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Implementing National Health Reform in California: Opportunities for Improved Access to Care

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by

Melinda Dutton, J.D.

Alice Lam, M.P.A.

MANATT HEALTH SOLUTIONS

About the Authors

Manatt Health Solutions is the interdisciplinary policy and business advisory division of Manatt, Phelps & Phillips, LLP, a law and consulting firm. Manatt Health Solutions provides expertise in health care coverage and access, health information technology, health care financing and reimbursement, and health care restructuring, as well as strategic and business advice, policy analysis and research, project implementation, alliance building/advocacy, and government relations services. For more information, visit www.manatt.com.

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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.

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I. Introduction and Background

SWEEPING FEDERAL HEALTH REFORM legislation enacted in March 2010 brings about new health coverage options to a significant portion of California's 6.8 million uninsured.¹ The Patient Protection and Affordable Care Act (PPACA) and subsequent amendments under the Health Care Education and Reconciliation Act of 2010 (HCERA), collectively referred to as the Affordable Care Act, or ACA, expand access to public and private health insurance while seeking to change the way care is provided and paid for across the United States.² This report is the second in a series of reports commissioned by the California HealthCare Foundation (CHCF) describing the wide-ranging implications and implementation tasks that lie ahead for California under the ACA. The initial policy analysis, published in June 2010, focused on health insurance coverage, describing provisions of the ACA that seek to expand the availability of health insurance and to restructure the insurance market.³ This report addresses provisions of the ACA that affect access to care, including those that invest in the health care delivery workforce and infrastructure and that realign resources to enhance access to care.

The expansion in health insurance coverage alone will certainly influence access to care in California. The ACA expands Medicaid to guarantee eligibility under California's Medi-Cal program for the majority of Californians under 133 percent of the federal poverty level (FPL). The ACA also establishes health insurance exchanges and offers premium subsidies to provide affordable, comprehensive coverage to another significant population of Californians who traditionally have difficulty obtaining coverage—individuals who work in small

businesses or who must buy insurance on their own. After the law is fully implemented in 2014, it is estimated that 92 percent of Californians will be insured.⁴ The newly insured will be better able to pay for care, which should improve access to care. At the same time, expanded coverage is likely to increase demand for health care services as the newly insured seek to use the health care system, often with greater unmet needs requiring more intensive levels of care. The ACA includes many provisions intended to improve states' capacities to meet this demand so that increased coverage translates to increased access to high quality, culturally competent health care. As the ACA's provisions are implemented, it will be important to monitor and address how well people—both insured and those remaining uninsured due to affordability exemptions, noncompliance, or immigration status—are using health care services.

The remainder of this report focuses on the ACA provisions meant to ensure access to care: greater investment in primary, community-based care; funding for uncompensated care directed to certain safety net providers; and new funding streams to support health care workforce development in the state. The discussion is structured to assist policymakers and stakeholders in navigating the legislation. A summary outlining the provision discussed is presented along with the effective date; the responsible entities; the decisions, tasks, and considerations facing California as implementation progresses; and “the bottom line.” The summary also distinguishes between funds appropriated for provisions and those merely authorized—implementation of authorized

initiatives is uncertain and contingent upon additional action by Congress. This report has been informed by the perspectives of 13 state officials, stakeholders, and thought leaders. The list of interviewees and draft reviewers are included in Appendix D.

Access to Care: The California Context

Access to health care is unevenly distributed across California's vast geography. The state faces shortages among many types of providers. Recent analysis of Medical Board of California data indicates that the state falls below, or at best at the lower end, of the recommended number of primary care physicians per capita.⁵ And although California has made strides even in the recent economic downturn, the shortage of nurses is predicted to continue well into the next decade.⁶ Allied health professionals are also in short supply—pharmacists, clinical laboratory scientists, and cardiovascular technologists, for example—which comprise 60 percent of the health care workforce in the state.⁷ A 2007 study conducted prior to the enactment of health care reform projected that to meet expected demand, the supply of an array of allied health professionals needed to grow by 11 to 559 percent, with a median of 79 percent.⁸ Another consideration for California is recruiting a diverse health care workforce, which has been associated with improved cultural competency, patient trust, and compliance with treatment.⁹ Compared to the state's general population, racial and ethnic minorities are underrepresented in California's provider pool.¹⁰ For example, while Latinos represent over a third of the state's population, they comprise only 5.7 percent of nurses, 5.2 percent of physicians, and 7.6 percent of psychologists.¹¹

Access challenges in rural California—which accounts for roughly 90 percent of the state's

geography and 8 percent of the state's population, or 2.8 million Californians—are also particularly acute.¹² Rural areas in the state tend to have fewer physicians per capita and significantly older ones, running the risk that these physicians will retire without successors to maintain the already scarce physician supply.¹³ In seven rural counties, one study found that over half of the practicing physicians were over age 55.¹⁴ There are also shortages of specialists in rural areas.

Provider participation in Medi-Cal is also inadequate, commonly attributed to the program's low payment rates. California physicians are much less likely to serve Medi-Cal patients (68 percent) than patients with private insurance (92 percent) or even Medicare coverage (78 percent), with widely varying participation rates among specialties.¹⁵ With California's continuing fiscal difficulties, the state has been hard-pressed to address payment rates and, further, has reduced state funding for community clinic services, home care, mental health, and a variety of other health programs.

Health reform offers California the opportunity to build health care capacity and infrastructure. Significant investments are made to ensure the availability of primary, community-based care, with a priority placed on reaching underserved areas. New initiatives are established to support health care workforce planning and analysis, as well as training and education for a variety of health professionals. Access to care will also be influenced by provisions beyond those addressed in this brief; including a number of ACA provisions that invest in delivery system reform and a host of initiatives already underway in the state, such as telemedicine. Nevertheless, the ACA's access provisions will enable California to prepare for the newly insured and to incrementally address underlying access problems.

California's 1115 Waiver— A Bridge to Reform

In addition to changes under the ACA, the recent approval of California's 1115 waiver renewal request will have implications for access to care. Under the authority of Section 1115 of the Social Security Act, the federal government may waive certain Medicaid statutory requirements so that states can receive federal funds for Medicaid services that would otherwise not be eligible for federal funding. California's original Medi-Cal Hospital/Uninsured Care Section 1115 waiver took effect in July 2005. After nearly a year of state analysis and planning, and negotiation with federal officials, California received approval to renew this waiver in November 2010 with significant additions.¹⁶ California's Bridge to Reform Demonstration is expected to allow California to leverage \$10 billion in federal funds between November 1, 2010, and October 31, 2015.¹⁷

- California is the first state in the nation to successfully pursue a set of policies aimed at early implementation of federal health reform while enhancing access. The cornerstone of California's waiver is the Safety Net Care Pool (SNCP), which covers uncompensated costs in public hospitals and finances other state health care programs. In the waiver renewal, designated qualifying California public hospitals (including University of California hospitals) continue to be able to draw down funding from the SNCP for uncompensated care through their own expenditures.¹⁸ To stretch limited state dollars, additional state health care programs—workforce programs, services for developmentally disabled individuals, and all county mental health services—are also permitted to draw down federal matching funds through the SNCP for allowable expenditures.
- The Low Income Health Program (LIHP) enables counties to provide Medi-Cal coverage to uninsured adults under 200 percent of the FPL, providing a head start in implementing the coverage expansions effective in 2014. The LIHP is composed of the Medicaid Coverage Expansion for those under 133 percent of the FPL and the Health Care Coverage Initiative for those between 133 percent and 200 percent of the FPL. The LIHP will allow the state to identify and enroll adults likely to be eligible under the federally mandated minimum Medi-Cal eligibility level in 2014, as well as those individuals who could be eligible for a Basic Health Program if California decides to pursue that option.¹⁹ In addition, the LIHP could provide a “bridge” coverage option for uninsured adults before additional coverage options become available in 2014 through Medi-Cal, the Basic Health Program, or the state health insurance exchange.
- Finally, the Delivery System Incentive Reform Payments (DSIRP), which are authorized under the waiver, support infrastructure development, innovation and redesign, and care improvement projects in public hospitals. Proposed infrastructure development projects include introducing telemedicine and enhancing interpretation services, which could bolster capacity to provide care. DSIRP innovation, redesign, and care improvement projects could also position California hospitals well for further health system transformation opportunities under the ACA.

II. Analysis of Provisions

THIS SECTION OUTLINES THE KEY PROVISIONS of the Affordable Care Act related to access to care.

Enhanced Medi-Cal Payments for Primary Care (HCERA § 1202)

California has struggled with the inadequacy of Medi-Cal provider payment rates. A recent study indicates that Medi-Cal pays less than half of what Medicare pays for primary care services, and overall fees rank 47th among all states.²⁰ A physician survey indicates that 25 percent of primary care physicians are providing care for 80 percent of Medi-Cal beneficiaries, with a similar pattern observed for specialists.²¹ The numbers of primary and specialty care physicians available per 100,000 Medi-Cal beneficiaries are also well below the benchmarks recommended by the Council of Graduate Medical Education.

To save money, the state has imposed repeated reductions in Medi-Cal provider payment rates in recent years. This practice is one of the few remaining tools to reduce Medi-Cal expenditures, given federal maintenance of effort conditions.²² In 2009, Medi-Cal rate reductions were met with legal challenges, and the state was prevented from reducing Medi-Cal rates for fee-for-service providers who offer physician, dental, adult day health care, optometry, clinic, and prescription drug services; nonemergency medical transportation; and home health services.

For calendar years 2013 and 2014, the ACA requires that Medi-Cal reimburses at no less than the Medicare payment rate for primary care services provided by family medicine, general internal medicine, and pediatric medicine physicians.²³ The ACA also provides full federal funding to help the

state close the gap between Medi-Cal and Medicare primary care payment rates. The statute directs that the calculation be based on the Medi-Cal payment rate as of July 1, 2009. This level is compared to the greater of the Medicare payment rate for 2013 and 2014, or the Medicare payment rate determined using the 2009 conversion factor for that year. Parity with the Medicare primary care payment rate applies both to fee-for-service and managed care reimbursement under Medi-Cal.²⁴

Federal officials will be issuing clarifying guidance for state implementation. One pressing issue is how this provision will play out in the managed care environment, which is how over half of Medi-Cal beneficiaries currently access their coverage. The state will need federal guidance to translate the enhancement from per-service to per-person, per-month terms. It will be important for the state to maximize the benefits of this provision and to minimize any administrative burdens or complexities.

The Medi-Cal primary care enhancement will certainly be welcomed by providers and will augment payments without taxing state coffers. However, the ACA requirement and enhanced federal funding is effective for only two years and is limited to primary care providers and services. The state will need to develop a long-term strategy to ensure provider networks can meet the needs of the increasing numbers of individuals expected to be covered by Medi-Cal. Creating an environment in which providers are willing to participate in Medi-Cal is but one factor in ensuring access to care. California also faces underlying provider supply challenges, which are discussed further in the Workforce section of this brief.

Table 1. Enhanced Medi-Cal Payments for Primary Care

What It Says	The ACA requires Medi-Cal to pay physicians for primary care services furnished in 2013 and 2014 at a rate no less than Medicare's.
Effective Date	January 1, 2013 through December 31, 2014
What Needs to Be Done	In 2011, the federal government is expected to issue regulations and guidance on implementation. California should begin to engage with the Centers for Medicare and Medicaid Services (CMS) to help shape implementation guidelines. The state will also need to develop a Medicaid state plan amendment and take other actions, such as to modify administrative systems and communicate with providers and plans.
Who's Responsible	Centers for Medicare and Medicaid Services (CMS), Department of Health Care Services (DHCS)
The Bottom Line	While the enhancement will be helpful, it does not obviate the need for California to explore long-term solutions for ensuring the adequacy of Medi-Cal payment rates.

Disproportionate Share Hospital Funding

Disproportionate Share Hospital (DSH) payments through Medicaid and Medicare help offset the cost of unreimbursed care for hospitals serving high volumes of Medi-Cal or uninsured patients. Medi-Cal and Medicare DSH payments are major sources of support for California hospitals—over \$2.5 billion each year.²⁵ The ACA starts to phase down DSH payments as the number of uninsured individuals and their uncompensated costs are expected to decline. DSH payments are reduced starting in federal FY 2014 and continue through federal FY 2020 for the Medicaid DSH program and in perpetuity for the Medicare DSH program. However, it remains to be seen whether the level and timing of coverage gains will reduce hospital uncompensated care costs and fully offset these authorized DSH reductions.

Medi-Cal DSH Reductions (HCERA § 1203)

Federal funds for Medicaid DSH payments are capped at an annual state allotment derived from a federal FY 2002 base amount, adjusted annually for inflation, and linked to state Medicaid expenditures.²⁶ Under the state's Section 1115 waiver, funds from Medi-Cal's DSH allotment are primarily used to make over \$1 billion in annual payments to qualifying public hospitals (including University of California and county-operated hospitals).²⁷ California further has authority to operate a DSH "swap" or "replacement" program that provides similar payments to private hospitals. Qualifying private hospitals receive approximately \$465 million in payments through this program annually.²⁸ The DSH replacement program's funding level is linked in state law and the Medi-Cal State Plan to the state's DSH allotment.

In anticipation of increased coverage leading to fewer uninsured, the ACA significantly reduces federal Medicaid DSH allotments from 2014 to 2020. Levels diminish by \$500 million in 2014, and the reduction grows annually to a high of \$5.6 billion in 2019. While future years' DSH allotment levels are not yet available, the Medicaid DSH allotment

levels estimated for FY 2011 of approximately \$11 billion may be used as a point of reference.²⁹

Table 2. Overall Reductions in Medicaid DSH Allotments

FEDERAL FISCAL YEAR	REDUCTION (IN MILLIONS)
2014	\$500
2015	\$600
2016	\$600
2017	\$1,800
2018	\$5,000
2019	\$5,600
2020	\$4,000
TOTAL	\$18,100

The HHS secretary will develop the exact methodology to impose these reductions on each state’s allotment, but the statute does articulate that the methodology should:

- Direct the largest reductions at states with the lowest uninsured rates that do not target DSH payments to high-need hospitals (those with high volumes of Medicaid inpatients and high levels of uncompensated care);
- Allow for smaller reductions for low-DSH states, those with smaller DSH programs as a proportion of their total Medicaid expenditures; and
- Take into account the extent to which DSH payments are included in budget neutrality calculations for state Medicaid waivers.

While it is not yet clear how DSH reductions will be allocated across the states, early estimates indicate that California’s share of reductions could total approximately \$1.3 to \$1.5 billion over a

ten-year period, or roughly 10 percent of the state’s DSH allotments for that timeframe.^{30,31} If DSH payment reductions are not offset by reductions in the demand for uncompensated care, the financial health of hospitals could suffer. The Safety Net Care Uncompensated Care Pool—authorized under the state’s Section 1115 waiver to support uncompensated care costs that are not otherwise

California’s Counties

County governments in California play a critical role in the state’s health care safety net. California law requires that counties “relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons are not supported and relieved by their relatives or friends, by their own means, or by state hospitals or other state or private institutions.”³² The counties operate and finance a variety of health programs—the Medically Indigent Program, Medical Services Program, Coverage Initiatives, and Children’s Health Initiatives—that provide limited to comprehensive benefits for medically indigent individuals ineligible for Medi-Cal. With the ACA’s increased coverage expected to offer comprehensive coverage options to a significant number of those enrolled in these programs, California’s counties could see a declining role on this front and an assumption of costs by other payers.

The counties also play an important role in the financing and administration of the Medi-Cal program. County hospitals pay a share of Medi-Cal DSH payments, and to the extent that the reduction in these payments are not offset by uncompensated care savings, public hospitals could require additional support from county governments. Counties also conduct eligibility and enrollment activities and manage major eligibility systems for Medi-Cal and other public benefit programs across the state. The ACA imposes new requirements on Medi-Cal eligibility and enrollment systems, including integration with health insurance exchange systems. These requirements and subsequent federal guidance may require the state to revisit the counties’ role in the eligibility process.³³

funded through Medi-Cal, claimed for DSH, or reimbursed by other payers—could help offset some reductions for designated California public hospitals. However, California’s private hospitals, which cannot access the pool, could be left searching for an alternative revenue source.

Medicare DSH Reductions (§ 1104)

Medicare DSH payments are also reduced in anticipation of fewer uninsured residents and their uncompensated care costs. The ACA makes changes to the Medicare DSH payment formula estimated to cut payments by \$22 billion between 2015 and 2019.³⁴ The HHS secretary has broad authority over several decisions that could impact DSH payments. Since there is no judicial review of these determinations, it will be important for the state to address these issues based on which decisions would result in more equitable payments to DSH hospitals in California. Current estimates indicate that California hospitals could face reductions in Medicare DSH of \$3.5 to \$4 billion over ten years, or roughly 25 percent of DSH payments for that timeframe.^{35,36}

Selected Medicare Payment Changes

Approximately 4.5 million individuals, 12 percent of Californians, use Medicare.⁴⁰ Medicare payments account for \$32 billion of health care services delivered in the state.⁴¹ A higher percentage of Medicare beneficiaries are enrolled in Medicare Advantage (MA) plans compared to the rest of the nation (34 percent versus 23 percent).⁴² In addition to Medicare DSH reductions, the ACA includes numerous changes related to Medicare reimbursement (§§ 3201, 3401–3403, 5501, 10501, and HCERA § 1102(b)). For example, changes made to Medicare provider and MA plan reimbursement calculations are estimated to reduce Medicare spending by \$326 billion between 2010 and 2019. In addition, general surgeons practicing in shortage areas and primary care-focused physicians, nurse practitioners, clinical nurse specialists, and physician assistants will receive Medicare payment bonuses estimated to enhance their reimbursement by \$3.5 billion between 2010 and 2019.^{43,44} The impact on beneficiaries’ access to services is difficult to predict, particularly given that they will be implemented alongside Medicare payment and delivery system reforms in the ACA and other federal legislation. Considering Medicare’s central role in health care coverage for California’s seniors, it will be important to closely monitor how these changes affect their access to care and choice of providers and plans, premiums and cost-sharing requirements, supplemental benefits offerings by MA plans (e.g., vision or dental services), and quality of care and outcomes.

Table 3. Medi-Cal and Medicare DSH Reductions

What It Says	From 2014 to 2020, the ACA reduces Medi-Cal and Medicare DSH payments.
Effective Date	FY 2014
What Needs to Be Done	The federal government will issue further details on how the DSH reductions will be calculated on a state basis for Medi-Cal and on a hospital basis for Medicare. The state will determine how to implement Medi-Cal DSH reductions on a hospital basis. This may require adjustments to DSH payment methodology.
Who’s Responsible	HHS, Centers for Medicare and Medicaid Services (CMS), Department of Health Care Services (DHCS)
The Bottom Line	It remains to be seen whether hospital revenues from increases in coverage will offset DSH losses (either in the aggregate or for individual hospitals).

Medicaid Adult Preventive Services

(§ 4106)

Effective in 2013, the ACA clarifies that the mandatory Medicaid benefit package include preventive services that are recommended under federal guidelines. Further, states will receive a one percentage point increase in the federal Medicaid matching rate for these services if they are provided without cost sharing. Studies dating back to the 1971 RAND Health Insurance Experiment have shown that higher cost sharing leads to reductions in medical care use, particularly among low-income individuals.³⁷ A recent study of other states' expansion of Medicaid coverage to childless adults found that cost-sharing requirements play an important role in the use of preventive services.³⁸ Currently, Medi-Cal beneficiaries are subject to \$1 copayments for physician office and clinic visits, but as a budget savings measure, Governor Jerry Brown has proposed an increase to \$5 per visit.³⁹

Beginning in 2011, Medicare beneficiaries similarly will not face cost sharing when accessing annual wellness visit services and preventive services recommended under federal guidelines. In addition, Medicare will provide coverage for an annual comprehensive health risk assessment and personalized prevention plan (§§ 4103 and 10402).

Medicaid Emergency Psychiatric Services Demonstration (§ 2707)

Medicaid reimbursement is not currently available for delivering care to adults in institutions for mental diseases (IMDs). IMDs are primarily engaged in providing inpatient diagnosis, treatment, or care, including medical attention, nursing care, and related services, to persons with mental diseases. In California, IMDs generally include facilities such as acute psychiatric hospitals, psychiatric health facilities (PHFs), skilled nursing facilities (SNFs) with a certified special treatment program (STP) for the mentally disordered, and mental health rehabilitation centers (MHRCs).

The ACA allows states to apply for three-year demonstration projects to reimburse private IMDs for delivering services to stabilize a Medicaid beneficiary who has an emergency medical condition. An individual with an emergency medical condition is defined as one “who expresses suicidal or homicidal thoughts or gestures if determined dangerous to self or others” and stabilized is defined as “the emergency medical condition no longer exists with respect to the individual and the individual is no longer dangerous to self or others.”

The ACA appropriates \$75 million for these demonstration projects, which HHS will allocate

Table 4. Medi-Cal Adult Preventive Services

What It Says	Starting in 2013, Medi-Cal could lift cost-sharing requirements for preventive services and receive a modest bonus in federal matching funds for these services.
Effective Date	January 1, 2013
What Needs to Be Done	The federal government will issue guidance to states on how they should implement this provision. The state will determine whether to participate. This decision is likely to be informed, in part, by whether the one percentage point bonus will offset anticipated cost-sharing revenue and operational systems changes.
Who's Responsible	Centers for Medicare and Medicaid Services (CMS), Department of Health Care Services (DHCS)
The Bottom Line	Medi-Cal beneficiaries are assured coverage for preventive services, potentially at no cost.

to approved states as matching funds for qualified state expenditures, generally on a dollar-for-dollar basis. qualified state expenditures, generally on a

dollar-for-dollar basis. Funds are available through December 31, 2015.

State Programs

California has a patchwork of targeted programs providing health coverage or services for specific populations or conditions. Most of the programs are limited to low or modest income individuals who are either uninsured or have inadequate coverage; and are funded through a combination of state and federal funds. Beginning in 2014, the ACA's public and private coverage expansions and private insurance reforms will open the door to comprehensive coverage to most Californians, raising questions about the future of such targeted programs in the state. Because the State commits significant state resources to these targeted programs each year, California officials are likely to evaluate whether comparable coverage will be available through other vehicles that could be more favorable to California fiscally. Expanded Medicaid coverage, the Basic Health Program (should the State take-up this option), and coverage through the Exchange with financial assistance will all be options and are primarily supported through federal dollars.

A review of several targeted programs summarized in Appendix B reveals while the ACA is likely to significantly decrease demand for most programs, it may not offer full coverage for the populations nor specialized services these programs provide. Many, though not all, of the individuals served by these targeted programs will be eligible for expanded coverage options in 2014. All but one of the programs limit eligibility to those with incomes below 400 percent FPL, and therefore would be eligible for subsidies under the ACA. However, it is likely that coverage will come at a higher cost under the ACA than under these existing programs, and that some individuals eligible for affordability waivers from the mandate would still seek targeted programs as a more affordable option for services or care. In addition, one notable group left behind by the ACA—and therefore

likely to continue to need these targeted programs—are recent or undocumented immigrants. Many of these programs* (e.g., Access for Infants and Mothers; Breast and Cervical Cancer Treatment Program; Child Health and Disability Prevention Program; and Family Planning Access, Care, and Treatment), provide coverage for individuals who have not satisfied federal requirements in immigration status. A small subset of these individuals—legal immigrants who have not met the required five year waiting period under federal Medicaid law—may be able to access new coverage options but undocumented individuals will not.

For most of these targeted programs, most of the covered services are likely to be included under the federally mandated “essential benefit package” under the ACA. However, there may be some exceptions. For example, some programs provide nutrition services or health education designed to meet the high needs of the target population. Because federal officials have yet to define the essential benefit package, it is unclear whether these types of services will be included. Further, it may be that the nature of these programs, which provide highly targeted benefits with specialized providers and reimbursement arrangements, deliver a level of quality or accessibility that would be hard to replicate in a commercial insurance product. To the extent that it may not be practical or feasible for other coverage vehicles to provide comparable levels of access, these targeted state programs may fill an important role for providing wraparound coverage. In light of shifting need and alternative options available under the ACA and the dynamic environment in the state, it may serve California well to periodically revisit the roles of these programs.

*For detailed information on the state programs—including populations covered, benefits, and funding—see [Appendix B](#).

Table 5. Medi-Cal Emergency Psychiatric Services Demonstration Opportunity

What It Says	The ACA allows California to operate a three-year demonstration project that would provide Medi-Cal reimbursement to private IMDs for emergency condition stabilization services.
Effective Date	March 23, 2010 through December 31, 2015
What Needs to Be Done	<p>The federal government will issue additional guidance on the application process and parameters of the demonstration project, and will conduct an evaluation of the demonstration project and submit a report to Congress by December 31, 2013.</p> <p>The state will determine whether to participate in this project and, if so, will develop a competitive application.</p>
Who's Responsible	Centers for Medicare and Medicaid Services (CMS), Department of Health Care Services (DHCS)
The Bottom Line	This is an opportunity to access federal funding for previously uncovered inpatient mental health services.

Community Clinics

California's 230 community clinics deliver comprehensive primary and preventive care services in 719 locations and form a major component of California's safety net delivery system.⁴⁵ Operating under public, private, or nonprofit structures and with multiple and overlapping definitions under state and federal law, California's community clinics are generally unified by one key feature: caring for a patient regardless of ability to pay.⁴⁶ It is estimated that community clinics see nearly four million patients a year, including one million, or 17 percent, of uninsured Californians.⁴⁷ Only about 7 percent of clinic operating revenues are derived from sliding-fee payments, self-pay, or private insurance. Medi-Cal (44 percent) and federal grant funds (16 percent) are major sources of clinic operating revenues.⁴⁸

The ACA provides new funding opportunities for federally qualified health centers (FQHCs), rural health clinics, and school-based health centers; however, FQHCs stand to benefit the most. More than 118 clinics in California have received the FQHC designation.⁴⁹ FQHCs are eligible for federal support of capital and operating costs through Section 330 of the Public Health Service Act and

receive special protections to ensure the adequacy of Medicare and Medicaid reimbursement, as well as other benefits.

Federally Qualified Health Centers (§ 10503)

The ACA boosts federal support for community health centers by establishing a Community Health Center Fund, which invests \$9.5 billion for enhancing operating capacity and \$1.5 billion for construction and renovation over the course of FY 2011–2015. These additional funds have the potential to offer a variety of benefits to California. Community health center funding could enhance capacity at the 1,049 delivery sites currently operated by California's 118 FQHCs as well as expand their reach through the establishment of new sites. Aside from current FQHCs, this funding could also support FQHC lookalikes—which meet all federal requirements but do not receive federal funds—to build new health centers in underserved communities.

The Health Services and Resources Administration (HRSA) within HHS is charged with administering FQHC grant funding and determining the application process. California's health centers

have been accessing a growing share of available federal funding each year. However, the proportion of California's uninsured seeking care in health centers has also continued to increase, offsetting these gains in funding. According to analysis by the California Primary Care Association, California's health centers receive from the federal government an equivalent of \$181 per uninsured individual served, which is significantly less than the national average of \$270 and of other similarly populous states like Texas, at \$229, and New York, at \$276.

HRSA awarded an initial round of capital grants in October 2010. Of the \$727 million awarded, California's FQHCs received \$92 million.⁵⁰ HRSA is in the process of awarding between \$270 and \$335 million for expanded services at current FQHCs. Although FQHCs must submit applications describing projects, the level of funding will be allocated on a formula basis.⁵¹ Also, HRSA has announced the availability of up to \$10 million in grants for the planning of new primary care health centers.⁵² A maximum of \$80,000 will be awarded competitively to 125 public or nonprofit private

entities not currently receiving Section 330 funds. This grant opportunity closed on March 18, 2011.

In addition to the dedicated Community Health Center Fund, the ACA authorizes higher federal levels for the existing federal community health center grant program (Public Health Service Act Section 330). However, the ACA does not include accompanying appropriations language. This means additional congressional action will be necessary for the higher spending levels to be realized in actual funding.

Finally, the ACA makes important changes related to Medicare reimbursement of FQHCs, which account for 7 percent of visits at California's FQHCs. Medicare payment to FQHCs are based on reasonable costs but capped at a per-visit limit that the Government Accountability Office found to be less than most FQHCs' submitted services costs.⁵³ The ACA lifts this cap, requires the HHS secretary to develop a Medicare prospective payment system to replace the cost-based reimbursement system in 2014, and adds additional preventive services for Medicare coverage at FQHCs (§ 10501).

Table 6. Federally Qualified Health Centers

What It Says	The ACA provides significant additional funding to expand FQHC capacity and to build new sites.
Effective Date	FY 2010
What Needs to Be Done	With the exception of the Community Health Center Fund, Congress will need to appropriate general funding for the community health center grant program. HRSA will need to issue guidance on the parameters of the funding and application process. FQHCs and FQHC lookalikes will need to monitor funding opportunities, submit competitive applications, and engage with federal officials on the factors considered in formula-based allocations.
Who's Responsible	Congress, HRSA, FQHCs, FQHC lookalikes
The Bottom Line	Generous new federal funding provides significant opportunities for California's community health centers to expand capacity, enhance services, and modernize aging facilities in anticipation of increased demand.

Teaching Health Centers (§ 5508[A])

To enhance teaching capacity, the ACA details a new approach to supporting the primary care workforce through the Teaching Health Center (THC) model and authorizes grants for the creation or expansion of primary care residency programs, including those that train family physicians, internists, pediatricians, OB-GYNs, psychiatrists, dentists (pediatric and general), and geriatricians. In addition to the broad range of community clinics eligible for the grants (FQHCs, community mental health centers, rural health centers, family planning centers, etc.), corporate entities may apply if health center collaboration or sponsorship of a community-based training site is a central component. The statute directs that grant funds of up to \$500,000 over a period not to exceed three years will be available to THCs for activities such as curriculum development; recruitment, training, and retention of residents and faculty; securing accreditation; faculty salaries during the development phase; and technical assistance. For THC grants, the ACA authorizes \$25 million in FY 2010, \$50 million for each of FY 2011 and 2012, and such sums as necessary for future years. Funding is again authorized but not yet appropriated; therefore, uncertainty remains around this opportunity until additional congressional action is taken.

Prior to the enactment of the THC model, other California programs sought to expand community-based training opportunities through partnering with community clinics. In 2005, the University of California, Davis, Internal Medicine residency program partnered with the Sacramento County Department of Health and Human Services to develop a teaching health center in the county's largest community clinic. Similarly, the Sonoma County-based Santa Rosa Family Medicine Residency Program formalized a partnership with the Santa Rosa Community Health Centers, a network of FQHCs. This partnership is one component of the program's consortium of sponsors, which also includes the University of California, San Francisco; Sutter Health; and Kaiser Permanente.

THCs will focus on delivering primary care graduate medical education (GME) in a community-based setting. Currently, hospitals and health systems are the predominant sponsors of residency training programs. To cover its share of costs associated with these programs, Medicare funds them through direct GME and indirect GME. In the THC model, Medicare GME funding flows to the clinic—or community-based consortia sponsoring the program—to cover medical resident training costs. The ACA authorizes and appropriates up to \$230 million over five years to cover costs associated

Table 7. Teaching Health Centers

What It Says	The ACA authorizes primary care workforce training through new Teaching Health Center (THC) model.
Effective Date	FY 2010
What Needs to Be Done	Congress will need to appropriate funding for THC establishment and expansion grants. The federal government will need to issue guidance on the funding and application process. Various clinic entities will need to apply for funding.
Who's Responsible	Congress, HRSA, clinics
The Bottom Line	THCs could provide California with a promising training model that could improve and stabilize access to community-based care.

with graduate medical education. In January 2011, HRSA awarded a first year of funds to qualified THCs. Valley Consortium for Medical Education in Modesto—which has participation from major health care organizations in Stanislaus County and is affiliated with the University of California, Davis School of Medicine, the proposed University of California, Merced School of Medicine, and the Midwestern Osteopathic Post-graduate Training Institute (OPTI)—is among the 11 grantees and received \$625,000 of the \$1.9 million awarded. HRSA has noted its intent to fund qualified THCs for the entire five-year program period, pending satisfactory performance of awardees and availability of federal funds.⁵⁴

The goals of the new model are threefold. First, because primary care physicians predominantly provide community-based ambulatory care, it is thought that a significant portion of medical training should occur in community-based sites. Currently, although residents can and do provide care in ambulatory care settings, a significant portion of their training is hospital based. Second, the ACA seeks to expand the primary care workforce through a number of different investments; the THC model represents one method to test the success of expanding available programs and slots in an effort to train more providers. Finally, THC grants could help promote greater stability among residency programs. Stability is important because residency program closure often leaves a community without a central source of care. According to the Accreditation Council on Graduate Medical Education, between 2008 and 2010, eight of the state's primary care residency programs applied for withdrawal.⁵⁵ In addition, a number of others were required to find new sponsoring institutions or risk closing their doors.

School-Based Health Centers

Currently, 176 health centers provide primary care, mental health services, health education, and/or dental care on California campuses.⁵⁶ The ACA authorizes two new grant programs for the establishment and operation of school-based health centers (SBHCs) and directs the HHS secretary to give preference to school-based health center applicants in high-need areas (e.g., those with large populations of children eligible for Medi-Cal or Healthy Families, and designated Health Professional Shortage Areas).

Establishment Grants (§ 4101)

Establishment grant funds of \$50 million are appropriated for each of FY 2010–2013. The ACA limits these funds to capital costs for school-based health center facilities and equipment (e.g., acquisition, construction, expansion, and improvement) and explicitly restricts the funding of personnel or health service provision. The initial opportunity for these funds closed in late 2010.⁵⁷ Each school-based health center was limited to one application with a maximum of ten projects. HRSA expects to award a total of \$100 million—up to \$500,000 per application—for a two-year budget period. Many school-based health centers across California applied for these grants. Awards will be announced prior to the project start date of July 1, 2011.

Operations Grants (§ 4101)

Operations grant funds are authorized, but not appropriated, for FY 2010–2014, requiring additional congressional action. No funding amount is specified in the law. If appropriated, these funds may be used for equipment leasing as well as training, program management, and personnel. The HHS secretary has additional discretion to

Table 8. School-Based Health Centers

What It Says	The ACA authorizes grant programs to support establishment and operations of school-based health centers.
Effective Date	Establishment funds: FY 2010–2013 Operations funds: FY 2010–2014
What Needs to Be Done	Congress will need to appropriate operations funding for the provision. HRSA must issue guidance to advise school-based health centers on the funding and application process. School-based health centers may complete applications to secure funding.
Who's Responsible	Congress, HRSA, school-based health centers
The Bottom Line	This is an opportunity to strengthen and expand California's school-based health center infrastructure. Proposed projects include construction of new SBHC facilities, improvements to existing SBHC facilities, and support of new capabilities such as mobile vans and electronic health records.

award construction grants for facility expansion and modernization. While the statute imposes a 20 percent cash or in-kind matching requirement on entities that receive funds, this requirement may be waived if it would impose a serious hardship.

School-Based Oral Health Program (§ 4102)

The ACA also increased the use of preventive measures in oral health care within school-based health centers and mandates that the Centers for Disease Control and Prevention and HRSA award grants to states, territories, and Indian tribes for the development of school-based dental sealant programs. A state must provide these funds to schools or school-based entities to provide children access to dental care and dental sealant services. Funding is authorized but not appropriated.

Nurse-Managed Health Clinics (§ 5208)

The ACA establishes a grant program to create nurse-managed health clinics, which are nurse-practice arrangements that:

- Provide primary care or wellness services to underserved or vulnerable populations;
- Are managed by advanced practice nurses; and
- Are associated with a school, college, university, or department of nursing, FQHC, or independent nonprofit health or social services agency.

The ACA authorizes appropriations of \$50 million for FY 2010 and unspecified funding levels for FY 2011–2014. In June 2010, HRSA issued a funding opportunity of \$15 million that would be accessible to grantees for three years. Two of the ten awards were given to California entities—Glide Health Services, which is a community clinic affiliated with the University of California, San Francisco, and the Tides Center Women's Community Clinic in San Francisco—each of which was awarded \$1.5 million.⁵⁸ The funding will

Table 9. Nurse-Managed Health Clinics Funding

What It Says	The ACA authorizes a grant program to support the development and operation of nurse-managed health clinics.
Effective Date	FY 2010–2014
What Needs to Be Done	Congress will need to appropriate FY 2011–2014 funding for this provision. The federal government must issue guidance to nurse-managed health clinics on the funding and application process. Nurse-managed health clinics may complete applications to secure funding.
Who’s Responsible	Congress, HRSA, nurse-managed health centers
The Bottom Line	This is an opportunity to bolster access to care for underserved Californians and facilitate training opportunities for California nurses who fulfill critical roles in the state’s primary care workforce.

provide additional access to primary care services and training opportunities for advanced practice nurses. The availability and amount of further funding will depend on congressional appropriations activity.

Workforce

Adequate provider supply and workforce development are longstanding challenges for California. Prior to the enactment of reform, the California Labor and Workforce Development Agency and the Department of Employment Development determined the need to educate over 206,000 additional health care professionals by 2014.⁵⁹ California has made several state-level investments. The Song-Brown Program, administered by the state’s Office of Statewide Health Planning and Development (OSHPD), provides financial support to family practice residency, nurse practitioner, physician assistant, and registered nurse education programs throughout California. Also operating out of OSHPD is the Health Professions Education Foundation, a statutorily created nonprofit. The foundation leverages tax-deductible contributions from other private foundations, hospitals, health plans, corporations, professional

associations, and other entities to place health professionals in underserved areas, typically inner-city and rural areas with disproportionately higher rates of uninsured patients. California’s health care safety net has benefited greatly from federally funded workforce programs, and the ACA establishes additional initiatives for workforce analysis on the state and national levels, creates new programs for training support, and bolsters funding for existing workforce programs.

With an array of opportunities available to state health care facilities, educational institutions, and directly to providers, it is critically important that California formulate a coordinated approach to ensure that it maximizes these benefits. Following the passage of the ACA, Governor Schwarzenegger established the Healthcare Workforce Workgroup as one component of a broader Healthcare Reform Taskforce. The workgroup included representatives of the Labor and Workforce Development Agency, the Office of Statewide Health Planning and Development (OSHPD), and the California Workforce Investment Board and focused on training and workforce development programs. Going forward, it will be important for this taskforce or

another entity to engage health care stakeholders, including employers, advocacy and professional associations, researchers, and educators, in a dialogue “on the workforce development challenges and opportunities presented by healthcare reform.”⁶⁰

Shortage Areas

Through evaluation of criteria such as the number of low-income or older individuals and the number of primary care physicians per capita, a geographic area, population group, or facility may receive special designations, under three classifications, as a health care shortage area.

- **Health Professional Shortage Area.** Urban or rural area, population group, or medical or other facility having a shortage of primary medical care (there are 559 in California), dental (317), or mental health (291) providers.
- **Medically Underserved Area.** Area with a shortage of personal health services (168).
- **Medically Underserved Population.** Group facing economic, cultural, or linguistic barriers to care (41).⁶¹

As an acknowledgement of high unmet need, services provided in areas or to populations with these designations enjoy special advantages, such as payment enhancements from federal health care programs, priority consideration for federal workforce funding opportunities, and designation as places where National Health Service Corps scholarship and loan repayment recipients must practice to fulfill obligations. OSHPD’s Shortage Designation Program provides technical assistance to clinics and other primary care providers seeking recognition.

State Health Care Workforce Grants (§ 5102)

The ACA establishes a competitive grant program to support state workforce investment boards representing health care employers, labor organizations, and educational institutions, or “state partnerships,” with planning and implementation activities leading to a coherent and comprehensive health care workforce.

State partnerships are eligible to receive:

- One-year planning grants of up to \$150,000, with a 15 percent cash or in-kind matching commitment; and
- Two-year implementation grants, with a 25 percent cash or in-kind matching commitment.

The California Workforce Investment Board, in partnership with the California Office of Statewide Health Planning and Development (OSHPD), successfully applied for and was awarded a \$150,000 planning grant by HRSA.⁶² The planning grant activities and requirements will be facilitated through the Health Workforce Development Council (Council), a special committee of the California Workforce Investment Board, and will work in collaboration with the Healthcare Workforce Workgroup. The goal is to develop a plan to expand the primary care full-time equivalent workforce 10 to 25 percent over ten years, with the Council using the planning grant funds to:

- Identify and create essential, strategic statewide and regional partnerships;
- Identify education and workforce data availability and gaps;
- Map education and career pathways necessary to supply the health workers required; and

Table 10. State Health Care Workforce Grants

What It Says	The ACA establishes a competitive grant program to support state partnerships, with planning and implementation activities leading to a coherent and comprehensive health care workforce.
Effective Date	FY 2010
What Needs to Be Done	Congress will need to appropriate funding for FY 2011 and beyond for this provision. The state will need to carry out its responsibilities under the planning grant and position California successfully to maximize implementation funding.
Who's Responsible	Congress, HRSA, California Workforce Investment Board, OSHPD
The Bottom Line	Federal funding is available to support continued workforce planning efforts and to help the state develop a strategic plan to guide future activities.

- Determine any legislative and administrative policy changes needed to increase the supply of providers necessary to improve health and bolster regional health access and economies.⁶³

Federal planning grant funds of \$8 million are authorized in FY 2010, with such sums as necessary for subsequent years, and federal implementation grant funds of \$150 million are authorized in FY 2010, with such sums as necessary for subsequent years. Both planning and implementation funds will be subject to the congressional appropriations process.

Medicare Graduate Medical Education Slot Redistribution and Other Program Changes
(§§ 5503–5506)

Medicare subsidizes teaching hospitals for medical residency training through direct graduate medical education (DGME) and indirect medical education (IME) payments. DGME primarily supports resident and faculty salaries and program administration costs. A program's DGME calculation is based on the number of its residents and the hospital's percentage of Medicare patients. In contrast, IME is used primarily to offset the sponsoring institution's costs for hosting the program.

The ACA provides for unused residency slots to be redistributed to residency programs that are training physicians in primary care or general surgery. Furthermore, the ACA also aims for communities to retain medical residency slots when a teaching hospital closes by prioritizing the redistribution of slots to nearby hospitals. Establishing a new program or expanding an existing one is governed by multiple factors, and it is challenging to create such new opportunities. By allowing for existing slots to be redistributed, the ACA allows for an easier path to increased primary care training opportunities.

On November 2, 2010, CMS issued a final rule that implements a number of the ACA's workforce provisions, including those affecting residency training slots.⁶⁴ Under the final rule, CMS will redistribute 65 percent of the residency slots that have gone unused by a hospital for the past three years. The ACA requires 70 percent of the unused slots to be redistributed to hospitals in states with resident-to-population ratios in the lowest quartile. The remaining 30 percent will be redistributed to hospitals located either in a rural area or in one of the ten states identified as having the highest proportion of the population living in a Health Professional Shortage Area (HPSA).

The effect on California of the slot redistribution provisions remains to be seen. Despite its workforce shortages, California is not among the states with the lowest resident-to-population ratios, nor is it one of the states CMS identified as having a high enough HPSA proportion to qualify. However, California is home to 66 rural hospitals.⁶⁵

National Health Service Corps

To help recruit clinicians for underserved communities, the National Health Service Corps (NHSC) provides both scholarships to students in health professional training programs and loan repayment aid to current health professionals. Recipients commit to delivering primary care services in designated high-need areas, often in community health centers. HRSA administers the scholarship and loan repayment program, and the state also administers a Scholarship Loan Repayment Program that receives federal support. Building on changes from the American Recovery and Reinvestment Act, the ACA includes several provisions that address the NHSC.

Increased Funding (§§ 5207 AND 10503)

Health professionals across the country, such as medical students, nurse practitioners, and physician assistants, will be able to access an additional \$1.5 billion in scholarship funds and loan repayment aid in FY 2011–2015 due to supplemental appropriations to the NHSC made through the ACA. The law also authorizes higher funding levels for the program, but whether these funds will be available will depend on annual congressional appropriations activity.

Program Changes (§ 10501[N])

Currently, 708 full-time-equivalent providers in 269 of California’s 1,167 federally designated Health Professional Shortage Areas participate in the NHSC.⁶⁶ However, NHSC providers in California are in high demand, with 873 unfilled placements as of December 2010.⁶⁷ The ACA makes a series of easements in the NHSC program aimed at attracting participation. These changes include allowing part-time clinical practice and a portion of teaching time to count toward the service obligation, and increasing

Table 11. National Health Service Corps

What It Says	The ACA enhances funding for scholarships and loan repayment available through the NHSC and makes several easements in the NHSC program designed to attract participation by health professionals.
Effective Date	FY 2011
What Needs to Be Done	While the ACA provides substantial supplemental appropriations for the near term, Congress will need to appropriate funds for the NHSC to realize the higher ongoing funding levels authorized for the program. Students in health professional training programs, and a variety of current health professionals, may apply with HRSA to participate in the NHSC. Additional FQHCs, rural health clinics, and other sites that care for low-income and uninsured people may also apply with HRSA to become approved sites where NHSC providers can fulfill their service obligations.
Who’s Responsible	Congress, HRSA, health professionals, health care sites in high-need areas
The Bottom Line	Additional investments are made to recruit and retain health professionals for delivering care in California’s underserved communities.

the individual loan repayment amount from \$35,000 to \$50,000, with annual adjustments for inflation.

The ACA's additional program investments and simplifications are significant, but whether they will be adequate to drive additional health professionals to California's underserved areas is as yet unclear.

Title VII and Title VIII Programs

Public Health Service Act Titles VII and VIII training programs also provide assistance for health care workforce development through grants to educational institutions. Health professional schools may use these funds to provide scholarships and loan repayment for students or to develop educational infrastructure, such as funding faculty and residency program activities. Funds are typically administered by HRSA and awarded through a competitive grant process. The ACA establishes new programs and authorizes additional funding for existing programs focusing on providers in a variety of areas, including primary care, direct care, geriatric care, mental health, nursing, and dentistry. These remain largely reliant on the congressional appropriations process. A listing of these provisions is included in Appendix C.

III. Conclusion

THE ACA CREATES THE OPPORTUNITY FOR significant improvements in Californians' access to health care. Due to both expansions in coverage and the targeted provisions described in this report, California's health care infrastructure will experience an infusion of federal investments, as well as private funds associated with the individual mandate. Increased funding for primary, community-based care and workforce development have the potential to expand the availability of services. However, whether that growth will be sufficient to meet the increased demand, whether it will address the needs of currently underserved populations and geographic regions, and whether it will fully offset losses in DSH funding and Medicare payments has yet to be determined.

Several factors will influence the extent to which strides in access are achieved. Most immediately, state and federal policy choices—many of which have yet to be made—will define provisions aimed at sustaining or expanding access to health care. In addition, a host of provisions under the ACA intended to improve the quality and efficiency of health care delivery, while beyond the scope of this paper, could bring the added benefit of expanding capacity. Finally, California's dynamic and shifting health care environment—most notably, continued state fiscal pressures, the ambitious Medi-Cal waiver, and the market response to coverage changes under the ACA—also will have a significant influence.

Appendix A: Access-Related Grants Awarded to Date to California

TITLE	NATIONAL	CALIFORNIA	
	TOTAL	AMOUNT	PERCENT
Nurse-Managed Health Clinics	\$15,000,000	\$3,000,000	20.0%
National Health Service Corps: Scholarships and Loan Repayment	\$11,807,058	\$2,410,000	20.4%
Federally Qualified Health Centers	\$727,000,000	\$92,000,000	12.7%
Teaching Health Centers	\$1,900,000	\$625,000	39.2%
State Health Care Workforce Planning Grants	\$5,600,000	\$250,000	4.5%
Workforce Opportunities	\$397,067,832	\$36,763,300	9.3%

Appendix B: California Health Coverage and Service Programs

	ELIGIBILITY/POPULATIONS COVERED	IMMIGRATION REQUIREMENTS?*	BENEFITS	EXPENDITURES	STATE	FEDERAL	OTHER
Access for Infants and Mothers (AIM)	Pregnant women between 200 and 300 percent FPL Uninsured or with high cost insurance Enrollment: 10,586 [†] (2010)	No	Comprehensive and pregnancy-related services	\$123,953,000 [†] (2010)	✓	✓	✓
Child Health and Disability Prevention (CHDP) Program	Under 19 years Income: < 200 percent FPL Enrollment: <ul style="list-style-type: none"> • CDHP Gateway: 87,090 estimated average monthly (FY 2010–2011) • CDHP: 34,808 estimated number of screens (FY 2010–2011) 	No	CHDP Gateway: Full-scope Medi-Cal benefits for up to two months CHDP: Periodic health assessments, vision and hearing tests, laboratory tests, immunizations, and health education	CHDP Gateway: \$133,395,000 [†] (FY 2010–2011) CHDP: \$2,419,000 [§] (FY 2010–2011)	✓	✓	
Omnibus Budget Reconciliation Act (OBRA) Program	Undocumented aliens and temporary visitors Enrollment: 817,000 estimated average monthly (FY 2010–2011)	No	Emergency, pregnancy-related, and nursing home care.	\$1,288,000,000 [†] (FY 2010–2011)	✓	✓	
Breast and Cervical Cancer Treatment Program (BCCTP)	Need breast and/or cervical cancer treatment Income: ≤ 200 percent FPL Enrollment: 12,173 (2010)	No	Medi-Cal benefits for uninsured women under age 65 with satisfactory immigration status Time limited breast and/or cervical cancer treatment and related services, payment of insurance premiums under certain circumstances	\$127,824,000 [†] (FY 2010–2011)	✓	✓	
Family Planning Access, Care and Treatment (FPACT) Program	Women under 55 years or men under 60 years Income: ≤ 200 percent FPL No access to family planning services Enrollment: 1,600,000 [#] (2008)	No	Family planning services	\$667,823,000 [†] (FY 2010–2011)	✓	✓	

*For select programs, enrollees do not need to satisfy federal immigration status requirements—generally be a U.S. citizen or a legal immigrant residing in the country for more than 5 years—to receive benefits. Except for emergency conditions, state funds wholly fund coverage for undocumented individuals due to strict prohibitions against federal funding being used.

[†]Supplied by MRMIB program staff. Represents July 2010 to June 2011 estimate.

[‡]DHCS November 2010 Medi-Cal Estimate.

[§]DHCS November 2010 Family Health Estimate.

[#]University of California San Francisco. *Fact Sheet On Family PACT: An Overview* (www.familypact.org).

Appendix B: California Health Coverage and Service Programs, *continued*

	ELIGIBILITY/POPULATIONS COVERED	IMMIGRATION REQUIREMENTS?*	BENEFITS	EXPENDITURES	STATE	FEDERAL	OTHER
Dialysis and Total Parenteral Nutrition (TPN) Program	Need dialysis and/or TPN related services No income limit Annual net worth: < \$250,000 Enrollment: Unavailable	Yes	Dialysis, parenteral hyperalimentation services, and other related services.	Unavailable	✓	✓	
Tuberculosis Program	Have TB Meet Medi-Cal income and asset requirements, but not considered disabled Enrollment: 1,063 [#] (2005)	Yes	Limited outpatient tuberculosis treatment	\$728,488 [#] (2005)	✓	✓	
Improving Access, Counseling, & Treatment for Californians with Prostate Cancer (IMPACT)	Men older than 18 years Income: ≤ 200 percent FPL Have prostate cancer Uninsured or underinsured Enrollment: 345 ^{**} (2010)	No	Prostate cancer treatment	\$2,759,625 ^{**} representing 11 months only (FY 2010–2011)	✓		
AIDS Drug Assistance Program	Have HIV Income: < 400 percent FPL Limited or no Rx coverage Enrollment: 39,483 ^{††} estimated (FY 2010–2011)	No	Medications to treat HIV or prevent related serious deterioration of health	\$476,402,147 ^{††} estimated (FY 2010–2011)	✓	✓	✓
Genetically Handicapped Persons Program	21 years and older Have eligible genetic medical condition (e.g., Cystic Fibrosis, diseases of the blood, etc.) No income limit Enrollment: 1,393 estimated average monthly (FY 2010–2011)	Yes	Comprehensive health services, including Special Care Center Services, pharmaceutical services, surgeries, nutrition products and medical foods, durable medical equipment	GHPP non-Medi-Cal: \$87,052,00 (FY 2010–2011) GHPP Medi-Cal: Unavailable	✓	✓	

[#]"Selected Data on Medi-Cal Program, California, 2005" (www.dof.ca.gov).

^{**}Supplied by IMPACT program staff.

^{††}California Department of Public Health, *AIDS Drug Assistance Program (ADAP) November 2010 Estimate Package 2011–12 Governor's Budget* (www.cdph.ca.gov).

Appendix C: Workforce Opportunities

PROVISION (ACA SECTION)	DESCRIPTION*	FUNDS AVAILABLE THROUGH	ELIGIBLE RECIPIENT	AMOUNT AND TIMING
Nursing Student Loan Program (5202)	Increases loan amounts and updates the eligible years for nursing schools to establish and maintain student loan funds.	Increase to existing loan amounts. Public Health Service Act amendment: <ul style="list-style-type: none"> Section 836(a) (42 U.S.C. § 297b(a)) 	Nursing schools	Increases maximum annual loans from \$2,500 to \$3,300 for FY 2010 and 2011.
Healthcare Workforce Loan Repayment Programs (5203)	Establishes a loan repayment program for those who are or will be working in a Health Professional Shortage Area, Medically Underserved Area, or with a Medically Underserved Population. Payments on loans of up to \$35,000 a year for up to three years during residency, fellowship, or employment.	New loan repayment. Public Health Service Act amendment: <ul style="list-style-type: none"> Part E of Title VII (42 U.S.C. § 294n et seq.) 	Qualified professionals (pediatric specialists and providers of mental and behavioral health services to children and adolescents).	Authorizes \$30 million for 2010–2014 (pediatric medical and surgical specialists) and \$20 million for 2010–2013 (child and adolescent mental and behavioral health specialists).
Public Health Workforce Recruitment and Retention Program (5204)	Establishes the Public Health Workforce Loan Repayment Program to ensure an adequate supply of public health professionals to eliminate shortages in federal, state, local, or tribal public health agencies. For each year of service, the HHS secretary may pay up to \$35,000. If eligible loans are less than \$105,000, the secretary shall pay an amount not to exceed one-third of the eligible loan balance for each year of service.	New loan repayment. Public Health Service Act amendments: <ul style="list-style-type: none"> Part E of Title VII (42 U.S.C. § 294n et seq.), as amended by Section 5203. 	Public health students and workers	Authorizes \$195 million for 2010 and sums necessary for 2011–2015.
Allied Health Workforce Recruitment and Retention Program (5205)	Offers loan repayment to those in acute care facilities, ambulatory care facilities, residences, and other settings located in Health Professional Shortage Areas, Medically Underserved Areas, or serving Medically Underserved Populations through the Allied Health Loan Forgiveness Program.	New loan repayment. Amendment: <ul style="list-style-type: none"> Section 428(k) of the Higher Education Act of 1965 (20 U.S.C. §§ 1078–1111) 	Allied health professionals in public health agencies or in the settings listed.	Authorizes \$2,000 per year in loan forgiveness for up to five years.

*As described in “The Patient Protection and Affordable Care Act as Passed: Section-by-Section Analysis with Changes Made by Title X included within Titles I–IX, where Appropriate.”

PROVISION (ACA SECTION)	DESCRIPTION*	FUNDS AVAILABLE THROUGH	ELIGIBLE RECIPIENT	AMOUNT AND TIMING
Grants for States and Local Programs (5206)	Awards scholarships to those in positions at the federal, state, local, or tribal level to receive additional training in public or allied health fields. Half is allotted to mid-career public health professionals and half to mid-career allied health professionals.	New scholarship. Public Health Service Act amendments: <ul style="list-style-type: none"> • Section 765(d) (42 U.S.C. § 295d) • Part E of Title VII (42 U.S.C. § 294n et seq.) 	Accredited educational institutions that offer a course of study, certificate program, or professional training program in public or allied health or a related discipline.	Authorizes \$60 million for 2010 and sums necessary for 2011–2015.
Training in Family Medicine, General Internal Medicine, General Pediatrics, and Physician Assistantship (5301)	Provides grants and contracts to support and develop primary care training programs and primary care capacity building through accredited schools of medicine.	New grants and contracts. Public Health Service Act amendment: <ul style="list-style-type: none"> • Part C of Title VII (42 U.S.C. § 293k et seq.) 	Accredited public or nonprofit private hospitals, schools of medicine or osteopathic medicine, academically affiliated physician assistant training programs, and public or private nonprofit entities with programs that educate students in team-based approaches to care, including the patient-centered medical home.	Authorizes \$125 million for FY 2010 and sums necessary for FY 2011–2014. Appropriated \$39 million for FY 2010 (October 1, 2009–September 30, 2010). Further, utilized a portion of the \$500 million FY 2010 appropriation for the Prevention and Public Health Fund: <ul style="list-style-type: none"> • Expansion of Physician Assistant Training Program: Awarded \$0.7 million to University of Southern California, \$2.1 million to Riverside Community College District/Moreno Valley Campus, and \$1.2 million to Samuel Merritt College. • Primary Care Residency Expansion: Awarded \$1.9 million to University of California, Davis. \$2.9 million to University of California, San Diego, \$1.9 million to Catholic Healthcare West/St. Mary Medical Center \$1.9 million to University of California, Los Angeles \$3.8 million to Children’s Hospital & Research Center at Oakland, and \$5.8 million to University of California, San Francisco.
Training Opportunities for Direct Care Workers (5302)	Provides grants for new training opportunities for direct care workers employed in long-term care settings.	New grants. Public Health Service Act amendment: <ul style="list-style-type: none"> • Part C of Title VII (42 U.S.C. § 293k et seq.) 	Institutions of higher education with a public-private educational partnership with a long-term care facility, and agencies and other entities providing home- and community-based services to individuals with disabilities, and other long-term care providers.	Authorizes \$10 million for 2011–2013.

*As described in “The Patient Protection and Affordable Care Act as Passed: Section-by-Section Analysis with Changes Made by Title X included within Titles I–IX, where Appropriate.”

PROVISION (ACA SECTION)	DESCRIPTION*	FUNDS AVAILABLE THROUGH	ELIGIBLE RECIPIENT	AMOUNT AND TIMING
Training in General, Pediatric, and Public Health Dentistry (5303)	<p>Reinstates dental funding in Title VII of the Public Health Service Act. Grants to be used for predoctoral training, faculty development, dental faculty loan repayment, and academic administrative units.</p> <p>Upon completion of each of the first, second, third, fourth, and fifth years of service, the program shall pay 10, 15, 20, 25, and 30 percent, respectively, of student loan balance.</p>	<p>Existing grants and loan repayment.</p> <p>Public Health Service Act amendment:</p> <ul style="list-style-type: none"> • Part C of Title VII (42 U.S.C. § 293k et seq.) 	Schools of dentistry, public or nonprofit private hospitals, and public or private nonprofit entities in the field of dentistry.	<p>Authorizes \$30 million for 2010 and sums necessary for 2011–2015.</p> <p>Appropriated \$15 million for FY 2010 (October 1, 2009–September 30, 2010).</p> <p>Post-doctoral Training in General, Pediatric and Public Health Dentistry: Awarded \$0.3 million to the University of Southern California and \$0.5 million to the Regents of the University of California, Los Angeles.</p>
Alternative Dental Health Care Provider Demonstration Project (5304)	Authorizes the HHS secretary to award grants to establish training programs to increase dental health care access in rural, tribal, and underserved communities.	<p>New grants.</p> <p>Public Health Service Act amendment:</p> <ul style="list-style-type: none"> • Subpart X of Part D of Title III (42 U.S.C. § 256f et seq.) 	Institutions of higher education, including community colleges; public-private partnerships; FQHCs; IHS facilities, tribes, and organizations; state and county public health clinics; health facilities operated by Indian tribes or tribal organizations; urban Indian organizations providing dental services; public hospitals and health systems accredited by the Commission on Dental Accreditation.	Authorizes grants of not less than \$4 million over a five-year period.
Geriatric Education and Training: Career Awards; Comprehensive Geriatric Education (5305)	<p>Authorizes funding for grants or contracts for training in geriatrics, chronic care management, and long-term care for family caregivers and faculty in health professions schools; developing curricula and best practices in geriatrics; expanding geriatric career awards; and establishing awards for those pursuing advanced degrees.</p> <p>Awards shall be \$150,000. No more than 24 geriatric education centers may receive an award.</p>	<p>New grants or contracts, expanded career awards.</p> <p>Public Health Service Act amendments:</p> <ul style="list-style-type: none"> • Section 753 (42 U.S.C. § 294c) • Section 855 (42 U.S.C. § 298) 	Entities that operate geriatric education centers. Contracts and awards to be granted to faculty, individuals preparing for education degrees in geriatric nursing, and those pursuing advanced degrees in geriatrics or related fields.	<p>Authorizes \$10.8 million for 2011–2014 and \$10 million for individual awards for 2011–2013.</p> <p>Appropriated \$37 million for FY 2010 (October 1, 2009–September 30, 2010).</p> <p>Geriatric Education Centers Grants: Awarded \$0.4 million to University of California, San Francisco, \$0.4 million to The Leland Stanford Junior University, and \$0.4 million to the University of California, Los Angeles.</p> <p>Geriatric Training Programs for Physicians Grants: Awarded \$0.6 million to the University of California, Los Angeles and \$0.6 million to University of California, San Francisco.</p>

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PROVISION (ACA SECTION)	DESCRIPTION*	FUNDS AVAILABLE THROUGH	ELIGIBLE RECIPIENT	AMOUNT AND TIMING
Mental and Behavioral Health Education and Training Grants (5306)	Awards grants for the development, expansion, or enhancement of training programs in social work, graduate psychology, professional training in child and adolescent mental health, and pre-service or in-service training to paraprofessionals in child and adolescent mental health.	New grant. Public Health Service Act amendment: <ul style="list-style-type: none"> Part D of Title VII (42 U.S.C. § 294 et seq.) 	Institutions of higher education to support social work training as well as the development of faculty in social work, programs of psychology for the development of behavioral and mental health services, programs in child and adolescent mental health, and state-licensed mental health nonprofit and for-profit organizations training paraprofessional child and adolescent mental health workers.	Authorizes \$8 million for FY 2010–2013 for training in social work; \$12 million for training in graduate psychology, of which not less than \$10 million shall be allocated for doctoral-, postdoctoral-, and internship-level training; \$10 million for training in professional child and adolescent mental health; and \$5 million for training in paraprofessional child and adolescent work.
Cultural Competency, Prevention, and Public Health, and Individuals with Disabilities Training (5307)	Reauthorizes and expands programs in health professions schools and continuing education programs to support the development, evaluation, and dissemination of model curricula for cultural competency, prevention, and public health proficiency and aptitude for working with individuals with disabilities.	Existing funds expansion. Public Health Service Act amendments: <ul style="list-style-type: none"> Section 741 of Title VII (42 U.S.C. § 293e) Section 807 of Title VIII (42 U.S.C. § 296e-1) 	Health professional societies; licensing and accreditation entities; health professions schools; and experts in minority health and cultural competency, prevention, and public health and disability groups; community-based organizations; and other organizations as determined by the secretary.	Authorizes sums as necessary for 2010–2015.
Nurse Education, Practice, and Retention Grants (5309)	Awards grants to strengthen nurse education and training programs and to improve nurse retention.	New grant. Public Health Service Act amendments: <ul style="list-style-type: none"> Section 831 (42 U.S.C. § 296p) Title VIII is inserted after Section 831 (42 U.S.C. § 296b) 	Accredited schools of nursing, health care facility, and partnerships of such schools and facilities.	Authorizes sums as necessary for 2010–2012. Appropriated \$39.9 million for FY 2010 (October 1, 2009–September 30, 2010). Nurse Education, Practice, and Retention Grants: Awarded \$0.1 million to California State University (Fresno Fund); \$0.3 million to the Regents of the University of California, Los Angeles; \$0.2 million to Kaiser Foundation Hospitals; \$0.4 million to Riverside Community College; and \$0.9 million to the Regents of the University of California, San Francisco. Further, utilized a portion of the \$500 million FY 2010 appropriation for the Prevention and Public Health Fund: <ul style="list-style-type: none"> Advanced Nursing Education Expansion: Awarded \$1.1 million to Western University of Health Sciences Pomona

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PROVISION (ACA SECTION)	DESCRIPTION*	FUNDS AVAILABLE THROUGH	ELIGIBLE RECIPIENT	AMOUNT AND TIMING
Loan Repayment and Scholarship Program (5310)	Makes faculty eligible for loan repayment and scholarship programs.	Loan repayment scholarship. Public Health Service Act amendments: <ul style="list-style-type: none"> • Section 846(a)(3) (42 U.S.C. § 297n(a)(3)) • Title VIII (42 U.S.C. § 296 et seq.) 	Nursing schools	Authorizes annual increase in loan forgiveness to \$35,500 for FY 2010 and 2011.
Nurse Faculty Loan Program (5311)	Establishes a federally funded student loan repayment program for those pursuing careers in nurse education. Payments: master's or equivalent degree in nursing, up to \$10,000 per calendar year or \$40,000 total in 2010–2011; doctorate or equivalent degree, up to \$20,000 per calendar year or \$80,000 total in 2010–2011.	New loan repayment. Public Health Service Act amendments: <ul style="list-style-type: none"> • Section 846A (42 U.S.C. § 297n–1) • Title VIII (42 U.S.C. § 296 et seq.) 	United States citizens, nationals, and lawful permanent residents who hold unencumbered licenses as RNs, have completed master's or doctorate nursing programs at accredited schools of nursing or are currently enrolled on a full-time or part-time basis.	Authorizes sums as necessary for 2010–2014. Appropriated \$25 million for FY 2010 (October 1, 2009–September 30, 2010). Nurse Faculty Loan Program: Awarded \$0.3 million to Azusa Pacific University; \$0.01 million to Mount St. Mary's College; \$0.2 million to the Regents of the University of California, San Francisco; \$1.2 million to the University of San Diego; \$0.2 million to the University of San Francisco; and \$0.5 million to the Western University of Health Sciences
Grants to Promote the Community Health Workforce (5313)	Authorizes the HHS secretary to award grants to promote positive health behaviors and outcomes in medically underserved areas through the use of community health workers who may offer interpretation and translation services, provide culturally appropriate health education and information, offer informal counseling and guidance on health behaviors, advocate for individual and community health needs, and provide direct primary care services and screenings.	New grant. Public Health Service Act amendment: <ul style="list-style-type: none"> • Part P of Title III (42 U.S.C. § 280g et seq.) 	Public or nonprofit private entities, including states and public subdivisions of states, public health departments, free health clinics, hospitals, and FQHCs.	Authorizes sums as necessary for 2010–2014.
Fellowship Training in Public Health (5314)	Authorizes the HHS secretary to address workforce shortages in state and local health departments in applied public health epidemiology and public health laboratory science and informatics.	Expansion of fellowship program. Public Health Service Act amendments: <ul style="list-style-type: none"> • Part E of Title VII (42 U.S.C. § 294n et seq.), as amended by § 5206 	Expansion of existing programs under the Public Health Informatics Fellowship Program at the Centers for Disease Control and Prevention and other applied epidemiology training programs that meet these objectives.	Authorizes \$39.5 million per year for 2010–2013: \$5 million for the epidemiology fellowship training programs, \$5 million for the laboratory fellowship training programs, \$5 million for the public health informatics fellowship program, and \$24.5 million for expanding the Epidemic Intelligence Service.

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PROVISION (ACA SECTION)	DESCRIPTION*	FUNDS AVAILABLE THROUGH	ELIGIBLE RECIPIENT	AMOUNT AND TIMING
Demonstration Grants for Family Nurse Practitioner Training Programs (5316)	Directs the HHS secretary to establish a training demonstration program for NPs who employ and provide a one-year training for practitioners who have graduated from a NP program for careers as PCPs in FQHCs and nurse-managed health clinics (NMHCs). Three-year grants awarded to eligible entities for an amount not to exceed \$600,000 per year. The secretary may award technical assistance grants to FQHCs or NMHCs that have demonstrated expertise in establishing a NP residency training program.	New demonstration grant.	FQHCs and NMHCs who employ NPs. Eligible NPs must be licensed or eligible for California licensure as advanced practice registered nurses or advanced practice nurses, be eligible or board-certified as family nurse practitioners, and demonstrate commitment to careers in FQHCs or NMHCs.	Authorizes sums necessary for FY 2011–2014.
Health Professions Training for Diversity (5402)	Provides scholarships for those who commit to work as PCPs in medically underserved areas, and expands loan repayments for individuals who will serve as faculty in eligible institutions. Faculty at schools for PAs are eligible for faculty loan repayment.	Existing scholarship. Public Health Service Act amendments: <ul style="list-style-type: none"> • Section 740(a) (42 U.S.C. 293d(a)) • Section 740(b) (42 U.S.C. 293d(b)) • Section 740(c) (42 U.S.C. 293d(c)) 	Disadvantaged students who commit to work in medically underserved areas, and faculty at schools for PAs.	Scholarships for Disadvantaged Students: Authorizes \$51 million in FY 2010 and such sums as necessary FY 2011–2014; appropriated \$49 million in FY 2010. Reauthorization for Loan Repayments and Fellowships Regarding Faculty Positions: Authorizes \$5 million for each of FY 2010–2015; appropriated \$1 million in FY 2010. Educational Assistance in the Health Professions for Individuals from a Disadvantaged Background: Authorizes \$60 million for FY 2010, and such sums as necessary FY 2011–2014; appropriated \$22 million in FY 2010. Awards unknown.
Primary Care Extension Programs (5405)	Creates a Primary Care Extension Program to educate PCPs and provide them technical assistance with evidence-based therapies, preventive medicine, health promotion, chronic disease management, and mental health. The Agency for Healthcare Research and Quality will award planning and program grants.	New planning and program grant. Public Health Service Act amendment: <ul style="list-style-type: none"> • Part P of Title III (42 U.S.C. § 280g et seq.) 	The secretary awards competitive grants to states for the establishment of state- or multistate-level Primary Care Extension Programs. State hubs including, at a minimum, the state health department, state-level entities administering Medicare and Medicaid, and at least one health professions school. May also include Quality Improvement Organizations, AHECs, and other quality and training organizations.	Authorizes \$120 million for 2011–2012 and sums as necessary for 2013 and 2014.

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PROVISION (ACA SECTION)	DESCRIPTION*	FUNDS AVAILABLE THROUGH	ELIGIBLE RECIPIENT	AMOUNT AND TIMING
Demonstration Project to Address Health Professions Workforce Needs, Extension of Family-to-Family Health Information Centers (5507)	Establishes a demonstration grant program through competitive grants to support those seeking occupations in the health care field. Also establishes a demonstration program to competitively award grants for three years for up to six states to develop core training competencies and certification programs for personal and home care aides. Extends funding for family-to-family health information centers.	New demonstration grant program. Social Security Act amendments: <ul style="list-style-type: none"> Title XX (42 U.S.C. § 1397 et seq.) Section 501(c)(1)(A)(iii) (42 U.S.C. § 701c1[A](iii)) 	States and other entities able to conduct demonstration projects involving low-income individuals, including recipients of state Temporary Assistance for Needy Families, who are seeking education and training for occupations in the health care field. Family-to-Family Health Information Centers: Operated by family leaders who have children with special health care needs and expertise in federal and state public and private health care systems, as well as by health professionals.	Authorizes and appropriated \$85 million for each of FY 2010–2014. \$5 million is set-aside for each of FY 2010–2012 for training and certification programs for personal and home care aides. Health Profession Opportunity Grants to Serve TANF Recipients and Other Low-Income Individuals: Awarded \$5 million to the San Diego Workforce Partnership for a five year project period. Further, utilized a portion of the \$500 million FY 2010 appropriation for the Prevention and Public Health Fund: <ul style="list-style-type: none"> Personal and Home Care Aide State Training Program: Awarded \$0.7 million to the Board of Governors of the California Community College, Family-to-Family Health Information Centers: Authorizes and appropriated \$5 million for each of FY 2010–2012. Awarded \$0.1 million for Support for Families of Children with Disabilities for FY 2010.
Increasing Teaching Capacity (5508)	Directs the HHS secretary to establish a grant program to support new or expanded primary care residency programs at teaching health centers. Also provides \$230 million under the Public Health Service Act for 2011–2015 to cover direct and indirect expenses of qualifying teaching health centers incurred in training primary care residents in certain expanded or new programs. Annual reporting is required.	New grant program. Public Health Service Act amendment: <ul style="list-style-type: none"> Part C of Title VII (42 U.S.C. § 293k et seq.) 	Organizations capable of providing technical assistance, including community-based ambulatory patient care centers that operate teaching health centers with primary care residency programs.	Teaching Health Center Development Grants: Authorizes \$25 million for 2010, \$50 million for 2011 and 2012, and sums necessary for each FY thereafter to carry out the program. Teaching Health Center GME: Authorizes and appropriated such sums as necessary, not to exceed \$250 million, for FY 2010–2015 Awarded \$0.6 million to Valley Consortium for Medical Education, Modesto.
Graduate Nurse Education Demonstration Program (5509)	Directs the HHS secretary to establish a demonstration program for up to five eligible hospitals to increase graduate nurse education training under Medicare.	New demonstration program under Title XVIII of the Social Security Act (42 U.S.C. § 1395 et seq.).	Eligible hospitals and critical access hospitals with written agreements in place with one school of nursing, and two or nonhospital community-based care settings.	Authorizes and appropriated \$50 million for each of FY 2012–2015 to remain available until expended.

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PROVISION (ACA SECTION)	DESCRIPTION*	FUNDS AVAILABLE THROUGH	ELIGIBLE RECIPIENT	AMOUNT AND TIMING
State Grants to Health Care Providers Who Provide Services to a High Percentage of Medically Underserved Populations or Other Special Populations (5606)	Establishes state grant programs for health care providers who treat a high percentage of medically underserved populations or other special populations.	New grant program. Amendments to the Public Health Service Act.	Accredited schools of allopathic or osteopathic medicine, and any combination or consortium of such schools serving medically underserved communities or other special populations.	Authorizes \$4 million for 2010–2013.

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Appendix D: Interview List

David Carlisle, director
Office of Statewide Health Planning and Development
California Health and Human Services Agency

Carmela Castellano-Garcia, president and CEO
California Primary Care Association

Janet Coffman, assistant adjunct professor
Department of Family and Community Medicine
University of California, San Francisco

Dustin Corcoran, president
California Medical Association

C. Duane Dauner, president and CEO
California Hospital Association

Catherine Douglas, president
Private Essential Access Community Hospitals Inc.

Toby Douglas, director
Department of Health Care Services
California Health and Human Services Agency

C. Dean Germano, CEO
Shasta Community Health Center

Elizabeth Landsberg, legislative advocate
Western Center on Law and Poverty

Gail Nickerson, interim executive director
California State Rural Health Association

Melissa Stafford-Jones, president and CEO
California Association of Public Hospitals

Marjorie Swartz, consultant
California State Assembly Committee on Health

John Wallace, chief of staff
LA Care Health Plan

Endnotes

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22. As a condition for receiving enhanced federal Medicaid matching funds through June 30, 2011, the American Recovery and Reinvestment Act prohibits states from reducing Medicaid eligibility levels or imposing additional enrollment procedures beyond those in effect July 2008. Under the ACA, states are further prohibited from restricting Medicaid and CHIP eligibility and enrollment through 2014 for adults and 2019 for children, or they risk losing all federal funding for both programs.
23. "Primary care services" are defined as those in the Evaluation and Management category, or those captured under specified vaccines and toxoids immunization administration codes, under the Healthcare Common Procedure Coding System used by Medicare.
24. The ACA directs that care reimbursement rates managed by Medi-Cal be at least consistent with the minimum payment level under this provision.

25. California's preliminary federal FY 2011 Medicaid DSH allotment from 76 Fed. Reg. 148. Medicare DSH figures from California Hospital Association analysis of 2008 CMS Medicare Cost Report.
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**CALIFORNIA
HEALTHCARE
FOUNDATION**

1438 Webster Street, Suite 400
Oakland, CA 94612
tel: 510.238.1040
fax: 510.238.1388
www.chcf.org