Achieving a Policy Change: Key Strategies and Factors for Success

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EXECUTIVE SUMMARY

In an era of increased grassroots responsibility for addressing the needs of California's vulnerable populations, clinic consortia mobilize resources and participate in policymaking in ways that are beyond the means of many individual clinics. They focus on policies and issues at the federal, state, and local levels to increase or maintain clinic financial stability and increase access to care for community clinic target populations. This Issue Brief summarizes two California policies targeted by consortia funded under The California Endowment's Clinic Consortia Policy and Advocacy Program from 2001 to 2006.

The first case study describes the coordinated efforts of the California Primary Care Association (CPCA) and the local and regional clinic consortia in the implementation of the ***Prospective Payment System (PPS),*** which transitioned Medi-Cal reimbursement for Federally-Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)[1] from a cost-based system to a fixed, per-visit payment system. The second case study illustrates the role played by the Alameda Health Consortium (AHC) in the planning, passage, and implementation of ***Measure A***, which increased the local sales tax to fund health care services. The two case studies provide valuable insights into the resources and advocacy activities required to pursue a policy strategy.

Several key themes emerge from the analysis of these case studies:

- Success depends on sufficient organizational capacity, the internal technical expertise of consortia, and the ability of consortia to "wear multiple hats" during all phases of the policymaking process.

- Through the creation of new coalitions and leveraging existing partnerships, consortia increased the likelihood of a policy success.

- Advocacy partnerships, particularly between advocates and their members, may be the linchpin to a successful policy change.

INTRODUCTION

In 2001, The California Endowment (The Endowment) provided funding to 15 local and regional community clinic associations and four statewide community clinic organizations (referred to as "consortia") through the Clinic Consortia Policy and Advocacy Program to strengthen the capacity of consortia to engage in advocacy on behalf of their member clinics. Clinic consortia are statewide, regional, and local associations of primary care clinics that undertake activities that individual clinics may not be able to do on their own. In 2004 and 2007, eighteen grantees were refunded for three years to undertake or continue a similar set of activities.

To achieve their goals, clinic consortia engage in multiple advocacy activities, including policymaker education, serving on advisory boards, training

patients and staff in advocacy, and partnering with other organizations. For example, to advocate for increased access to health care in a particular locality, a grantee may submit Letters to the Editor of a local newspaper to educate the public about the unmet needs of the uninsured, give clinic tours to local policymakers, and also serve on a countywide committee that focuses on the uninsured. Many consortia focus on policies and issues at the federal, state, and local levels to increase or maintain clinic financial stability and increase access to care for community clinic target populations.

METHODS

To characterize the range of tactics used by grantees to secure a policy "win", two policies that represented different levels of decision-making (state and local) were identified. UCSF staff conducted open-ended interviews in 2006 and 2007 with decision makers, clinic consortia staff, and community clinic Executive Directors who were involved with each policy. Informants were asked to focus on the policy advocacy activities utilized, key stakeholders involved, and lessons learned. (*Please note that lobbying activities were not funded under this program, and are assumed to be funded by other funding sources*.)

TWO CASES

Prospective Payment System Legislation (SB 36)

Medicaid (referred to as "Medi-Cal" in California) is a major revenue source for California's Federally Qualified Health Centers (FQHCs), accounting for approximately 37 percent of total clinic revenues.[2] In 1989, federal law required state Medicaid programs to reimburse clinics on the basis of their costs as determined by Medicare "reasonable cost" principles. "Reasonable costs" were defined as the necessary direct and indirect costs related to patient care services covered by the Medicaid program.[3] While this cost-based reimbursement method ensured that clinics were paid for necessary costs, it also was regarded as potentially inflationary because providers could increase their payments by raising their stated costs. Moreover, while cost-based reimbursement took into consideration fluctuating factors such as the complexity of the procedure and skill level of the provider, it often took up to three years to finalize cost reports.

In 2000, this payment system was changed at the federal level to a prospectively determined approach or the "prospective payment system" (PPS), under the Benefits Improvement and Protection Act (BIPA).[4] A primary objective of BIPA was to create financial incentives for clinics to reduce their costs, operate more efficiently, and increase state control over their Medicaid budgets. Clinics that kept their costs below their payment amount would profit; conversely, clinics would lose money if their service costs exceeded the payment amount. PPS also afforded states an increased ability to predict and budget for the cost of clinic Medicaid expenditures.

California's quick decision to adopt PPS on January 1, 2001 prior to the development of the required framework for annual "scope of service" adjustments was considered by many to be a "preemptive strike." While the move was intended to position the state in a strong place from which to negotiate with the federal government on the details of the PPS implementation, it had the potential to place clinics at a financial disadvantage. However, California's clinic consortia were well positioned to strengthen the clinic position and negotiate many of the key decisions that were anticipated to have a serious impact on clinics.

From 2001-2003, the California Primary Care Association (CPCA), a statewide association representing 403 FQHC and FQHC-look-alike clinic sites, negotiated the service definitions, rates, and terms of the PPS reimbursement system with the California Department of Health Care Services (DHCS). All of these issues determined how much clinics were to be reimbursed for Medi-Cal services. CPCA took the lead role in the line-by-line implementation negotiations, working with legislators' offices and chairing the FQHC Committee. At the same time, local and regional clinic consortia provided technical assistance and education to member clinics and local decision makers about the changes that would impact them. They also helped mobilize member clinics to tap into relationships with state legislators. Through this two-tier approach and exchange of information between consortia, clinics, and decision makers, clinics were "heard" and workable solutions were developed.

In the end, consortia and clinics made some concessions, such as the adoption of the Medicare Economic Index (MEI), an adjustment that does not take into consideration the cost of inflation. However, consortia and clinics did achieve some "wins," such as securing a more beneficial alternative payment methodology for most clinics. PPS-negotiated rates eliminate the uncertainty and wide fluctuations that come with cost-based reimbursement. Lastly, clinics are rewarded for being efficient, helping clinics reorient as economic hubs that provide competitive, professional services, as opposed to simply charity care.

Measure A (Alameda County)

In March 2004, 71 percent of Alameda County voters approved Measure A, which increased the local sales tax from 8.25 to 8.75 percent, generating an estimated $90 million annually for safety net health care services. Measure A was proposed in large part to address the serious financial shortfall experienced by the county health care delivery system. The Alameda County Medical Center (ACMC) had an estimated $71 million budget deficit. Moreover, the county's health care safety net was under severe stress, as community clinics were serving more people due to the closure of two county clinics and displacement of 20,000-25,000 patients. Finally, the 2004 state budget deficit crisis and lack of action at the state level to alleviate the county's crisis forced decision makers to consider options at the local level.

Measure A funds were distributed two ways: 75 percent of funds generated ($71 million in FY 04/05) were allocated to the ACMC Board of Trustees and the remaining 25 percent ($20 million in FY04/05) was allocated to the non-ACMC Health Care Safety Net Fund. The latter funds were to be allocated based on demonstrated need and the county's commitment to a geographically dispersed network of providers.

Alameda Health Consortium (AHC), a clinic consortium that represents eight community clinic corporations operating 35 sites in Alameda County, was involved in the planning, passage, and implementation of Measure A. It helped in the development of various ordinance provisions and provided technical assistance that included training clinic staff and patients to undertake grassroots advocacy. A dedicated staff person developed relationships with the media and disseminated information, held press conferences, and pitched stories, such as the increase in the number of working uninsured in California. AHC also worked closely with member clinics to reach consensus about overarching funding priorities and worked with its member Board to establish general principles that would be used to determine the allocation of $5 million in Measure A funding for individual primary care clinics.

Measure A provided new funding (approximately $16.8 million over three years) to community clinics, strengthening the county's safety net. Initial data suggests that AHC clinics were successful in using Measure A funds to increase the number of uninsured patient visits, expand clinic facilities, stabilize the clinic network, and secure additional state, federal, and foundation funding.

FACTORS FOR SUCCESS

While AHC and CPCA used similar advocacy strategies, there were some differences due in large part to the differences in the policies. For example, AHC's media advocacy contributed to increased policymaker and community awareness about the role of clinics while the media played less of a role in the implementation of PPS. Additionally, PPS negotiations included discussions with federal, state, and local decision makers while Measure A was primarily a local decision. Despite these differences, the two case studies reveal common factors for success, including:

Staff expertise: Having sufficient organizational capacity and technical expertise was critical to the outcomes of both policies. In the case of the PPS, CPCA provided leadership and technical expertise on the FQHC Committee where strategies and issues were deliberated. Similarly, AHC staff applied their technical expertise in conducting data analyses and developing Measure A allocation formulas using clinic data.

Participation in all stages of the policy process: Having dedicated staff and consultants allowed consortia and member clinics to have a presence throughout the policymaking process. Educating and partnering with decision makers contributed to increased knowledge about the safety net and high visibility of the consortia as a credible voice. For example, CPCA was a constant presence throughout the PPS negotiations, playing a leadership role and mobilizing consortia and clinics. Similarly, AHC's early involvement and its ongoing communications with the county health agency and Board of Supervisors established the consortium as a key player.

Building coalitions and mobilizing stakeholders: By developing new coalitions and leveraging existing partnerships, consortia increased community-wide input and participation, improving the likelihood that a policy was successfully adopted and implemented. For example, CPCA staff worked with the Department of Health Care Services and Audits and Investigations to finalize the critical issues relating to implementation of the relevant State Plan amendments. AHC staff built coalitions and expanded existing coalitions early on with labor groups, the Alameda County Medical Center, faith-based groups, mental health agencies, Vote Health, and various other stakeholders and allies.

Leveraging partnerships with member clinics: The case studies highlight the importance of working with member clinics to expand consortia reach and provide valuable expertise. In the case of the PPS, clinics played a key role in championing their cause. Individual clinic directors tapped into their relationships with state legislators, many who were long-time supporters of clinics and clinic policy issues. AHC's ability to achieve consensus of the Measure A allocation methodology was in part attributable to good working relationships with the clinics as well as development of a process to solicit clinic input on reimbursement proposals.

CONCLUSIONS

The two policy "wins" achieved by clinic consortia and member clinics resulted in more people having access to more services. However, these were by no means easy wins, requiring considerable staff time and technical and advocacy expertise. Given the potential for failure (such as the fact that measures require two-thirds majority to pass), organizations should carefully weigh their expertise and the costs to the organization against the amount of new funding likely to be secured. For example, in 2006, Santa Clara County voters rejected a proposed sales tax that would have funded some safety net health services.

The analysis of the role played by consortia in the planning and implementation of state and local policies speaks to the ability of clinic consortia to use their technical expertise and to "wear multiple hats", particularly:

- ✓ *Developing the capacity to undertake diverse advocacy activities;*
- ✓ *Participating in all stages of the policymaking process;*
- ✓ *Building coalitions and mobilizing stakeholders; and,*
- ✓ *Leveraging partnerships with member clinics*.

The similarity in key success factors for the two policies suggests that many advocacy tactics are transferable from one policy issue to another. However, not all issues lend themselves to media coverage or require increased visibility for a successful outcome.

Moreover, advocates might want to consider whether they should go it alone or adopt a partnership approach. CPCA and local/regional consortia developed an effective "hub" model that linked state and local advocacy activities as well as maximized the efficient use of resources.

In summary, through a combination of education, advocacy, technical expertise, and mobilization of key stakeholders, consortia created and/or supported the conditions under which two important policy "wins' benefiting clinics and their target populations were possible.

END NOTES:

[1] FQHCs are "Federally Qualified Health Centers" and RHCs are "Rural Health Clinics" – sometimes referred to respectively as "health centers" or "clinics" where only FQHCs and RHCs are being discussed. These urban and rural health centers provide comprehensive community-based primary care services to individuals regardless of their ability to pay. They are public or nonprofit entities that operate under the direction of a governing board with a majority of directors who represent the community being served by the health center. In California, there are 87 FQHCs (349 clinic sites) and 36 FQHC look-alikes (84 clinic sites). (Source: Safety Net Clinics: A Primer. California HealthCare Foundation. November 2005)

[2] Ibid

[3] 42 C.F.R. § 413.9.

[4] 42 U.S.C. § 1396a(bb).

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