproportionate share of services to Medicaid patients and the uninsured. In California, nearly three million individuals are treated annually at more than 1,000 locations by the state's 118 federally supported health centers.

The program has long been viewed as a panacea of sorts by inner-city clinics and represents a powerful bulwark for stemming the erosion of uninsured care funding. But as Central Neighborhood quickly learned, achieving FQHC status can spawn unexpected administrative and financial problems and, in and of itself, provides no guarantee of financial stability.

> *"The only way we were going to survive was to convert from a for-profit to a nonprofit and become an FQHC."*
>
> — BASSETT BROWN, MD
> CENTRAL NEIGHBORHOOD HEALTH FOUNDATION

"The devil truly is in the details, especially after you've been approved as an FQHC," said Steven Rousso, a senior principal and co-founder with HFS Consultants in Oakland, California. "There is no handbook for all the requirements and tasks, and no instructions. So if you don't have the expertise or don't get it from someone who does, you are almost certainly going to get in trouble."

Financial Morass

Rousso last year helped extract Central Neighborhood from a financial morass that threatened to swallow the clinic after it was certified as a so-called FQHC Look-Alike in August 2010. Missed opportunities, faulty filings, and other administrative miscues resulted in total underpayments to the clinic of between $500,000

ISSUE BRIEF

JULY 2012

and $750,000 over a 16-month period and brought the clinic to the brink of closing.

Brown, Central Neighborhood's founder and current chief executive officer, now 75, acknowledges that administrative shortcomings contributed to the difficulties the organization faced as it transitioned to FQHC Look-Alike status. But he says the process of applying for FQHC designation and then operating under the program's guidelines would have been trying under the best of circumstances.

"If we had more resources, if we had more knowledge, if we had more time, I'm sure we could have done this in a more thoughtful, deliberate, and effective way," he said. "But it was, in fact, a very difficult process and a steep learning curve. So we were left scrambling to put out fires left and right just to keep the organization alive."

"FQHCs are an extremely complex corner of an already complex system."

— BOBBIE WUNSCH
PACIFIC HEALTH CONSULTING GROUP

Consultants like Rousso and others underscore that the FQHC program remains an essential tool for meeting the health care needs of the underserved in California and nationwide. But they also agree that the federal program's sometimes convoluted requirements, coupled with similarly elaborate — and often duplicative — state demands, can test even the most sophisticated organizations.

"FQHCs are an extremely complex corner of an already complex system," said Bobbie Wunsch, founder and partner of San Anselmo, California-based Pacific Health Consulting Group, a firm that provides management consulting to public sector health care entities.

"Keeping up with the reporting requirements is a constant struggle, and I don't think there is anyone who would dispute that the system is far too complicated. But the reality is that everybody has their own rules. And everybody wants them followed."

A Model Community Clinic

The origins of the health center date back to the 1920s, when it was opened by a Baptist church group to provide care for Southerners coming to Los Angeles in pursuit of work. But the organization fell on hard times after the Watts riots of 1965. Brown, then a recent grad of Loma Linda University School of Medicine, was working as an emergency medicine intern at nearby Los Angeles County General Hospital in 1967 when he responded to a plea for help from the clinic.

Brown quickly found his calling providing care to the underserved and acquired what few assets the clinic owned in a non-cash transfer designed to keep the doors open. The physician was able to stabilize the clinic and, in short order, introduced new capabilities, including lab services and an x-ray machine. The construction of a modern, 9,000-square-foot medical arts building — half of which Brown financed himself — was completed in 1970. For many, the clinic's rebirth was seen as emblematic of the hoped-for recovery for Watts. The assistant U.S. surgeon general was among the dignitaries present for the grand opening ceremonies.

Through the years, Brown continued to strengthen and expand services for the largely Hispanic and Black populations in the area. The practice grew to 10 full-time primary care doctors, and specialist clinics were conducted on a regular basis. At its peak in the mid-1970s, Central Neighborhood employed over 100 and was seeing more than 300 patients a day. A visiting nurse program was developed to provide follow-up care in the home.

A Changing Financial Landscape

The road the clinic traveled from a funding standpoint, at least in the early years, was relatively smooth. The newly created Medi-Cal program provided strong support, and a separate, prepaid contract from the state for indigent care — one of the first in California — lent further sustenance. But by the early 1990s, changes in the Medi-Cal program that essentially inserted subcontracting IPAs and managed care companies between the state and community providers had the effect of spawning new competition and diluting funds available for care. In an attempt to adapt, the clinic entered into an arrangement with Blue Cross to provide Medi-Cal managed care services. But the partnership was ill-suited.

The net result was that Central Neighborhood lost many of its patients to other providers, and the clinic's capitation rate — which had been $25 per member per month — tumbled to $15. Because the clinic operated as a for-profit entity, grant funding was unavailable.

"Our patient load was dropping, so we had to let doctors and personnel go, one by one," Brown said. "Everything was dying on the vine, and we realized that ultimately the only way we were going to survive was to convert from a for-profit to a nonprofit and become an FQHC. But we knew it would take time."

330s and Look-Alikes

The forerunner of today's FQHC program, the federal community health initiative was established in the 1960s to provide federal grants to clinics located in medically underserved areas and treating patients regardless of their ability to pay. Two other qualifications for community health centers were codified under Section 330 of the Public Health Service Act: The clinic also was required to provide a detailed scope of primary health care and supporting services, and it had to be governed by a majority of community members who represented the population served.

Federal community health centers originally were complementary to — and independent of — the state-federal Medicaid program, But that separation ended in 1989 when Medicaid revenues were harnessed to bolster the federal grants. Medicaid dollars thus became the primary source of funding for community health centers.

The Omnibus Budget Reconciliation Act of 1989 also drew a distinction between Federally Qualified Health Centers (known as 330s after the defining section of the Public Health Service Act) and FQHC Look-Alikes. The key differences were that, unlike 330s, Look-Alikes were not eligible for federal grants, nor could they take advantage of free malpractice coverage or gain special safe harbor protection under federal anti-kickback provisions.

Otherwise, both 330s and Look-Alikes were entitled to cost-based reimbursement calculated from allowable health center costs in lieu of standard Medicaid and Medicare fee-for-service rates. The cost-based rates allowed FQHCs to pay for fixed and variable overhead and infrastructure costs, in addition to primary care services, and proved a major financial boon for many clinics. But by 1999, cost-based reimbursement was deemed inflationary and was replaced by a prospective payment system (PPS). This approach nonetheless continued to take into account clinic overhead expense, and Look-Alikes and 330s consequently were able to maintain significantly higher per-visit rates than the Medicaid fee-for-service reimbursements paid to non-FQHC providers.

Chasing FQHC Status

It was that prospect of a major bump in cash flow — from $18 per basic Medi-Cal visit to a projected $155 — that drew Central Neighborhood Health Foundation to the FQHC program. The clinic had struggled financially through much of the 1990s, and Brown worked to sustain it with ever-increasing personal financial contributions and loans. But the situation continued to worsen, and pursuit of FQHC designation consequently

began in earnest in 2004. At the suggestion of a colleague, Brown was able to recruit a group of graduate students from the University of California, Los Angeles School of Public Health to assess the clinic's readiness for meeting the requirements of the FQHC program.

The grad students' 215-page report was finished in late 2004 and largely confirmed that, assuming the clinic's successful conversion to nonprofit status, Central Neighborhood was well-positioned to take advantage of the FQHC program. However, the authors warned that the clinic's documentation of clinical policies and processes needed to be strengthened to meet FQHC requirements. Administrative and financial management capabilities also were deemed deficient. Numerous policies and procedures, the report said, "were found to lack the detail required to sufficiently and successfully maintain the accounting system, including billing, credit, and collection processes." The center further lacked "adequate internal controls that should ensure fiscal integrity of financial transactions and reports."

Brown said the clinic attempted to make the necessary management and financial reporting changes recommended in the report. "We understood that we needed to beef those areas up," Brown said. "But cash flow was tight and it was difficult to take all the steps we needed to."

Complicating the run-up to submission of the FQHC application was the need to simultaneously convert the clinic's organizational structure from for-profit to nonprofit. The transfer of assets and contracts, including a critically important county contract for indigent care awarded in 2005, effectively required the simultaneous operation of two parallel businesses for an extended period of time.

Central Neighborhood also had to secure licensure and certification as a primary care clinic from the California Department of Public Health (CDPH) before becoming an FQHC. Like the federal application, the state process took time and effort to complete.

As part of the FQHC application process, Central Neighborhood was required to obtain letters of support from other FQHCs operating in the same area. But of the five L.A.-area clinics that Brown approached, only one agreed to provide a letter to federal regulators on Central Neighborhood's behalf.

Of the five L.A.-area clinics that Brown approached, only one agreed to provide a letter to federal regulators on Central Neighborhood's behalf.

"They were fearful of competition, but it was an insane fear," Brown said. "I've been in the community for more than 40 years, longer than any of them. It came down to the fact that they perceived us to be a competitive threat. But the truth is, all of us together can barely put a dent in the overall need here. So that was very disappointing."

Central Neighborhood ultimately submitted its inch-and-a-half-thick FQHC application, in triplicate, in March of 2009. "It was extremely elaborate," Brown said. "We had to show that we met all the requirements and that we understood the whole concept of managing care so as to achieve good outcomes."

Missing Paperwork

Approval of Central Neighborhood's FQHC Look-Alike status came in August 2010 from the federal Health Resources and Services Administration (HRSA), the administrators of the FQHC program. An application submitted two months later to win the full 330 designation (and attendant annual grants of up to $650,000) was put on hold by HRSA, due to shortcomings identified by the agency.

Those problems included the absence of letters of support from other FQHCs; failure to identify gaps in health services or other private practices accepting public insurance; along with the need for further development of policies, procedures, strategic goals, objectives, outcomes, evaluation measures, and plans for recruiting and retaining additional staff, according to a comment letter from HRSA.

With Look-Alike status nonetheless secured and the clinic's prospective payment system (PPS) rate established by HRSA at $155 per patient visit, the clinic next approached the Medi-Cal program about setting a so-called Code 18, or "wrap-around rate." Under federal law, the state is required to make a supplemental, or wrap-around, payment to cover 80 percent of the difference between what managed care organizations reimburse the clinic and the clinic's full PPS rate. The remaining 20 percent of the PPS can be recovered through a reconciliation process at year-end.

The wrap-around rate represents an increasingly key component of the overall FQHC reimbursement structure as more Medi-Cal beneficiaries are shifted into managed care plans. In Los Angeles, the Medi-Cal rate for non-FQHCs is around $18 per visit. The clinic's wrap-around, therefore, should have been, at minimum, in the neighborhood of $110.

In reality, however, the state pegged the rate at a mere $30. Brown questioned the judgment, but the state was "adamant" in justifying the calculation, he said. Central Neighborhood consequently accepted the decision, and cash flow collapsed from projected levels.

With the financial situation spiraling out of control, Brown turned to community health center experts at the California HealthCare Foundation for advice. The Foundation, in turn, recommended that Central Neighborhood work with Rousso, a consultant specializing in community health centers and FQHCs. Rousso conducted a detailed review of the clinic's documentation and quickly discovered the primary problem.

"Basically, the clinic hadn't submitted the proper paperwork to the state to show what their Medi-Cal managed care plan reimbursements were, so the rate was set at a very low level," Rousso said. "It was a lack of knowledge about the requirements on the part of the clinic, poor communication on the part of the state, and also the absence of anyone advocating on the clinic's behalf."

The consultant's review uncovered other omissions. Two other state programs that offered enhanced reimbursement for FQHCs — Healthy Families Code 19 and Medi-Medi Code 02 (for enrollees who are both Medicare and Medi-Cal eligible) — had not been accessed by the clinic. The result was additional foregone revenue.

Finally, the clinic had not been properly enrolled as a Medicare FQHC provider. Like Medicaid, Medicare also pays an enhanced reimbursement rate to 330s and Look-Alikes. But because Central Neighborhood was unaware of this fact, the clinic was continuing to receive standard fee-for-service rates and thus leaving dollars on the table with each Medicare patient treated.

'A Lot of Land Mines'

Central Neighborhood's unfamiliarity with myriad FQHC rules collectively cost the clinic between $500,000 and $750,000, Rousso estimated, the bulk of which resulted from Medi-Cal underpayments. Yet the consultant said he didn't fault the clinic's management for the problems. Unfortunately, he said, it's a scenario he's encountered many times before.

"I've seen these kinds of mistakes over and over again, particularly with new centers," he said. "They get FQHC status, but no one tells them what to do after that, like how to enroll in Medicare and Medicaid, how to get the various rates, how to bill, the different codes to bill, provider numbers, how to get registered with the right agencies. And then there are ongoing reimbursement issues after start-up. So there are just a lot of land mines out there."

> *"He's dedicated his life to providing care to the underserved. How could he be expected to know this stuff? It's like me trying to do a colonoscopy."*
>
> — STEVEN ROUSSO
> HFS CONSULTANTS

One of the biggest problems facing new FQHCs, Rousso said, is the fragmented nature of agency oversight and compliance.

"You're dealing with HRSA, you're dealing with one state agency on licensing issues, another on provider enrollment, another for audits and investigation for rates; with CMS for approvals on the Medicare side, and you're dealing with the Medicare fiscal intermediary. So right there, you're interacting with five or six organizations, and there is no real communication between them. That, in itself, is troubling."

"Dr. Brown is a physician and his main focus is medicine," Rousso added. "He's dedicated his life to providing care to the underserved. How could he be expected to know this stuff? It's like me trying to do a colonoscopy."

Ongoing Demands

Wunsch, founder and partner at Pacific Health Consulting, agreed that the application and enrollment processes associated with start-up FQHCs can seem overwhelming. But the challenges don't stop there. Once a clinic is operational, it must comply with a host of ongoing reporting requirements. These include detailed annual reports to both HRSA and Medi-Cal, as well as to the Office of Statewide Health Planning and Development (OSHPD) and county agencies. Each report typically has different parameters, questions, and terminologies, although there is frequent overlap between them.

Moreover, because many FQHCs receive funding from private foundations, those entities likewise require reports designed to account for, and justify, the grants. Finally, case, morbidity, outcomes, and quality information must be collected and shared on a regular basis with multiple agencies to accommodate the larger quality objectives of the FQHC care model.

"A clinic literally could have up to 50 different funding sources, and 50 different reports that must be turned in at different times of the year," Wunsch said. "I think it's every community health director's dream that the process be simplified."

She added that although the vast majority of FQHCs ultimately get a handle on the reporting and compliance

demands, sustaining the appropriate level of oversight is an increasingly difficult task.

"In the last five years, a lot of FQHCs have brought in compliance officers," she said. "I think that illustrates perfectly the fact that the system has become so complex that you basically need a whole department to make sure you're following the rules."

Back from the Brink

Today, Central Neighborhood is steadily climbing back on solid financial ground. Rousso said corrected and missing documentation is being resubmitted to Medicare, Medi-Cal, and other state agencies, and the odds are good that a significant portion of the lost revenues from 2010 and 2011 can be recovered. The consultant has helped Central Neighborhood clarify its Medi-Cal managed care utilization and reimbursements, and a new wrap-around rate has been set by the state at $132 per patient visit.

Central Neighborhood is currently seeing about 200 patients per day and employs five physicians, six physician extenders, and 12 medical assistants. Last summer, the health center was awarded a Healthy Way L.A. contract to provide a medical home for low-income patients as part of the Bridge to Health Care Reform established by the Obama administration. Healthy Way provides free health care coverage to low-income, uninsured adult citizens and legal residents via a medical home delivery model. The clinic likewise has secured a parallel Disability Assessment Contract with the county's Department of Public Social Services. The contract will provide an opportunity for hundreds of indigent and homeless patients to access and establish a medical home through Central Neighborhood.

Separately, Central Neighborhood is exploring the possibility of working with area hospitals to decompress crowded emergency departments by establishing satellite clinics at the hospitals. The clinics could absorb uninsured patients through the Healthy Way L.A. program. "It's something that could save these hospitals a lot of money," Brown said.

Meeting the clinic's ongoing reporting requirements — particularly in the area of quality and outcomes data — should get easier as Central Neighborhood's automation capabilities are strengthened. According to Brown, the clinic was certified as a "meaningful user" of electronic medical records in 2011. As such, Central Neighborhood will be eligible under the 2009 HITECH Act for financial assistance over the next five years to help bolster its information infrastructure.

Brown said he is enthusiastic about the medical home case management and disease tracking components of the FQHC program. "I think that once all the electronic medical records are in place, it's going to be a huge step forward toward improving the health status of the community," he said.

And while the future of the Patient Protection and Affordable Care Act remains very much up in the air, the prospect that many of the currently uninsured ultimately could receive care through an expanded Medicaid program raises the prospect of potentially significant additional reimbursement for Central Neighborhood.

Building for the Future

As for the overall lessons gleaned from the clinic's recent experience, Brown recommended that community health centers considering a conversion to an FQHC hire a qualified consultant or attorney at the outset — both to work with the organization through the application process and to stay involved once operational status is achieved. One possibility, he said, was that multiple clinics could band together to spread the cost of a top-notch consultant. He added that retaining a financial officer who was experienced in managing the reimbursement complexities of FQHCs likewise was essential.

Although Central Neighborhood's FQHC odyssey has been daunting, Brown said he feels positive about how the situation is playing out.

"I can see light at the end of the tunnel now," he said. "This work has been my life, and the job that needs to be done is enormous. I think I've always had good insight into the problem of treating the underserved and what the potential solutions were. And that's why I pursued FQHC for the clinic. More than anything, I want to establish a solid foundation for the clinic's future, so that it will continue when I'm gone, and not die with me."

About the Foundation

The California HealthCare Foundation works as a catalyst to fulfill the promise of better health care for all Californians. We support ideas and innovations that improve quality, increase efficiency, and lower the costs of care. For more information, visit us online at www.chcf.org.

ATTACHMENT C

Public Health Fund

Fund 203

	FY 2011 Actual	FY 2012 Actual	FY 2013 Actual	FY 2014 Actual	FY 2015 Adopted	FY 2015 Revised	FY 2015 Est Actual	FY 2016 Projected	FY 2017 Projected	FY 2018 Projected
Beginning Fund Balance	632,522	353,771	1,035,794	1,011,177	(1,085,092)	(1,085,092)	(1,085,092)	(3,062,914)	(4,237,996)	(4,487,097)
SOURCES										
Sales Tax	710,827	708,804	669,575	806,824	650,828	650,828	712,175	287,930	293,689	300,297
Licenses and Permits	897,784	1,003,625	1,041,414	1,291,328	1,098,770	1,098,770	1,346,179	1,185,000	1,208,700	1,235,896
Intergovernmental-Local	213,855	264,207	387,282	444,041	790,402	790,402	417,041	675,206	688,710	704,206
Charges For Services	537,438	537,538	625,136	735,390	1,046,335	1,046,335	794,169	505,139	501,689	512,977
Charges For Services-Quasi Ext	49,759	49,759	-	-	49,758	49,758	-	-	-	-
Federal Grants Indirect-State	3,684,319	4,751,143	5,005,501	3,740,546	4,768,511	4,768,511	3,952,349	3,692,100	2,800,719	2,800,719
Federal Grants-Direct	282,854	195,701	0	474,285	515,026	515,026	1,075,330	1,436,605	799,313	500,000
State Grant Direct	275,021	275,568	282,340	293,037	333,805	333,805	217,671	306,410	188,731	188,731
State Non Grant Direct	2,581,934	2,549,468	3,362,987	3,603,403	4,612,020	4,612,020	2,997,914	2,817,492	1,077,735	1,101,984
Transfers In	1,425,214	1,054,131	1,341,455	-	-	-	-	-	-	-
General Fund Contribution	-	-	-	-	-	-	-	-	-	-
Other Financing Sources	77,000	37,945	-	-	60,920	60,920	-	-	-	-
Rental Income	18,960	73,750	(14,336)	14,428	12,480	12,480	13,439	-	214,494	214,494
Miscellaneous Revenue	(6,236)	79,497	753,848	106,958	1,391,040	1,391,040	101,960	340,145	1,543,645	1,578,377
Total Revenue	**10,748,729**	**11,581,137**	**13,455,202**	**11,510,240**	**15,329,895**	**15,329,895**	**11,628,227**	**11,246,027**	**9,317,425**	**9,137,681**
EXPENSES										
Personnel	7,088,292	6,969,363	8,132,126	9,348,154	10,971,123	11,281,597	9,441,443	8,403,784	6,369,800	6,119,800
Services & Supplies	3,040,159	2,799,368	4,085,302	2,811,671	1,824,026	2,638,546	2,419,589	2,147,477	1,500,859	1,440,859
Internal Services	899,029	1,130,383	1,262,389	1,390,761	1,574,909	1,574,909	1,574,909	1,670,804	1,695,866	1,734,023
Transfers	-	-	-	55,923	-	-	170,108	199,044	-	-
Total Expenses	**11,027,480**	**10,899,114**	**13,479,817**	**13,606,509**	**14,370,058**	**15,495,052**	**13,606,049**	**12,421,109**	**9,566,526**	**9,294,682**
Net Income	(278,751)	682,023	(24,617)	(2,096,269)	959,837	(165,157)	(1,977,822)	(1,175,082)	(249,101)	(157,001)
Adjustment										
Transfer to Capital Projects Fund										
Ending Fund Balance	**353,771**	**1,035,794**	**1,011,177**	**(1,085,092)**	**(125,255)**	**(1,250,249)**	**(3,062,914)**	**(4,237,996)**	**(4,487,097)**	**(4,644,098)**

ATTACHMENT D

	A	B	C	D	E	F	G	H	I	K	L	M	N
1	**Public Health Fund**												
2	**Fund 203**	**FY 2008**	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**
3		**Actual**	**Actual**	**Actual**	**Actual**	**Actual**	**Actual**	**Actual**	**Adopted**	**Est Actual**	**Projected**	**Projected**	**Projected**
4	Beginning Fund Balance	131,812	(799,762)	(53,840)	632,522	353,771	1,035,794	1,011,177	(1,085,092)	(1,085,092)	(3,062,914)	(5,072,469)	(8,750,533)
5													
6	**SOURCES**												
7	Sales Tax	811,596	723,742	680,644	710,827	708,804	669,575	806,824	650,828	712,175	287,930	292,249	296,633
8	Licenses and Permits	644,195	579,070	713,619	897,784	1,003,625	1,041,414	1,291,328	1,098,770	1,346,179	1,185,000	1,202,775	1,220,817
9	Intergovernmental-Local	81,368	64,587	221,634	213,855	264,207	387,282	444,041	790,402	417,041	599,168	608,156	606,050
10	Charges For Services	653,908	575,059	728,880	537,438	537,538	625,136	735,390	1,046,335	794,169	808,527	820,655	832,965
11	Charges For Services-Quasi Ext	44,000	46,906	48,782	49,759	49,759	-	-	49,758	-	-	-	-
12	Federal Grants Indirect-State	4,062,802	4,471,429	4,032,660	3,684,319	4,751,143	5,005,501	3,740,546	4,768,511	3,952,349	5,272,524	4,009,622	4,069,766
13	Federal Grants-Direct	-	-	102,044	282,854	195,701	0	474,285	515,026	1,075,330	1,436,605	1,325,330	1,125,330
14	State Grant Direct	452,530	668,729	293,671	275,021	275,568	282,340	293,037	333,805	217,671	306,410	311,006	285,137
15	State Non Grant Direct	3,180,419	2,341,430	2,992,744	2,581,934	2,549,468	3,362,987	3,603,403	4,612,020	2,997,914	3,963,610	4,023,064	4,083,410
16	Transfers In	1,085,121	1,077,803	1,069,302	1,425,214	1,054,131	1,341,455	-	-	-	-	-	-
17	General Fund Contribution	-	1,250,000	899,644	-	-	-	-	-	-	-	-	-
18	Other Financing Sources	50,000	-	122,240	77,000	37,945	-	-	60,920	-	-	-	-
19	Rental Income	12,493	13,572	13,959	18,960	73,750	(14,336)	14,428	12,480	13,439	-	14,494	14,494
20	Miscellaneous Revenue	122,541	404,874	15,767	(6,236)	79,497	753,848	106,958	1,391,040	101,960	435,145	100,000	100,000
21	**Total Revenue**	**11,200,973**	**12,217,199**	**11,935,588**	**10,748,729**	**11,581,137**	**13,455,202**	**11,510,240**	**15,329,895**	**11,628,227**	**14,294,919**	**12,707,351**	**12,634,602**
22													
23	**EXPENSES**												
24	Personnel	8,113,767	7,984,960	7,418,395	7,088,292	6,969,363	8,132,126	9,348,154	10,971,123	9,441,443	11,538,171	11,740,147	11,945,658
25	Services & Supplies	2,994,613	2,542,038	2,707,980	3,040,159	2,799,368	4,085,302	2,811,671	1,824,026	2,419,589	3,039,576	2,893,479	2,893,479
26	Internal Services	1,015,445	944,279	922,853	899,029	1,130,383	1,262,389	1,390,761	1,574,909	1,574,909	1,670,804	1,695,866	1,721,304
27	Transfers	-	-	200,000	-	-	-	55,923.00	-	170,108	55,923	55,923	55,923
28	**Total Expenses**	**12,123,825**	**11,471,277**	**11,249,228**	**11,027,480**	**10,899,114**	**13,479,817**	**13,606,509**	**14,370,058**	**13,606,049**	**16,304,474**	**16,385,415**	**16,616,364**
29													
30	**Net Income**	(922,852)	745,922	686,360	(278,751)	682,023	(24,617)	(2,096,269)	959,837	(1,977,822)	(2,009,555)	(3,678,064)	(3,981,762)
31													
32	**Adjustment**												
33	Transfer to Capital Projects Fund	(8,722)											
34													
35	**Ending Fund Balance**	**(799,762)**	**(53,840)**	**632,521**	**353,771**	**1,035,794**	**1,011,177**	**(1,085,092)**	**(125,255)**	**(3,062,914)**	**(5,072,469)**	**(8,750,533)**	**(12,732,295)**

Memorandum

Date: June 8, 2015

To: City Council and City Manager

From: Steve Mermell, Assistant City Manager

Subject: Additional Information Regarding Public Health Department Recommended Operating Budget

The Pasadena Public Health Department, as part of its recommended operating budget for Fiscal Year 2016, is recommending the elimination of certain clinical programs, most notably the prenatal and HIV/AIDS programs, as well as reductions in other services to better align available resources with expenditures and to position the Department for success following the implementation of the Patient Protection and Affordable Care Act. The purpose of this memorandum is to provide background information regarding these recommendations.

The Pasadena Public Health Department is one of only three cities in California with its own Health Department; Berkeley and Long Beach are the other two. The following table summarizes the services provided by each of these departments.

Service/Function	Pasadena Pop: 139,731	Berkeley Pop: 116,768	Long Beach Pop: 469,428
Department Budget FY15	$14.4 M	$9 M	$38 M[1]
Per capita expenditure	$103	$77	$81
Vital Records	●	●	●
Communicable Disease Control Program	●	●	●
Tuberculosis Clinic	●		●
Communicable Disease Surveillance & Epidemiology	●	●	●
Immunization program	●	●	●
Immunization Clinic	●	●	●
Travel Clinic	●		●
STD Clinic	●	●	●
School-based clinics		●	●
Public Health Laboratory	●		●
Prenatal Clinic	●		
Maternal, Child, and Adolescent Health (MCAH) program	●	●	●
Child Health and Disability Program	●	●	●
Nutrition programs (NEOP-funded)	●	●	●
Tobacco programs	●	●	●
Women, Infants, and Children (WIC) Program	●	●	●
Emergency Preparedness and Bioterrorism Program	●	●	●

Environmental Health Programs	•	2	•
HIV/AIDS clinic and wrap-around services	•		•
HIV/STD outreach, testing, and counseling	•	•	•
HIV/AIDS Surveillance program	•	•	•
HIV/AIDS Food pantry	•		
Black Infant Health Program	•	3	•
Dental Clinic	•		
Mental Health Programs	•	2	•
Substance Abuse Prevention program (Project Alert)	•		
Substance Abuse Outpatient Treatment program	•		
Diabetes/Chronic disease programs	•	•	•
Substance Abuse- Driving Under the Influence (DUI)	•		
Healthy Kids insurance enrollment grant	•		•
Homeless Drop-in Clinic and Services			•

Notes: 1. Long Beach Health Department includes the Housing Authority of Long Beach. Total budget is $117 M, Health portion is $38 M. 2. Berkeley has Environmental Health and Mental Health in separate divisions, not under Public Health. 3. Berkeley's Black Infant Health Program (BIH) will no longer qualify as a state BIH program effective 7/1/15. It will be incorporated into the City's MCAH program.

As indicated by the table above, the services provided by each California municipal Health Department vary. In terms of what services a local health department is required to provide, the California Health and Safety Code sets forth requirements in various portions of the Code. These requirements include:

- Appointment of a Health Officer who must be a licensed physician, who shall:
    - Enforce local health orders and ordinances
    - Uphold State and local regulations and statutes
    - Assess community health status
    - Direct mandated public health protection
    - Respond to public health emergencies
    - Provide leadership in health policy

- Provision of the following basic services:
    - Collection, tabulation and analysis of public health statistics
    - Health education programs
    - Communicable disease control
    - Tuberculosis control
    - Maternal and child health promotion
    - Environmental health and sanitation services
    - Nutrition services (education and prevention)
    - Services in chronic disease
    - Services directed to social factors affecting health (community planning)
    - Appropriate services in the field of family planning
    - Public Health nursing
    - Have available the services of a public health laboratory

The reductions proposed in the Health Department's recommended operating budget will not affect the Department's ability to carry out these core functions. Rather, the proposed reductions are in non-mandated clinical programs that despite not being financially viable, served as a safety-net for those in Pasadena and surrounding communities who were on Medi-Cal or uninsured.

The following table provides census information regarding these programs:

Program	Total Clients	% Pasadena Residents
Prenatal	252	48%
HIV - Medical Outpatient Program	300	25%*
HIV - Medical Care Coordination	241	26%
HIV - Benefits Specialty Services	180	17%
HIV - Mental Health, Psychiatry	85	24%
HIV – Home-Based Case Management	123	7%
Dental Clinic - HIV and Denti-Cal	839	25%
Alcohol Recovery DUI	74	50%

*Extrapolated based on number of uninsured patients

The advent of the Patient Protection and Affordable Care Act (ACA) coupled with California's Managed Medi-Cal expansion has created a system whereby other service providers are now in place to provide not only these specialty services, but the entire range of essential health services mandated by the ACA, thereby reducing the need for the City of Pasadena to provide these services. Prior to delving further into the impact of the ACA, a brief review of the financial performance of the Department is useful to provide context.

Public Health Fund Overall Financial Performance

The current fund sheet for the Public Health Fund (Attachment A) indicates (line 30) that the fund had positive net income in three of the last eight years inclusive of Fiscal Year 2015 projected. However, although the fund sheet shows positive net income in Fiscal Years 2009 and 2010, the General Fund provided support in the amounts of $1.25 million and $900,000 respectively in those years. But for these General Fund subsidies, the fund would have posted a loss in all seven of the eight years included.

The Public Health Department is funded primarily by grants and cost reimbursable contracts. For FY15 these sources represented roughly $10 million or about 67% of the Department's budgeted revenues. The balance of the Department's revenue is made

up of fees for services $2.2 million (14%), provided mainly through Environmental Health activities such as plan check and routine inspections, realignment funds provided by the state of California $2.5 million (16%) and the remaining 3% is various miscellaneous revenues. The following is a list of current grants and cost reimbursable contracts.

GRANT NAME	FY15 Contract Award	Funding Agency
AIDS Drug Assistance Program (ADAP)	15,917	State of California
HIV Counseling & Testing Storefront (Base)	65,969	County of Los Angeles
HIV/AIDS Benefits Specialty Services	92,024	County of Los Angeles
HIV/AIDS Home Based Case Management	728,743	County of Los Angeles
HIV/AIDS Medical Care Coordination	526,490	County of Los Angeles
HIV/AIDS Oral Health	571,000	County of Los Angeles
HIV/AIDS MH Psychiatry	75,000	County of Los Angeles
HIV/AIDS MH Psychotherapy	279,594	County of Los Angeles
Medi-Cal Administrative Activities (MAA) - Base	425,000	State of California
Medi-Cal Administrative Activities (MAA) - School-Based MAA	900,000	State of California
HIV Counseling & Testing (PFP)	43,980	County of Los Angeles
HIV/AIDS SPAS-2-8 Ambulatory Outpatient Services (Fee for Service, Imaging, Lab, and Pharmacy) (Medical)	142,612	County of Los Angeles
Alcohol - General Relief (outpatient)	28,000	County of Los Angeles
Black Infant Health (BIH) FFLA	216,206	First5LA
Black Infant Health (BIH) State	300,744	State of California
BT - Bioterrorism and E.R. (Includes Base, CRI, and Carryover(s))	291,973	County of Los Angeles
BT - Pandemic Influenza Preparedness	64,719	State of California
California Nutrition Network	557,951	State of California
California Wellness Grant (Oral Health)	150,000	California Wellness Foundation
Child Health Disability Prevention (CHDP)	330,366	State of California
Childhood Lead Poison Prevention Grant	127,419	State of California
Choose Health LA (CTG)	390,000	County of Los Angeles
FDA Food Inspection Tablet System (Federal)	84,189	Health & Human Services
Healthy Kids	60,000	County of Los Angeles
Healthy Kids DHCS Medi-Cal Outreach	20,050	County of Los Angeles
HIV Surveillance (State)	24,540	State of California
HRSA Special Project of Natl Significance (Federal)	299,313	Health & Human Services
Health Immunization Action	65,273	State of California
Maternal Child Adolescences Health (State)	126,632	State of California

PACE - KAISER (56029)	60,000	Kaiser Permanente
PACE - La County (56030)	100,000	County of Los Angeles
Pasadena Reach Project (Federal)	500,000	Health & Human Services
SAMHSA (Federal)	594,473	Health & Human Services
SAPC - Alcohol & Other Drug Prevention	200,000	County of Los Angeles
Tuberculosis State Local	32,924	State of California
Tobacco Control	150,000	State of California
WIC Little-By-Little	136,995	County of Los Angeles
Women, Infant, Children (WIC) and Breast Feeding Peer Counselor Program	1,128,873	State of California
Total $	9,906,969	

In some cases over the past few years the Department has had difficulty fully recovering the total amount of grant funds/contract dollars available. For example, in fiscal years 2013, 2014 and 2015 the Department under-billed its contracts with Los Angeles County for various HIV services by $1,132,915; $528,747 and $1,570,383, respectively.

There are several factors that contribute to under-billings. For most grants the City can only bill for costs incurred so when there are staff vacancies potential revenues go unclaimed, however, in such cases there are offsetting cost savings. As a result of staff turnover in the Department's Administration and reductions in staffing in the Finance Department's Grant Accounting Section, which previously was responsible for invoicing funders, revenue collections fell behind in Fiscal Year 2014. Over the course of the past fiscal year, the Department has successfully cleared its backlog and is up to date in all invoicing. Nevertheless, the overall fund balance currently stands at negative $2,235,038.

Even when Department programs are fully staffed and invoicing is done in a timely manner, the Department is limited in its recovery due to the fact that a number of grants, totaling over $4 million, do not allow for the billing of administrative overhead and the remaining $6 million of grants cap allowable overhead costs. For example, the HIV services contracts from the County of Los Angeles cap allowable overhead at 10%, which falls significantly short of covering the Department's true overhead when considering the cost of City internal services (charges from Building Maintenance and Department of Information Technology) and cost allocation (the allocation of costs provided by central-service General Fund departments such as Finance, Human Resources, and City Manager's Office). In the case of cost allocation, the cost of services provided by City General Fund departments was not allocated to the Health Fund prior to Fiscal Year 2013. For Fiscal Year 2015 the Fund will be charged a total of $241,102 in allocated costs. While it is appropriate for non-general funds to reimburse the General Fund for the cost of support, in the case of the Public Health Department, this cost cannot be recaptured from its grants.

Despite these challenges, with the adoption of the Fiscal Year 2015 budget, it appeared that the Health Fund would generate positive net income, with revenues exceeding expenses by nearly $900,000. Based on year to date actuals, however, this projection will not be realized and instead the Fund will incur a shortfall which will approach or potentially exceed $2 million for the second year in a row. One reason for this is that it was anticipated that revenues not received in Fiscal Year 2014 would be received in Fiscal Year 2015, however, much of this had already been accounted for in existing fund balance figures. Additionally, the Department expected to fully recover the contracted amounts for HIV services contracts from Los Angeles County. It should be noted that in mid-2012 the Department expanded its HIV services by acquiring additional County contracts and increased staffing by 15 FTE following the closure of the AIDS Service Center. Another 5.0 FTEs were added to provide service in the Michael D. Antonovich Dental Clinic when it opened in 2013.

These service expansions, although well intentioned to address the needs of underserved populations, have posed challenges for the Department. By way of example, in the Dental clinic two types of patients are seen, those covered by Medi-Cal and those with private insurance. Since the implementation of the ACA, Federally Qualified Health Centers (FQHC) such as CHAPcare enjoy the ability to bill Denti-Cal, the Medi-Cal coverage for dental, for many more procedures and at a higher rate per procedure than non-FQHCs such as the Pasadena Public Health Department. Attachment B illustrates the differences between billable and non-billable services for FQHCs and non-FQHCs. Moreover, for those procedures where the Public Health Department is able to bill Dent-Cal, the reimbursements are not sufficient to cover program costs. As discussed at greater length in a recent article from the Sacramento Business Journal (Attachment C), other providers are leaving the Denti-Cal arena because of low reimbursement rates.

To further the point that Denti-Cal and Medi-Cal reimbursements are insufficient to cover the City's costs of providing clinical services, staff recently examined the billing activity for 100 patients who visited one or more of the Health Department's clinics in Calendar Year 2014. The analysis indicated that the average cost to serve the patient exceeded the average reimbursement paid by Medi-Cal by approximately 35%, with the average cost per Medi-Cal Patient being $125.20 and the average reimbursement $80.92.

In terms of accepting private insurance, the Department's prenatal clinic does not take insurance because obstetrics in not considered a specialty care service and therefore not eligible. As a specialty care service provider the HIV clinic is able to accept and bill insurance, but the lack of infrastructure including electronic health records, has hampered success.

Through investments such as the implementation of electronic health records (an estimated cost of several hundreds of thousands of dollars), improved financial management which is already underway and other actions, it is conceivable that the Department could improve its clinical programs' financial results, but given low reimbursements from Medi-Cal and Denti-Cal, the City's relatively high overhead rate in form of employee compensation, benefits, and central services, and the inability to bill

various grants for their recovery, the Department is expected to continue to experience significant financial losses.

Impact of the Affordable Care Act

The purpose of the Affordable Care Act (ACA) is to make health insurance more affordable for those with little or no coverage. Although the law includes some provisions intended to control costs, the most immediate impact to consumers will be on insurance premiums and out-of-pocket costs for health care and on access to insurance. The law is aimed at people who would not or could not buy insurance as well as those underinsured; people who have health care coverage that does not adequately protect them from high medical expenses. These target populations represent the patient profile of the Pasadena Public Health Department.

Consequently, in developing a strategy to address the Department's significant financial challenges, staff sought to better understand how the rollout of the ACA would impact the clinical programs provided by the Pasadena Public Health Department. To assist in this effort, staff engaged The Camden Group, one of the largest healthcare business advisory firms in the country. Camden conducted interviews with Health Department management, reviewed various financial and utilization reports related to the Department's clinical programs, met with top management from Huntington Memorial Hospital and Community Health Alliance of Pasadena (CHAPcare) the local Federally Qualified Health Center (FQHC) and prepared four separate reports (Attachments D, E, F and G) covering the following subject areas:

- HIV/AIDS Services
- Obstetrics and Prenatal Services
- Communicable Disease Prevention
- Mental Health and Substance Abuse Services

The Camden Group's assessment identified the following key findings:

- **As more people obtain coverage through the ACA the need for services provided by the Pasadena Public Health Department will diminish.** Today 17 million Americans who previously were without medical insurance currently enjoy coverage as a result of the ACA. Moreover, pre-existing conditions such as HIV are no longer barriers to coverage. As a result, people are finding medical homes which provide a range of Essential Health Benefits beyond the specialty services provided by the Public Health Department. By way of example, current participation in the Department's Prenatal clinic is roughly 225 women, whereas several years ago participation was close to 700 based on staff's estimates.

- **If it chooses to continue providing clinical services, the Pasadena Public Health Department will see increased competition from Federally Qualified Health Centers (FQHCs) and Medi-Cal managed care plans, which provide services to nearly 12.2 million Medi-Cal beneficiaries throughout California.** FQHCs operate within a cost/reimbursement structure that allows them to care for patients, cover their costs and generate profit. Most recently Huntington Memorial

Hospital announced that it would accept Medi-Cal managed care plans. The Pasadena Public Health Department cannot receive the enhanced reimbursement rates of FQHCs; the Department's reimbursements will always be lower thus placing the City at a disadvantage.

- **Current funding sources such as Federal Ryan White dollars will continue to diminish.** The Federal Ryan White program functions as the payer of last resort for low-income individuals with HIV/AIDS. In California, many Ryan White services will likely transition to Medi-Cal, since under the ACA, Ryan White cannot be used to deliver services for which patients are eligible through other health coverage programs. The result is a shift from a more generous payer source, which does not fully cover the City's costs, to an even less generous one.

- **Decreasing Medi-Cal reimbursements will make cost recovery increasingly difficult.** The Public Health Department's patient population is primarily insured with Medi-Cal or uninsured, and with decreasing Medi-Cal reimbursement rates, there likely is a small economic opportunity with this model.

- **The Department currently lacks the infrastructure to become an FQHC.** An FQHC must to be governed by a Community-Board, separate from the City structure. Moreover, given that there is already an existing FQHC in Pasadena, CHAPcare, with two locations in City facilities, it is unlikely that the Federal Government would grant approval to create another local entity. Even if it were possible, substantial investments in information technology such as electronic health records and other systems would be required.

Taken as a whole i.e., the financial and structural realities of the Public Health Department along with the fundamental changes affecting the entire medical industry, the Department's leadership team determined the best course of action would be to no longer offer clinical programs, which could now be provided by other qualified non-City providers, and instead focus on core public health functions and general health promotion activities. It's worth noting that this same decision has been made by many other public health jurisdictions including locally the Long Beach Public Health Department.

Projected Fiscal Year 2016 Budget

In preparing the Fiscal Year 2016 operating budget, revenues and expenses were scrutinized very closely to ensure the most accurate projections possible. Based on this analysis, unless changes are made, it is expected that the Department will once again face an operating loss of approximately $2 million, which would continue to grow in subsequent years.

As indicated in the following table, the majority of the anticipated loss is related to the clinical programs of HIV services, Prenatal, Alcohol Recovery and the Public Health Laboratory which supports the HIV and Prenatal program. The balance of the anticipated loss of roughly $392,000 is spread across other Departmental programs.

FY16 Anticipated Program Loss $	
HIV Services (including Dental clinic)	(1,084,057)
Public Health Laboratory	(304,104)
Prenatal Clinic	(155,318)
Alcohol Recovery Center DUI	(122,573)
Department wide	(392,000)
Total	(2,058,052)

Proposed Program Eliminations

1. HIV Services. Total Budget FY16 $4,336,099. Total FTEs 32.00. Program Description: The HIV Services program known as the Andrew Escajeda Comprehensive Care Services is designed on an integrated HIV Medical Home approach, which includes the Michael D. Antonovich Dental Clinic. The Program integrates a social and medical model that seeks to promote and improve the overall care of individuals, partners and families from a cultural, biological and psychological perspective. The programs are developed with a client-centered approach both in care and preventive measures. The services being provided in this model are, medical outpatient services, mental health (psychotherapy and psychiatry), medical care coordination, benefits specialty services, oral health (dental services), home-based case management services, AIDS Drug Assistance Program (ADAP), medical transportation and a partnership with AIDS Project Los Angeles (APLA) for the provision of food services. In addition, the program created partnerships with other HIV programs to provide housing case management services.

2. Prenatal Clinic. Total Budget FY16 $947,543. Total FTEs 7.88
   Program Description: Comprehensive Perinatal Service Program (CPSP) provider that offers perinatal services solely servicing Medi-Cal eligible clients. The Prenatal Clinic also offers Family Planning services via the Family Planning, Access, Care and Treatment (PACT) program billed to Medical.

   As more of the population is eligible for health insurance to include Medi-Cal managed care, the number of clients eligible with regular Med-ical, solely accepted by Pasadena Public Health Department, is decreasing. Clients that are ineligible for health insurance are currently seeking other providers and Federally Qualified Health Care Centers. The lack of an electronic health record and billing system compounds the limitations related to realizing the revenues versus increasing expenses. The Prenatal Clinic will continue to provide services to a majority of its existing clients for the remainder of their pregnancy until the proposed date of closure date of December 31, 2015.

3. Alcohol Recovery Center DUI. Total Budget FY16 $272,573. Total FTEs 4.0. Program Description: Currently the Department offers three substance abuse programs:

    - Prevention Project ALERT – an evidenced based prevention program for middle school students
    - Substance Abuse Outpatient Services
    - Driving Under the Influence (DUI) Services (Wet & Reckless, 3, 6 and 9-month)

    The program proposed for elimination, as of July 1, 2015, is the Driving under the Influence (DUI) Services (wet and reckless program, 3, 6 and 9 month services). This is a fee for service program whose participants have been mandated by a court to attend. The program has not been financially viable and other providers are available in Pasadena and neighboring communities as indicated later in this memorandum.

4. Public Health Laboratory. Total Budget FY16 $336,566. Total FTEs 2.15. Program Description: The Public Health Laboratory offers laboratory services for communicable disease prevention and control activities. Historically, the laboratory has primarily supported the Department's in-house clinics with clinical diagnostic testing. Given the proposed reduction in clinical services, in-house laboratory testing will no longer be necessary. All other laboratory testing for communicable disease activities will be provided by the Los Angeles County Department of Public Health laboratory (LACDPH) or The California Department of Public (CDPH) Health's laboratory.

Proposed Program Reductions

In addition to the program eliminations discussed above, the following reductions in Public Health Department programs are incorporated into the recommended operating budget.

1. Reduction of .5 FTE Program Coordinator I currently filled with a City Temporary Worker, in the Women, Infants & Children (WIC) Breastfeeding program.

2. Reduction of 1.0 FTE vacant Community Services Representative II in Maternal Child & Adolescent Health program.

3. Reduction of .50 FTE vacant Program Coordinator I in the PACE diabetes prevention program.

4. Change in staffing in Black Infant Health Program resulting in the reduction of a currently filled, limited-term 1.0 Community Service Representative II position and its replacement with 1.0 Social Worker in order to meet state of California requirements for minimum education. However, the incumbent has been offered another position within the Department and is currently considering the offer.

Further, it should be noted that the State of California has actually moved to eliminate Pasadena's funding for this program, however, by working with Los Angeles County, the Public Health Department will be able to retain the program by becoming a sub-contractor to the County of LA.

Impact on Employees

The proposed program eliminations and program reductions will, in combination, result in the elimination of 48.05 FTEs, of which 26.68 are currently filled by 10.30 regular employees and 16.38 limited term (i.e., at will) staff; the balance of 21.37 are vacant positions.

Since announcing to staff the proposed budget recommendations, the Human Resources Department has provided a series of seminars open to all members of the Department but specifically targeted at those whose positions would be impacted by the recommendations. These have included:

- Resume Writing Workshops – Two offered exclusively for PPHD employees; one offered through the City's training program that several PPHD employees attended;

- Individual resume writing counseling/support offered at the Health Department;

- Interviewing skills class offered through the City's training program that several PPHD employees attended;

- Human Resources, State Employment Development Department and Foothill Workforce Investment Board representatives spent an afternoon at the PPHD to answer questions.

- Human Resources has meet individually and with groups of employees over the past month and a half on multiple occasions. The Department has been actively answering emails, phone calls, searching for open positions, discussing separation benefits, and providing other support.

- Two days of a *career boot camp* will be offered in July.

Furthermore, every effort has been made to identify other job openings either in the Public Health Department or other City departments, where impacted staff can transfer. As a result, seven individuals have transferred to other positions and three additional transfers have been offered. Additionally, one employee has obtained a position in CHAPcare's prenatal clinic and two have voluntarily separated from the City. The cumulative result of these efforts has been to reduce the number of impacted employees to 23, of which 10 are regular employees and 13 are limited-term staff.

Alternative Service Providers

As indicated by the analysis prepared by The Camden Group, many of the clinical services provided by the Pasadena Public Health Department are available locally from other providers. Going forward, the Public Health Department will provide referral services to these other community providers in the following service areas:

Prenatal services:

- CHAPcare 1855 N. Fair Oaks, Pasadena
- Dr. Babatunde A. Eboreime 2595 E. Washington Blvd, Ste. 105, Pasadena
- Dr. Jonathan Tam 105 N. Hill Ave, #203, Pasadena

Alcohol Recovery:

- The High Road Program, Pasadena
- Right On Programs, Inc., Burbank
- Safety Education Center, Inc., Burbank
- San Gabriel Valley Drive Improvement, Alhambra
- Adapt-Aware Zone, Inc., Glendale
- Right On Programs, Inc., Glendale, CA 91205
- ABC Traffic Safety Program, Rosemead
- Alhambra Safety Services, Monterey Park

HIV Services: Currently there are no other providers in Pasadena that offer the full range of 'wrap-around' and specialty services provided by the Pasadena Public Health Department. Staff has spoken to providers located outside of Pasadena who have expressed an interest in operating out of the Pasadena Public Health Department location to offer these services. Additionally, CHAPcare has indicated its willingness to begin providing these services; however, such an approach is complicated by the fact that CHAPcare does not possess the necessary level of experience that would make it eligible for delegation of the County contracts currently held by the City. Staff is currently exploring with CHAPcare and the County whether some form of arrangement can be made whereby the City continues to provide the services, with CHAPcare providing the administrative support and covering any remaining financial losses so as to protect the City. It is anticipated that within the next few weeks a final determination as to the viability of this approach will be made. Should it not prove viable, other options to ensure that Pasadena remains a service delivery location will be pursued.

The following is a list of HIV specialty service providers in the greater Los Angeles area:

- APLA Gleicher/Chen Health Center, Los Angeles
- Jeffrey Goodman-Gay and Lesbian Center, Special Care Clinic, Los Angeles,
- AltaMed HIV/AIDS Services, Los Angeles, CA 90022
- JWCH, Center for Community Health, Downtown Los Angeles, Bell Gardens, Bellflower, Downey, Lynwood, Norwalk, Whittier
- AIDS Healthcare Foundation (AHF), Los Angeles
- East Valley Community Health Centers, West Covina and Pomona

- St. Mary Medical Center's C.A.R.E., Long Beach
- Northeast Valley Health Corporation, Sun Valley, North Hollywood, Van Nuys

Moving Forward

While difficult, the proposed transition of clinical programs from the Pasadena Public Health Department to other agencies better equipped to provide these services, will enable the Department to focus on core public health services: assessment of health status and health problems, policy development, and assurance and protection of the health of the public. The Department will extend existing collaborative efforts with other City departments, local medical providers, non-profits and the Pasadena Unified School District. Through the pursuit of national accreditation, the Department will strengthen its foundations and operations.

ATTACHMENT A

	A	B	C	D	E	F	G	H	I	K	L	M	N
1	**Public Health Fund**												
2	**Fund 203**	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2015	FY 2016	FY 2017	FY 2018
3		Actual	Actual	Actual	Actual	Actual	Actual	Actual	Adopted	Est Actual	Projected	Projected	Projected
4	Beginning Fund Balance	131,812	(799,762)	(53,840)	632,522	353,771	1,035,794	1,011,177	(1,085,092)	(1,085,092)	(3,062,914)	(5,072,469)	(8,750,533)
5													
6	SOURCES												
7	Sales Tax	811,596	723,742	680,644	710,827	708,804	669,575	806,824	650,828	712,175	287,930	292,249	296,633
8	Licenses and Permits	644,195	579,070	713,619	897,784	1,003,625	1,041,414	1,291,328	1,098,770	1,346,179	1,185,000	1,202,775	1,220,817
9	Intergovernmental-Local	81,368	64,587	221,634	213,855	264,207	387,282	444,041	790,402	417,041	599,168	608,156	606,050
10	Charges For Services	653,908	575,059	728,880	537,438	537,538	625,136	735,390	1,046,335	794,169	808,527	820,655	832,965
11	Charges For Services-Quasi Ext	44,000	46,906	48,782	49,759	49,759	-	-	49,758	-	-	-	-
12	Federal Grants Indirect-State	4,062,802	4,471,429	4,032,660	3,684,319	4,751,143	5,005,501	3,740,546	4,768,511	3,952,349	5,272,524	4,009,622	4,069,766
13	Federal Grants-Direct	-	-	102,044	282,854	195,701	0	474,285	515,026	1,075,330	1,436,605	1,325,330	1,125,330
14	State Grant Direct	452,530	668,729	293,671	275,021	275,568	282,340	293,037	333,805	217,671	306,410	311,006	285,137
15	State Non Grant Direct	3,180,419	2,341,430	2,992,744	2,581,934	2,549,468	3,362,987	3,603,403	4,612,020	2,997,914	3,963,610	4,023,064	4,083,410
16	Transfers In	1,085,121	1,077,803	1,069,302	1,425,214	1,054,131	1,341,455	-	-	-	-	-	-
17	General Fund Contribution	-	1,250,000	899,644	-	-	-	-	-	-	-	-	-
18	Other Financing Sources	50,000	-	122,240	77,000	37,945	-	-	60,920	-	-	-	-
19	Rental Income	12,493	13,572	13,959	18,960	73,750	(14,336)	14,428	12,480	13,439	-	14,494	14,494
20	Miscellaneous Revenue	122,541	404,874	15,767	(6,236)	79,497	753,848	106,958	1,391,040	101,960	435,145	100,000	100,000
21	**Total Revenue**	**11,200,973**	**12,217,199**	**11,935,588**	**10,748,729**	**11,581,137**	**13,455,202**	**11,510,240**	**15,329,895**	**11,628,227**	**14,294,919**	**12,707,351**	**12,634,602**
22													
23	**EXPENSES**												
24	Personnel	8,113,767	7,984,960	7,418,395	7,088,292	6,969,363	8,132,126	9,348,154	10,971,123	9,441,443	11,538,171	11,740,147	11,945,658
25	Services & Supplies	2,994,613	2,542,038	2,707,980	3,040,159	2,799,368	4,085,302	2,811,671	1,824,026	2,419,589	3,039,576	2,893,479	2,893,479
26	Internal Services	1,015,445	944,279	922,853	899,029	1,130,383	1,262,389	1,390,761	1,574,909	1,574,909	1,670,804	1,695,866	1,721,304
27	Transfers	-	-	200,000	-	-	-	55,923.00	-	170,108	55,923	55,923	55,923
28	**Total Expenses**	**12,123,825**	**11,471,277**	**11,249,228**	**11,027,480**	**10,899,114**	**13,479,817**	**13,606,509**	**14,370,058**	**13,606,049**	**16,304,474**	**16,385,415**	**16,616,364**
29													
30	**Net Income**	(922,852)	745,922	686,360	(278,751)	682,023	(24,617)	(2,096,269)	959,837	(1,977,822)	(2,009,555)	(3,678,064)	(3,981,762)
31													
32	**Adjustment**												
33	Transfer to Capital Projects Fund	(8,722)											
34													
35	**Ending Fund Balance**	**(799,762)**	**(53,840)**	**632,521**	**353,771**	**1,035,794**	**1,011,177**	**(1,085,092)**	**(125,255)**	**(3,062,914)**	**(5,072,469)**	**(8,750,533)**	**(12,732,295)**

CDT CODES	PROCEDURE CODE DESCRIPTION	PROCEDURES COVERED by NEW 2014 DENTI-CAL PROGRAM, non-FQHCs	ADDITIONAL DENTI-CAL COVERAGE for FQHCs
DIAGNOSTIC			
D 0120	Periodic oral evaluation - established patient		Yes
D 0140	Limited oral evaluation - problem focused		Yes
D 0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver		
D 0150	Comprehensive oral evaluation - new or established patient	Yes	Yes
D0160	Detailed and extensive oral evaluation - problem focused, by report		Yes
D 0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)		Yes
D 0180	Comprehensive periodontal evaluation on new or established patient		
D 0210	Intraoral - complete series of radiographic image	Yes	Yes
D 0220	Intraoral - periapical first radiographic image	Yes	Yes
D 0230	Intraoral - periapical each additional radiographic image	Yes	Yes
D 0240	Intraoral - occlusal radiographic image		Yes
D 0250	Extraoral - first radiographic image		Yes
D 0260	Extraoral - each additional radiographic image		Yes
D 0270	Bitewing - single radiographicimage	Yes	Yes
D 0272	Bitewings - two radiographic images	Yes	Yes
D 0273	Bitewing - three films		
D 0274	Bitewings - four radiographicimages	Yes	Yes
D 0277	Vertical bitewings - 7 to 8 films		
D 0290	Posterior-anterior or lateral skull and facial bone survey radiographic image		Yes
D 0310	Sialography		Yes
D 0320	Temporomandibular joint arthrogram, including injection		Yes
D 0321	Other temporomandibular joint arthrogram, including injection		
D 0322	Tomographic survey		Yes
D 0330	Panoramic radiographic image	Yes	Yes
D 0340	Cephalometric radiographic image		Yes
D 0350	Oral/Facial photographic images	Yes	Yes

ATTACHMENT C

From the Sacramento Business Journal
:http://www.bizjournals.com/sacramento/news/2015/05/20/western-dental-says-denti-cal-is-broken-starts.html

Western Dental says Denti-Cal is broken, starts closing doors to new patients

May 20, 2015, 2:32pm PDT Updated: May 20, 2015, 2:48pm PDT

Kathy Robertson
Senior Staff Writer- *Sacramento Business Journal*
Email | Twitter | LinkedIn | Google+

Western Dental will begin to close the door to new Denti-Cal patients next month — and will shut some offices altogether — as the company reassesses participation in the state dental program for the poor.

One of the largest providers of Denti-Cal services in the state, Western Dental says low reimbursement and increased demand makes the business untenable. The Southern California-based company serves between 650,000 and 700,000 a patients a year, including thousands in the Sacramento region.

Two weeks ago, Moody's Investors Services downgraded the company's parent because of weak financial performance related to growing numbers of low-margin patients. This is primarily due to growth in the Medi-Cal program under federal health reform and partial expansion of adult dental benefits last year. That's caused a shift in Western Dental's clientele to a higher proportion of low-margin patients who need a lot of care.

"Denti-Cal is broken and driving away providers," Western Dental CEO Simon Castellanos told me. "Our company has served California over 50 years. For the first time, we are reassessing whether to continue."

Dentists haven't gotten a pay increase since fiscal 2000-2001 and rates were cut 10 percent in 2013, but salaries and other expenses continue to climb, Castellanos said. "It's not a sustainable model."

Western Dental will stop taking new Denti-Cal patients at 13 offices on June 1. The company plans to shut down two offices altogether. Where, Castellanos would not say. Western

Dental operates at least six dental centers in the Sacramento region, but Castellanos would not disclose whether any local sites will be immediately affected.

"This is just the first wave. Every month, we'll convert more (sites) to traditional insurance," Castellanos said. "Our facilities are flooded and have caused a shift in financial situation at our clinics," he added. "We we need to limit Denti-Cal to serve our existing patients."

Western Dental is not alone in concern about the program.

The **California State Auditor** blasted the Denti-Cal program in a December report that says rates for the ten most common procedures in 2012 averaged $21.60, or 35 percent of the national average of $61.96.

A statewide coalition of health, education medical groups has launched a campaign to get the governor and state lawmakers to put more resources for dental care into the new state budget. And California's Congressional delegation weighed in last week on low provider reimbursement in Denti-Cal.

"This has had a significantly negative impact on the number of dentists in California still willing and able to participate in the program, even those who have been long enrolled in Denti-Cal," states a May 13 letter from the delegation to to Gov. Jerry Brown and state legislative leaders. "For Denti-Cal to be a meaningful benefit, enrollees must have access to care," the letter adds. "We urge you to prioritize improvements to the Denti-Cal program in this year's budget."

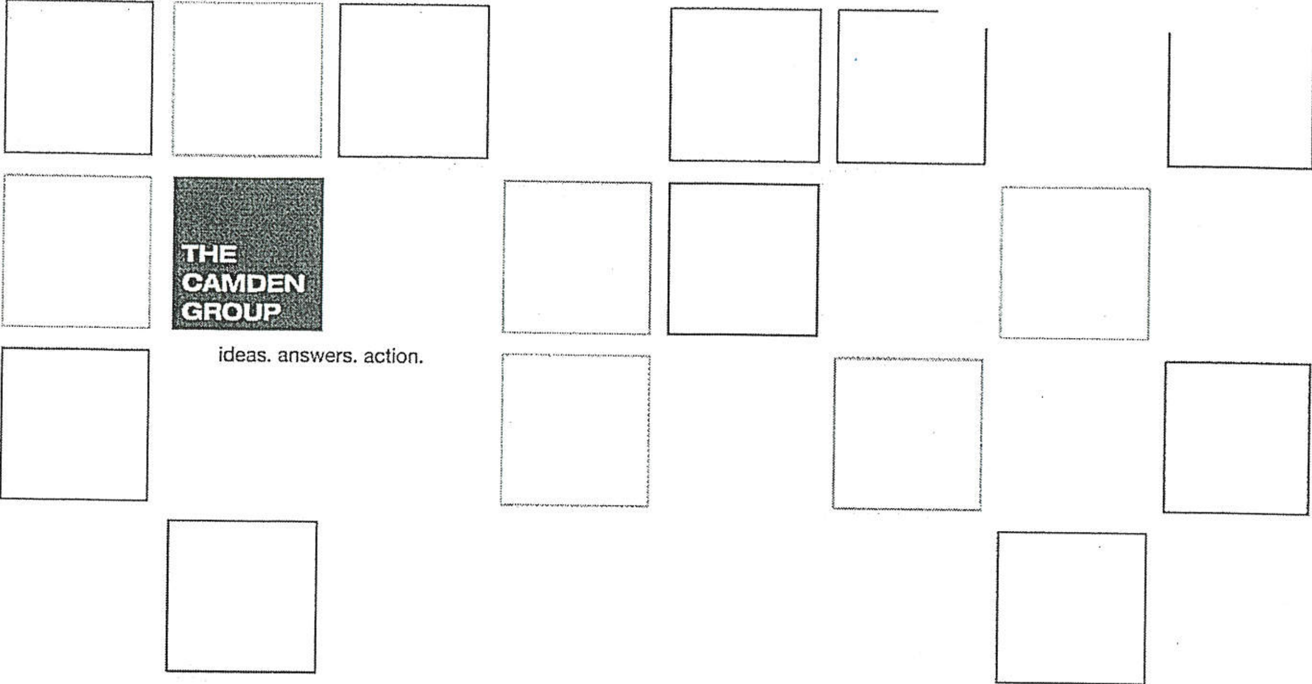
"The department is very concerned about the potential impacts to Medi-Cal beneficiaries resulting from service reductions by Western Dental," said spokesman Tony Cava at the **California Department of Health Care Services**, which oversees Medi-Cal and Denti-Cal. "We remain committed to working to ensure that our Medi-Cal members have access to quality dental care and are evaluating necessary steps to ensure those beneficiaries who have been receiving services from these providers are able to find new providers."

State health officials are closely monitoring the situation and say they will act swiftly should it be necessary to ensure access. They also hope to get additional money from the federal government for new providers who agree to dedicate part of their practice to Medi-Cal patients and to existing providers who expand the number of Medi-Cal patients they will see.

Read a PDF of the auditor report on Denti-Cal. Read a PDF of the Congressional delegation letter.

Kathy Robertson covers health care, law and lobbying, labor, workplace issues and immigration for the Sacramento Business Journal.

ATTACHMENT D



Impact of Healthcare Trends on Public Health Services

City of Pasadena
Pasadena, California
March 16, 2015

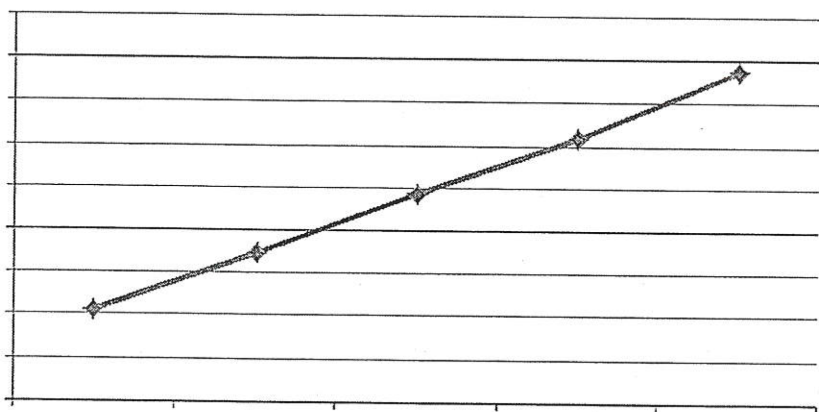
Impact of Healthcare Trends on Public Health Services

HIV/AIDS Services Background

Throughout the past 25 years, many advances in HIV/AIDS education and treatment have significantly altered the manner in which HIV/AIDS care is provided; as a result, the healthcare programs and organizations that served these patients have continued to adapt their model of care. With the implementation of the Patient Protection and Affordable Care Act ("ACA"), AIDS service organizations ("ASOs") are once again being challenged financially and forced to address the shifting environment and the opportunities of a new reality of health delivery.

HIV/AIDS Prevalence

Over the past five years, the number of reported HIV/AIDS cases in Pasadena has increased steadily each year. Between 2010 and 2014, the number of HIV/AIDS cases increased by 12.0 percent, from 942 to 1,055.



During this same period of time, the number of reported HIV/AIDS cases in Los Angeles County rose from 72,546 to 82,383, an increase of 13.6 percent.

While there are not significant HIV/AIDS volumes reflected in the Pasadena data, there is sufficient volume to warrant the provision of HIV/AIDS services within the Pasadena community.

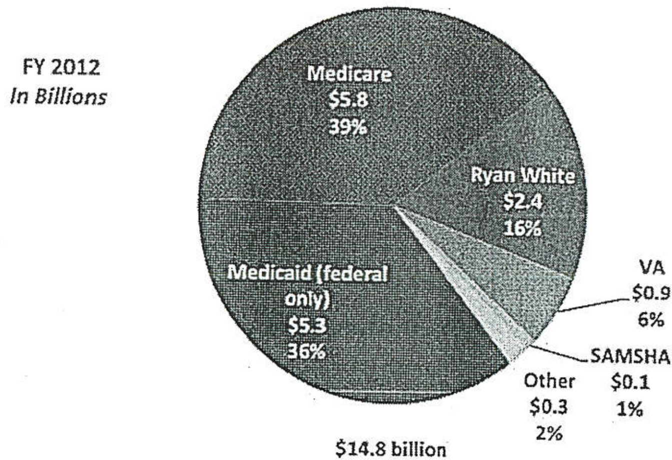
Impact of Healthcare Trends on Public Health Services

Coverage for HIV/AIDS Services

As a result of the ACA, men and women living with HIV/AIDS will experience a transition from an existing HIV-specific payer source to a new, comprehensive payer source. Prior to the ACA taking effect, access to HIV/AIDS care was facilitated primarily by the Ryan White HIV/AIDS Program and the AIDS Drug Assistance Program ("ADAP"). These programs cover nearly a third of all people with AIDS receiving care.

Ryan White HIV/AIDS Program

The Ryan White Program was first enacted in 1990 and is the single largest federal program designed specifically for people with HIV/AIDS in the U.S. and the third largest overall.

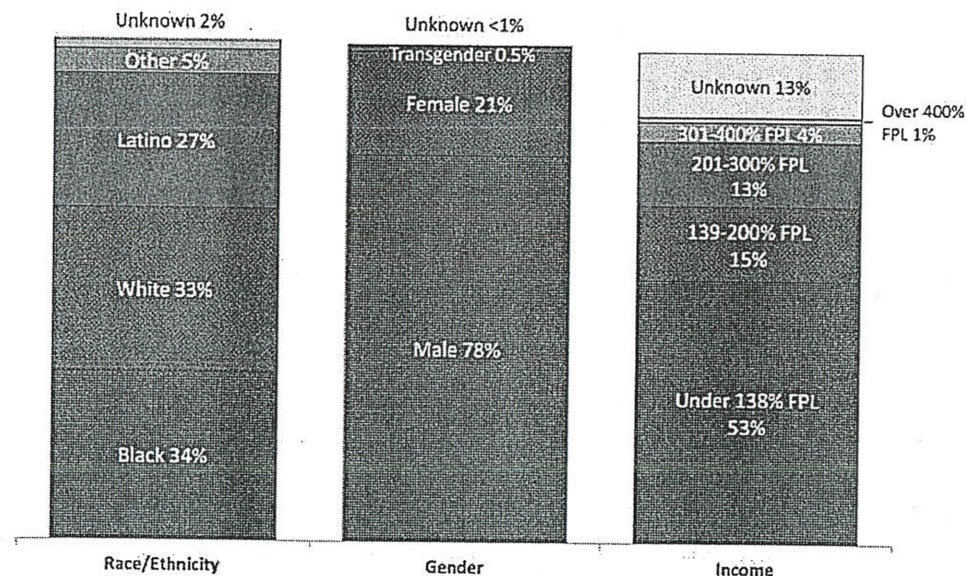


The Ryan White program functions as the "payer of last resort" for low-income individuals with HIV/AIDS who have gaps in care, face coverage limits, or have no other source of coverage. The demand for the Ryan White program care and services has consistently exceeded the available funding. Many of the Ryan White services are critical to patient engagement in care and support patients along the treatment continuum, such as non-medical case management, treatment adherence supports, and referrals to health and support services. Many Ryan White services may transition to Medi-Cal or Covered California covered services with the implementation of the ACA since Ryan White cannot be used to deliver services for which patients are eligible through other health coverage programs, such as Medi-Cal or private insurance. This transition will require careful attention to the integration of services and

continuity of care, as many of these healthcare providers may not be as well-versed in the intricacies of HIV/AIDS care.

AIDS Drug Assistance Program

ADAPs provide HIV-related medications to people living with HIV/AIDS who are uninsured or under-insured and have limited to no prescription drug coverage. As the number of people in the United States living with HIV/AIDS has increased, ADAPs have felt additional strains, leading to the provision of emergency funding in 2010, 2011, 2012, and 2013.

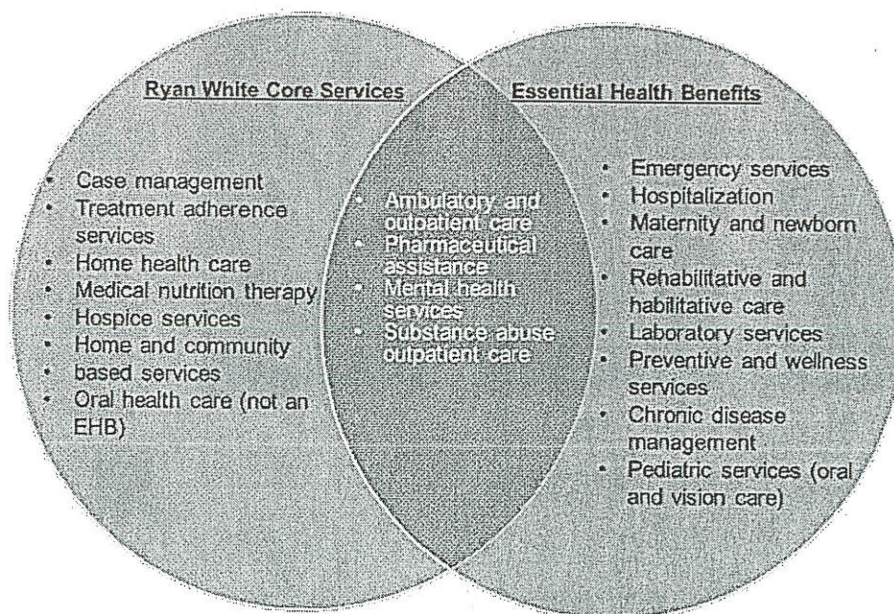


In fiscal year ("FY") 2013, more than 31,000 Californians were enrolled in ADAPs. Beginning in 2015, ADAP beneficiaries are also being transitioned to Medi-Cal through Covered California and changes brought by the ACA, to shift the burden of coverage from foundations and state programs to Covered California insurers. To encourage enrollment in Covered California and assist patients with high out-of-pocket expenses, development of administrative capacity to cover these costs will need to be developed.

Affordable Care Act

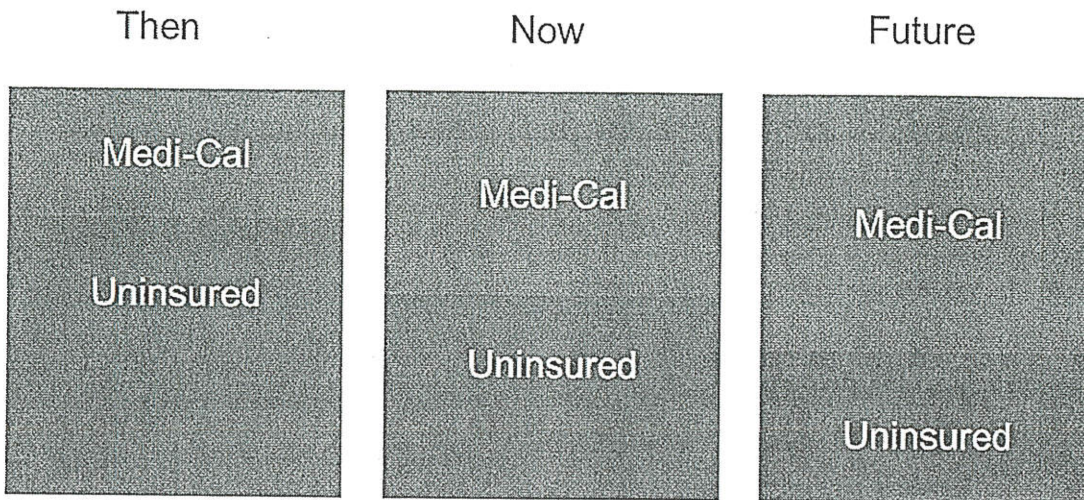
Prior to the ACA, over 29 percent of people with HIV were uninsured as it was nearly impossible for these individuals to obtain individual health insurance and few were insured through an employer. The ACA has improved access to care for individuals living with HIV/AIDS and has

reformed the private insurance sector. Individuals with HIV/AIDS or other chronic conditions can no longer be denied insurance because of a pre-existing health condition; furthermore, health plans cannot drop beneficiaries from coverage if they contract an illness. Covered California, California's health insurance exchange, will help people compare different health plans, providing financial assistance to low and middle income individuals. Each of these marketplace plans must provide the Essential Health Benefits, which address many HIV healthcare needs, and must include essential community providers, including Ryan White providers. These health plans cannot charge a higher premium based upon health status or gender. The Ryan White program will continue to be needed to provide coverage completion, fill gaps in affordability, and provide care for those living with HIV/AIDS who are left behind (due to geography or immigration status). Below is a diagram depicting the overlap in covered services between Ryan White and the essential benefits for the ACA Qualified Health Plans.



California has also opted to expand Medi-Cal, which means people living with HIV who meet the income threshold no longer have to wait for an AIDS diagnosis before becoming eligible for Medi-Cal; these people can access care and treatment before the disease has significantly damaged their immune system. The shift in coverage for individuals living with HIV/AIDS is anticipated to follow the trend on the following page (proportions are approximate):

Impact of Healthcare Trends on Public Health Services



Reimbursement Trends for AIDS Services

The issue of financial solvency for AIDS providers and clinics has been a key concern throughout this transition of AIDS coverage. These concerns arose from the fact that many HIV/AIDs patients will be transitioning from the Ryan White Program to Medi-Cal, a more generous payer source to a relatively less generous payer source, respectively. As the proportion of patients covered by Medi-Cal increases and the proportion covered by Ryan White decreases, reliance on Ryan White funds to support comprehensive HIV/AIDS services will no longer remain a viable strategy. Currently, there are no cuts in the state of California's AIDS assistance in the 2014 and 2015 budget. However, due to the shift in coverage for AIDS patients towards Covered California health plans and Medi-Cal, ADAP funding is expected to decrease. To improve financial solvency, AIDS clinics and providers may look to include the use of the Ryan White model for HIV specialty care with modifications to offset some of the current expenses though Medi-Cal expansion.

Service Area HIV/AIDS Services

Pasadena Public Health Department

Andrew Escajeda Comprehensive Care Services ("AECCS") is run through a partnership between community agencies and the Pasadena Public Health Department ("PPHD") and is a prominent HIV/AIDS service provider offering comprehensive HIV medical treatment, mental health, risk re-education, and HIV education prevention services to individuals throughout Pasadena and Los Angeles. A number of agencies in the surrounding areas also offer services for individuals living with HIV/AIDS.

Other

Aid for AIDS

Aid for AIDS is dedicated to preventing homelessness and hunger and improves the quality of life and independent living for those living with HIV/AIDS. Aid for AIDS helps individuals pay for the necessities of life, such as housing, utilities, transportation, nutritional supplements, medications, and fresh food, with a specific focus on finding housing for HIV/AIDS-impacted individuals and families.

AIDS Service Center

The AIDS Service Center ("ASC") has been serving the HIV/AIDS community in Los Angeles County for over 25 years. ASC recently transferred the majority of its federally-funded care programs into AECCS, allowing the organization to focus most of its effort on outreach and prevention, HIV testing, and basic needs services (such as housing and food).

AIDS Project LA

AIDS Project LA ("APLA") serves more than 11,000 individuals in the greater Los Angeles area, providing HIV/AIDS care and prevention programs. APLA provides healthcare support services aimed at promoting positive medical outcomes, such as case management, dental services, care management, short-term counseling, housing, and food and nutrition programs. Additionally, APLA offers HIV testing and education programs, targeting those at greatest risk for infection.

AltaMed

AltaMed provides HIV/AIDS services to Latino, multi-ethnic, and underserved individuals living in Los Angeles. AltaMed offers medical, dental, behavioral health and pharmaceutical services in addition to HIV testing, case management, nutrition, education, and prevention programs, and support groups.

California Drug Consultants

California Drug Counseling ("CSC") provides outpatient education, counseling, and support to individuals with alcohol and substance abuse problems. CSC provides HIV/AIDS education and prevention services, treating approximately 100 patients in the HIV/AIDS program per month.

Community Health Alliance of Pasadena

Community Health Alliance of Pasadena ("ChapCare") provides medical, dental, behavioral health, outreach, and health education services from four health center locations in the San Gabriel Valley. They have plans to expand to additional locations. They currently sub-contract the HIV/AIDS care of their patients to PPHD.

Impact of Healthcare Trends on Public Health Services

Foothill AIDS Project

The Foothill AIDS Project ("FAP") provides HIV/AIDS services to individuals living in Los Angeles, San Bernardino, and the western Riverside counties. FAP offers a full spectrum of integrated programs and services, including HIV/AIDS medical care management and supportive care services (including support groups and individual sounding), HIV education and risk reduction, and HIV/AIDS housing case management services.

The Laurel Foundation

The Laurel Foundation services children, youth, and families affected by HIV/AIDS. The Laurel Foundation offers free, year-round camp, mentorship, life enhancement workshops, and support programs to children, youth, and families with the goal to provide education and support. Serving approximately 500 individuals annually, The Laurel Foundation looks to continue to expand its programs, allowing as many children, youth, and families to attend, as possible.

Los Angeles LGBT Center

The Los Angeles LGBT Center is the world's largest organization dedicated to serving the lesbian, gay, bisexual, and transgender community in the greater Los Angeles area. The Los Angeles LGBT Center offers low-cost HIV/AIDS specialty healthcare, primary care, health education and HIV-prevention programs, clinical research, counseling, and support groups.

While currently not serving the Pasadena market, it is highly likely that Medi-Cal specialty groups, such as Molina Healthcare, will begin penetrating the market. Furthermore, any local accountable care organizations ("ACOs") or clinically integrated networks will begin, or have begun, contracting with providers to provide HIV/AIDS care.

Impact of Healthcare Trends on Public Health Services

Clinic Mergers and Closures

Due to reimbursement strains, many clinics providing HIV/AIDS services have been forced to close and/or change the manner in which they provide HIV/AIDS services over the past few years. Many of these headlines are included in the table below:

Headline	Source
"**Funding Cuts** Force Group to End Free HIV/AIDS Testing"	Union Leader (Manchester, NH), June 2012
"Boston Living Center **Merges** with Victory Programs"	bostonlivingcenter.org, March 2012
"Colorado AIDS Groups **Merge** to Provide Clout"	Denver Post, October 2011
"Local HIV/AIDS Agencies Fight for Life as State, Federal Aid Falls"	Press Democrat (Santa Rosa), August 2012
"North Texas AIDS Agencies Face **Funding Cuts**"	CBS News, September 2011
"AIDS Groups in Ohio **Merge**"	The Chronicle of Philanthropy, May 2011
"We're Going to Be in Trouble: AIDS Groups Plan for **Funding Cuts**"	The Atlantic, December 2011
"South Jersey AIDS Group to **Close**"	Cherry Hill Courier-Post, June 2010
"Maine AIDS Alliance **Closing its Doors**"	mpbn.net, March 2011
"AIDS Agencies **Scramble for Funds**"	Boston Globe, August 2011
"Silicon Valley AIDS **Center to Close**"	San Jose Mercury News, November 2010
"Memphis Gay and Lesbian Center's HIV Testing Program **Suspended After State Funding Cut**"	Commercial Appeal, February 2012

Models for HIV/AIDS Service Providers

As organizations prepare for the changing HIV/AIDS and healthcare environment, creative models or partnership options could be explored to maintain sustainability and the provision of services. Organizations should look to maximize the opportunities available to them, in order to make continued progress in getting more individuals with HIV or AIDS better supported in systems of care. New service delivery models or financing models may become the necessary next step. More and more health plans are experimenting with bundled payments; ASOs could reach out to private insurers to encourage them to offer bundled payments for HIV treatment. Also, among both providers and health insurers there is an increasing popularity of ACOs.

ASOs could reach out to ACOs in the community and begin conversations regarding participation in the ACO network.

Impact of Healthcare Trends on Public Health Services

ASOs may also evaluate strategic options to diversify their funding. Options may include:

- Subcontract with health providers to provide the following services:
  - Population access and outreach
  - Patient navigation
  - Linkage, retention in care, and coverage completion/facilitative services
  - Case management
  - Treatment adherence promotion
  - Health outcomes
- Strategic alliances/mergers with health providers
  - Supply effective chronic disease management and other services similar to the subcontracting option, but sharing in costs and revenue through a more formal contractual relationship
  - Provider supplies medical and reimbursement expertise
- Transition from social services to medical services
  - Requires a change in focus (both in terms of services provided and populations served)
  - Need to build expertise in medical services, reimbursement, and regulatory compliance

Federally Qualified Health Center and Patient-Centered Medical Home

As freestanding ASOs are increasingly unable to respond to the needs of an increasing number of patients with a decreasing amount of public funding, some are looking to become certified Federally Qualified Health Centers ("FQHCs") or patient-centered medical home ("PCMHs"). As such, ASOs become more integrated into the healthcare delivery system. Even prior to the ACA, FQHCs were increasingly playing a leading role in the provision of HIV/AIDS care. FQHCs can receive a higher reimbursement for their care and thus this is an attractive model for some. To become an FQHC, organizations must be able to meet the rigorous management and financial reporting requirements, follow documented clinical policies and processes, and maintain robust policies and procedures to govern the billing, credit, and collection process.

A PCMH is a model in which the whole-person care is coordinated and integrated. Within this model, the physician arranges the care and oversees and coordinates the care team. Providers must use electronic health records, patient registries, and care coordinator services, allowing them to provide comprehensive care. ASO skill sets and services can enhance the PCMH model through their extensive care management experience, holistic care models, expertise in cultural and linguistic competence, and goals to improve health outcomes and reduce

healthcare costs. To receive PCMH recognition, an organization must make significant care management, information technology, and personnel investments, enabling it to consistently employ evidence-based guidelines, conduct quality improvement, and demonstrate improved quality outcomes. The application process for both PCMH and FQHC can be daunting for many organizations and many do not have the resources to meet the minimum requirements.

Medicaid Health Home

The Medicaid Health Home ("MHH") is a model where states pay for care coordination services for Medicaid enrollees with chronic illness. The emphasis in these models is the connection to community-based resources. MHHs are required to help enrollees get non-medical supports and services; social workers, nutritionists, dieticians, and behavioral health providers are often part of the healthcare delivery team. Several states have established HIV-focused MHHs:

- Alabama: Uses existing enhanced primary care practices
- New York: MHHs contract with organizations to provide additional care
- Washington: Regional health homes contract with community-based care organizations
- Wisconsin: Utilizes ASOs and provides one-time payment for assessment/care plan development

Massachusetts Case Study

In 2001, Massachusetts expanded Medicaid coverage to pre-disabled people living with HIV with an income up to 200 percent of the Federal Poverty Level ("FPL"). In 2006, private health insurance reform was enacted, implementing a heavily-subsidized insurance plan for those with an income of up to 300 percent of the FPL. Through these efforts, ASOs were encouraged to integrate into healthcare delivery systems; furthermore, these new delivery systems encouraged a stronger interaction between health and social service providers. For example, Fenway Health and AIDS Action Committee ("Fenway Health") of Massachusetts entered into a strategic partnership. Within this partnership, one corporate structure existed with joint governance and back office services. Each entity retained their nonprofit status, chief executive officer, and branding while Fenway Health provided the medical services and AIDS Action provides the housing, transportation, community, and care coordination services.

Implications for PPHD

With reimbursement and coverage being transitioned to the expanded Medi-Cal program or the

Covered California health plans, the degree of need for the services provided by the PPHD will diminish. PPHD will need to evaluate its business strategy and potentially re-focus its efforts.

To maximize cash flow, PPHD will need to enhance its revenue cycle and cash management strategies. PPHD will need to pursue the collection of co-pays and charges more aggressively to ensure owed funds are not lost. Co-pays should be collected in advance of all visits and a requirement prior to the provision of services. Also, few to no services should be provided free of cost to reduce the amount of uncollected monies.

As PPHD provides specialty HIV/AIDS care, a bundled payment arrangement for the provision of HIV/AIDS services is an opportunity for the restructuring of reimbursement. HIV/AIDS bundles would be outpatient in nature and the opportunity for success with those bundled is still very much unknown and may have potential. However, PPHD's patient population is primarily Medi-Cal or uninsured patients, and with decreasing Medi-Cal reimbursements, there likely is a small economic opportunity with this model. Entry into the Medi-Cal bundled payment market should be calculated given the unfavorable economics; furthermore, poor patient engagement and compliance by this population mean an even greater risk.

Designation of FQHC status is another avenue through which PPHD could obtain enhanced reimbursement. In its current state, PPHD does not have the infrastructure in place to receive this designation. An FQHC needs to be governed by a Community-Board, which PPHD would need to implement. Substantial investments, particularly in information technology, reporting, and clinical procedures, would need to be made to become an FQHC candidate. Furthermore, the application process is arduous and would require dedicated resources. The impact of ChapCare, a nearby FQHC, on the success of PPHD gaining a FQHC designation would need to be taken into consideration. PPHD could also investigate becoming a sponsor for ChapCare, or potentially acquiring it, expanding services, and appointing Board members over time.

PPHD is going to experience increased competition by AltaMed and Molina Healthcare; organizations who are dedicated to the Medi-Cal population, as more and more individuals enroll in Medi-Cal. Organizations such as these are going to aim to grow their number of enrolled beneficiaries and will have contracts with HIV/AIDS providers. In order to complete with these organizations, PPHD will need to explore potential contracts with Covered California qualified health plans or Medi-Cal managed care plans. Without these contracts in place, PPHD will be vulnerable to beneficiaries leaving the community to receive their HIV/AIDS care from a provider who is covered by their health plan.

Impact of Healthcare Trends on Public Health Services

With increased competition, PPHD will need to re-focus their strategies to become a consumer-retail business with an emphasis on becoming consumer-friendly. Beneficiaries will now have a choice regarding where to receive their healthcare services. PPHD will need to compete with other providers for business and will need to consistently show their beneficiaries that they are providing the most high-quality, cost-effective care while maintaining high patient satisfaction. PPHD should consider regularly administering a patient satisfaction survey from which it can receive feedback and implement a yearly quality improvement plan. Also, in an effort to compete, PPHD will need to evaluate the depth of the services they provide against the reimbursement they are likely to receive in the future. Unless the current level of services can be covered by the fee-for-service reimbursement and grant funding, the PPHD will have to adjust the services they provide to work within the financial realities of the HIV/AIDS market.

Major Risks

If PPHD begins aggressively collecting owed monies, patients who chose to visit PPHD for free or low-cost services or who were unable to pay for services may no longer view PPHD as a favorable option. Currently, PPHD is a preferred provider for many uninsured individuals because they do not need to pay a monthly premium and the cost for services is lower. If PPHD prices begin to mirror those of other clinics, there will be more competition and patients will have many more choices for their healthcare provider.

If FQHC designation is a favorable route for PPHD, they will likely experience significant backlash and competition from ChapCare. Currently, HIV/AIDS care is a carved out benefit from ChapCare and referrals are made to PPHD for these services. If PPHD chooses to pursue an FQHC designation, they would be in direct competition with ChapCare and would alienate this referral source. ChapCare is a more sophisticated healthcare delivery system with an enhanced infrastructure and would argue that they could provide all services, including HIV/AIDS, thereby negating the need for PPHD to become an FQHC. Furthermore, as mentioned above, substantial investments would need to be made to obtain this designation and there is no guarantee that PPHD would be awarded this designation.

When exploring contract opportunities, PPHD may find that their current operations are inadequate for the health plan. PPHD may need to invest in staff, information technology, revenue cycle management, equipment, supplies, or other resources in order to execute necessary contracts. Competing organizations likely have these components in place or have begun the process to enhance their clinic(s).

Impact of Healthcare Trends on Public Health Services

Financial Review

The latest financial analysis for HIV/AIDS services provided by PPHD in FY 2014 showed an overall loss of $1.9 million (including $77,000 in mental health and substance abuse services). This included accrued revenue of $968,000, of which almost $600,000 was uncollected. Collecting this due amount would result in adjusted losses of $1.3 million. In addition, a random sample analysis of Medi-Cal and Medicare payments, most of which has not been attributed to specific programs, showed that 53 percent related to HIV/AIDS services. Using this ratio, it can be assumed that $988,000 of the total Medi-Cal and Medicare payments in FY 2014 should have been allocated to HIV/AIDS, versus the $30,000 that was credited. Applying these adjustments, results in a $340,000 loss for FY 2014.

PPHD will need to assess the possibility of raising additional grant funding to make up for this deficit in the future, while also evaluating the possibility to reduce expenses in anticipation of increased competition for HIV/AIDS patients, especially those covered by Medi-Cal, and the likely reduction of reimbursement from all sources, both through insurance payments and grant funding.

ACA Impact

- More people insured, have more choice
- Expanded Medi-Cal in California, more people covered go to Medi-Cal managed care provider
- FQHCs were given additional funding to expand services and payment to physicians to improve access to the uninsured and newly insured
- The Ccty of Pasadena faces growing competition from provider networks serving Medi-Cal and Covered California health plans offered through the Silver and Bronze levels

Conclusion

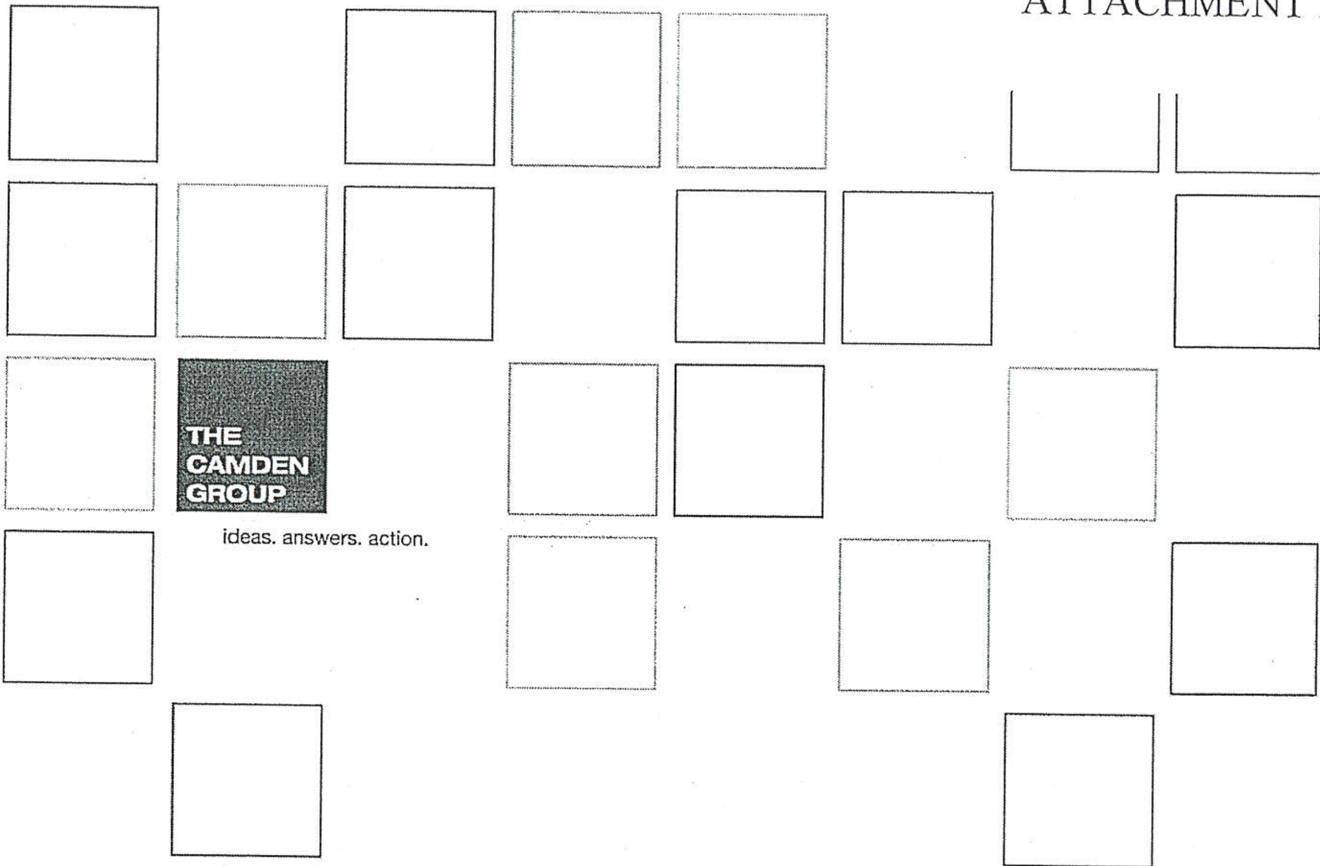
The environment around HIV/AIDS services is becoming more competitive. PPHD needs to evaluate their ability to compete for the patients they care for under new market trends which will mean they will depend on Medi-Cal reimbursement and grant funding, both of which are likely to be reduced over time. The overall strategic option to convert PPHD's clinic services to an FQHC will provide more favorable overall reimbursement, but will come with increased requirements in both infrastructure and governance, and will most likely be met with significant resistance from existing FQHCs serving the Pasadena area, including ChapCare. Therefore, that strategy needs to be further evaluated to assess whether it is viable. An assessment of

what makes PPHD's HIV/AIDS services competitive, or not competitive, should be performed. It should include interviews with patients and referral sources. Once all these variables have been evaluated, PPHD leadership needs to decide whether it is possible to continue to provide these services in a financially sustainable fashion.

Conversion to FQHC Status

PPHD will need to consider a number of factors when determining the viability of converting HIV/AIDS services to an FQHC model. PPHD initially will need to ensure that leadership has an aligned vision and similar goals for the future; FQHC status may provide greater financial stability but would greatly limit independence due to oversight by a Governing board of community members who are also past users of the clinic. Over 50 percent of the FQHC Governing Board must consist of users of the FQHC's services. PPHD will also need to assess its existing resources dedicated to management systems and reporting. The ability to measure and report on quality improvement is a central component of the FQHC application. Furthermore, it will need to demonstrate support from the community and existing FQHCs, which may be difficult as ChapCare will view this as significant competition. A market analysis of the unmet needs in the community will need to be conducted and PPHD may need to explore the development of additional services to meet the full scope of services required.

ATTACHMENT E



Impact of Healthcare Trends on Public Health Services

City of Pasadena
Pasadena, California
March 12, 2015

CITY OF
PASADENA

Impact of Healthcare Trends on Public Health Services

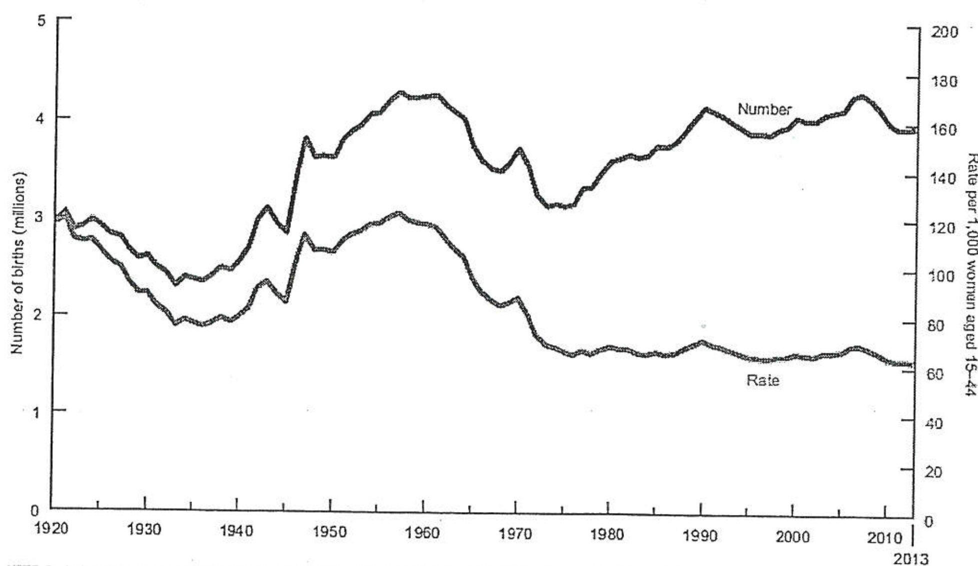
Community Health Services: Obstetrics and Prenatal Services

Background

Obstetrics and prenatal services support women throughout their pregnancies. Receiving early and regular prenatal care is one of the best ways for a woman to promote a healthy pregnancy. Prenatal care often includes education and counseling about how to handle different aspects of pregnancy, such as nutrition, physical activity, what to expect during labor and delivery, and basic infant care. Obstetrical care also plays an important role in maintaining a healthy pregnancy. Regular tests are conducted during the pregnancy to check for any complications and help develop a treatment guide, if necessary. Routine tests include blood and urine tests and screenings for birth defects.

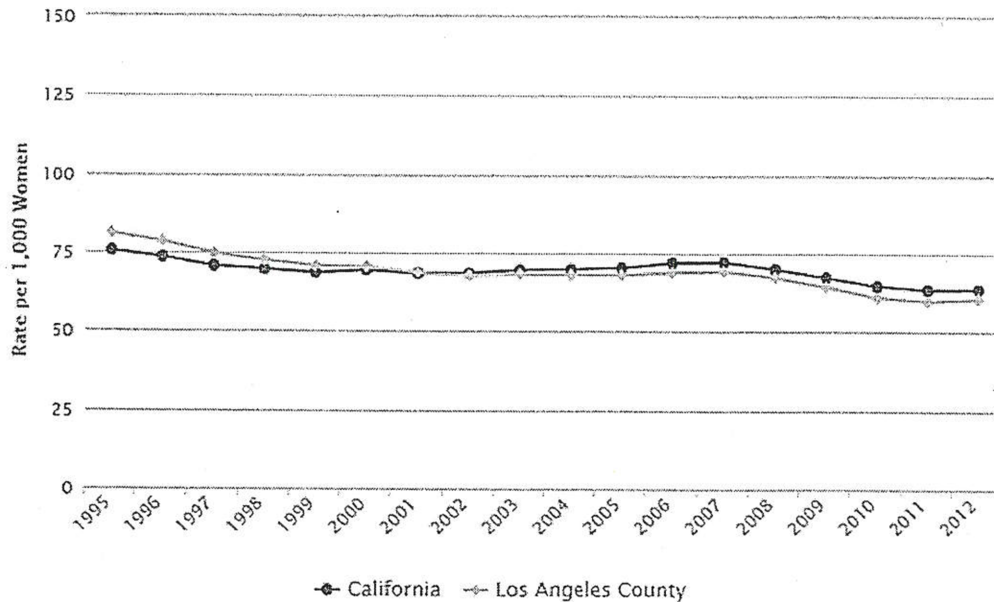
Birth Rate and Adequate Prenatal Care

In 2013, the birth rate in the United States reached an all-time low, at 62.5 births per 1,000 women between the ages of 15 and 44. There were 3.93 million babies born, which is less than 1 percent down from 2012 and 9 percent less than 2007. In 2013, Californians gave birth to about 504,000 children which is equivalent to 13.1 births per 1,000 residents. This is the lowest birth rate in California since 1933, which was in the heart of the Great Depression. The largest decline in births came among non-Hispanic whites, which dropped from 149,000 in 2012 to 146,000 in 2013.



NOTE: Beginning with 1959, trend lines are based on registered live births; trend lines for 1920–1958 are based on live births adjusted for underregistration.
SOURCE: CDC/NCHS, National Vital Statistics System.

This trend in declining birth rate is also occurring in Los Angeles County; between 1995 and 2012, Los Angeles County experienced a 25.5 percent decrease in its birth rate per 1,000 women.



Data Source: California Dept. of Finance, Race/Ethnic Population with Age and Sex Detail, 1990-1999, 2000-2010, 2010-2060; California Dept. of Public Health, Center for Health Statistics, Birth Statistical Master Files; Centers for Disease Control & Prevention, Natality data on CDC WONDER; Martin et al. (2013), Births: Final Data for 2012, National Vital Statistics Reports, 62(9) (Mar. 2014).

Prenatal Care

In California, between 2010 and 2012, the percentage of births to mothers who begin prenatal care in the first trimester was 83.6 per 100 live births; this was a small improvement from the previous 3-year average of 82.7 per 100 live births. In Los Angeles County, this 3-year rate was slightly higher, at 85.6 per 100 live births. Los Angeles maintained the eighth highest rate in the state for prenatal care began during the first trimester, indicating that access to prenatal care and education about prenatal care within the county is high.

Coverage for Obstetrics and Prenatal Services

The goal of prenatal care is to provide the best care for pregnant women and their unborn children and to prepare the mother-to-be for the delivery of a healthy baby. Prenatal care can be provided by a wide array of medical professionals, including an obstetrician, a family physician, a nurse practitioner, a certified nurse midwife, or a perinatologist. Implementation of the Patient Protection and Affordable Care Act ("ACA") greatly expanded the covered prenatal services for women. Through the ACA, women have access to a large number of preventive health services that are completely covered by their health insurance plan. The inclusion of maternal and newborn care as one of the essential health benefits was a crucial step in improving access to

prenatal care for low-income women. Prior to this, only 12 percent of plans sold in the individual market offered maternity coverage and approximately 52 percent of all pregnant women reported delaying prenatal care due to the cost. The lack of insurance before pregnancy limited the ability for a large segment of childbearing women to use health services and plan a successful pregnancy. Furthermore, the process of establishing Medi-Cal eligibility after confirming pregnancy was often a barrier to timely access to care. Women without timely and adequate access to prenatal care often have a much more high-risk pregnancy, which can also result in more costly obstetric services. As of January 1, 2014, approximately 8.7 million women were guaranteed access to maternity care in all new individual and small group plans.

Medi-Cal

In California, there are several options for uninsured pregnant women to get health coverage. Medi-Cal and the Medi-Cal Access Program ("MAP") are open for enrollment throughout the year and depend upon income. Medi-Cal is one of the major insurers for obstetrics and prenatal services and currently pays for 46 percent of all births in California. As a result of Medi-Cal expansion in California, it is anticipated that over a million new enrollees will be eligible for Medi-Cal in 2015, thereby drastically increasing Medi-Cal obstetrics and prenatal needs.

Comprehensive Perinatal Services Program

The Comprehensive Perinatal Services Program ("CPSP") was enacted in 1984 in response to findings from the OB Access Project, which found that a comprehensive approach reduced both low birth weight rates and healthcare costs in women and infants. CPSP provides a wide range of services to Medi-Cal women who are pregnant from conception through 60 days postpartum. In addition to standard obstetrics services, women receive enhanced services in the areas of nutrition, psychosocial health, and health education. Medi-Cal providers who provide services to pregnant women may apply to become a CPSP provider. Medi-Cal managed care plans are required to provide access to CPSP-comparable services.

Covered California

In addition to the Medi-Cal expansion described above, there has been significant expansion of obstetric and prenatal coverage through Covered California. As of August 2012, new private plans were required to cover an additional set of preventive services for women, including: contraceptives as prescribed by a provider, breastfeeding supplies, screening for domestic violence, well-woman visits, and several counseling and screening services. All Covered California plans must include prenatal care and labor and delivery services (which includes

postpartum care, breastfeeding support and supplies, and counseling), as one of the ten essential benefits.

Reimbursement

Despite the fact that Medicare covers just a fraction of births in the United States, its fee schedule greatly influences the reimbursement levels of other payers. The ACA specifies that the Medicare fee schedule will reimburse certified nurse-midwives at the rate of 100 percent of the physician rate (beginning in 2011). This 100 percent reimbursement is expected to increase access to nurse-midwife care, which allows for growth in this practice. This change also makes nurse-midwives more visible in group practices because the previous reduced rate provided incentives to bill at 100 percent rates through the physician.

Service Area Obstetrics and Prenatal Services

Pasadena Public Health Department

The Pasadena Public Health Department's ("PPHD") Prenatal Clinic is a CPSP offering prenatal care, nutrition counseling, health education, and psychological counseling. The Prenatal Clinic offers healthcare services and health education classes to help mothers prepare for birth, such as pregnancy testing, prenatal check-ups, routine lab tests and ultrasounds, and a six week post-partum check-up. The Clinic also offers on-site pregnancy insurance enrollment assistance and referrals to a wide array of community-based resources.

Other

Community Health Alliance Pasadena

Community Health Alliance Pasadena ("ChapCare") is an FQHC that serves the residents of Pasadena and its surrounding areas. ChapCare offers medical, dental, behavioral health, and outreach services, including medical services for pregnant women. As an FQHC, ChapCare is eligible for favorable reimbursement for the provision of these medical services.

Fair Oaks Women's Health

Fair Oaks Women's Health provides a full range of obstetrics services including normal and high-risk pregnancy, genetic testing and screening, and full-time in-office ultrasounds. Fair Oaks Women's Health operates its own lab, allowing it to do blood draw and labs on-site.

Huntington Hospital

Impact of Healthcare Trends on Public Health Services

Huntington Hospital offers a full range of obstetric and prenatal care services. The obstetric department offers combined labor, delivery and recovery rooms and women have access to the most advanced equipment and monitoring systems. Huntington Hospital also offers childbirth preparation classes that focuses on pregnancy through the birth of the newborn.

Many healthcare providers in the Pasadena and Los Angeles areas could serve as competition for PPHD in the provision of prenatal and obstetric services. DaVita/HealthCare Partners, AltaMed, and a number of individual practitioners service individuals living in Pasadena and its surrounding areas. Since PPHD only accepts Medi-Cal and cash payment, newly insured women through Covered California may be driven to healthcare providers other than PPHD based upon which providers are included within their network. The uninsured will likely continue to present at PPHD to receive services.

Models for Obstetrics Service Providers

Current trends in maternity care in the United States show an increase in the use of costly, medically unnecessary interventions that have resulted in higher costs and poorer outcomes for mothers and infants. The historical healthcare system rewarded hospitalizations, c-sections, and complications. As viable options for payment reform are addressed, interest in new models for maternity care delivery continues to gain momentum.

Bundled Payment

Many physician leaders, policy makers, and payers view maternity care as ideally suited for a bundled payment strategy. Maternity care is high-volume and high-cost with high rates of costly obstetric procedures. Additionally, a pregnancy is a perfect "episode of care" with a well-defined beginning and a definite end. Most births also involve a small number of providers, which has the potential to reduce the complexity of the implementation of the bundle. Combining all maternity costs into a single, episode-based payment creates financial incentives for providers to be more accountable for efficiency and coordination across care settings. Two different organizations, the Integrated Healthcare Association and the Pacific Business Group of Health, recently were given the same task of developing a maternity bundle for their respective grants. The comprehensive definition bundles all facility and professional services for prenatal care, labor and delivery, and postpartum care. These bundles aim to incentivize practitioners to utilize evidence-based practice measures and coordinate their care. The two maternity episode definitions are on the following page.

Impact of Healthcare Trends on Public Health Services

	Delivery Only Definition	Comprehensive Definition
Episode Structure	Begins on date of admission	Begins 270 days prior to delivery
Warranty	Not Applicable	60 days postpartum
Standard Services	Only facility and professional services for labor and delivery included	Prenatal, labor and delivery, and post-partum services for both facility and professional services are included
Exclusions	Can be customized for patient qualifications, co-morbidities and severity markers	Can be customized for patient qualifications, co-morbidities and severity markers
Contracting	Health plan & hospital: Blended per diem (vaginal and cesarean)	Health plan, hospital & physicians: Plan pays hospital and hospital pays physicians

Source: Integrated Healthcare Association

Midwives and Birth Centers

In an effort to reduce maternity costs and improve the quality of care, the popularity of midwife-led birth centers has grown substantially. In the United States, nearly half of all births are funded by the state and federal government. Care for childbearing women and their infants was the second reason for hospitalization and five of the top ten most commonly performed procedures in hospitals are childbirth related. Additionally, costs associated with a cesarean delivery are approximately 50 percent more than vaginal birth for both mother and baby. At a birth center, costs of services are lower and the rate of cesarean deliveries is lower. In a recent study, 15,574 low-risk, healthy mothers obtained care by a midwife at one of 79 birth centers. The cesarean delivery rate for this group was 6 percent, compared to the 32.8 percent nationally. Over a 3-year period, these births saved more than $30 million in facility costs alone (not including any other potential savings for additional providers or surgical anesthesia). The spending on maternity care in the United States could drop by $5 billion if the cesarean rate dropped to 15 percent. While the United States is still many years away from this rate, the model of midwife-led care at a birth center is growing in popularity.

The Laborist Model

The Laborist Model was developed based upon the successful implementation of hospitalist and intensivist programs. The model utilizes a physician whose sole focus of practice is managing the patient in labor; a fully trained obstetrician is physically available 24 hours per day, on labor and delivery, with no assigned tasks or other responsibilities, to manage all patients who

present to labor and delivery. The model frees the practicing obstetrician/gynecologist from having office hours disrupted by a patient arriving on the labor suite. It also significantly reduces on-call requirements, thereby enhancing the personal time afforded to the physician. It has also been suggested that the model improves patient care and nurse satisfaction, as a doctor is always available to see patients in the labor and delivery suite. All of these benefits prevent physician burn-out, which is important given the diminishing numbers of medical students entering the obstetrics/gynecology specialty.

Strong Start for Mothers and Newborns Initiative

The Strong Start for Mothers and Newborns Initiative is a joint effort between the Centers for Medicare & Medicaid Services, the Health Resources and Services Administration, and the Administration on Children and Families. The initiative aims to reduce pre-term births and improve outcomes for newborns and pregnant women. There are currently 182 participating sites involve in the initiative, including the Los Angeles County Department of Health Services. The program has no-cost for participants and covers physician or midwife services, nutritionists, health educators, care coordinators, mental health providers, and referrals to community agencies.

Implications for PPHD

With the introduction of maternity and newborn care as one of the ten essential benefits, the number of women in California without access to adequate and affordable prenatal care will substantially decrease. PPHD will only be able to benefit from the Medi-Cal volume growth, not the enrollment in Covered California health plans. There is a large shift towards Medi-Cal managed care plans who will maintain a network of obstetrics providers. PPHD may lose more volume if women are re-directed based upon their Medi-Cal managed care plan to an in-network obstetrician. Furthermore, one of PPHD's tactics to maintain volume at the clinic has been to disenroll women from their health plan to qualify them for services at PPHD. Since maternal services are now a covered benefit, fewer women will be willing to disenroll to obtain services at PPHD.

Major Risks

Obstetrics services are often a gateway for patients unfamiliar with the healthcare system to begin receiving care. Health plans and medical groups recognize this as a patient engagement strategy, hoping that women will continue to access care for themselves and their child within the same healthcare group or system. Due to this, PPHD will face increased competition from ChapCare, Medi-Cal managed care plans, and healthcare providers in the local areas. PPHD

will continue to care for the under- and uninsured, although this population may shrink in volume as more women are eligible for insurance through Covered California or Medi-Cal expansion.

Financial Review

Prenatal Clinic

The latest financial analysis for the Prenatal Clinic for services provided in FY 2014 showed an overall loss of $69,000. A random sample analysis of Medi-Cal and Medicare payments showed that 38 percent of reimbursement related to the Prenatal Clinic; therefore, approximately $708,000 was allocated to the Prenatal Clinic, resulting in the $69,000 loss. As of December 31, 2015, the mid-way point within FY 2015, the Prenatal Clinic showed an overall loss of $47,000, which suggests an overall loss of $94,000 at the end of FY 2015.

PPHD will need to assess the viability of the Prenatal Clinic based upon the increased competition described previously. Due to the covered essential health benefits included in the ACA health plans, the Prenatal Clinic will likely experience a drop in volume as patients can receive covered prenatal services elsewhere. Furthermore, is it anticipated that Medi-Cal reimbursement will continue to drop as Medi-Cal managed care providers contract with medical groups or other healthcare providers to offer prenatal services for newly insured Medi-Cal beneficiaries.

Community Health Services

The latest financial analysis for Community Health Services for services provided in FY 2014 showed an overall loss of $1.1 million. As of December 31, 2015, the mid-way point within FY 2015, Community Health Services showed an overall loss of $73,000, which suggests an overall loss of $94,000 at the end of FY 2015. This analysis is inclusive of all Community Health Services per the FY 2015 division definition, excluding the Prenatal Clinic and services related to Tuberculosis and Infectious Diseases. Based upon the random sample analysis of Medi-Cal and Medicare payments, none of this reimbursement is attributed to these programs. It is concerning that there is such a big change from one year to the next. It could mean that the proper allocation of revenue to this department has resulted in significant improvement in the financial standing of this department. It will be up to PPHD staff to determine if the overall loss in FY 2014 was due to improper allocation of revenue and/or expenses.

Impact of Healthcare Trends on Public Health Services

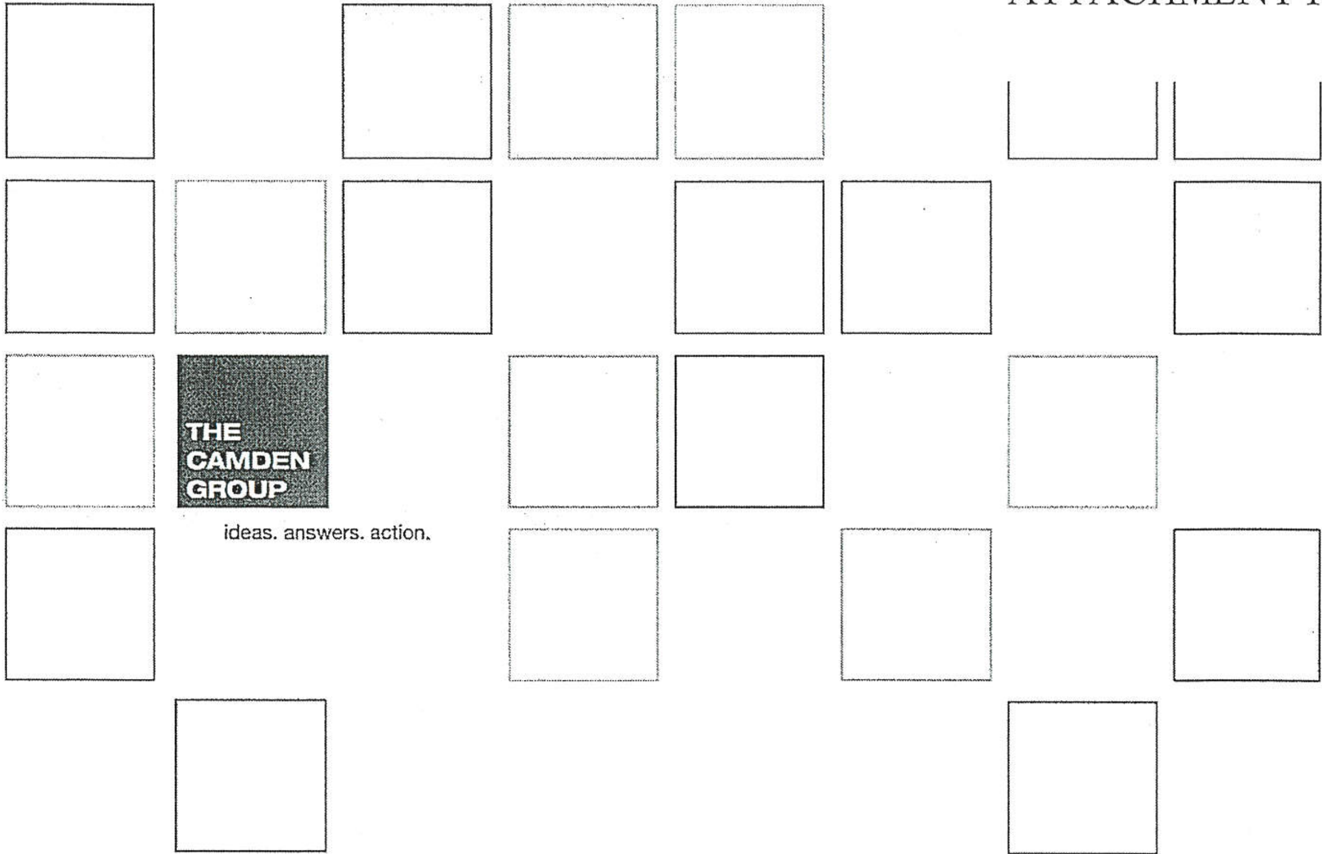
ACA Impact

- More people insured, have more choice
- Women's care services are now one of the ten essential benefits with little to no share of cost for beneficiaries
- Expanded Medi-Cal in California providing more access for women to obtain coverage
- The city of Pasadena faces growing competition from provider networks serving Medi-Cal and Covered California health plans offered through the Silver and Bronze levels

Conclusion

PPHD should consider two primary options with regards to its obstetrics and prenatal services. First, PPHD could choose to maintain its obstetrics and prenatal services in their current state. This program has experienced some losses in the past, but the revised losses can be offset by focused reductions in expense. However, as mentioned above, PPHD should expect increased competition from ChapCare and other providers. It will be important for PPHD to track monthly volume to ensure that appropriate volumes are maintained to support the cost of the fixed staffing expenses associated with the program. Second, PPHD could consider enhancing its relationship with ChapCare and the Huntington Hospital obstetrics program to keep these patients engaged in their own healthcare. Since these services are not mandated, PPHD could choose to serve as a best-practices knowledge/process transfer agent for a period of time to ensure that patients who will be cared for by ChapCare receive the same exemplary service they have been receiving at the PPHD Prenatal Clinic. The location of ChapCare next to PPHD's clinic location ensures a smooth transition can take place with minimal disruption to active patients.

ATTACHMENT F



Impact of Healthcare Trends on Public Health Services

City of Pasadena
Pasadena, California
March 12, 2015

CITY OF PASADENA

Impact of Healthcare Trends on Public Health Services

Communicable Disease Background

In the United States, people continue to contract diseases that are preventable through appropriate vaccine use, such as viral hepatitis, influenza, and tuberculosis ("TB"). Some of these diseases are among the leading causes of illness and death in the United States and account for substantial healthcare expenditures due to the related consequences of infection. Despite the fact that these diseases can be prevented, healthcare systems often do not utilize their resources effectively to support prevention efforts. Historically, the United States healthcare system has focused on treatment and intervention instead of health promotion and population health management; therefore, patients did not always receive adequate or appropriate information about prevention and healthy lifestyles.

Important defenses against infectious disease include:

- Proper use of vaccines
- Antibiotics
- Screening and testing
- Scientific improvements in the diagnosis of infectious disease-related health concerns

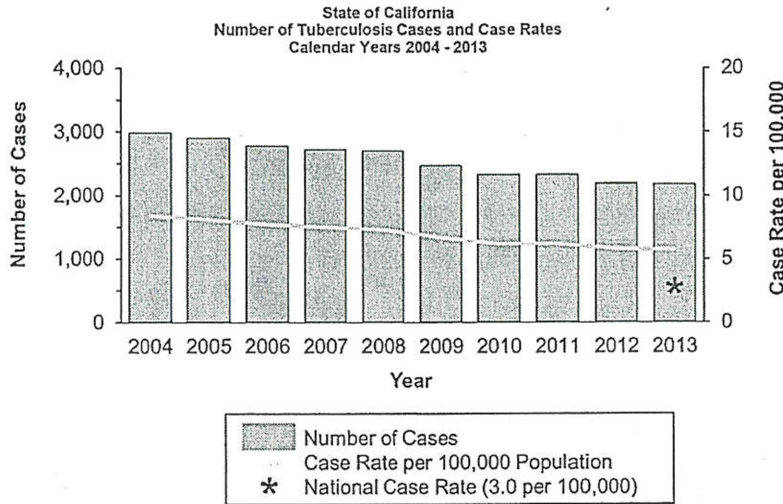
The United States' healthcare infrastructure must continue to evolve and respond to emerging issues in the area of immunization and infectious diseases. The ability to provide culturally appropriate preventive healthcare is a critical success factor for managing the spread of infectious diseases. As the demographics of the population continue to shift, healthcare systems must be able to expand their capacity to meet the needs of a diverse population. A coordinated strategy will be necessary to understand, detect, control, and prevent infectious disease.

TB immunization and testing is now a federal focus through the Centers for Disease Control ("CDC"). Continued progress in controlling TB will depend on an increased focus on TB prevention, particularly among persons at-risk for developing TB; racial and ethnic minorities and foreign-born individuals continue to be the most affected by TB. United States will need to continue to focus on domestic TB control and develop focused initiatives around improving awareness, testing, and treatment of TB.

Tuberculosis Prevalence

In the United States, California contributes the highest number of TB cases, accounting for approximately 23 percent of all cases in 2013. California posts the third-highest TB rates among states, behind Alaska and Hawaii. Over the past few years, significant efforts have been made to reduce the prevalence of TB in California. In 2013, there were 2,169 TB cases recorded

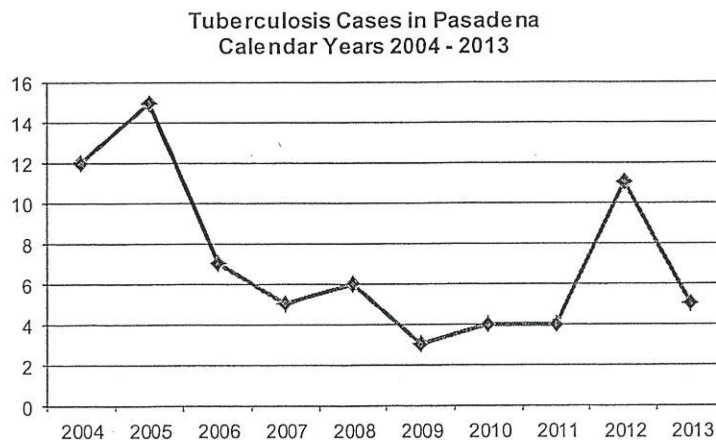
which was the lowest number ever recorded in California and represented a decline of less than one percent from 2012.



California Department of Public Health, Tuberculosis Control Branch

Despite these efforts, TB outbreaks continue to occur in high-risk populations and improvements have not been seen in key indicators such as pediatric TB, deaths with TB, and multidrug-resistant TB. TB rates in California jumped approximately 20 percent in children less than 5 years of age between 2012 and 2013. More than 30 percent of California's TB cases were among individuals who are 65 years of age or older.

TB cases are submitted to the California Department of Public Health for 61 health jurisdictions, including Pasadena. In 2013, TB was reported in 44 of the 61 local health jurisdictions. Between 2012 and 2013, Pasadena improved from the fifth highest TB case rate to the twenty-first highest TB case rate (a drop from 11 TB cases to 5), a 54.5 percent improvement. With the exception of this peak in cases in 2012, Pasadena's TB cases have been steadily dropping since 2004 with a 58.3 percent improvement over this period of time.



Source: California Department of Public Health, Tuberculosis Control Branch

Impact of Healthcare Trends on Public Health Services

Communicable Disease Services and Reimbursement

The primary healthcare services related to communicable diseases in the United States are vaccinations and screenings. Vaccines are typically widely available through private doctor offices, pharmacies, workplaces, community health clinics, health departments, federally-funded health centers, or other community locations. Through the implementation of the Affordable Care Act ("ACA"), there is an increased focus on increasing care coverage and access to these community resources by mandating insurers to include vaccines. All Covered California plans, and most other private insurance plans, must cover the following list of vaccines:

- Hepatitis A
- Hepatitis B
- Herpes Zoster
- Human Papillomavirus
- Influenza
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Tetanus, Diphtheria, Pertussis
- Varicella

TB Testing

There are two types of TB tests conducted to determine whether an individual has been infected with TB bacteria: the tuberculin skin test and the TB blood test. The Los Angeles County Department of Public Health requires all students who have never attended a California school to receive the tuberculin skin test prior to matriculation. TB tests are generally not needed for adults with a low risk of infection with the TB bacteria. In the United States, TB typically affects those with the least access to healthcare insurance (i.e., homeless, undocumented immigrants, etc.) or those who work with at-risk populations (i.e., social workers, hospital staff, homeless shelter staff, etc.). Of the 2,169 Californians diagnosed with TB in 2013, 80 percent were immigrants.

California Department of Public Health

The Tuberculosis Control Branch of the California Department of Public Health awards funds to local health jurisdictions to support TB healthcare services. The amount of funding is based upon factors such as the incidence of TB, number of foreign-born persons, homelessness, HIV/AIDS co-infection, and substance abuse. Local health jurisdictions prioritize TB control activities based upon those priorities identified by the CDC:

- Identifying and treating persons who have active TB and ensuring they complete appropriate therapy, including Directly Observed Therapy

- Finding and evaluating persons who have been in contact with TB patients to determine whether they have TB infection or disease
- Targeted testing of high-risk populations

Medi-Cal Tuberculosis Program

The Medi-Cal TB Program is funded under Title XIX of the Social Security Act to treat individuals who are infected with TB. This program covers outpatient TB-related services for individuals who are TB-infected and beneficiaries receive services at a zero Share of Cost; these services include: medications, physician and clinic services, laboratory and radiologic services, Directly Observed Therapy, and case management.

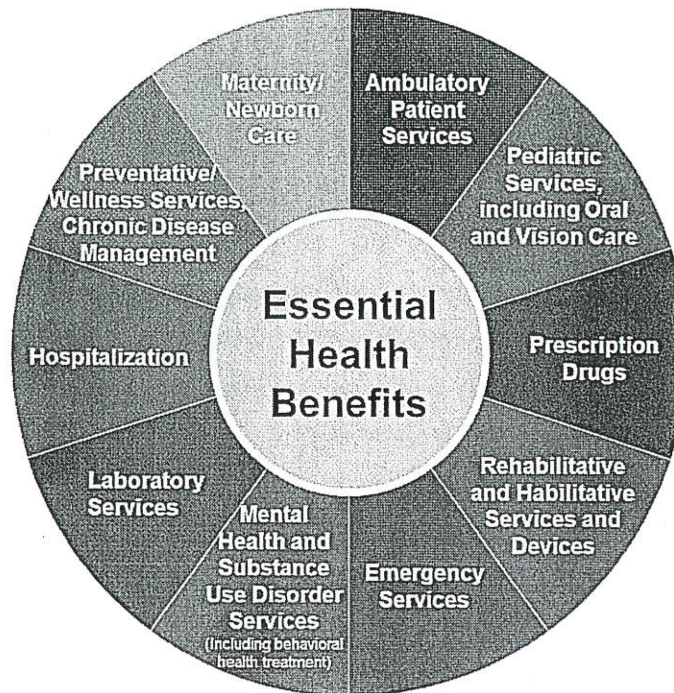
Federally Qualified Health Centers

Federally Qualified Health Centers ("FQHCs") are safety net providers who often fill a substantial void in the United States healthcare system. FQHCs service some of the most vulnerable and high-risk populations and qualify for enhanced Medicare and Medicaid rates. TB and other infectious disease services are often covered by FQHCs as they are preventive primary health services.

Affordable Care Act

The Patient Protection and ACA mandated coverage for a number of preventive services by Health Insurance Exchange qualified health plans. All Covered California plans, Qualified Health Plans through California's health insurance exchange, will be required to offer ten essential benefits, one of which is preventative and wellness services and chronic disease management.

Impact of Healthcare Trends on Public Health Services



However, it is anticipated that the expansion of health insurance coverage through Covered California may not substantially decrease the need for TB public health services in California. Ten percent of residents in Los Angeles are undocumented immigrants and will not benefit from the enhanced access to health insurance. Furthermore, this population is a more high-risk population, as they are foreign-born. While the importance of vaccinations and screenings is widely distributed, it is probable that the most high-risk populations are still not receiving appropriate care and public health services will still be necessary.

Service Area Tuberculosis Services

Pasadena Public Health Department

The Pasadena Public Health Department ("PPHD") Tuberculosis Clinic offers TB screening, treatment, and case management services with the goal of controlling and preventing the transmission of TB within the Pasadena community. The PPHD Tuberculosis Clinic (the "Clinic") offers health services for individuals diagnosed with TB, such as a medical check-up, a chest X-ray, and prescribed medications. Additionally, the Clinic offers Directly Observed Therapy to assist patients with medication adherence and provides case management resources to coordinate all resources and referrals.

Other

Community Health Alliance Pasadena

Community Health Alliance Pasadena ("ChapCare") is an FQHC that serves the residents of Pasadena and its surrounding areas. ChapCare offers medical, dental, behavioral health, and outreach services, including the care for patients with TB or other infectious diseases. As an FQHC, ChapCare is eligible for favorable reimbursement for the provision of these medical services.

CVS (Or Other Retail Pharmacy)

The Minute Clinic at CVS (and similar wellness centers at other retail pharmacies) offers walk-in TB testing. Insurance is not accepted for this service, but these clinics offer convenient and quick TB testing.

Most healthcare providers in the Pasadena and Los Angeles areas could serve as competition for PPHD in the provision of healthcare services for individuals with TB or other infectious diseases. DaVita/HealthCare Partners, AltaMed, and a number of specialty groups and individual practitioners service individuals living in Pasadena and its surrounding areas. Treatment for TB often includes prescription medication, Directly Observed Therapy, and chronic care management services. Newly insured individuals may be driven to healthcare providers other than PPHD based upon which providers are included within their network. The underinsured or uninsured will likely continue to present at PPHD to receive services.

Implications for PPHD

One of the central tenets of the ACA is to provide access to health insurance for more individuals; it is anticipated that this push will result in greater patient volumes for physicians who treat TB and other infectious diseases. At-risk populations will be encouraged to undergo regular screenings for these conditions and those infected will have greater access to care. However, the physicians who will benefit most from this increase in volume are those who contract with Medi-Cal managed care plans or Covered California's Qualified Health Plans. PPHD will likely lose volume to these plans while it will continue to serve the under- and uninsured population for whom reimbursement is incredibly poor.

Major Risks

As a greater proportion of PPHD's population becomes the under- and uninsured, PPHD will have an increased risk for caring for individuals diagnosed with TB or other infectious diseases. As mentioned previously, one of the populations at the greatest risk for developing TB is the

undocumented immigrants. Undocumented immigrants are one of the key cohorts not eligible for health insurance through the ACA. The costs associated with caring for these patients will be substantial for PPHD and PPHD will have little reimbursement to offset these costs of treatment.

Financial Review

The latest financial analysis for Communicable Diseases and Tuberculosis services provided by PPHD in FY 2014 showed overall profits of approximately $800,000. As of December 2014, a mid-year point through FY 2015, communicable disease and tuberculosis services showed an overall loss of $165,000 suggesting an overall loss in FY 2015 of $330,000. Furthermore, in FY 2015, PPHD lost its TB State Local Assistance Revenue, which totaled $4,342 in FY 2014. A random sample analysis of Medi-Cal and Medicare payments showed that none of the FY 2014 reimbursement was related to the provision of these services.

PPHD will need to continue to assess the viability of providing communicable disease and tuberculosis services to its patients. As a greater proportion of PPHD's clientele has access to healthcare insurance, where preventive and wellness services are covered benefits, PPHD will likely experience a drop in volume. PPHD will need to determine if there are alternate avenues through which it can generate patient visits for these services. Alternatively, PPHD will need to institute a more aggressive fee schedule for these services to offset the dip in volume and recover the associated operating costs.

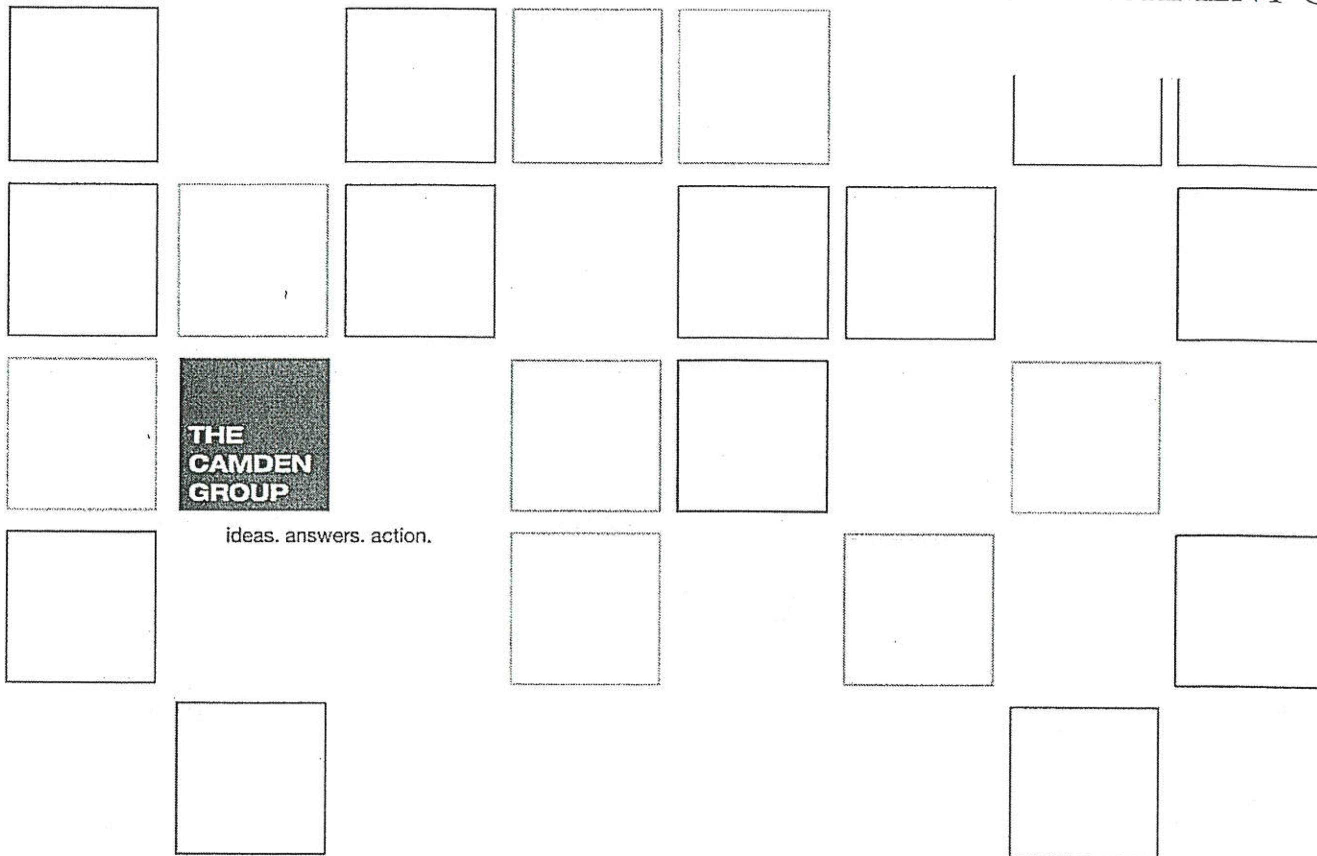
ACA Impact

- Preventive/Wellness services is one of the covered ten essential benefits
  - TB screening for at-risk populations
- Expanded Medi-Cal in California, more people covered go to Medi-Cal managed care provider
  - Medi-Cal managed care providers will contract with local FQHCs and medical groups to provide high-quality care to patients diagnosed with TB or other infectious diseases
- FQHCs are eligible for enhanced funding to pay for healthcare services for patients diagnosed with an infectious disease
- The city of Pasadena faces growing competition from provider networks serving Medi-Cal and Covered California health plans offered through the Silver and Bronze levels

Conclusion

As the pool of patients for whom PPHD provides services continues to shrink from an already small patient base, the remaining patients will be the under- and uninsured. At-risk individuals will be more proactive about undergoing screenings and will seek treatment from providers who are covered under their health plan. It is likely that PPHD will no longer maintain a TB patient panel that is large enough to justify offering these services. PPHD will need to evaluate the cost of continuing services for patients with TB and consider contracting with Medi-Cal or a Covered California health plan to encourage individuals with health insurance to access PPHD's services. The continued provision of these services will be dependent on PPHD's ability to secure grant or other outside funding, should efforts to expand the patient base through expanded contracting prove unsuccessful. An alternate option would be to identify an alternate provider of these services, and contract with them to ensure provision of these services for at the under- and uninsured, with PPHD providing the funding but not the actual services.

ATTACHMENT G



Impact of Healthcare Trends on Public Health Services

City of Pasadena
Pasadena, California
March 12, 2015

CITY OF PASADENA

Impact of Healthcare Trends on Public Health Services

Mental Health and Substance Abuse Services Background

Mental health and substance abuse treatment is a necessity for many Californians suffering from crippling conditions. Despite the prevalence of these disorders, less is known about the mental health system than about the medical system. There is a wide variety of mental health disorders, some acute and some persistent, and mental illness diagnosis is often based on level of difficulty with functioning:

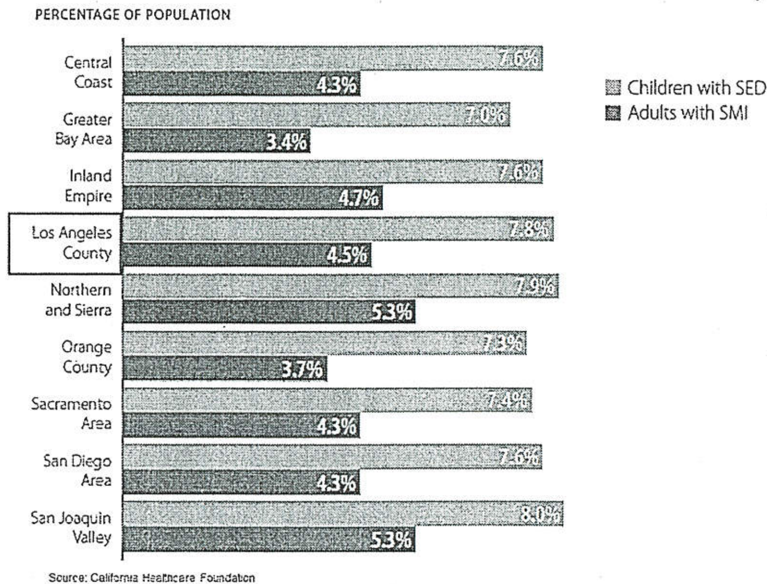
- Mental illness: any person 18 years or older who currently had, or at any time in the past year had, a diagnosable mental, behavioral, or emotional disorder, regardless of the level of impairment in carrying out major life activities
- Severe mental illness ("SMI"): a categorization for adults age 18 and older, any mental illness that results in substantial impairment in carrying out major life activities. This can encompass a wide range of diagnoses.
- Sever emotional disturbance ("SED"): a categorization for children age 17 and under, any mental, behavioral, or emotional disorder that is currently present, or has presented within the last year that meets the diagnostic criteria for a mental illness and has resulted in functional impairments that substantially limits participation in family, school, or community activities
- Major depression episode ("MDE"): a period of at least two weeks when a person has experienced a depressed mood, or loss of interest or pleasure in daily activities, and had a majority of specified depression symptoms.

A significant portion of the mental health practice involves patients seeking safety and managing anxiety, trauma, depression, drug use, and/or disruptive behavior. Historically, a stigma has been attached to the provision of mental health services, causing many individuals to shy away from professional help; 19 percent of Californians reported that they would not be likely to seek professional mental health counseling or treatment even if it were covered by insurance and created no financial burden. Mental illness is a psychological disorder with severe biological health consequences (resulting in unnecessary Emergency Room visits or inpatient admissions) and an emphasis has been placed on the access and provision of mental health services to avoid unnecessary medical costs.

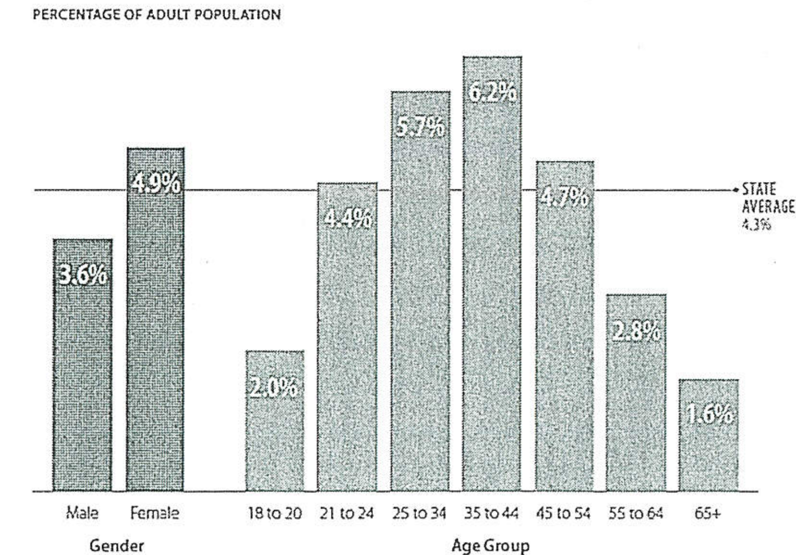
Impact of Healthcare Trends on Public Health Services

Mental Health and Substance Abuse Prevalence

In California, approximately 1 in 20 adults suffers from a serious mental illness and nearly 1 in 6 has a mental health need (though rates vary widely by region, see graph below). Among children, the rate is even higher: 1 in 13 suffers from a mental illness.



Adult California women are more likely than men to experience serious mental illness (4.9 percent of adult female population vs. 3.6 percent of adult male population). Rates of serious mental illness also increased steadily by age group with a peak in the 35 to 44 cohort at 6.2 percent of the adult population.



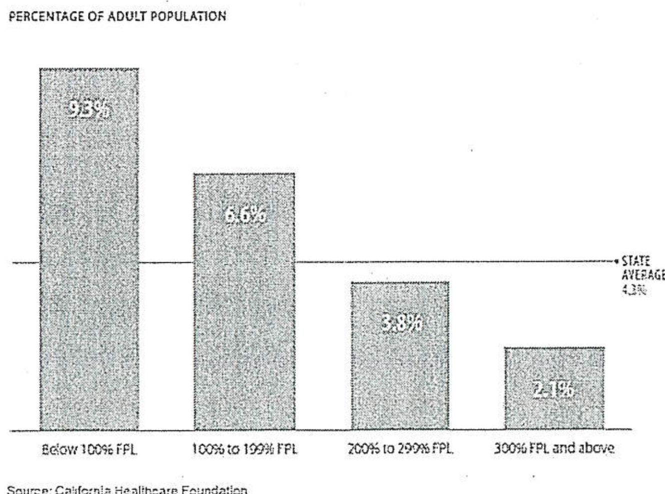
Impact of Healthcare Trends on Public Health Services

Coverage for Mental Health Services

Over the past 20 years, the delivery of mental health services has evolved significantly, resulting in changes in the location of mental health treatment, the personnel providing mental health treatment, and the expenditures for mental health treatment. Expenditures for inpatient residential treatment have continued to decline as expenditures for prescription drugs and outpatient care increased as a percentage of total expenditures. Throughout this transition, community health centers and counties have continued to play a large role in the financing and delivery of mental health services; public mental health services in California are delivered primarily through county systems that operate separately from other publicly funded healthcare services. Counties are responsible for administering nearly 90 percent of public mental health services funding in California.

Medi-Cal

The majority of federal funding that California receives for public mental health is used to reimburse the state and counties for services provided to Medi-Cal beneficiaries. Medi-Cal is one of the primary payers of mental health services in Los Angeles primarily due to the high correlation between serious mental health illness and low socioeconomic status. The table below shows the percentage of adults in California with serious mental illness by income level.



Source: California Healthcare Foundation

California's public mental health system provides services to many low-income individuals with mental illness. A variety of county entities provide more specialized mental health services to Medi-Cal enrollees, underinsured individuals, or uninsured individuals.

Impact of Healthcare Trends on Public Health Services

	MEDICAID HEALTH PLANS AND MEDICAID FEE-FOR-SERVICE	LOCAL SPECIALTY MENTAL HEALTH PLANS	COUNTY-BASED MENTAL HEALTH SAFETY-NET PROVIDERS
Payer	Medi-Cal (federal and state)	Medi-Cal (federal and state/local)	County, Mental Health Services Act, realignment funds,* and other funding sources
People Served	Medicaid eligibles with mild and moderate mental health conditions	Medicaid eligibles with SED or SMI	Uninsured with SED or SMI
Services Provided	Outpatient mental health services, crisis intervention, psychiatry, inpatient mental health care	Same as Medicaid, plus specialized rehabilitative and supportive care	Outpatient mental health services, crisis intervention, psychiatry, short- and long-term inpatient mental health, as well as rehabilitative and supportive services and other services as resources allow

*Realignment is the transfer of administrative and financial control from the state to counties.
Source: California Healthcare Foundation

Through the Affordable Care Act ("ACA"), due to the expansion of Medi-Cal, it is estimated that approximately 124,000 individuals who are now eligible for Medi-Cal will need mental health services. The two largest groups of mental health workers in California are Marriage and Family Therapists and Social Workers. However, California law prohibits Marriage and Family Therapists from participating as Medi-Cal providers unless they are members of county clinic staff; this restriction prevents a large percentage of the mental health workforce from providing services to Medi-Cal beneficiaries.

Mental Health Services Act

In 2004, California passed the Mental Health Services Act ("MHSA") to address a broad continuum of prevention, early intervention, service needs, and care coordination for mental health services, along with the infrastructure necessary to support this system. MHSA created 1 percent surtax on personal income over $1 million to provide additional revenue for community-based mental health services. MHSA provides increased funding, personnel, and other resources to support county mental health programs. As the role of the MHSA on mental health funding increases, the sources of funding for public mental health services are expected to shift. In Los Angeles County, a wide range of programs will be expanded in 2015, according to the MHSA Los Angeles 2014 Budget Plan; this expansion will include mental health services for adults and children to combat homelessness, urgent care center capacity, housing, and wellness centers.

Impact of Healthcare Trends on Public Health Services

Substance Abuse and Mental Health Services

Substance Abuse and Mental Health Services Administration ("SAMHSA") block grants are an additional source of federal mental health funding in California. SAMHSA grant funding is awarded to counties based upon an application process and a legislative formula. SAMHSA funding makes up a very small percentage of the total public mental health budget, but remains a flexible funding course for services for adults and children who are ineligible for Medi-Cal and have no other form of health coverage.

County Funding

California's 58 counties also utilize revenue from local property taxes, patient fees, and some payments from private health insurance companies to fund mental health services (in addition to federal and state funding sources). The total amount of county funding is approximately three percent of the total funding counties administer to provide mental health services. The total mental health program expenditures by county likely vary substantially between counties.

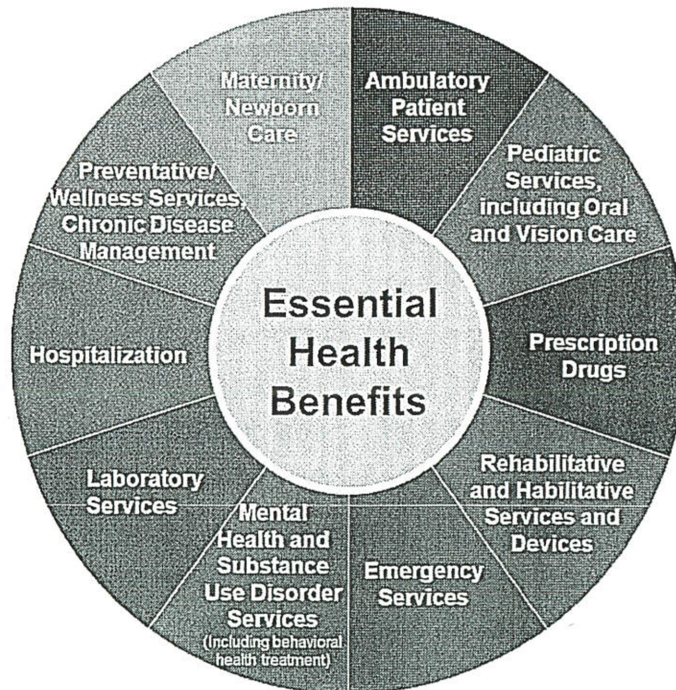
Mental Health Parity Law

California, like most states, has a Mental Health Parity Law. The California Mental Health Parity Act of 1999 eliminated mental health benefit limits and cost-sharing requirements that are less comprehensive than those for physical conditions. The law applies to private insurers but not to Medicare or self-insured health plans. Additionally, the law requires that every insurer that provides hospital, medical or surgical coverage shall provide coverage for the diagnosis and medically necessary treatment of those with covered conditions, including outpatient services, inpatient hospital services, partial hospital services, and prescription drugs, if the health plan covers prescription drugs. Furthermore, California mandates that health insurance plans cover nine mental health conditions: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa. California's mental health parity provisions are among the strongest in the country; however, low public awareness about the law often results in a denial of care or individuals who choose not to seek care. In 2008, the federal Mental Health Parity and Addiction Equity Act was passed, requiring health plans and health insurance issuers to ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

Impact of Healthcare Trends on Public Health Services

Affordable Care Act

Beginning January 1, 2014, the Patient Protection and ACA expanded the Mental Health Parity and Addiction Equity Act of 2008 to almost all forms of health insurance. The ACA required all large group employer plans, state regulated plans, small group plans, and individual market plans to comply with deferral parity requirements. The ACA strengthened the 2008 law by requiring insurers to include coverage for mental health and substance use disorder services as these services are now one of the ten required Essential Health Benefits. All Covered California plans, Qualified Health Plans through California's health insurance exchange, will be required to offer these ten essential benefits; Covered California is expected to significantly increase the number of mental health patients seeking treatment.



Reimbursement Trends for Mental Health Services

Over the past 20 years, the distribution of spending on mental healthcare in the United States has changes drastically. Inpatient and residential care spending has continued to decrease while outpatient and prescription drug spending has increased. Today, the majority of mental health treatment is conducted in an outpatient setting.

With the implementation of the ACA, insurance regulations are changing and public awareness of mental health service coverage is growing; these changes, in addition to an ever-growing need for mental healthcare, are resulting in a shift in consumer behavior which continues to

impact mental health and addiction treatment providers. Implementation of the ACA presents both opportunities and challenges related to mental health service delivery. With the expansion of Medi-Cal in 2014, counties received additional federal funding to provide healthcare services to the expanding Medi-Cal population. However, the federal funding will decrease over the coming years and there are concerns about some counties' capacity to serve this population. Furthermore, providers are growing more frustrated with Medi-Cal rates and continue to feel the strain of decreasing Medi-Cal reimbursement schedules. Despite parity laws and expanded health insurance coverage, concerns remain with regards to sufficient coverage and access to mental health services.

Service Area Mental Health Services

Pasadena Public Health Department

Andrew Escajeda Comprehensive Care Services ("AECCS") is run through a partnership between community agencies and the Pasadena Public Health Department ("PPHD") and offers psychiatric and mental health services to individuals living in Pasadena and the surrounding communities. AECCS provides comprehensive mental health support groups, crisis intervention services, referrals for long-term mental health counseling or substance abuse treatment, clinical case management, and short-term counseling services. A number of agencies in the surrounding areas also offer mental health and substance abuse services.

Other

AltaMed

AltaMed provides mental health services, psychiatry, and substance abuse treatment referrals to Latino, multi-ethnic, and underserved individuals living in the Los Angeles area. AltaMed also offers a drug treatment and prevention program that specializes in the treatment of heroin addiction through narcotic replacement therapy.

Foothill Family Service

Foothill Family Service ("FFS") provides mental health services to individuals living throughout the San Gabriel Valley with family centers located in Pasadena, El Monte, West Covina, and Duarte; many of their programs and services are also available at schools, community centers, and through in-home visits. FFS primarily serves children and families and offers counseling, social services, mental health treatment, education, and outreach services. The majority of the children and families who receive services from FFS are from poverty-level or low-income families.

Hathaway-Sycamores

Hathaway-Sycamores Child and Family Services ("Hathaway-Sycamores") is a mental health and welfare agency dedicated to providing services to children, youth, young adults, and families facing serious life challenges. With eleven locations through Southern California (including a main location in Pasadena), Hathaway-Sycamores provides outpatient and school-based mental health services, psychological testing, and grief counseling.

Hillsides

Hillsides is dedicated to providing services to vulnerable children, youth, and their families. Hillsides operates several Family Resource Centers in Los Angeles County and provides parenting classes, mental health support, and additional crucial resources for vulnerable children and their families. The services provided include individual and group therapy, psychological testing and psychiatric evaluation, psychotropic medication management, parenting and substance abuse groups, and case management. Hillsides also offers school-based mental health services in the Pasadena, Los Angeles, Baldwin Park, and Glendale/Burbank school districts.

Huntington Hospital – Della Martin Center

The Della Martin Center ("DMC") at Huntington Hospital provides mental health services to patients and their families, offering comprehensive diagnosis, treatment, and rehabilitation of adult patients with psychiatric disorders. DMC offers the following mental health programs: Psychiatric Acute Treatment Program, Psychiatric Inpatient Program, Geriatric Psychiatric Medical Program, and Outpatient Psychiatric Services.

Pasadena Mental Health Center

The Pasadena Mental Health Center ("PMHC") provides mental health services to adults, children, couples, and families in the Pasadena and Altadena area and in the surrounding communities. Available services include individual counseling, couple's therapy, family therapy, and support groups. PMHC operates on a sliding scale fee schedule to provide services to individuals from all cultural and socioeconomic backgrounds.

Pacific Clinics

Pacific Clinics offers a range of services from prevention and early intervention to recovery and wellness maintenance, with an emphasis on programs for children and their families. Pacific Clinics offers outpatient, integrated treatment programs for individuals with co-occurring substance abuse and mental health disorders. Pacific Clinics operate throughout Los Angeles County (including numerous sites in Pasadena) and in four other counties in California.

Impact of Healthcare Trends on Public Health Services

Prototypes

Prototypes provides mental health and substance abuse services for individuals who suffer from complex issues such as addiction, poverty, homelessness, mental illness, and domestic violence. Prototypes offers 14 locations through Southern California, including an Outpatient Behavioral Health Services Center, Community Assessment Service Center, Wellness Center, and a Mental Health Services Center in Pasadena. The Centers provides comprehensive mental health and substance abuse services, ranging from assessment referrals to more intensive services such as counseling, medication management, and case management.

The Arroyos

The Arroyos is a multidisciplinary group of psychologists and psychiatrists who provide comprehensive mental health services across a wide spectrum of treatment settings. The Arroyos provides concierge mental healthcare to their patients and services individuals with nearly all psychological and psychiatric conditions.

As the demand for high-quality mental health services increases, it is highly likely that qualified health plans and large medical groups will begin contracting with behavioral health management organizations to provide mental health services. Behavioral health management organizations (such as Magellan, Value Options, or Windstone) can provide services to Medi-Cal, Medicare, and commercial populations and will continue to grow their market through enrollment in Medi-Cal managed care and Covered California Qualified Health Plans.

Clinic Mergers and Closures

Due to reimbursement strains and a shift towards outpatient mental health services, many clinics and inpatient centers providing mental health services have been forced to close and/or change the manner in which they provide mental health services over the past few years. Many of these headlines are included in the table below:

Headline	Source
"Chicago Mental **Health Clinic Closings** Spark Opposing Views"	Chicago Tribune, August 2014
"Proposed **Closure of Mental Health Clinic** Spurs Outrage"	Citizenactionny.org, October 2014
"Protesters Upset Over **Closing** of Sharon Mental Health **Clinic**"	WKBN, October 2014
"One Last Chance to Argue Against **Mental Health Clinic Closure**"	WSKG, November 2014

Impact of Healthcare Trends on Public Health Services

Headline	Source
"Branstad Seeks to **Close** Two Mental Institutes"	The Des Moines Register, January 2015
"Missouri Psychiatric **Treatment Center for Youth Closing** Under State Budget Woes"	St. Louis Today, July 2014
"Mental Health Clinic **Takes Hit** in Budget Plan"	Press Connects, September 2014
"Mental Health Programs **Closing** Across Kentucky"	Courier Journal, July 2014
"Minn. Mental Health Center **Shuts Down**"	Star Tribune, March 2014
"Kansas Mental Health System Under **Increasing Stress**"	KHI News, August 2014

Models for Mental Health Service Providers

As organizations strive to achieve the Triple Aim™ and improve the health outcomes of their population, the integration of mental health services with physical health services becomes a key priority. A central tenet of the ACA is promoting the coordination of care across all care settings and integrating this care by aligning financial incentives. Within California, a number of models are being implemented across the state to increase the integration of primary care and mental health services at the delivery site. The Federal Government, heath plans, and healthcare delivery networks have realized that many costly, preventable health events are due to poor mental health services and the historical separation between mental health and primary care. In the coming years, organizations will continue to work on the integration between these disciplines in an effort to continue to reduce overall health expenditures, improve population health outcomes, and improve patient satisfaction.

California's Coordinated Care Initiative

California's Coordinated Care Initiative was implemented in 2014 with the intent to integrate medical, long-term services and supports ("LTSS"), and mental healthcare. Through this initiative, the state Medi-Cal program and the federal Medicare program are working together to promote coordinated care delivery and drive high quality care for the vulnerable dual eligible population. The program, known as Cal MediConnect, aims to shift services out of institutional settings and into the home and community. The dual eligible population historically had to navigate two distinct healthcare systems (Medi-Cal and Medicare) with two different cards, two different sets of benefits, and two different groups of providers accountable for services. Under the Cal MediConnect program, all healthcare services are provided through a single organized delivery system and providers are incentivized to coordinate all types of care.

Impact of Healthcare Trends on Public Health Services

Patient-Centered Medical Homes

The Patient-Centered Medical Home ("PCMH") implemented by the National Committee for Quality Assurance is a model for care that emphasizes team-based care and calls for mental health integration into primary care. Within this model, a team of clinicians offers accessible, personal, coordinated, and comprehensive care that meets all of a person's healthcare needs, including behavioral health; behavioral healthcare services provided in this model include mental healthcare, substance abuse care, health behavior change, and attention to other psychosocial factors. PCMH aims to provide a whole person orientation to care; since nearly half of primary care patients have a mental or behavioral health diagnosis or symptoms, a whole person orientation cannot be achieved without including the mental health component with the physical. Furthermore, the PCMH model aims to reduce fragmentation in care which is one of the primary factors that most seriously harms the quality of care. Fragmentation within the United States healthcare system can be seen most clearly in the separation of mental health and physical health services. The PCMH model incentivizes the care team to address mental health concerns, conduct regular screenings, share information among providers, and coordinate all care plans.

Primary and Behavioral Health Care Integration Program

The Substance Abuse and Mental Health Services Administration developed the Primary and Behavioral Health Care Integration ("PBHCI") program, which aims to provide support to communities to integrate primary care services into publicly-funded, community-based behavioral health settings. The purpose of this program is to establish projects for the provision of coordinated and integrated primary and specialty care in community-based behavioral health settings. The goals of the program are to:

- Improve access to primary care services
- Improve prevention, early identification, and intervention
- Increase availability of integrated, holistic care
- Improve the overall health status of patients

Medicaid Health Home

The Medicaid Health Home ("MHH") is a model where states pay for care coordination services for Medicaid enrollees with chronic illness. MHHs offer a mechanism through which the primary, acute, mental health, and long-term and social needs of beneficiaries can be addressed using a single care plan. The integration of physical and mental healthcare is an important aspect of the

Medicaid health home model. Behavioral health problems such as depression, anxiety, or substance abuse are among the most common health conditions in the U.S. and often co-occur with chronic medical disease; however, due to the fragmented healthcare delivery system, these health concerns often are overlooked and continue to plague beneficiaries. Collaborative care programs are developed within the MHHs where a single care plan is developed and primary care providers, care managers, social workers, and psychiatric consultants work together to provide care and monitor patients' progress. These programs have been proven to be both clinically-effective and cost-effective for a number of mental health conditions. In return for providing high-quality, cost-effective care, MHHs are financially incentivized to provide the essential components of care management and care coordination.

Implications for PPHD

With the introduction of mental health as one of the ten essential benefits, and as mental health parity becomes increasingly regulated, the need for mental health and substance abuse services will continue to grow. Simultaneously, the expansion of the Medi-Cal program as well as enrollment into Covered California qualified health plans will increase the number of insured individuals seeking mental health services while a shortage of mental health providers continues to exist.

Mental health reimbursement will continue to be driven by a number of factors. The mental health diagnosis will be a primary driver in the level of reimbursement. Organizations who provide services to those struggling from severe mental health disorders will receive greater reimbursement for those services. Furthermore, the type of services provided (individual vs. group counseling) and the level of clinician (psychiatrist, licensed, or unlicensed social worker) will greatly affect reimbursement. With the shortage of psychiatrists, organizations will be looking to contract with mental health providers that can offer psychiatric services and medication reconciliation. Medi-Cal reimbursement rates will continue to be low while opportunities exist in the Medicare and commercial markets for greater reimbursement.

Medical groups and health plans are contracting with behavioral health management organizations to provide their behavioral health services. Medical groups and health plans do not want to apply resources to develop behavioral health networks or assume risk for managing behavioral healthcare services, since that is not their area of expertise. If PPHD wishes to expand their provision of mental health services, they will need to contract with behavioral health management companies who can service Medi-Cal, Medicare, or commercial populations. Many social service agencies have already assessed the mental health market and

have identified this trend; local, community-based mental health agencies are reaching out to behavioral health management organizations to become part of their mental health network.

Major Risks

Organizations that provide similar mental health and substance abuse services may be ahead of PPHD and may have already established contracts to provide these services. PPHD may not add enough providers or offer a wide enough array of services to be attractive partners to other healthcare organizations. Furthermore, behavioral health management organizations are often more interested in partnering with organizations whose sole focus is the provision of mental health services; PPHD's diverse set of services may limit its options for partnership.

Many behavioral health management companies are primarily interested in adding psychiatrists to their network as services performed by psychiatrists demand the greatest reimbursement. There is a shortage of psychiatrists and they are costly to employ. Without a psychiatrist on staff, PPHD will continue to find that reimbursement for mental health services is poor and that patients are accessing mental health services within their healthcare network.

Financial Review

The latest financial analysis for mental health and substance abuse services provided by PPHD in FY 2014 showed an overall loss of approximately $77,000. As of December 31, 2014, a mid-way point through FY 2015, the financial analysis for these same services showed an overall loss of $185,000; this suggests an overall loss in FY 2015 of $370,000. In FY 2015, PPHD also lost all revenue associated with Social and Mental Health Services – General Activity, which totaled $14,269 in revenue in FY 2014. A random sample analysis of Medicare and Medi-Cal payments showed that none of the FY 2014 revenue is related to mental health and substance abuse services.

As access to grant funding to offer mental health services becomes more limited, PPHD will need to assess the possibility of contracting with other organizations to receive additional reimbursement for the provision of mental health services. PPHD will also need to evaluate the possibility of reducing expenses in anticipation of increased competition for these services, as they are covered benefits under ACA health plans.

Impact of Healthcare Trends on Public Health Services

ACA Impact

- Mental health and substance abuse treatment is one of the covered ten essential benefits
- Expanded Medi-Cal in California, more people covered go to Medi-Cal managed care provider
  - Medi-Cal managed care providers may contract with large behavioral health management organizations to provide high-quality mental health services
- PCMHs and health homes are provided additional funding to provide care management and care coordination services, integrating the delivery of primary and mental healthcare
- The city of Pasadena faces growing competition from provider networks serving Medi-Cal and Covered California health plans offered through the Silver and Bronze levels

Conclusion

The environment around mental health services is becoming more competitive. PPHD needs to evaluate their ability to provide mental health services in an environment where the integration of primary care and mental healthcare is becoming a requirement. PPHD will need to evaluate their staff for appropriateness, as higher reimbursements will be made available to psychiatrists and licensed mental health staff.