SUPPLEMENTAL MATERIAL DISTRIBUTED BY STAFF REGARDING PUBLIC HEALTH

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			
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			
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.

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."*

"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

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 [illegible].

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)**