Recommendations to the Fairfax County health Care Reform Implementation Task Force

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Health Administration and Policy
&
CENTER FOR
HEALTH POLICY RESEARCH
& ETHICS

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Table of Contents

EXECUTIVE SUMMARY

The purpose of this report, as well as the research and Task Force deliberations it reflects, is to present health reform implementation options for Fairfax County to consider. The county provides, finances, and arranges for a comprehensive array of needed health services to residents who have few, if any, other sources for care. Intensifying federal, state, and local budget pressures, plus the implications of the coverage expansion provisions of the recent federal reform law, provide context and rationale for a re-examination of county human service priorities and the most efficient ways to meet them in the future.

Fairfax County Health Status and Health Resources

The Fairfax Community Health Status Assessment (CHSA) provided information on community health needs and selected aspects of health care access, resource availability and utilization in Fairfax County and the cities of Fairfax and Falls Church (Fairfax CHSA, 2011). Key findings from the 2011 CHSA and data supplied by the county provide context for George Mason University's (GMU) report and recommendations to the Fairfax County Health Reform Implementation Task Force. The Fairfax community is an asset-rich, racially and ethnically diverse, well-educated community that has high per capita income and abundant community resources (social, cultural, and intellectual). However, segments of the population have low socioeconomic status, low educational attainment, high unemployment, low health status, lack health insurance coverage, and have lower life expectancy. There are differences in availability and access to health services and significant contrasts in health status found across different geographic areas and population groups throughout the community. These contrasts present challenges in planning and providing services to improve public health and address health and quality-of-life needs of all residents. Additionally, there is evidence of disparities in health and access to health services indicating vulnerable groups in the community have a disproportionate burden of disease.

- Despite the Fairfax area's wealth, more than 1 out of every 10 residents in the county lacked health insurance in 2010; among children age 5 and under, 8.2% live in poverty.
- The overuse of costly, acute care services could be reduced**.** Approximately 26 % of the region's Emergency Department (ED) visits in 2009 were found to have conditions that did not require ED care. A large percentage of these were by residents with low socio- economic status, who lack health insurance coverage. Primary care offices or clinics are more appropriate and a less costly setting to address non-acute medical conditions.
- Fairfax County's primary care capacity is increasingly insufficient to meet projected service demand. In 2010, 39 % of all primary care physicians in the area were age 60 or older. New physicians entering the medical profession are less likely to elect primary care, and those who do choose

a primary care practice specialty are not entering at a rate fast enough to replace those who are leaving. Moreover, the number of primary care providers who accept Medicare and Medicaid in the Fairfax community is expected to be insufficient in the future.

- Increased health insurance coverage and the requirements of insurers to improve health care value and assure quality underscore the importance and need for primary care providers and expanded medical home capacity.

Utilizing a robust safety net optimally is increasingly important as resource availability becomes more problematic. In a region that continues to have population growth and increasing racial/ethnic diversity, integrated, efficient, and cross-agency approaches will be needed to manage resources for vulnerable populations, especially those with more than one chronic disease and the disabled.

Even as the demand for services provided by the safety net will change as more residents obtain health insurance coverage, a variety of factors including availability of primary care providers and individuals care seeking behavior will continue to support the need for safety net providers.

Federal Health Reform Legislation

Enacted in March 2010, the Patient Protection and Affordable Care Act, (PPACA) is designed to increase the number of people in the United States with health insurance and make health insurance and care more affordable. The law also provides a variety of avenues for developing and testing innovation in service delivery and payment models. This report summarizes the provisions of PPACA designed to increase access to affordable health insurance and provide funding opportunities for local public health departments, statewide Medicaid grants and programs, and other state provisions. Among the major provisions in PPACA include: expansion of Medicaid eligibility, private health insurance premium and cost-sharing subsidies, creation of state health insurance exchanges, new rules for health insurance companies and plans, an individual requirement to maintain creditable coverage, and employer responsibilities. In 2014, individuals and families with incomes up to 133% of the Federal Poverty Guidelines will be eligible for Medicaid, which will open up Medicaid to many uninsured adults. For those with incomes above 133% but not exceeding 400% of poverty, the Federal Government will offer health insurance premium tax credits to those who purchase in the new health insurance exchange. Also available will be cost sharing credits that are designed to lower out of pocket health expenses for individuals with incomes up to 250% of poverty. Both these credits are available to those who do not have access to qualified, affordable employer sponsored health insurance, nor to public coverage such as Medicare.[1] Health insurance exchanges will be consumer friendly and transparent marketplaces for individuals and small groups to purchase health insurance. Insurance companies will be required to provide insurance with a minimum benefits package known as the essential health benefits. A portion of the benefit structure, beyond the minimal federal requirements, could be defined by each state. In 2014, health plans may no longer determine

1 Report R41997.Affordable employer sponsored coverage is health coverage with the employees' share of the premium for the self only plan equaling to less than 9.5% of income. Minimum coverage is defined as coverage of at least 60% actuarial value which covers the essential benefits package requirements. These topics are discussed in detail within the report. Mulvey, J., Baumrucker, E., Fernandez, B., Scott, C., "PPACA for Certain Medicaid Provisions and Premium Credits" Congressional Research Service, October 24, 2011, Report R41997.

coverage decisions and or prices based on an individual's current or past health status. Premiums will be allowed to vary only for age, smoking status, location, and family size. All individuals, with a few exceptions, will be required to maintain health insurance or be subject to penalty taxes. Companies with more than 50 full time workers will be subject to penalties for not offering insurance or for those employees who choose to seek insurance subsidies in the exchange because their out-of-pocket premium at work is too high a percentage of their income. Public health provisions in PPACA include a new and unprecedented $15 billion fund for public health programs. Under this program, Fairfax County was awarded a five year Community Transformation Grant (CTG) of $499, 559 for each year. This grant will be used to review county policies and services in order to strengthen programs and improve the health of the community in priority areas. In so doing, the goal is to reduce health disparities, promote healthier eating and lifestyles, reduce tobacco use, lower the rate of hypertension, and create a healthy and safe environment in Fairfax.

In addition to public health, PPACA has provisions designed to encourage both insurance plans and employers to provide wellness programs. The legislation also has provisions to promote health and prevent disease. For example, regulations have been promulgated to require published nutritional information on the offerings from the largest restaurant chains and vending machines.

Virginia Health Reform Initiative

In August 2010, Governor McDonnell appointed 24 high profile stakeholders and office holders from around the state to the Advisory Council of the Virginia Health Reform Initiative (VHRI), an effort spearheaded by the Secretary of Health and Human Resources, William A. Hazel Jr., MD. After numerous meetings, briefings, expert analyses and debates, in December of 2010 they issued a report to the Governor and General Assembly (GA), with 28 substantive recommendations. The most important recommendations with implications for Fairfax were: Virginia should make its own insurance market exchange to prevent federal takeover of the small group and individual insurance markets; Virginia should prepare Medicaid for coverage expansion with improved information systems, care coordination pilots, and value based benefit redesign; and the Secretary should be as catalytic and proactive as possible in order to promote delivery system reform across the Commonwealth.

The General Assembly followed the first recommendation of the VHRI when it passed HB 2434 early in 2011. This law directed the Secretary to consult stakeholders and report back with a plan to implement a health benefits exchange that will work for Virginia and satisfy PPACA requirements. A subsequent report and recommendations, delivered to the GA by the Governor in November of 2011, again recommended a Virginia-run exchange with the caveat that it not be more demanding of health plans than what is specified in federal law. It also recommended that a future exchange in Virginia be governed by an independent board much like the Virginia Housing Development Authority, thus giving the exchange some independence from the legislature and governor. However, frustration over delays in receiving federal guidance on various aspects of the exchange, the impending Supreme Court decision (in June or July 2012) on the constitutionality of the law, and the general politics of polarization that plague our nation have raised serious doubts about whether Virginia will create an exchange in the 2012 legislative session. As such, it risks a federal

takeover, for at least 2014. Developments on this front should be closely watched. Meanwhile, the Secretary was successful in working with key stakeholders such as the Medical Society of Virginia, the Virginia Health and Hospitals Association, and the state Chamber of Commerce to jointly sponsor a new Virginia Center for Health Innovation in order to stimulate payment and delivery system reforms and promote gains in population health and wellness.

Quantitative Analysis of Health Insurance Coverage

Even though Fairfax County is one of the richest counties in the nation, the most recent data (American Community Survey (ACS), 2010) indicates that over 144,000 or 12.9% of residents are now uninsured. George Mason University consultants used advanced estimation and micro-simulation techniques, and credible data from a variety of federal sources, along with Fairfax ACS data, to develop a PPACA implementation model to predict how many and which residents in Fairfax will either purchase insurance or enroll in Medicaid or stay uninsured based upon expected prices and/or insurance program eligibility. Because of the robust nature of the analytic methods, the results of sensitivity analyses and the credibility of the data, we are confident the models developed predict insurance choice behavior post-reform, when new eligibility rules, subsidies and insurance market exchanges will drastically change access to health insurance and health insurance prices for so many. Our best estimates are as follows: About half of Fairfax's uninsured will gain coverage and slightly more than half of these will get private coverage instead of Medicaid. Furthermore, the remaining uninsured are less likely to be children or very low income. Ordinarily, this development would suggest a commensurate reduction in county-provided and financed safety net health services. However, it will take time for new enrollment to occur and for the healthcare marketplace to adjust to the large-scale changes in insurance coverage among local residents. Therefore, county services will be needed to ensure continued access to services while newly insured residents and health service providers adjust over time.

At present, the county is unable to provide systematic unduplicated counts and lacks uniform demographic data on service users across all of its programs. Therefore, it is impossible to precisely estimate the share of the uninsured the county serves now. Our best estimate (based on nationally representative survey data and aggregate county service rolls) is that the county serves a large majority of the uninsured who currently seek health care. Another serious complication of PPACA's implementation is that not all those who will become eligible for insurance will enroll immediately; thus the model's quantitative estimates should be interpreted as closer to a "fully phased in" estimate, not an estimate for calendar year 2014. Also, Medicaid payment rates are low compared to private payment rates in northern Virginia, so that it is likely that many new Medicaid enrollees will face difficulties finding willing private sector providers to serve them. Low provider reimbursement rates are compounded by shortages in specific health specialties and lack of information about primary care and medical home capacity. For example, there is already a profound shortage of mental health providers in northern Virginia, especially for the seriously mentally ill, regardless of insurance coverage. Finally, the scale of the Commonwealth's anticipated Medicaid expansion is very large, and for that reason alone may be slowed from the pace anticipated in the federal reform law, regardless of how the Supreme Court decision and elections turn out. For these

reasons, we caution against precipitous decisions to reduce county support for local safety net capacity until more is known about both PPACA implementation and the effects of reform on residents and health care providers is clearer.

Peer Counties Review

Understanding what similar counties offer in terms of safety net supports and how they organize their system(s) to deliver those services is useful as Fairfax County explores its own options. After a detailed selection process, six counties were chosen for the peer county review: Montgomery County, Maryland, Hennepin County, Minnesota, Travis County, Texas, Cobb County, Georgia, Wake County, North Carolina, and Jefferson County, Colorado. Findings from the review of these counties show similar challenges as those found in Fairfax, but selective adoption of different approaches to addressing local needs. The array of interventions used ranged from offerings focused on disease prevention (Jefferson County, CO), to establishing a separate political subdivision with taxation authority to fund comprehensive services to low income uninsured (Travis County, TX). Others jurisdictions such as Hennepin County, Minnesota and Montgomery County, Maryland were found to be strengthening already robust health care services for county residents. Many of these counties are working to support service integration within Federally Qualified Community Health Centers and their county social-service partners. Among these peers, we found reinforcement for the importance of information technology as critical infrastructure needed to assure effective, efficient public health and social service systems.

Cobb County, GA and Travis County, TX have strong public mental health divisions that operate similarly to the Fairfax-Falls Church Community Services Board. Both counties promote efforts to integrate mental health and primary care services. Travis County program efforts are very much like those provided collaboratively by the Fairfax-Falls Church CSB and the local Community Health Care Network (CHCN).

The efforts and programs found in the peer counties assessment provided examples of alternative service delivery programs and methods for Fairfax County to consider. This included efforts that focus on distinct governance models, comprehensive intake models, public-private partnerships and service delivery cooperation.

Recommendations

In total, George Mason University consultants identified six major challenges and offered twelve recommendations for the County's consideration in the future.

Recommendation #1: Work collaboratively with INOVA to develop its first Community Health Needs Assessment (CHNA) required by PPACA and collaborate indentifying priorities and potential solutions for population health improvement. These efforts should build on and extend the Health Department's MAPP Strategic Planning process and Community Transformation Grant efforts.

Recommendation #2: Develop explicit agreements or requirements (non-statutory), in collaboration with private providers (nonprofit or not) for sharing the burden of caring for the uninsured and safety net patients. Information about care gaps (health needs not being met) will help county and Commonwealth officials assess the wisdom or need for more formal requirements for private health providers in the future.

Recommendation #3: Develop a strategic and operating plan for centralizing county contracts with all health care and service providers (especially medical sub-specialists). Develop an evidence- based model for integrated service delivery across all county agencies and a system to support the coordination of county financed and/or provided health care and service referrals.

Recommendation #4: Continue to pursue "medically underserved population or area" (MUP/A)" Exceptional MUP Designation (also known as a "Governor's Special Designation") concurrent with efforts to establish a "New Access Point (NAP)" or expansion of existing Community Health Centers (CHC) in Fairfax, that enhances Medicaid and Medicare reimbursement under the "federally qualified health centers" (FQHC) benefit.

Recommendation #5: Expand the use of existing streamlined eligibility systems. Support current efforts to expedite utilization of the new cross-program integrated eligibility system that the Virginia Department of Health and Human Resources is currently developing to combine eligibility for multiple programs across the secretariat.

Recommendation #6: Invest in integrated information technology that supports uniform or standardized data collection and enables a comprehensive array of clinical care and administrative functions (including client information, billing and information exchange) across all county health and human service agencies and programs.

Recommendation #7: Continue to include dental care as a part of the safety net services and expand access to local dental service programs for more adults. Work with other safety net and community providers to achieve this expansion.

Recommendation #8: Prepare the CHCN to accept an array of payer sources including self-pay, Medicaid, Medicare and private insurance, especially in preparation for expansion of public and private coverage in 2014. The ability to collect money from newly eligible and enrolled Medicaid patients will be particularly important, as many patients who use CHCN now will likely become Medicaid eligible.

Recommendation #9: Develop an outreach campaign in 2013 to inform the diverse community about new coverage options and Medicaid expansion coming in 2014. Expand self-sufficiency services to support future Medicaid expansion.

Recommendation #10: Plan for some safety net reduction and/or consolidation, since the scale of the insurance coverage expansion under PPACA could be substantial eventually. But since expansion will not be immediate and Medicaid payment rates are likely to remain low, it is important to anticipate newly eligible beneficiaries (maybe most) having trouble finding private clinicians, especially those patients with behavioral health needs. For these reasons, we recommend keeping the CSB at its current scale until after 2016 and reducing CHCN capacity only after reductions in need can be demonstrated.

Recommendation #11: Create a new government entity and structure which will enable cross sector, cross agency integration, coordination, and planning in order to reorganize access to services through an authority that will manage and/or leverage resources and coordinate services and programs. The statutory authority to take action is available to the County Executive under 15.2-5200 to establish a Fairfax County Health Commission or 32.1 to establish a Fairfax Health Partnership Authority (herein

referred to as the Entity). This Entity would report to the Board of Supervisors but would have operational autonomy assuming Supervisor-determined objectives and priorities were being met.

Recommendation #12: Develop a privately-funded evaluation program for the proposed Entity, wherein independent contractors conduct a gross and net impact analysis and report to the Board of Supervisors (BOS) every five years (however, the first evaluation should be initiated following the first three years of implementation). Evaluate the program by the priorities determined by the BOS.

INTRODUCTION

This report is the result of collaborative work conducted between the Center for Health Policy Research and Ethics (CHPRE) at George Mason University and the Fairfax County Health Care Reform Implementation Task Force over more than a year spanning 2011 and 2012. The Task Force was appointed by Deputy County Executive Patricia Harrison to explore options for improving Fairfax County's management of programs and services that form the core of the local health care safety net (where many residents turn for health care, when they have no other place to go) following health care reform. This effort by Fairfax County followed the Virginia Health Reform Initiative (VHRI) phase I and ran partially concurrently with VHRI phase II efforts, in order to prepare the County for the impact of various healthcare reforms. The George Mason team was engaged to inform and advise the Task Force and its deliberations and develop options and recommendations for the county to consider in the future. The resulting report reflects Task Force deliberations and independent research and data analyses conducted by GMU consultants.

This report begins with a survey of the services Fairfax County government delivers or finances, followed by a summary of the major provisions of PPACA deemed most likely to impact Fairfax County. Next, the Commonwealth's health reform activities are reviewed, followed by a quantitative analysis of how many residents will gain health insurance coverage as reform is implemented in 2014. This is followed by an analysis of Peer Counties and a discussion of their approaches and programs that may be applicable in Fairfax County. The report concludes with recommendations. Report recommendations were developed to practically inform the County's health reform implementation plan (considering the Task Force vision, planning principles and work goals), in response to current and emerging changes in public and private health systems, population health and demographic trends, GMU's insurance coverage analysis, the 'peer counties' assessment and perceived problems or challenges identified by various entities during Task Force presentations and discussions.

Why this Effort and Why Now?

The Patient Protection and Affordable Care Act (PPACA) was signed into law by President Obama in March 2010. It is a landmark piece of legislation that aims to enable all Americans to have access to health insurance coverage and health care services that are affordable to families and society alike. To pursue these aims, the law changes long standing rules, methods, and incentives that are expected to transform insurance markets, health service delivery processes, and public health outcomes. PPACA implementation includes major decisions and actions to be taken by both the federal government and states. As a result, states have many responsibilities and opportunities to shape how health reform is implemented within their own borders. Health care markets are local, though, and many states, like Virginia, devolve much responsibility for care for

the most vulnerable citizens and residents to counties. Fairfax County has long been a leader in service provision and a more ambitious funder and coordinator of safety net health services than most counties in the nation and in the Commonwealth.

Guided by a 'vision' of increased access to healthcare, better management of care availability, appropriate and affordable care, prevention and quality of life standards, the Fairfax Health Reform Implementation Task Force initially identified five principles (planning assumptions) to inform its work. These principles and planning assumptions are found in Table 1.

Table 1: Fairfax Health Reform Implementation Task Force	
Planning Assumptions and Principles	**Work Scope/Goals** *The Task Force worked initially to perform the following:*
1. Support Individual Responsibility Promote a culture that supports each person to be responsible for his/her own health. The county should provide information and assistance to low income individuals to access appropriate health resources and supports, including information on resources available and what they may be eligible for – a "road map" o Including community education and prevention efforts; County services/systems should not be designed on assumption that low income persons lack resources to address barriers related to their health care needs. The county should not assume that all low income persons lack health care.	Build on existing relationships with private sector and nonprofit health service providers and representatives of health care industry to identify areas of common interest and concern regarding the principles and goals of health reform Pursued discretionary and innovation grant opportunities resulting from PPACA and other federal initiatives Identify strategies for improved access to information to consumers on available health services Identify comprehensive systems and integration activities to improve county delivered and financed health services and social supports, specifically regarding: o Access and referral points o Integration of medical, behavioral and oral health services o Improved/integrated care coordination o Realignment of data, technology, service outcomes

Table 1: Fairfax Health Reform Implementation Task Force	
Planning Assumptions and Principles	**Work Scope/Goals** *The Task Force worked initially to perform the following:*
2. Seek System Integration/Optimization The alignment of the existing health care system must change. o The county should not be in the business of providing medical services provided by the community when community or private capacity exists ; (no duplication of services); o An integrated health care delivery system includes appropriate and affordable health care for all persons ▪ The county should strive to create an integrated network for primary, behavioral and oral health care in partnership with community providers; ▪ Low income insured and uninsured persons should receive a coordinated, quality system of care that leads to a medical home; o There are benefits to improvement of the Fairfax health care "safety net", regardless of the outcome of federal reform efforts; o Leverage prior work to address/ impact identified community health needs (i.e. the Beeman Commission, MAPP planning efforts, Long Term Care Council and the Systems of Care initiative for children and families); Focus recommendations on achieving a system of integrated health care that addresses local, state and federal program and legislative mandates.	Identify known gaps in Fairfax County safety net Understand (fully) existing county programs and services and resident eligibility requirements and needs (including identification of those not served and why) Identify available community and public sector primary and preventive services Analyze impact to the community on anticipated community practice changes Compare Fairfax County to other systems [Peer county assessment] o recommend effective models for an integrated system of care Describe anticipated enrollment impacts and workload associated with new and expanded/changing health services including: o how individual participants will be tracked/supported as income/eligibility fluctuates; o documentation of enrollment and health data exchanges;

Table 1: Fairfax Health Reform Implementation Task Force	
Planning Assumptions and Principles	**Work Scope/Goals** *The Task Force worked initially to perform the following:*
	o electronic health records interfaces and state systems; o connections to safety net providers (hospitals, FQHCs, local government, CBOs) Analyze managed care and potential partnership opportunities for low income, older adults, persons with chronic conditions, serious mental illness, etc. Create medical home models – using primary provider/referral systems or network of linked providers in "managed care" settings; Recommend realignment of services to fill the gaps o Articulate public sector role in the health "safety net" o Identify steps to implement recommendations Identify Phase one and long term impacts of Health Care Reform under PPACA Analyze possible choices/scenarios based on Commonwealth of Virginia action steps, including o impact of various managed care scenarios on local residents

Table 1: Fairfax Health Reform Implementation Task Force	
Planning Assumptions and Principles	**Work Scope/Goals** *The Task Force worked initially to perform the following:*
	and the Fairfax network o analysis of Medicaid and factors in both service availability, capacity and reimbursement o study of health care exchanges and opportunities for the Fairfax County community o analysis of available Medicaid waiver opportunities and possible advocacy recommendations for Commonwealth participation o relationship with accountable care organizations and possible relationships/partnerships/contractual services options o analysis of data exchange/electronic data needs and state plans for health insurance exchange data design o review of state position regarding payment reform and monitoring state corporation commission regulations regarding insurance

Table 1: Fairfax Health Reform Implementation Task Force	
Planning Assumptions and Principles	**Work Scope/Goals** *The Task Force worked initially to perform the following:*
3. Ensure Accountability, Transparency and Improvement The health reform efforts should support community health outcomes that; o Understand program outcomes and impacts for all county programs, community services (and 'networks') individually and cross-cutting as they influence community health overall; o Identify opportunities for improvement (understanding what we do, what is working and what is not working.	Conduct planning and information sharing conversations with private and nonprofit providers on business models being developed by community providers (i.e. Inova, FQHCs, CBOs, etc.) o Discuss community outcomes and accountability for an integrated health system. o Document potential changes/service delivery impact resulting from future plans
4. Pursue Advocacy and Stewardship Consistent with the County's Mission Advocate for policies in the Commonwealth that support the needs of county residents; Seek to eliminate health disparities for specific populations.	To identify and communicate state and federal initiatives, policies, regulations, laws and financing that impacts the Fairfax community health safety net and related services To integrate internal county activities related to identification of public policies affecting disproportionate health outcomes and elimination of those differences

Background of Services Provided by Fairfax County

The Fairfax County government and its agencies provide services and resources to ensure an economically vital community with a high quality of life and health. In collaboration with its community partners, the county plays an important role in ensuring the health of the entire community, including the poor and uninsured. Amidst growing fiscal constraints and increasing public accountability expectations, the challenge of meeting community needs is expected to become more difficult in the future.

Over the last two years, the Fairfax Health Department has engaged the community it serves in a participative strategic planning process called Mobilizing for Action through Planning and Partnerships (MAPP) for the purpose of improving public health. [2] As part of the MAPP process, a Community Health Status Assessment (CHSA) was conducted. The Fairfax Community Health Status (CHSA) Report provides information on community health needs and selected aspects of health care access, resource availability and utilization in Fairfax County and the cities of Fairfax and Falls Church (Fairfax CHSA, 2011). [3] Key findings from the 2011 CHSA Report and data supplied by the County provide context for GMU's report and recommendations to the Fairfax Health Reform Task Force.

Overview of the County

The Fairfax Community is an asset-rich, racially and ethnically diverse, well-educated community that has a high per capita income and abundant community resources (social, cultural, and intellectual). However, segments of the Fairfax population have low socioeconomic status, low educational attainment, high unemployment, poor health status. Many lack health insurance coverage and have lower life expectancy. There remains a disproportionate gap in health status among different geographic areas and populations throughout the community. Many residents lack access to services and resources that promote health and wellness or address health problems. These contrasts present challenges in planning and providing services to improve public health and address health and quality-of-life needs of all Fairfax residents. Additionally, there is evidence of disparities in health and access to health services that indicates vulnerable groups in the Fairfax community have a disproportionate burden of disease (Fairfax CHSA, 2011).[4]

Race and Ethnicity

Fairfax Community census data indicates it is one of the most racially and ethnically diverse areas in Virginia. Whites comprise 62.7 % of the population, followed by Asian/Pacific Islanders (17.6 %), Other/Multiracial (10.2 %), and Blacks (9.2 %). The largest ethnic group in the area is Hispanic/Latino (15.1 %). Fairfax is also identified as an immigrant gateway – a place immigrants choose as their destination on entering the United States: Approximately 10% of area residents are foreign-born; almost 35 % of households speak a language other than English at home (Spanish being the most common); and over 100 different languages are spoken in the homes of school age children across the county with 7.5 % of households classified as linguistically-isolated (Fairfax CHSA, 2011).

2 Fairfax Department of Health MAPP: http://www.fairfaxcounty.gov/hd/mapp/

3 Fairfax Department of Health MAPP, 2011: http://www.fairfaxcounty.gov/hd/mapp/pdf/comm-health-assess-tech-rpt-02.pdf

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Age

The Fairfax Community is aging. By 2025, 1 out of every 8 residents will be 65 years or older. Nevertheless, trends indicate that growth will occur across all age cohorts (including the young) as the size of population continues to increase.

Income

In 2009, Fairfax County had one of the highest per capita incomes in the country at $47,103. This contrasts sharply with the growing number of residents living below poverty. In recent years, the geographic distribution of poverty has changed as individuals moved from urban to suburban areas to follow jobs.

- Poverty: More than 14 % of county residents have low incomes (200 % of federal poverty levels or FPL). Households with gross incomes at or below 200% of FPL increased 33 % from 2000 to 2009. Those living in poverty are more likely to be children from a racial or ethnic minority group (primarily Blacks and Hispanics). In total, nearly 58,000 county residents live in poverty, including 1 out of every 15 children.
    - Health Insurance: Despite the Fairfax area's wealth, more than 1 out of every 10 residents lacked health insurance in 2009.
    - Persons living in low and moderate income households in Fairfax County are more likely to lack health insurance coverage. Some 36% of Fairfax County residents who live in poverty were uninsured, compared to 27.8 % nationally. Among residents who had incomes between 300% and 399 % of FPL, 15.3 % of Fairfax County residents lack health insurance coverage (compared to 11.5 % nationwide.
        - While residents age 65 and older were the most likely to have health insurance, young adults age 18 to 34 were the least likely to have health insurance. Health insurance coverage was also lacking for 6.4 % of children under the age of 18.
    - Quality of Life: The cost of living (e.g., housing, food, transportation in particular) is high and negatively impacts the quality of life for many living on low and fixed incomes in our area (Fairfax CHSA, 2011)

Overall Health Conditions

Fairfax is considered a healthy community. Many health status indicators showed favorable health outcomes among those who live here (Fairfax CHSA, 2011).

- Death rates are low. Death rates across all age, race, and gender demographic groups from all diseases and conditions in Fairfax County continue to be lower than those reported statewide.
- Birth outcomes are favorable. Infant mortality rates in Fairfax County, as well as Fairfax City and Falls Church City, are consistently below regional, state, and national infant mortality rates.
- Hospital use is comparatively low. An analysis of inpatient hospital utilization for the region indicates

patient days and discharge rates have decreased over the last decade. The rates of Ambulatory Care Sensitive Condition (ACSC) discharges – conditions that may be effectively managed in a medical office or clinic (e.g., diabetes complications, hypertension, and adult asthma) decreased 14.8 % from 2000 to 2009.[5]

- Long-term care facility use is comparatively low. Nursing home rates have decreased steadily for more than 25 years, a function of favorable demography, changes in treatment (diagnostic and preventative), and alternative care options (e.g., assisted living, adult day health care, etc.).

Despite the Fairfax Community's good health and relatively efficient use of health care facilities, many challenges to improving population health and resource efficiency remain.

- The use of costly, acute care services could be improved**.** Approximately 68,000 of the region's 257,000 ED visits (26 %) in 2009 were found to have conditions that did not require emergency department care. While this is more favorable than is found in many other communities, it accounts for a large number of visits and is a large, avoidable expense. Care delivered in a primary care office or clinic is a more appropriate alternative for non-emergencies and is less costly for treating non-acute medical conditions.
- Fairfax County's primary care capacity may not be adequate to meet projected service demand. In 2010, 39 % of all primary care physicians in the area were age 60 or older. New physicians entering the medical profession are less likely to elect primary care, and those who do choose a primary care practice are not entering at a rate fast enough to replace those who are leaving. Half of all Virginia RNs are expected to reach age 65 by 2014; between 20-25 % (18,248-22,810) are likely to reduce their work hours in preparation for retirement.
- The capacity of selected primary care and specialty health care providers may not be adequate. Providers who serve children, the chronically ill, the elderly, and those with disabilities and/or mental disorders will be in greatest demand in the future, particularly those who participate as a provider under Medicare and Medicaid programs.
- There are substantial disparities in health status and access to health care services across race, ethnic, age and income groups living in certain neighborhoods**.** Although the region ranks high in overall health and wellness, there are a growing number of individuals and selected populations who carry a disproportionate share of poor health and disease.

5 For a more thorough discussion of tertiary care utilization trends and service delivery efficiency opportunities, see the Fairfax CHSA Report, Chapter 3, Part II, page 61, September 2011.

Health Disparities

A growing number of individuals and selected populations across the county and in specific geographic areas are in poor health. In comparing differences between groups of residents such as Blacks and Whites in Fairfax County, there are negative differences in health status found for all reported health indicators. Similar outcome differences are found between Whites and Hispanic/Latino or Multiracial groups as well. Additionally, there is evidence of poorer health in geographic areas with high concentrations of low income residents (Fairfax CHSA, 2011). Differences that qualify as health disparities are found for the following of health outcomes:

- Mortality**:** Among the 3 leading causes of death in Fairfax County (heart disease, cancer, and stroke), Blacks had the highest age-adjusted mortality rates;
- Birth Outcomes: Teen pregnancy, low-weight birth and infant death rates are higher among Blacks than any other racial group;
- Disease: Death rates from cancer and high blood pressure are higher among Blacks, as are communicable disease rates for HIV/AIDS and Chlamydia;
- Chronic Disease Risk Factors: Black and Hispanic youth are less likely to eat 5 or more fruits and vegetables a day and are more likely to drink sodas;
- Mental Health: Black, Hispanic, and Multiracial youth are more likely to report mental health issues;
- Health Insurance and Access to Medical Care**:** Hispanics/Latinos were the most likely to be uninsured, accounting for 30.2 % of the county's total uninsured population; immigrants are more likely than native-born residents to lack health insurance.

The highest concentrations of racial and ethnic minorities are found in the Route 1 Corridor, Bailey's Crossroads-Culmore area and the Reston-Herndon area. The highest concentration of poor community health indicators is also found in these areas.

- Birth Outcomes: Census tracts located in the Reston-Herndon area, Central and Eastern Fairfax (especially Bailey's Crossroads-Culmore area), and the Route 1 Corridor have the highest rates of low birth weight infants.
- Hospitalizations**:** Higher emergency department use and higher hospitalization rates are found among residents living in Reston-Herndon, Bailey's Crossroads-Culmore, and the Route 1 Corridor.

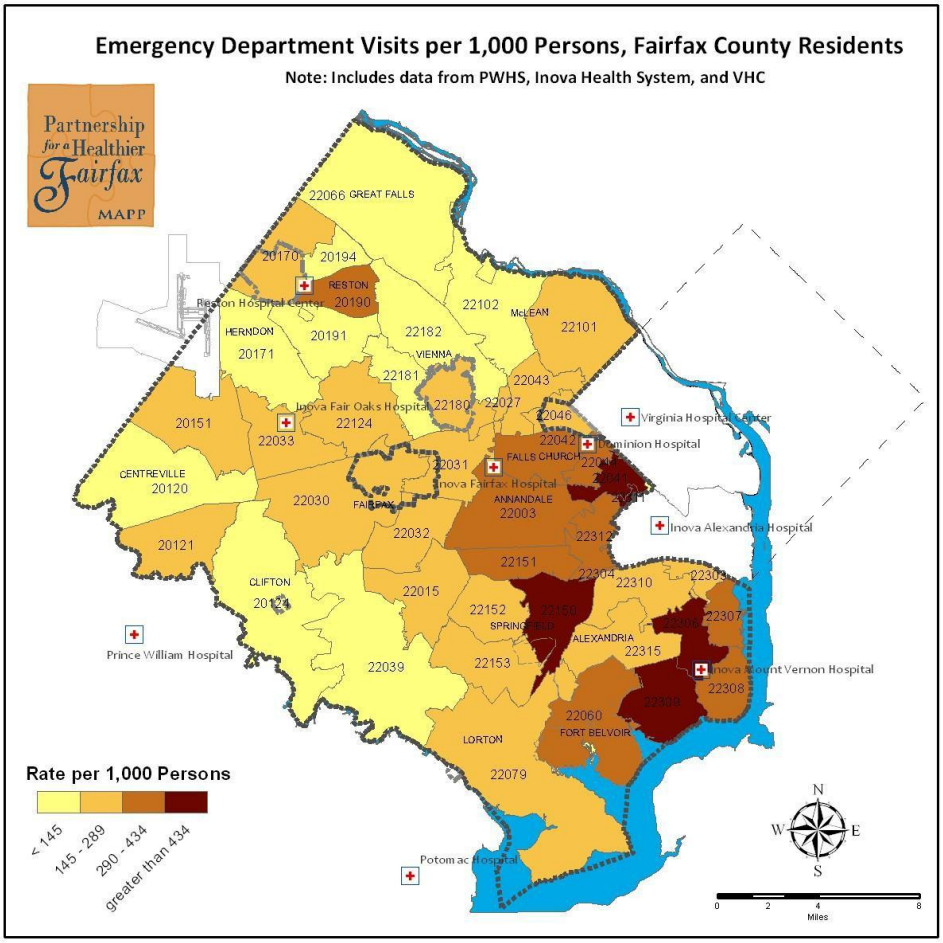
Emergency Department Utilization

Data from Inova Health System, the Virginia Hospital Center (Arlington), and Prince William Health System were reported on emergency department (ED) facilities use for Fairfax County residents and others. Emergency Department Data from Reston Hospital Center (northwestern Fairfax County) was requested by the CHSA taskforce, but was not available by the time of the CHSA report publication. Findings from the analysis of data on hospital emergency medical services use indicated wide variation across the Fairfax Community.

ED use by resident's zip code indicated differences that ranged from fewer than 100 visits per 1,000 residents to more than 500 per 1,000 residents. Use rates were found to be much higher for residents living in the Route 1 corridor and in communities in central Fairfax (Fairfax City), and the Reston-Herndon area. Across these areas, four zip codes in the Route 1corridor and Bailey's Crossroads (areas with a larger number of low-income and uninsured households) had higher ED use rates.

Between one-fourth and one-third of Fairfax County residents who visited emergency departments did so for diagnosis or treatment of conditions that did not require emergency care. Approximately 68,000 of the 257,000 ED visits (26 % in 2009), were found to have conditions that did not require emergency department care. Figure 1 depicts substantially higher ED use for basic medical services among residents from communities along the Route 1 corridor and in specific communities within the Capital Beltway in central and southeastern Fairfax County (Fairfax CHSA, 2011). Some 72.6% of the 4,100 individuals on the CHCN waitlist reside in the Route 1/South County area.

Figure 1: Fairfax CHSA, 2011



Source: HSANV 2010; Fairfax MAPP CHSA Technical Report, 2011

Overall, available data indicates emergency department use in the Fairfax community is relatively low, compared to other jurisdictions. However, variation ED use for non-emergency care is substantial for selected zip codes, particularly those with a higher percentage of low-income residents. Although the percentage of emergency department visits that are deemed "inappropriate" is relatively low for the area overall (approximately 26 %), they account for about 70,000 hospital emergency department visits by Fairfax residents each year and a larger percentage of low income residents (Fairfax, CHSA, 2011).

Health Workforce

Across Virginia, there are anecdotal concerns about the adequacy of the primary care workforce (physicians, nurse practitioners, physician assistants, and mental health professionals) and dental care professionals to meet the health care demands of low- income residents and those on public insurance (Medicaid and Medicare). While current data on the willingness and overall capacity of providers in the county to serve these populations is not available, we do know that there is an aging primary care workforce in this area. In 2010, 39 % of all primary care physicians in the Fairfax area were age 60 or older (NCAHD, Maddox, 2011).

The CHSA report identified concerns about sustaining current service levels, while addressing increased demand for health services that is expected from an aging population, the challenge of managing chronic illness in community settings, and increased access to health insurance under health reform. Concerns about the adequacy of the area's health workforce were identified relative to: inadequate supply, lack of diversity among providers and the imbalance between primary care and specialist providers. These concerns are consistent with the findings of the Governors Health Reform Advisory Committee and Virginia Health Reform Capacity Task Force (VHRI, 2011)[6]. "Virginia must acknowledge the health workforce capacity issues facing the Commonwealth today."

While having an adequate supply of health care providers is an important factor for access to health care, there are other considerations that contribute to workforce adequacy as well. The VHRI went beyond a discussion of workforce shortage concerns to identify four strategies to increase health care provider capacity in local communities (each one is relevant/has implications for Fairfax County in the future): 1) re-organizing care delivery practice into "teams" that can leverage scarce physician capacity by more extensive use of non-physicians in ways that are more consistent with their education and training than many current practices permit; 2) changing scope of practice laws to permit more health professionals to practice up to the evidence-based limit of their training; 3) expanding the use of information technologies, like telemedicine, electronic health records and health information exchanges to extend the geographic reach of existing health professionals; and 4) increasing the supply of health professionals. Specific recommendations for workforce development include increasing clinical training slots in the community for sought after health professionals and re-activating loan forgiveness and other programs that will increase retention of health professionals educated in Virginia."[7]

6 Virginia Health Reform Initiative: http://www.governor.virginia.gov/news/viewRelease.cfm?id=532
7 IBID

Fairfax Community Low Income and Safety Net Resources and Programs

An assortment of free and reduced-cost health services and resources are provided by a variety of public and private healthcare entities in Northern Virginia. As part of the Health Reform Task Force Planning Effort, the County compiled an inventory of Fairfax County Health Assets and Resources (FCHAR). The inventory identifies programs/providers and describes services the county supports. For some programs it reports data on populations served and budget/staffing resources provided (FCHAR, April 2011). In addition to the "recognized" safety net, other private healthcare providers (e.g., HCA Reston, Kaiser Permanente; Inova Health) make substantial contributions to direct and subsidized care for low income and uninsured area residents.

Our analysis of current safety net resources is based on the FCHAS (Appendix I) and two reports (recent and historical) that include observations about low income and Safety Net providers in this community (CHSA, 2011; Nolan, 2004). [8,9] We also reviewed the Institute of Medicine Report on America's Safety Net, 2000 (IOM, 2000).[10] Although no single commonly accepted definition of the 'safety net', the IOM committee defines it as follows: "Those providers that organize and deliver a significant level of health care and other related services to uninsured, Medicaid, and other vulnerable patients" (IOM, 2000, pg 4).

According to the IOM, core safety net providers typically include public hospital systems; federal, state, and locally supported community health centers (CHCs) or clinics (of which federally qualified health centers [FQHCs] are an important subset); and local health departments. In most communities, smaller special service providers (e.g., family planning clinics, school- based health programs, and Ryan White AIDS programs) also are considered a part of the core safety net. In some communities teaching and community hospitals, private physicians, and ambulatory care sites with a focused mission on serving the poor and uninsured fulfill the role of core safety net providers.[11]

Nationwide and in Fairfax, the health care safety net is neither comprehensive, nor well integrated. The Fairfax County Health Assets and Resources Inventory indicates a patchwork of entities and programs (county agencies, public, private and faith based organizations) that are providing a wide array of services ranging from information dissemination and advocacy to financial assistance/insurance, as well as direct health and medical care, mental and behavioral health, oral health and social support services.

Over the course of the Health Reform Task force meetings, a number of knowledgeable institutional representatives provided information and data on selected programs identified as part of the health safety net in this and adjacent communities. Presentations included detailed information about the organizations and their program missions

8 Fairfax Community Health Status Assessment, 2011: Fairfax Department of health MAPP website: http://www.fairfaxcounty.gov/hd/mapp/pdf/comm-health-assess-tech-rpt-02.pdf

9 Nolan, L. et al, "An Assessment of the Safety Net in Fairfax County, Virginia" 2004: http://urgentmatters.org/media/file/aboutProject_reports_Final_Fairfax.pdf

10 Lewin, M.E et al., America's Health Care Safety Net: Intact but Endangered (2000) Institute of Medicine, National Academy of Sciences.

11 Lewin, M.E et al., America's Health Care Safety Net: Intact but Endangered (2000) Institute of Medicine, National Academy of Sciences.

as well as information and data on their operations and contributions to serving the low-income and uninsured. The task force included heard from the following representatives from organizations: Inova, HCA, Kaiser Permanente, Montgomery County Primary Care Coalition, ANHSI, Greater Prince William Area Community Health Center, Loudoun Community Health Center. A representative from Cobb County- Douglas Georgia Community Services Board also presented to the Task Force. A complete list of guest presenters is found on page ii. Providers and programs that addressed the Task Force indicated that regardless of different scenarios for health reform implementation, a large number of disadvantaged and underserved in Northern Virginia and Fairfax County will continue to rely on the local array of safety net providers for the majority of their health care services. Thus, the local safety net programs may be the only providers available and accessible to low income and the uninsured. Many of these providers are uniquely situated and focused on addressing the special needs of defined groups in the community.

The Northern Virginia Health Services Coalition reported primary care safety net contributions to residents of Fairfax County and the cities of Fairfax and Falls Church by patient count. In 2010, 61,232 enrolled patients (unduplicated within programs) were served by 10 programs/entities, including the 3 FQHCs located outside Fairfax County. A subset of these programs (those with data) reported that 90 % of patients had incomes equal or lesser than 133 % of FPL and 70 % were uninsured. Among the insured, 30 % were covered through Medicaid and Medicare (28.8 % through Medicaid).[12]

Among county based programs, the Self-Sufficiency division of the Department of Family Services (the primary program responsible for public program eligibility and enrollment) reported a monthly average of 3,200 applications for financial assistance, 1,400 for Medicaid. From July to March 2011, they reported a total of 66,600 Medicaid program enrollees. In 2010, the Department of Medical Assistance Services (DMAS) identified a total of 72,516 Medicaid recipients from Fairfax County and the City of Fairfax with 63,650 children enrolled in the SCHIP program.

12 Northern Virginia Health Services Coalition, 2011

Table 2: Fairfax County, City of Falls Church and City of Fairfax Residents Seeking Financial and Medical Assistance services	
Assistance Program	**Active Enrollment/Patient Visits**
Medicaid Adult	28,322
Medicaid Children	61,061
FAMIS [Virginia SCHIP program]	9,357
Kaiser (children?)	2,108
Private Physician	248
Kaiser Bridge*	870
CHCN adults and children	26,588

*Contribution of nonprofit services to safety net/4.5 SYE Nurse Practicioners
Source: Fairfax Dept. of Family Services, Self-Sufficiency Division 2011

In 2010, the County supported Community Health Care Network of reported serving 26,197 adults, providing 51,447 primary care visits through three clinic sites. Annual in house and referred specialty care was provided to a total of 14,000 clients who received care from 280 contracted specialists. In 2011, 26,588 children and adults (unduplicated count) were enrolled. Program costs totaled over $9 million and fees collected amounted to $1,045,000.

Table 3 : County Health Services Program Activity, 2010		
Program	**Type**	**FY2010**
Adult Day Health Care	Unduplicated clients	357
Communicable Disease Services	Adult Immunization Visits	32,087
Homeless healthcare Program	Unduplicated Clients	439
Dental Services	Unduplicated Clients	2,401
Maternity Services	Unduplicated Clients	2,807
Women, Infants and Children (WIC)	Participants	19,122
Community Health Care Network	Clients Enrolled	26,157

Source: Fairfax Health Department, 2011

The Fairfax-Falls Church Community Services Board (CSB) provides behavioral health, substance abuse and disability services to a range of adults and children and has a growing primary care/behavioral health care program. CSB programs and services are directly operated or provided by private organizations licensed by the Virginia Department of Behavioral Health and Developmental Services. Service delivery is provided at 6 community outpatient mental health sites, more than 10 residential treatment facilities, and a 24- hour emergency services program. Recovery-oriented community-based services include: day support, residential, individual and group treatment, case management, and assistive community treatment (Fairfax County DMB, 2011).

In 2010, Mental Health Services served 11,447 individuals (slightly increased from 2009) with expenditures of over $56 million. The CSB reports serving an increased number of clients with co-occurring medical problems along with intensive mental health needs. One in four of their clients are over age 55 (a population that is aging in place). The CSB reported 2010 expenditures of over $25 million for Substance Abuse Treatment, $4 million for emergency mental health and $6 million for infant and toddler services for Part C IDEA eligible children.

In FY 2011 the CHCN reported providing services to 19,370 individuals from a total 26,588 enrolled. The Fairfax-Falls Church CSB reported providing services to 20,058 individuals. A total of 39,428 individuals received services from both agencies; 33,611 (unduplicated) were uninsured.[13]

Cost and Contribution of Fairfax County Health Programs

An approximation for the over-all cost of county supported health and social service programs and their direct contribution to community health services can be estimated from program budget/staffing expenditures. However the full cost of county supported and

13 Email communication from Ginny Cooper, January 26, 2012.

or operated health programs is not known and an estimate of the county's contributions relative to other community partners cannot be determined. Data gaps and inconsistencies prohibit a comprehensive analysis of program contributions by performance metrics. At present, it is not possible to make an objective determination of exactly who is being served (unduplicated counts and demographics) within and between programs. A compilation of agency self-reported and described assets, (number of clients served, and program costs or expenditures) for County programs is reported in the Fair fax County Health Assets and Resources (FCHAR), located in Appendix I.

An audit to check for client duplication was conducted by the CHCN and CSB by staff in those agencies in spring 2012. They reported the following findings:

The bottom line is the county's contributions to health and related human services programs (funding for direct and indirect services) to support a variety of services for a variety of 'needy' residents is significant, even with an incomplete data set. In addition, the county leverages private community resources and services and pursues public/private partnerships (e.g. MCCP) to ensure access to essential health services for selected populations. While this effort and the resources that support it are considerable, these health services are an important factor that contributes to the quality of life and economic vitality found in the Fairfax community.

Health Department Initiatives

As part of the Mobilizing for Action through Planning and Partnerships (MAPP) process, in November 2008, the Fairfax County Health Department brought together diverse representatives from the community, private organizations, public agencies, and commercial enterprises to conduct a Local Public Health System Assessment for the Fairfax Community. One weakness identified in the assessment was the local public health system's inability to mobilize partnerships to address community health issues. This prompted the formation of the Partnership for a Healthier Fairfax (PFHF). PFHF was established to address public health needs in the Fairfax community through collaborative action across the local public health system, including government, nonprofit, academic, faith, and business sectors.[14]
Promoted nationally since its development in 2001 by the National Association of City and County Health Officials and the Centers for Disease Control and Prevention, the MAPP initiative has brought together public, private, and corporate entities to conduct a comprehensive community health assessment, identify public health issues, develop goals and strategies to address them, and take action that will help the PFHF reach its vision: **"**Fairfax – An engaged and empowered community working together to achieve optimal health and well-being for all those who live, work and play here."
Using the MAPP process for public health planning (Figure 2), five strategic issues were identified for the Fairfax Community:

- Inadequate access to health services, including primary, oral, and behavioral health
- Inadequate Data
- Inadequate Environment and infrastructure
- Inadequate Health workforce
- Unhealthy lifestyles

14 Information on the Partnership for Healthier Fairfax may be found at http://www.fairfaxcounty.gov/hd/mapp/

Figure 2: Mobilizing for Action through Planning and Partnership (MAPP) Process[15]

15 Mobilizing for Action through Planning Partnerships Handbook, National Association of County and City Health Officials NACCHO; http://www.naccho.org/topics/infrastructure/mapp/upload/MAPP_Handbook_fnl.pdf

Over the next several years, the PFHF will develop goals and strategies to address these issues and take action steps to improve community health.[16] To support and extend this effort, Fairfax was awarded a Community Transformation Grant (CTG) by the CDC in 2012 [17]. As such, expanded community engagement for planning to improve the health of the community will be supported by the grant. An important goal of the grant is to establish sustainable relationships and programs that will address priority health improvement opportunities and health disparities in the community. Key to achieving sustainability is development of high level, cross-cutting leadership from public and private sectors alike and the development of infrastructure and arrangements to leverage available resources to meet defined health needs/goals, these needs will continue to change, as the community changes over time.

Based upon data and program information presented to the Health Reform Implementation Task Force from a variety of sources indicates the following challenges/concerns were identified:

1. The financial viability of core safety net providers is a concern because of the combined effects of four factors: (1) the rising number of uninsured currently and prior to PPACA; (2) Inadequate Medicaid and Medicare reimbursement levels and provider perceived excessive administrative demands; (3) the erosion of direct and indirect subsidies that have helped support safety net functions and; (4) uncertainty of private sector health service provider support and contributions (direct and indirect) to the CHCN and specialty clinics.

2. Difficulty in tracking the capacity, operations and contributions of Fairfax County Health Assets and Resources and their patchwork funding (both County and non-county entities), especially for programs and providers serving the uninsured and selected vulnerable populations. At present, it is not possible to objectively quantify capacity and access adequacy across the county.

    a. Fairfax County funds and operates primary care and dental clinics that provide comprehensive and basic primary care services exclusively to uninsured county residents. However, it is widely thought that only a portion of the total needs in the county are met through these programs. Waitlist information maintained by Dental Clinics and the CHCN are an indication of unmet needs at a given point in time.

3. While many county programs, area FQHCs and private health care providers currently serve low income and uninsured residents, it is clear that they have adapted to changing environmental conditions over, the last several years. The stresses of these changes and those

16 Fairfax MAPP and Partnership for Healthier Fairfax http://www.fairfaxcounty.gov/hd/mapp/mapp-partnership.htm

17 Information about the Community Transformation Grant http://www.fairfaxcounty.gov/news/2011/updates/healthier_communities_grant.htm

anticipated under health reform make it increasingly difficult to maintain their missions while protecting financial viability. In addition, the consequences of changing market forces, the increase in uninsured and eroding levels of reimbursement rates are discouraging or reducing the availability of providers and adversely affect the local capacity to serve these groups.

4. Many safety net providers in the county have successfully collaborated to improve access to services and the continuum of care offered to uninsured and underserved populations. However, a significant number of those serving vulnerable populations operate independently, with no formal linkages to other providers. More importantly, no data sharing is available with private providers and currently agency supplies are not integrated. Moreover, their data elements are not standardized and data validation and sharing must be done manually. Program data collection is neither standardized nor consistent across county department and programs much less than those provided by private sector partners. It is not possible to identify who is being served and they cannot identify what care and selected services might be optimized through care coordination, service integration and/or consolidation.

5. The county has limited capacity or authority for monitoring the capacity, utilization, costs and service quality among all providers and the patchwork of agencies and programs identified in the FCHAR. The county lacks the ability to obtain reliable, timely data to be able to take action to improve access to health services or program quality. Because of inadequate date and territorial data collection and management, the county cannot make a determination about the adequacy, effects and contributions of these programs on county needs, much less and assess the impact of changing environmental conditions on county resources.

As boards, authorities, commissions and county departments develop their own planning initiatives, there is a growing risk of uncoordinated planning. Technically, non-uniform planning assumptions and the proliferation of differing models that inform individual planning efforts with their unique 'take' on population health needs, will add confusion, not clarify an understanding of needs. Over time, this will contribute to a lack of system integration. This reinforces the importance of the County's leadership role in cross-program planning and performance management to effectively address health priorities and optimize resource use in the community. With implementation of various health reform initiatives, the county and local private health care providers will face increasingly complex choices to contain costs and assure essential health services. Efforts to provide and manage services and leverage resources from new sources are beyond

the scope or capacity of the public sector and reinforces why collaboration with private health providers in this region will be increasingly important in the future.

PPACA AND FAIRFAX COUNTY

In March 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law. The law is designed, among other things, to expand health care coverage to millions of Americans using a variety of policies and programs. This section of the report will address many provisions of the law which are likely to affect the rules of how healthcare insurance coverage and services are organized and obtained by individuals. The report will emphasize provisions of the law related to:

- Public health including various funding opportunities including grants;
- Medicaid expansion;
- Premium and cost-sharing subsidies for private health insurance coverage;
- Creation of new health benefit exchanges,
- New rules affecting some aspects of how insurance companies operate.

An implementation timeline of major PPACA provisions especially those items related to Fairfax County and Virginia is attached as Appendix II. PPACA includes a variety of provisions, which are designed to preserve and expand health insurance coverage. Some of these provisions became effective shortly after the law was passed, while others will be phased in over the next few years.

Provisions of the law will affect citizens, businesses, nonprofits, the Fairfax County government, and state governments in a variety of ways and to varying degrees. Fairfax County government will be affected by PPACA and health reforms both as a provider of health care services and as an employer that provides health insurance to its employees.

Early Implementation Provisions

Coverage expansion policies and programs included in PPACA, which have already been implemented, include a special insurance program for individuals with pre-existing conditions who have been uninsured for at least six months and meet other health status criteria making it unlikely that health insurance companies would offer these individuals coverage via the regular market. Virginia is participating in the program administered by the federal government[18]. Additionally, early policy changes include requiring employers offering family health insurance coverage to cover children up to age 26, even if the child is no longer living with his/her parents[19], prohibits lifetime coverage limits for essential benefits, requires first dollar coverage for preventive health services, and

18 Information on the high risk pool insurance coverage and application procedures are available from: http://www.healthcare.gov/law/features/choices/pre-existing-condition-insurance-plan/va.html

19 The law does not require coverage of dependents of the covered adult child. In other words, if a person covered under his or her parents' health insurance has children, a spouse, or in some states a domestic partner, the insurance plan is not required to cover these dependents.

prohibits health insurance companies from applying a pre-existing coverage denial for individuals under the age of 19. The Virginia legislature passed a law during the 2011 session which makes Virginia law consistent with the new Federal laws listed above and allows the Virginia Bureau of Insurance to enforce them.[20]

In 2014, additional rules related to insurance coverage will be implemented including prohibitions on pre-existing coverage exclusions for adults, elimination of annual coverage caps for services required under the essential benefits packages. In 2014 individuals, with a few exceptions, will be required to maintain health insurance coverage or be charged a special tax by the IRS. The requirement to maintain insurance is coupled with a guaranteed issue requirement that all insurance companies must accept all applicants for coverage regardless of pre-existing conditions, an expansion in Medicaid eligibility for those with incomes up to 133% of the Federal Poverty Guidelines, premium subsidies for health insurance coverage for individuals and families with incomes up to 400% of the poverty guidelines, and health insurance exchanges to provide individuals and small group employers an organized and unbiased market place to purchase insurance.[21]

Medical Loss Ratio

PPACA has provisions designed to reduce the costs of health insurance premiums, through minimum loss ratio requirements. A loss ratio is the fraction of premium dollars spent on medical services. One minus the loss ratio is also referred to as the "load" for a given premium, since it reflects the fraction of premium dollars going not for medical care but for marketing, selling, underwriting, administration, and profits or margins. Beginning with 2011 health plan years, insurance companies will be required to spend at least 80% of premium dollars (85% for large group plans) for health care and quality improvement.[22] Health plans which spend less than the minimum percentage of premiums on health care services and quality improvement will be required to issue refunds for the difference to enrollees. In other words if a small group health plan only spent seventy-five %% of the groups premiums towards clinical healthcare services and quality improvement efforts, the plan would be required to refund the 5% difference to the enrollees because the plan spent less then eighty %% for the coverage year. While many large plans already comply with these guidelines, in some states many insurance plans in the small and individual group markets spend well below the minimum loss ratio and they will have to change their business models or pay rebates. This is one of the points of insurance market reforms in the law; that is to essentially render excessive underwriting unprofitable after 2014.

Individual Mandate paired with Health Benefits Exchanges and Medicaid Expansion

Under PPACA there will be a new federal mandate for individuals to purchase health insurance beginning in 2014. There are several provisions that affect both individuals and employers with respect to health insurance coverage; including new tools to help individuals and small businesses

20 Virginia Acts of Assembly -2011 Reconvened Session, Chapter 882, Approved April 29, 2011. Specific code sections include: 38.2-3438 though38.2-4319

21 Various provisions of PPACA, copy of law found at: http://www.healthcare.gov/law/full/index.html

22 Healthcare.gov, "Medical loss ratio: Getting your money's worth on Health Insurance" posted November 22, 2010. Retrieved January 6, 2012 from: http://www.healthcare.gov/news/factsheets/2010/11/medical-loss-ratio.html

purchase health insurance. This will primarily be achieved using Health Insurance Exchanges, revising medical loss ratio requirements, and implementing premium credits and cost sharing credits for individuals and families, and implementing guaranteed issue of insurance (regardless of the enrollees' current or past health status). Additionally, some provisions address insurance companies and limit the variables they may use in the future to justify differences in individual premiums.

As regards premiums, PPACA allows for a difference in premiums only for certain factors including: location, age (no more than 1 to 3) and smoking status (no more than 1.5 to 1). Currently, health insurance companies, especially in the individual and small group markets, often collect extensive health information of the potential enrollees for use in underwriting the plans and determining the premium price and deductible levels for health insurance plans. In 2014, collection of this information to determine the premium and deductible will no longer be allowed for health plans inside and outside of the exchange. Utilizing community ratings, rather than individual/group underwriting, represents a fundamental change in the way in which health insurance will be sold in the United States.

Health Benefits Exchange

A major component of national health care reform legislation is that it calls for establishing healthcare benefits exchanges, to support the purchasing of affordable individual and small group insurance plans.[23] The health benefits exchanges will also make information about the various plans available in ways that are comparable and non-biased (the exchange employees will not have an interest in any customer selecting any specific plan). The Exchanges will also screen individuals and families for eligibility for Medicaid and premium and cost- sharing subsidies (discussed in detail below) for plans purchased though the exchange. Historically, the small and individual group health insurance markets have provided a lower value per premium dollar than the large group market for a variety of reasons. Some have to do with the selling, administrative, and risk pooling economies of scale which small groups and individuals purchasing insurance on their own never can match. Many of the selling and administrative costs are fixed, so the per person cost falls as group size rises. With large numbers, there is less variance in health expenditures between large and small groups. Small groups and individuals have unpredictable variations all the time, and insurers demand risk premiums to cover that. PPACA allows each state the option to develop one or more health insurance benefits exchanges to provide a market place to individuals and small group markets or to have the federal government come in and run the marketplaces. The exchanges are designed to provide transparent information on available health insurance plans and also serve to screen individuals for eligibility for Medicaid as well as premium subsidies and cost sharing credits. Plans offered inside the exchange will be required to cover an essential benefits package which will include a minimum set of services and benefits. The Department of Health and Human Services recently published a proposed rule that allows each state to determine the minimum benefits package as long as it includes services in several major categories.[24] The Department sets some guidelines but the law allows states to make a variety of choices to tailor the design of the exchanges to the preferences of the states. Details regarding some of the

23 PPACA Section 1302 [U.S.C. 18022]

24 Essential Health Benefits: HHS Informational Bulletin, December 16, 2011. http://www.healthcare.gov/news/factsheets/2011/12/essential-health-benefits12162011a.html

choices that states have in designing their exchanges are discussed in a later section of this report in the context of deliberations of the Virginia Health Reform Initiative (VHRI).

Under PPACA, the Federal Government will operate exchanges in states that choose not to develop their own. Individuals legally in the United States will be eligible to participate in the health insurance exchanges, with all enrollees under 400% of the poverty line eligible to receive premium credits (subsidies) with those under 250% of poverty receiving cost sharing credits in addition to the premium credits. The cost sharing credits are designed to reduce the out of pocket costs paid for health care services by these individuals.

The premium subsides and cost -sharing credits will be based on the second lowest cost for the silver level plan, 70% actuarial value (explained below), in the specific exchange where the individual is eligible to purchase their insurance. Individuals will be eligible to utilize a specific exchange based on their geographic location and only one exchange may cover any given geographic location. Multiple plans are expected to be offered within each exchange. PPACA designates five levels of plans that will be available within the exchange. The levels are designated by the actuarial value the plan will cover. The actuarial value is the average percentage that the plan will pay for specific covered services obtained by the average enrollee. The remainder of the costs will be out of pocket costs paid by the enrollee. Plans will have latitude to design the actuarial value in different ways, for example, through the use of co-pays, co-insurance, and deductibles. However, the law limits deductibles to a maximum of $2,000 for individuals and $4,000 for families. Plans within the same level can also have different organization types such as HMO and PPO. The five levels of plans in the law include Bronze, Silver, Gold, Platinum, and Catastrophic. The Catastrophic plans are limited to individuals under 30 years of age who meet additional criteria. The chart below shows the actuarial value for each level.[25]

25 Chart created from information in PPACA Section 1302

Table 4 : Plan Types	
Level	Actuarial Value
Bronze	60%
Silver	70%
Gold	80%
Platinum	90%
Catastrophic	Actuarial Value not determined. The plan may only be offered in the individual market, participants must be under 30 years of age who meet certain financial criteria

Understanding Actuarial Value

As discussed above, the actuarial value of each plan determines what percentage of the costs the plan will pay towards the health services an enrollee will receive and how much the enrollee is expected to pay. The example below will illustrate how the actuarial value relates to the amount the enrollee will pay throughout the year for services, and how this relates to their income.

Example:

Jill, Tim and Sam all work for the same company in Virginia. Jill is a full time receptionist and earns an annual income $14,405 or just over 133% of the poverty line. Tim is an administrative assistant and earns a salary of $ 28,158 or 260% of the poverty line. Sam is an accounting assistant at the same firm who earns $43,321 annually or just over 400% of the poverty line. Their employer offers a health insurance plan with an actuarial value of 70% and a load of .2 and an annual premium of $5,200. The company pays 50% of the premium for the individual (self only) coverage with the employee required to pay the other 50%. In this case the employees pay $2,600 towards the premiums and expect to pay an average of $1,857 out of pocket based on the actuarial value of 70% after insurance coverage for health care expenses. If Jill accepts enrollment in the plan she will be paying 18% of her income for the premiums and an additional 13% of her income in out of pocket health care expenses. Jill will be eligible to enter the health benefits exchange, enroll in a health plan and receive both premium subsides and cost sharing credits because her share of the employers premium is above 9.5% of her income. Premium tax credits and Cost Sharing are described in greater detail below. As shown in the premium assistance section below, Jill would likely be better off accepting exchange coverage as she would only be expected to pay 3-4% of her income for her health insurance. Jill's employer would be charged a penalty tax if Jill chose to purchase a health plan though the exchange with subsidies instead of accepting the

employer coverage. Under the employer plan, Tim's health insurance premium is 9% of his income and the expected out of pocket expense are an additional 6.6% of his income. Tim may be expected to pay a similar or slightly less percentage of his income towards a similar plan in the Exchange. Tim will be ineligible for premium subsidies and cost sharing credits as the premium is below 9.5% of his income. Sam's health insurance premium is 6% of his income and his expected out of pocket expenses are an additional 4% of his income. Because Sam's income is above 400% of poverty, if he chose to purchase coverage though the exchange instead of enrolling in the employer's plan, his employer would not be charged a penalty because he would not be eligible for a subsidy.

Table 5 : Examples of Health Insurance Spending by Exemplar Individual

Employee	Salary	Health insurance* premium share of employee	Premium as a % of income	Expected out of pocket expenses	Expected out of pocket expenses as a % of income	Total health expenditure by employee	Total health expenditures as a % of employees income
Jill	$14,405	$2,600	18%	$1,857	13%	$4,457	31%
Tim	$28,158	$2,600	9%	$1,857	6.60%	$4,457	15.80%
Sam	$43,321	$2,600	6%	$1,857	4%	$4,457	10%

*The total annual premium for this plan is $5,200 with the employer and employee sharing the costs 50/50

It is important to note that as individuals' income rises they are more likely to be better off with their employer offer of health insurance as the exchange subsidies phase out and the percentage of their income going towards health insurance premiums goes down. The chart below shows the premium and expected out of pocket expenditures by Employer penalties for not offering coverage and for employees who receive subsidies in the Exchange are explained later in this section. [26]

26 Expected out of pocket payout calculated: P=(1+L) E[B] p=premium, L=load, E= , B=payout by insurer, AV = Actuarial value, X=Expected health spending, from example above: 5200=(1+.2) E[B] = 5200/1.2=4333.33; E[B] =$4333.34/.7=$6,190= total health spending so E[B]=$6,190-$4333.33=$1857.14

Medicaid Expansion

Individuals who are below 133% of the Federal Poverty Level (FPL) are eligible for Medicaid and are not eligible for subsidies within the exchange. Individuals and families with income at or below 133% of poverty will be eligible for Medicaid.[27] Determination of financial eligibility rules for Medicaid involves complex formulas including which sources of income are included in the calculation in addition to the value of certain owned asset limits in some categories. These formulas vary by state and eligibility categories. For many categories of eligibility PPACA provides standardize formulas for income determination called the Modified Adjusted Gross Income (MAGI). Additionally, the new eligibility rules include a 5% income disregard for certain eligible classes in Medicaid and for the exchange subsidies. Determination for dual eligible and a few other categories (individuals eligible for both Medicare and Medicaid) will be maintained under the existing system. [28]

A significant change in Medicaid eligibility will be that neither family status nor health status (i.e. disability or pregnancy) will be taken into account for those under age 65. This opens up Medicaid to new groups of people, especially childless adults, who currently have had limited access to Medicaid in most states including Virginia. It is important to note the categories of eligibility for those over 65, will remain under current rules (income and health status). Additionally, individuals who age out of foster care will be eligible for Medicaid coverage until the age of 26. States will be required to screen individuals and determine if they are eligible under the existing rules (2010 rules) or are newly eligible due to PPACA. States will continue to receive funding for individuals enrolled in Medicaid under existing rules in the same way they are today, which is based on a federal-state financial match rate. In Virginia, the state share is usually around 50%. The newly eligible and enrolled populations will be covered at higher rates by a significant change in Medicaid eligibility will be that neither family status nor health status (i.e. disability or pregnancy) will be taken into account for those under age 65. This opens up Medicaid to new groups of people, especially childless adults, who currently have had limited access to Medicaid in most states including Virginia. It is important to note the categories of eligibility for those over 65, will remain under current rules (income and health status). Additionally, individuals who age out of foster care will be eligible for Medicaid coverage until the age of 26. States will be required to screen individuals and determine if they are eligible for Medicaid and under the original or expansion eligibility rules.

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27 PPACA Sections 2001-2004. Also legal immigrants who do not meet the five year residency requirement to qualify for Medicaid can enroll in the exchange with subsidies if their income is in Medicaid range.

28 Mulvey, J., Baumrucker, E., Fernandez, B., Scott, C., " Definition of Income in PPACA for Certain Medicaid Provisions and Premium Credits" Congressional Research Service, October 24, 2011, Report R41997.

Premium Assistance

Beginning in 2014, individuals with incomes equivalent to 133% to 400% of poverty line are eligible to receive premium assistance credits on a sliding scale if they purchase insurance through the individual exchange. The scale provides greater assistance for those with lower income than those with higher income.[29] Individuals receiving premium assistance will be able to purchase individual or family insurance plans from the health care exchange in their area. The subsidy will be based on the premium price for the second lowest cost silver level plan within the specific health exchange and the amount paid for the credits will be determined based on a percentage of the income of the enrollee(s) as described in the chart below. The credits will pay the difference of the premium of the second least expensive silver plan in the exchange from which the individual is purchasing the insurance from and the premium share for the individual based on a % of their income. PPACA states that the premium assistance will be based on a linear scale within the guidelines shown in the chart below. The US Secretary of HHS will determine the exact formula though regulation. Should the person choose a different plan then the one the subsidy is based on the person will be required to cover the premium difference. For example, if the person chooses gold instead of silver plan they will have to pay the difference.[30]

29 PPACA, Premium tax credit, Sections 1401

30 In the table below calculations were made based on 2010 poverty guidelines and PPACA sections
PPACA, Sec 1401 Sec 36(B)(A), http://www.healthcare.gov/law/full/index.html
Poverty Guidelines from US Department of Health and Human Services, http://aspe.hhs.gov/poverty/10poverty.shtml, http://aspe.hhs.gov/poverty/10poverty.shtml

Table 6 : Determination of Premium Assistance			
Household income as percent of the poverty line	Actual income using 2010 poverty guidelines	Percent of income required by individuals/families for premiums	Annual premium share for individual (based on 2010 income levels)
Under 133%	>$14403.90	Eligible for Medicaid	
133% up to 150%	$14,403.9 - $16245.00	3%-4%	$432.11 - $649.80
150% up to 200%	$16245 - $21,660	4% to 6.3%	$649.80-$1364.58
200% up to 250%	$21,660-$27,075	6.3% to 8.05%	$1364.58-$2,179.54
250% up to 300%	$27,075-$32,490	8.05% to 9.5%	$2,179.54-$3086.55
300% up to 400%	$32,490-$43,320	9.5% to 9.5%	$3086.55-$4115.40

Cost Sharing Credits

The Federal Government will provide individuals and families below 250% of the poverty line with cost sharing credits to raise the actuarial value of their cost sharing (the effect of this is to lower their out of pocket costs such as co-pays or co-insurance etc.) Cost sharing credits will also be calculated on a sliding scale moving from 133% of poverty to 250% of poverty. The cost sharing credits are only available for use with a silver level plan and will raise the actuarial value of the benefits for coverage. The cost sharing credits are provided directly to the health plan in the form of a capitated payment for each eligible enrollee in the plan. [31]

31 Information on cost sharing credits from: Angeles, J. "Making health care more affordable: the new premium and cost-sharing credits" Center for Budget and Policy Priorities, May 19, 2010: http://www.cbpp.org/cms/index.cfm?fa=view&id=3190

Table 7: Cost Sharing Credits	
Income as a Percent of Poverty	Actuarial Value*
>150%	94%
150% up to 200%	87%
200% up to 250%	73%

* The Cost Sharing credits work are added to silver level plans (70% actuarial value) to raise the AV as shown in the chart

Individual Mandate

Penalties for not having credible health insurance coverage will be phased in over several years. The penalties are based on a % of income. The penalty for those below the age of 18 will be half the adult rates. The penalty will be prorated monthly. For each month not covered, the penalty will be 1/12 the annualized total.[32] There will be exemptions for hardship and for those who meet specific requirements to qualify for a religious objection.

32 PPACA (Consolidated),Chapter 48- Maintenance of Minimum Essential Coverage. Sec 1501/5000A, pages 145-150 http://housedocs.house.gov/energycommerce/ppacacon.pdf. This section was also used to create the table 8.

Table 8 : Penalties for Individuals without Health Insurance		
Year	Percentage of income	Minimum flat fee
2014	1%	$95.00
2015	2%	$325.00
2016	2.50%	$695.00
2017	2.50%	Indexed based on formula

Reinsurance for Early Retirees

The Reinsurance program for early retirees (those between 55 and 65) provides reimbursement to employers health plans to reduce the risk of covering former employees who may need significant and/or expensive health services. The program works by reimbursing an employer's health plan for health services for individuals whose expenditures reach a minimum threshold. Currently, Fairfax and Fairfax County Public Schools are participating in this program.[33]

Employer Incentives

Beginning in 2010, small business with 25 or fewer full time equivalent employees and average annual wages below $25,000 can receive refundable tax credits for up to 35% of the employer share of the premiums.[34] The owners or partners of small businesses are not counted toward the number of employees nor are their family members. The tax credits are designed to assist small employers who have not offered health insurance in the past year with financial incentives to offer health insurance to their employees.

Employer Penalties

It is important to note small employers with 50 or fewer full time equivalents (FTE) are not subject to penalties if their employees purchase insurance though the exchange and receive premium subsidies or for not offering

33 Healthcare.gov; Virginia Early Reinsurance Program. http://www.healthcare.gov/law/features/employers/early-retiree-reinsurance-plan/va.htm

34 PPACA, Small Business Tax Credit, Section 1421

insurance at all.[35] The law defines a full time equivalent employee to be an employee who works an average of more than 30 hours per week. There will be penalties for employers with more than 50 full time equivalents who have employees who purchase a health plan though the Exchange and receive a premium subsidy or for employers who do not offer creditable health insurance coverage (minimum 60% actuarial value covering the essential benefits package) to their employees. The method and amounts used for calculating penalties is depicted below:
Employers with more than 50 FTE's who do not offer health insurance will be required to pay a penalty as follows: $2000 per employee after the first 30 full time equivalent
$2000 (N-30) = penalty where N=Total number of full time equivalent employees

Penalty = the lesser of [$3000(E)] or [$2000 (N-30)]

E=number of employees receiving subsidy from the exchange

N=Total number of full time equivalent employees

An additional requirement for employers with greater than 200 FTEs who offer health insurance coverage will be required to automatically enroll new employees into one of the health plans they offer. The company can provide employees an opportunity to opt out of the coverage or choose if the company offers more than one plan to choose among the health plans well.

Employers Who Offer Health Insurance

Employers who offer health insurance coverage to their employees must be at least a bronze level plan which is 60% of the actuarial value in order for the coverage to count as creditable insurance coverage. The employer will be penalized on an individual employee basis for each employee who chooses to obtain coverage and receives subsidies from the Exchange. The employee will be eligible for a subsidy if their income is 400% or less of the poverty line. The employer will be penalized $3,000 per employee that receives a subsidy for insurance coverage purchased though the exchange. The employer's penalties are capped at the penalty amount for not providing insurance at all. The Penalty Formula for employees receiving subsidies though the Exchange is as follows:

35 PPACA, Shared Responsibility for Employers, Section 1513 and Sec 4980H

PUBLIC HEALTH PROVISIONS

Funding Opportunities

PPACA includes a variety of public health provisions. Of significance is a $15 billion commitment over ten years to public health programs though the creation of the Prevention and Public Health Fund (PPHF). States, local governments, and private organizations have already received significant funds though grant, demonstration, contracts, and other programs. Fairfax County was awarded a Community Transformation Grant of $499,559 for each of the next five years for capacity building to create policies that will reduce and prevent obesity, chronic disease, and smoking rates within Fairfax County as a whole. Additional funding opportunities will be announced over the next several years. A chart detailing programs expected to be undertaken for which Fairfax County, Virginia, or DMAS may be eligible to apply is found in Appendix III.

Nonprofit Hospitals: Community Health Needs Assessment

Related to the health care safety net, is the requirement that nonprofit hospitals must complete a Community Health Needs Assessment, (CHNA) every three years, determine specific healthcare needs of the community served by the hospital *and* explain how they will, or why the hospital cannot , fulfill the health needs of the community they serve.[36] The law requires each hospital to complete a separate assessment, even if they are owned by an organization with multiple hospitals. The IRS has already published rules and guidance for these assessments and will serve as the main regulatory authority over the Community Health Needs Assessment requirements. Hospitals will face a $50,000 excise penalty for failure to complete the assessment. The assessment must include the participation of the individuals and/ or organizations which are knowledgeable about of the needs of the community. The report must be publically available. The IRS rules do not require a specific amount or percentage of charity care and community benefit that must be performed to maintain nonprofit status. The IRS does require that nonprofit hospitals report the charity care on form 990H. Nonprofit hospitals are required to maintain a charity care policy, make the policy publically available and provide copies to patients[37].

Medically Underserved Populations (MUP), Medically Underserved Areas (MUA), Health Professional Shortages Areas (HPSA) determination rules

Fairfax County has undertaken several efforts since 2002 towards obtaining a Medically Underserved Population designation. The early efforts included a regional "application for Exceptional Medically Underserved Population Designation" for areas within Fairfax and Arlington Counties and the City of Alexandria. However, upon further review of the data, the application was amended prior to submission to Health Resources and Services Administration (HRSA) by dropping Fairfax County in order to improve chances for the Arlington and Alexandria areas to gain the MUP designation. After the completion of a Primary Care Physician Survey report, the Fairfax County Health Department submitted an Application for

36 PPACA, Additional Requirements for Charitable Hospitals, Section

37 Implementation information available from IRS, New Requirements for 501c3 Hospitals Under the Affordable Care Act, http://www.irs.gov/charities/charitable/article/0,,id=236275,00.html

either a Medically Underserved Population or Exceptional Medically Underserved Population Designation for Spanish-speaking residents in select contiguous census tracts of Bailey's Crossroads region in Fairfax and Arlington Counties to the Virginia Department of Health. The application was not forwarded to HRSA. In January 2012, Fairfax County submitted an application to the Virginia Department of Health for review. The current application is seeking an Exceptional Medically Underserved Population Designation for contiguous census tracts in the Mt. Vernon (Route One) area of Fairfax County.

The US Department of Health and Human Services has a committee to create new rules for designation MUPs, MUAs, and HPSAs[38]. When a community has one of these designations, it is eligible for a variety of special funding opportunities and programs to provide health care services. Currently Fairfax County does not have any of these designations, despite a large number of uninsured individuals. A major program for communities with one of these designated is the Federally Qualified Health Centers, (FQHCs). These centers are often known as Community Health Centers (CHCs). Community Health Centers focus on primary care and also offer dental and behavioral/mental health services. A major advantage of CHCs is that they receive some operational funding from the Federal Government and also receive cost based reimbursements for Medicaid and Medicare patients. Federally qualified health centers are considered safety net clinics and are required to accept patients on Medicaid, Medicare and individuals without insurance. Most also accept some private insurance plans.

Menu and Vending Machine Labeling Rules

As a part of the public health and prevention provisions in PPACA, the federal government is creating regulations requiring that certain nutrition information be on large chain restaurant menus and items sold though vending machines. This provision is intended to help people make healthier choices when purchasing prepared foods and improve daily calorie intake.[39]

38 Information on the committee and proceedings available http://www.hrsa.gov/advisorycommittees/shortage/

39 PPACA, Nutrition labeling on standard menu items at chain restaurants, Section 4205; Additional information available from the FDA at http://www.fda.gov/food/labelingnutrition/ucm217762.htm

VIRGINIA HEALTH REFORM INITIATIVE

Introduction

The federal health reform law is designed to ensure cooperation and collaboration with states on many issues, especially health insurance coverage expansion. State government choices are extremely important to understand policy options for counties and citizens alike. This section summarizes and describes the Commonwealth's activities that are most relevant to health reform in Fairfax County.

The Virginia Health Reform Initiative

In August of 2010 Governor McDonnell appointed 24 high profile stakeholders and office holders from around the state to the Advisory Council of the Virginia Health Reform Initiative (VHRI). This effort was spearheaded by Secretary of Health and Human Resources, William A. Hazel, MD. It was tasked with developing an overall implementation plan that will work best for the Commonwealth.[40] The VHRI Advisory Council and six task forces then met three times each. December of 2010, the Council made 28 formal recommendations to the Governor and General Assembly.[41] The most important recommendations as they relate to Fairfax County were:

1. Virginia should create its own health benefits exchange, to avoid the risk of federal takeover of its insurance markets.
2. Virginia should seek appropriate federal grants to get ready to implement the reform law.
3. Virginia should pass insurance market reforms congruent with the PPACA so that it can enforce the new insurance market laws and not depend upon the federal government.
4. Virginia should strive to make the insurance market work better for small businesses.
5. Virginia Medicaid should require electronic claims forms submission at a date certain, soon.
6. Virginia Medicaid should explore care coordination opportunities.
7. Virginia Medicaid should explore demos and pilots pursuant to the PPACA.
8. Virginia Medicaid should study the potential role of cost sharing and incentives in benefit design and access to the highest possible quality of care.
9. The Secretary should be a catalyst for payment and delivery reforms within the Commonwealth by convening, articulating, and leveraging information and initiatives to spread as fast as possible.
10. Virginia should seek federal funding for payment and delivery reforms and the state should be flexible where necessary

40 Elmendorf, Doug. CBO's Analysis of the Major Health Care Legislation Enacted in March 2010, http://www.cbo.gov/ftpdocs/121xx/doc12119/03-30-HealthCareLegislation.pdf .
41 Hazel, Bill et al. Virginia Health Reform Initiative http://www.hhr.virginia.gov/initiatives/healthreform/ .

to facilitate these new models being tested.

11. Virginia should protect the safety net and smooth its transition to the health care system of the future.
12. Virginia should expand access to telemedicine.
13. Virginia should undertake to become a Medicare demonstration project for the underserved which can be addressed through telemedicine.
14. Virginia should target broadband access investments.
15. Virginia should explore an all payer claims data base to promote transparency and to focus reform efforts appropriate for each community.
16. Virginia should study how to reorganize care delivery practices into "teams."
17. The Secretary should develop recommended changes to scope of practice laws.
18. Virginia should promote the expansion of health information technologies.
19. Virginia should increase the supply and improve the distribution of health professionals.

Pursuant to these recommendations, in the short legislative session of January-February 2011 the General Assembly passed two bills that the governor signed into law. HB 1958 gave the Commonwealth the authority to enforce the insurance market reform provisions that went into effect in September of 2010. HB 2434 was even more important, for it directed the Secretary to consult Commonwealth stakeholders and experts and submit a report to the Governor and to the General Assembly by October 1, 2011 which will outline a plan for creating and operating a health benefits exchange that is compliant with the PPACA. In addition, the Governor's budget submission included new state moneys devoted to the state share of an information system that Medicaid would leverage to purchase with a 90-10 federal-state match and thereby, for minimal state investment, create a one-stop enrollment and eligibility determination system across all social and health services. It is intended for the system to improve enrollment efficiencies across social programs for the Commonwealth and its citizens, as well as be compatible with the "no wrong door" eligibility system required by the PPACA for the new health benefits exchange and the Medicaid program. That RFP has been issued, an information system contractor has been selected, and work has begun. This new eligibility and enrollment system could have implications for Fairfax County enrollment procedures and staffing, once it is operational in 2013.

The Secretary chose to use the VHRI's Advisory Council to perform the consulting/advice role envisioned by the legislature in HB 2434. The VHRI Advisory Council met three times from May until September, heard presentations from experts and debated key choices, and voted in September to recommend four key points to the Governor and General Assembly that Virginia:

1. Create its own health benefits exchange (HBE) rather than have the federal government run one in the Commonwealth
2. House the Exchange in a new quasigovernmental entity, like the Virginia Housing Development

Authority, with a balanced and independent governing board
3. Combine the administrative functions of the HBE into one entity but have separate risk pools for small groups and for individuals
4. Design its HBE to be compliant with PPACA but not take more aggressive steps to become an "active purchaser," i.e., to place more requirements on plans to qualify to sell within the HBE than already required by PPACA.

The Secretary submitted his report, explaining the process and recommendations of the Advisory Council, to the General Assembly on November 25, 2011. The Governor appended a transmittal letter, in which he expressed his continuing opposition to PPACA and his belief that the Supreme Court will strike the law down in its entirety. He also iterated his opinion that reform is necessary to improve Virginia's health system, but he expressed frustration with various delays in federal regulation and guidance pursuant to PPACA that have made it difficult for Virginia to complete its exchange planning process and led him to question the viability and wisdom of a state-run health benefits exchange over a federal exchange, if implementation is indeed forced upon Virginia in 2014.[42] Thus, the McDonnell administration's legislative strategy for creating or opposing a state-based exchange in 2012, and thus to minimize the risk of a federally run benefits exchange in 2014, (if the law still stands then), is unclear at this time.

42 Hazel, Bill et al. Report Pursuant to House Bill 2434: Virginia Health Reform Initiative (VHRI) Advisory Council recommendations for a Health Benefit Exchange (HBE). http://www.hhr.virginia.gov/initiatives/healthreform/docs/LetterAndHB2434Report2011.pdf

The Supreme Court is expected to rule on the constitutionality of the law, and various specific provisions in it, including the individual purchase requirement or mandate and the very large Medicaid expansions, by the end of June 2012. At that point, a special session of the legislature may be necessary to avoid the risk of the federal government implementing a federal exchange in Virginia, should President Obama be re-elected in November of 2012. In January of 2013, HHS will assess states' progress toward having an exchange operational by January of 2014. In the meantime, essential and seamless ("one-stop shop") eligibility and enrollment system development, which will be efficiency enhancing to the entirety of DHHR and Fairfax County whether PPACA survives or not, is proceeding with all appropriate speed.

Pursuant to Secretary Hazel's leadership consistent with the VHRI Advisory Council's recommendation to be a catalyst for delivery system transformation, (recommendation 9) in December of 2011, the Virginia Chamber of Commerce, the Virginia Health and Hospitals Association and the Medical Society of Virginia agreed to jointly support the creation of the Virginia Health Innovation Center (VHIC). The Center is designed to help design and coordinate collaborative projects among Virginia health providers, plans and employers to improve quality, lower cost, and improve the health of Virginians. The VHIC is currently coordinating applications and negotiations with the federal Center for Medicare and Medicaid Innovation, the lead federal agency for national systems transformation.

The Virginia Department of Medical Assistance Services (DMAS) is currently

planning implementation of PPACA's projected large (over 400,000 people) expansion of Medicaid coverage in Virginia beginning in 2014. However, regardless of the outcome of the national elections in the fall of 2012, a flurry of state requests for slowing the expansion to match enrollment staffing and state budgeting realities may occur. While the federal government pays 100% of the costs of the newly eligible for Medicaid in the first two years (and 90% in perpetuity thereafter), the current state match (50-50 for a high income state like Virginia) would apply to what could be a large number of currently eligible, but un-enrolled, Virginians. Thus, the increase in state spending on Medicaid, even in 2014, could be substantial. Should Virginia opt to pursue delays in expansion scheduled for 2014, this will significantly impact the estimated 32,000 Fairfax residents who would otherwise be enrolled in the newly created health exchanges and the 27,,000 we expect to enroll in Medicaid, and would continue to create increasing service pressure on the local health safety net providers, both public and private.

To provide a frame of reference for future Medicaid growth in this area, in 2010, DMAS reported the number of Fairfax County and Fairfax City adults served through its Medicaid fee for service and HMO programs totaled 72,516. Also for 2010, some 16,555 children from Fairfax County and the City of Fairfax received services under the Virginia CHIP program.

QUANTITATIVE ANALYSIS

Introduction and Big Picture Results

One of the major goals of the federal reform law is to greatly expand access to affordable health insurance coverage and quality care. Since Fairfax County's health service providers and funding priorities largely serve the uninsured population with few alternative options to obtain the care they need, it is of paramount importance for the Health Care Reform Task Force to be able to understand and anticipate changes in the size and composition of the uninsured population. The type of coverage gained (or lost) will also be important to analyze, since many county providers today do not serve Medicaid patients on the historically reasonable assumption that they would be able to obtain needed services elsewhere, either from safety net health centers, hospitals, or private physician offices.

The Congressional Budget Office estimated at the time of the reform law's passage in March of 2010 that roughly 2/3 of the uninsured or 33 million Americans would gain coverage, thereby reducing the national uninsured rate from sixteen per cent to six % by 2019. Of those who gain coverage, over half are expected to enroll in Medicaid.[43] For the Virginia Health Reform Initiative [44], the Urban Institute estimated that about half of the Commonwealth's uninsured would acquire coverage, or 594,000 Virginians, leaving 8.6% uninsured. For Virginia as a whole, they estimate that 420,000 of the newly covered, or roughly 3/5ths, would be eligible for and enroll in Medicaid.[45]

As reported in the peer county review section, the population of Fairfax County has a much higher average income than that of the Commonwealth and the nation. As a consequence, private insurance coverage is much more common here, and living without health insurance less so. Still, according to the US Census Bureau's most recent American Community Survey (ACS) 144,532 Fairfax County residents were uninsured in 2010. This represents 14.9% of the non-elderly population (13.5.4% of the total population). Thus, even in the richest county in Virginia and one of the richest in the nation, one in seven in have no health insurance.

The data and methods used in our methodology yielded results that informed the following effects of health reform in the county:

1. The number and % of uninsured will fall by slightly more than half (58,718).
2. More than half of these (32,461) will gain private insurance and slightly less than half (27,320) will gain Medicaid coverage; and

43 Elmendorf, Doug. CBO's Analysis of the Major Health Care Legislation Enacted in March 2010, http://www.cbo.gov/ftpdocs/121xx/doc12119/03-30-HealthCareLegislation.pdf .Enacted in March 2010, http://www.cbo.gov/ftpdocs/121xx/doc12119/03-30-HealthCareLegislation.pdf .

44 Virginia.gov. Secretary of Health and Human Resources. Virginia Health Reform Initiative. http://www.hhr.virginia.gov/initiatives/healthreform/

45 Hazel, Bill et al. Report Pursuant to House Bill 2434: Virginia Health Reform Initiative (VHRI) Advisory Council recommendations for a Health Benefit Exchange (HBE). http://www.hhr.virginia.gov/initiatives/healthreform/docs/LetterAndHB2434Report2011.pdf

3. The remaining uninsured (over 54,000) will, on average, be higher income than the uninsured today. These predictions have profound implications for the desired scale and mix of services and subsidies that Fairfax County, in its role as health care safety net provider, contractor and financier, may find it most desirable to provide and finance.

Data and Model Development

Baseline: The Task Force required an accurate prediction of the number of persons with access and utilizing private insurance or Medicaid and how many persons remain uninsured in the post-2014/reform environment. To make predictions of this kind, the George Mason team developed models to predict consumer choices regarding enrollment in private insurance and applications to Medicaid. These models have been built on statistically valid data sets with variables that are relevant to people's choices. For any prediction to be credible, the modelers would need to demonstrate the model is capable of predicting consumer behavior in the current environment. The predictive model needed to go beyond use of Census ACS statistical estimates of coverage status as a baseline and application of an untested (and often, unspecified) model to predict coverage status in 2014. The modelers, therefore, developed and tested the model's ability to predict today's choices, and then applied the best model to the choices people will face in 2014.

Our model and baseline were created following techniques employed by economists, mathematicians and statisticians at Rand[46] and at the Urban Institute[47] , the two premier micro-simulation modeling teams in the nation. To be as accurate as possible for a geographic unit as small as a county, we started with the Census Bureau's ACS data, which includes demographic, socioeconomic, housing, employment, and health insurance information on almost 2 million households, making it by far the most accurate survey for sub-national geographic areas in the history of our nation.[48] We used the Public Use Micro-data Area files (PUMA) .Next we pooled data from the two most recently available years, 2008 and 2009, to increase countywide sample size and increase the precision of our estimates. We then calibrated our data set of 21,521 individuals to 2010 Census estimate totals by age, sex, and race, to make our weighted population the right size and distribution for 2010. Figure 1 illustrates Fairfax County within the Commonwealth of Virginia and the individual PUMAs within Fairfax County, respectively. Figure 2 shows that there is considerable variation in uninsured rates across the county, with PUMA 301 (roughly between Bailey's Crossroads and Annandale, south of Falls Church) exhibiting 16.7%, whereas in PUMA 305 in the northwest corner of the county only 7.8% of residents are uninsured.

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46 Girosi, Federico, et al "Overview of the COMPARE Microsimulation Model," Comprehensive Assessment of Reform Efforts (COMPARE) http://www.rand.org/health/feature/compare.html .

47 Blumberg, Linda J. et al.The Health Insurance Reform Simulation Model (HIRSM) http://www.urban.org/publications/410867.html , and Buettgens, Matthew et al. Health Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid http://www.urban.org/publications/412310.html

48 U.S. Census Bureau, American Community Survey. http://www.census.gov/acs/www/ .

Figure 3: Fairfax County Source: US Census Bureau, 2009 American Community Survey

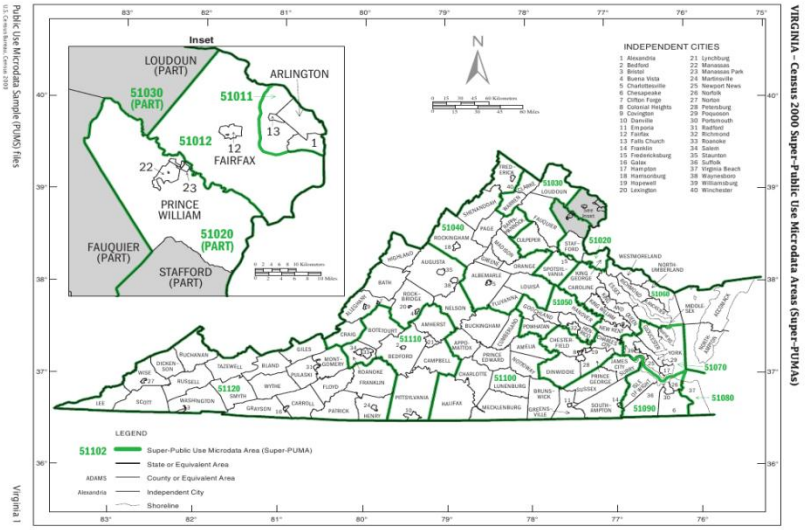


Figure 4: Distribution of Uninsured in Fairfax County, by PUMA

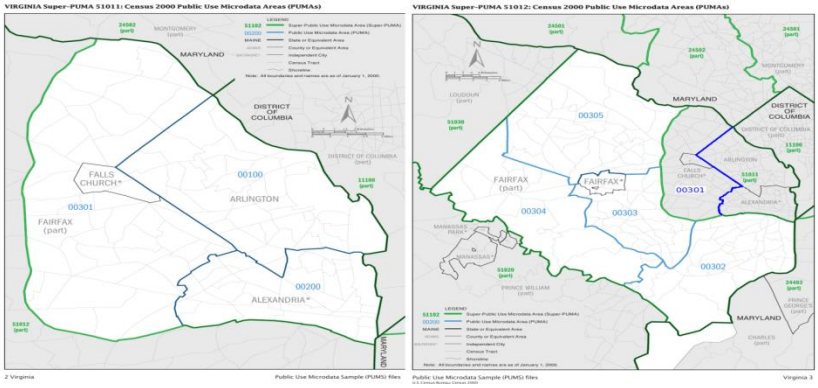
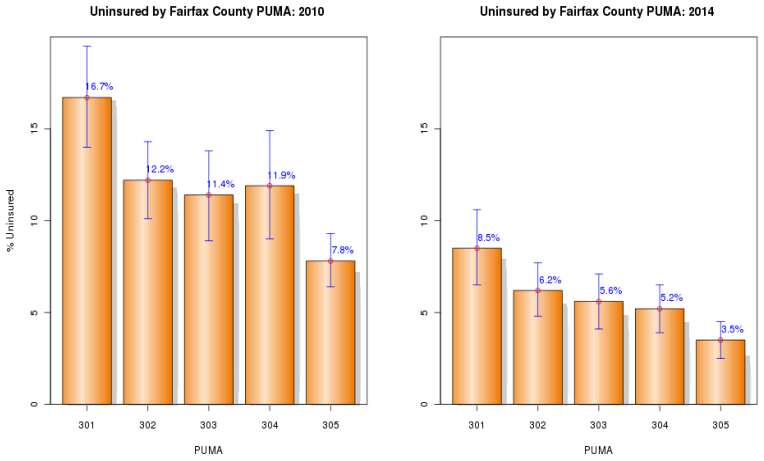


Figure 5: Uninsured in Fairfax County 2010-2014



Since the ACS does not have data on health expenditures, health status, and employer characteristics, and because these are highly relevant to health insurance opportunities and choices, we impute these variables from the AHRQ's MEPS Survey for the Southern region[49], using standard statistical matching techniques, employing variables that are common to both data sets (sex, age, race/ethnicity, family income, employment status and poverty level). After merging the ACS and MEPS-HC we compared the distribution of key variables such as insurance coverage, sex, age by insurance coverage in the merged data with those observed in the base ACS data. For example we checked that the donated insurance coverage variable from the MEPS-HC to the ACS matches the actual ACS insurance coverage variable in distribution within a generally acceptable margin of error. In computing these estimates, we employed replicate weights provided in the ACS PUMS data and complex survey design adjustments to take into account the complex design of the ACS as recommended by the ACS documentation. All analysis was done in the R statistical software[50] that implements the survey package[51] for complex survey design analysis. We restricted the model and all analysis to the non-elderly population.

Model Development Overview

Not all people have the same opportunities in life or in health insurance. Importantly, eligibility for Medicaid depends on family income, age, assets, and disability status. If a person is not eligible, then he/she cannot enroll. For private insurance, there are more options, but all cost more than Medicaid does if the person is eligible. For this reason, we use published criteria for Medicaid eligibility {aged, blind, or disabled; pregnant, child up to 19, or parent of child up to 19 with low enough income levels; Medically needy (a function of recent medical spending to income)} to separate Fairfax residents into those who are Medicaid eligible and those who are not. For those who *are* believed to be Medicaid eligible, we build a model that predicts which of the eligible will enroll or "take-up" Medicaid. We then use the model to estimate the size of the Medicaid population now, comparing it to the ACS estimates to check the model's validity. Once the model performs well, it is then capable of predicting Medicaid enrollment in the future, when eligibility criteria – specifically, raising the income thresholds for non-pregnant adults – are changed under reform in 2014. Because current law eligibility criterion is so different, we estimate separate equations for children (under 19) and adults.

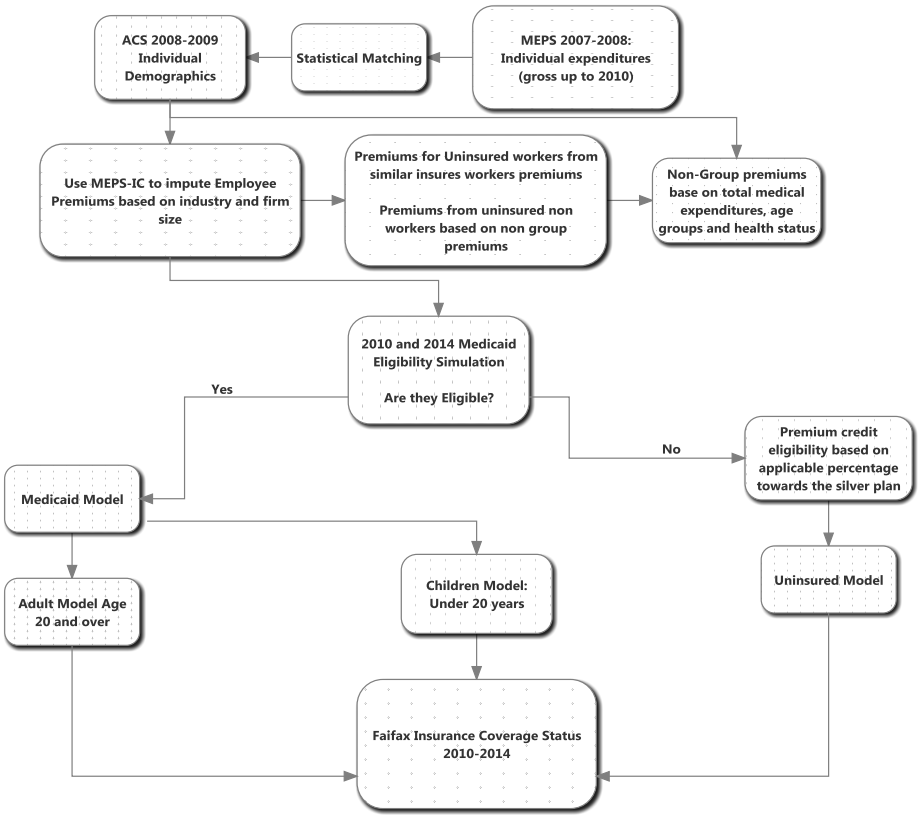
For people who are not Medicaid eligible, the analysis took into account factors that affect whether they become uninsured or insured. Factors include: access to group coverage through an employer, access to the non-group market if their employer does not offer or they are self-employed, or no access if they are not in the workforce (examples of populations in this category include under-age dependents and/or unemployed individuals). Employment status and firm size are significant factors: Firm size is an excellent predictor of offer and of out of pocket premiums for

49 AHRQ, Agency for Healthcare Research and Quality. Medical Expenditure Panel Survey. http://www.meps.ahrq.gov/mepsweb/
50 R Development Core Team (2011). R: A language and environment for statistical computing. R. Foundation for Statistical Computing, Vienna, Austria. ISBN 3-900051-07-0, URL http://www.R-project.org/.
51 T. Lumley (2011) survey: analysis of complex survey samples. R package version 3.24.

employees. For the non-Medicaid eligible population, the model predicts whether individuals are covered, using all relevant explanatory variables (employment status, firm size, and out of pocket premiums). The model is capable of predicting future choices to purchase private insurance or not.

The biggest change PPACA implementation is expected to bring in 2014 relates to privately insurance access and premium and cost-sharing subsidies through the Health Benefits Exchange, for those in households (a) without an employer offer; (b) with incomes between 133% and 400% of poverty; and who (c) are not eligible for Medicaid (or other public programs).

Figure 6: Data Set and Model Development Process



Summary of Data Development and Models

We report the models' equations and statistical results in Appendix IV. Briefly, Medicaid take-up, conditional on having characteristics that enabled us to predict when a person to be eligible, is posited to depend on number, age, gender, marital status, educational attainment, income employment status of adults in the household, employment of adults, health status and presence of specific health conditions of children and of adults, and race/ethnicity. Private insurance take-up is determined by the entire set of identified variables, including firm size of employed

adults in the household and their income level (private insurance "take-up" is clearly higher for higher income individuals).

We report the most important and intuitive results of model validity in tables 9 and 10 that follow.

Table 9 : Benchmark Estimates and Model Prediction

Group	ACS Total	Model Total	Difference	PCC	PCC SE
Children Medicaid	32,891	33,207	316	91.08	1.02
Adult Medicaid	13,188	14,544	1,356	92.58	1.10
Uninsured	102,541	92,407	-10,134	97.18	0.12

Estimates according to the Census Bureaus' American Community Survey (ACS) and the Agency for Health Research and Quality's Medical Expenditure Panel Survey (MEPS) data.

The first three columns of Table 9 show that each model is relatively accurate in predicting the number of Medicaid enrollees and uninsured, respectively. Column four also shows that predictions about individual people (classification accuracy) are relatively accurate as well, with no model doing worse than 91%. Figure 5 provides more detail on this intuitive measure of model accuracy: Where the yes-yes and no-no cells represent the correct classification of individuals into their baseline insurance status for modeling purposes. We also report more technical measures of model accuracy in Appendix IV (e.g., Receiver Operating Characteristic, sensitivity, specificity, and kappa). Results indicate the model achieved very high levels of accuracy for the purposes intended in this report.

Table 10 : Model Accuracy

ACS Medicaid Coverage (Children)			
Predicted Medicaid Coverage		Yes	No
	Yes	410	36
	No	34	305

ACS Medicaid Coverage (Adult)			
Predicted Medicaid Coverage		Yes	No
	Yes	217	33
	No	9	305

ACS Medicaid Coverage (Non-Eligible)			
Predicted Uninsured		Yes	No
	Yes	1191	174
	No	326	16055

Estimates according to the Census Bureaus' American Community Survey (ACS) and the Agency for Health Research and Quality's Medical Expenditure Panel Survey (MEPS) data.

Application of the Models to Predict Coverage Status in 2014

Table 10 outlines the basic logic of how we use the developed models to predict coverage in 2010 and in 2014. The main changes reform brings are that more people will be Medicaid eligible (and thus move into the possible Medicaid take-up equation) and those who are not Medicaid eligible nor have employer offers but have incomes lower than four times the federal poverty level will have access to premium-subsidy tax credits and a guarantee that they cannot be denied private health insurance nor charged a higher premium due to health conditions, pre-existing or not.

Figure 7: Model Logic and Coverage Change

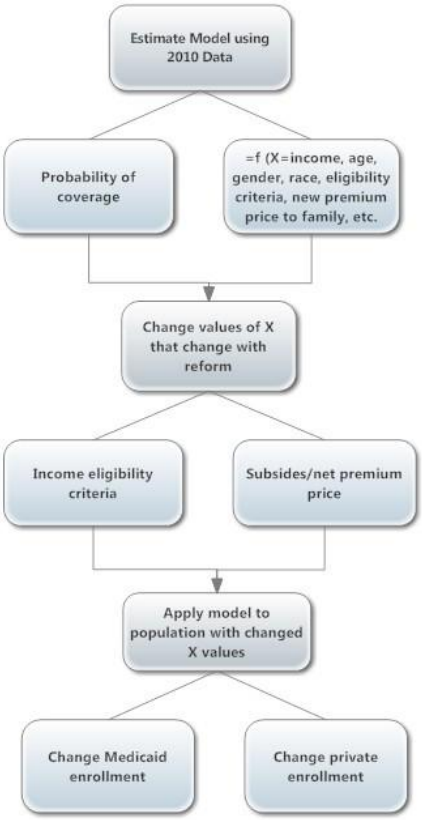


Table 11: contains the basic results of the models aggregate coverage changes between 2010 and 2014.

Table 11 : Coverage Status of the Non-Elderly in Fairfax County

Group	2010	2014	Change
Medicaid	46,079	73,399	27,320
Private	811,902	844,363	32,461
Other Public	3,786	2,681	-1,154
Uninsured	113,712	54,994	-58,718

Estimates according to the Census Bureaus' American Community Survey (ACS) and the Agency for Health Research and Quality's Medical Expenditure Panel Survey (MEPS) data.

Source: Center for Health Policy Research and Ethics, George Mason University estimates of health insurance coverage using models and methods described in text and appendix, based on ACS and MEPS-HC data. Some individuals with Other Public coverage gained Medicaid and some gained private coverage, post-reform.

These results are important for the Task Force to consider because they suggest that the total number of uninsured (candidates for county-provided or financed safety net health services) will be reduced by a little more than half[52]. Those who are expected to remain uninsured are not citizens or legal residents. Two populations present a challenge: Medicaid eligible individuals who are hard to reach to enroll; and/or modest income individuals who make the financial or philosophical decision to stay uninsured and pay a smaller penalty for not participating in available health insurance. The model predicts that more individuals residing in the county will gain private coverage than will be enrolled in Medicaid, but there are substantial gains in both categories. If PPACA is implemented as expected, the percentage of uninsured persons is expected to fall to only 5.6% of the non-elderly population.

In addition to shrinking by slightly more than half, Table 2 reports important ways the demographic and socioeconomic profile of the uninsured in Fairfax County is expected to change.

Table 12 : Profile of % Uninsured Changes 2010 and 2014

Group	2010	2014	Change
Children (0-19)	19%	12%	-7%
Young Adult (20-34)	38%	45%	7%
Male	53%	57%	4%
Hispanic	42%	49%	7%
Family Income < $25k	19%	9%	-10%
Income < 133% of FPL	26%	12%	-14%

Estimates according to the Census Bureaus' American Community Survey (ACS) and the Agency for Health Research and Quality's Medical Expenditure Panel Survey (MEPS) data.

52 The 2010 ACS estimates were not available when GMU completed its analysis in the fall of 2011, so projections of the number of uninsured for 2010 were based on actual 2008 and actual 2009 data and Census-supplied population growth estimates. The ACS estimate of the uninsured fell by 2,000 in 2009 from 2008, but jumped by 32,000 from 2009 to 2010. That is why the number of uninsured in 2010 in our tables differs from the current 144,532 figure cited in the text above. We are confident the proportional reductions in uninsured from our micro-simulation model estimating the impacts of reform on behavioral choices are still the best estimates available, but our estimated baseline number of uninsured in Fairfax is lower than the current ACS estimate suggests. It will be important to compare the 2011 estimates when they come out next year, for they will suggest whether this higher number of uninsured is a stable estimate or perhaps reflective of statistical noise due to small area sampling realities.

Model results suggest that children and the very poor will become less frequent clients of the Fairfax safety net than is currently the case.

To some extent, the presumed reduction in demand for Fairfax health services *assumes* that private providers will be willing to accept the 27,000+ newly enrolled Medicaid patients, in addition to the more than 32,000 newly privately insured patients. This unknown, which will depend on state-determined Medicaid payment rates and overall local health workforce capacity, will factor into our scale and mix recommendations for the County in the concluding section of this report.

Implications for the Scale of County Safety Net Services

Without current, detailed data on the number of clients using one or more services, it is impossible to suggest a precise scale of future safety net capacity. Current county information systems do not permit total "unduplicated counts" of clients served across all county programs on an ongoing basis. Some clients may seek physical health, mental health, maternal health, HIV, and substance abuse services in a given year, yet each program maintains its own distinct records without a system-wide patient identifier. Nor does each current county program data permit precise estimates by the income classes relevant to future Medicaid and Exchange subsidy eligibility.

In FY2011, 26,588 patients were enrolled in CHCN, of which, 99 %% were adults 11,447 receive ongoing mental health (MH) and 5,115 receive substance abuse (SA) treatments through the CSB of Fairfax and Falls Church. An reported 7,849 received emergency mental health or substance abuse services. It is not known how much overlap there is between those who receive emergency and ongoing behavioral health services. However, it seems reasonable to assume some, if not most, emergency patients will later be referred to MH or SA clinics. It is also reasonable to assume most of the 6,900 who get medication management services are included in the MH and SA counts above. Finally, 2,697 infants and toddlers and 1,100 children and families are served by the CSB's Infant Toddler Connection and at-risk youth programs, respectively.

Unfortunately, the county does not have a comprehensive data system that permits ongoing tracking of how many and which clients use more than one program in a given year. Therefore, assumption must be made to compare the current scale of county-provided safety net services with the uninsured population of Fairfax County. Senior county staff used their best information, experience and judgment to estimate that about 33,611 unduplicated uninsured clients are served by the CSB and the CHCN combined. This represents roughly 23% of the uninsured in 2010, according to ACS survey estimates. [53]
It is important to remember that nationwide, according to the Agency for HealthCare Research and Quality's (AHRQ) Medical Expenditure Panel Survey (MEPS), only about 40% of the uninsured seek care each year. This is due to the fact the uninsured are mostly healthy and often do not seek care for conditions

53 Email Communication string from Christina Stevens from 1/30/2012

they believe will be temporary and resolve on their own, mostly to avoid lost wages and out of pocket costs. If this national proportion holds for Fairfax, then the largest county programs currently serve over half of the uninsured that actually seek care in a given year in Fairfax County. Our best quantitative model estimated the County's uninsured population will fall roughly by half. Therefore, all else equal, we would recommend the county scale back its safety net capacity and support by half as well. But all else is not likely to be equal.

Even as the demand for services provided by the safety net will change as more residents obtain health insurance coverage, a variety of factors, (including availability of primary care providers and individuals' care seeking behavior) will continue to support the need for safety net providers.

Two major unknowns will affect the appropriate scale of county health service provision and financing. One: how many newly insured *former clients* will find willing providers in the private marketplace? Two: Will the population that is still uninsured after 2014 be sicker or healthier than the currently uninsured population? There is insufficient data to answer the second question precisely, so again we must make assumptions. Based on data we do have, our quantitative estimates and logic (shown in Table 12) suggest that if the PPACA is implemented as intended, the remaining uninsured will be less likely to be children, more likely to be young adult, more likely to be male, more likely to be Hispanic, and most importantly much less likely to be very low income.

The higher income of those who will remain uninsured post-reform strongly supports two conclusions. First, the uninsured are likely to be healthier than they are now, since health is positively correlated with income. Second, the county should consider using a steeper sliding fee scale for CHCN services. A fee scale such as that used by Prince William FQHC may be more appropriate at that time. This higher fee scale might also be an important political strategy to maintain support for the safety net after 2014, when some may wonder why anyone is still uninsured.

On the question of how many current clients will seek and find willing providers to see them in the private sector, we turn to Health Resources and Services Administration data.[54] Fairfax has twice as many physicians per capita as the national average, the same number of family practitioners, more internal medicine, (5 times as many), more pediatricians (7 times), and more specialists (7 times). This abundant private sector capacity would suggest reducing the county's health service provision capacity by more than half would be appropriate. But the reality of low Medicaid payment rates relative to private rates in Northern Virginia, plus normal patient inertia in care seeking patterns, both argue against a presumed one-half reduction in physical health capacity consistent with the decline in the uninsured population. In large part, increased health insurance coverage and the requirements of insurers to increase health care value and quality underscore the importance of primary care and medical home capacity.

In addition, it is anticipated pace and scale of the coverage expansion is likely to be slower and lower than simple mathematics implies. Factors include: budget pressure

54 Click on Fairfax County at http://arf.hrsa.gov/arfwebtool/Counties_list.asp

and political opposition within Virginia General Assembly.

Furthermore, the importance of mental and behavioral health in the county's service provision portfolio, especially relative to the private sector's capacity and (lack of) willingness to take on the more difficult patients who are currently served by the CSB, suggests that a reduction in capacity of mental and behavioral health capacity should be less than half, perhaps maybe even zero. In fact, given the perceived likelihood that many of the lowest income currently uninsured who will gain Medicaid coverage may very well have unmet substance abuse and other behavioral health needs, and given the local private sector's unwillingness to accept Medicaid mental health patients, a case can be made that CSB capacity should grow, at least in the short run. It is impossible to be precisely confident in the absence of more detailed data. Appropriate net capacity changes will depend on the achieved degree of service integration between behavioral and physical health (i.e., the CSBs and the CHCN or other primary care partners). At a minimum, delaying any reduction in CSB capacity, at least until solid, post-reform data is available, would seem to be highly prudent.

Medicaid payment rates are another big unknown, but it is unrealistic to expect the Commonwealth to substantially increase them immediately, given the enrollment expansion our limited tax dollars will be forced to finance. Therefore, we will recommend the county not even consider scaling back CSB capacity until 2016, when the first wave of private sector responses to the totality of coverage expansion that policy changes will have brought about will become clearer.

PEER COUNTIES

Part of this study included the review of other selected counties' health programs in order to understand what they offer. These findings were then compared to Fairfax County, with the intention of learning about innovative programs and effective processes which could potentially be used and/or adapted by Fairfax. The counties for inclusion in the study were chosen from a larger list of counties after gathering and comparing data related to such factors as: population size, medium family income, percentage of population below poverty, % unemployed, % of workforce in managerial and professional jobs, health status, race and ethnicity makeup, and state Medicaid policies. The data was supplied and discussed with the Task Force in order to obtain input for final selection of the peer counties for this study. The selection process yielded six counties. They are: Montgomery County Maryland, Travis County Texas, Hennepin County Minnesota, Jefferson County Colorado, Cobb County Georgia, and Wake County North Carolina. In addition to the GMU study of the six peer counties, a county interagency staff workgroup completed reviews of best practices from around the nation. The interagency findings are included in this report as Appendix V.

The two charts on the following page include most of the selection criteria for the six selected counties and Fairfax County.[55] [56]

55 Table 13 data from: United States Census Bureau, 2010 Decennial Census, retrieved from: http://2010.census.gov/2010census/

56 Table 14 data from: Income, poverty, employment, insurance, and workforce data from: United States Census Bureau, 2009 American Community Survey, retrieved from: http://www.census.gov/acs/www/
56 Health Status data from: United States Centers for Disease Control and Prevention, 2009 Behavioral Risk Factor Surveillance System, SMART: Selected Metropolitan/Mircopolitan Area Risk Trends: http://apps.nccd.cdc.gov/BRFSS-SMART/SelMMSAPrevData.asp

Table 13 : Peer Counties Population and Race						
County	State	2010 Population	% White	% African American/Black	% Asian	% Hispanic/Latino
Fairfax	VA	1,081,726	62.70%	9.20%	17.50%	15.60%
Jefferson	CO	534,543	88.40%	1.10%	2.60%	14.30%
Cobb	GA	688,078	62.20%	25.00%	4.50%	12.30%
Wake	NC	900,993	66.30%	20.70%	5.40%	9.80%
Travis	TX	1,024,266	69.30%	8.50%	5.80%	33.50%
Montgomery	MD	971,777	57.50%	17.20%	13.90%	17.00%
Hennepin	MN	1,152,425	74.40%	11.80%	6.20%	6.70%

Table 14 : Peer County Income, Employment, and Health Status								
County	State	Median Family Income	% Below Poverty	% Unemployed	% Uninsured	% Workforce Management/Professional	Health Status Good/Better	Health Status Fair/Poor
Fairfax	VA	$122,651	5.60%	5.70%	10.60%	56.90%	92.10%	7.80%
Jefferson	CO	$81,085	8.20%	8.00%	11.70%	43.10%	91.70%	8.30%
Cobb	GA	$77,980	11.00%	9.20%	18.90%	43.50%	92.60%	7.40%
Wake	NC	$82,074	10.10%	7.90%	13.00%	48.80%	88.70%	11.30%
Travis	TX	$67,030	16.20%	7.70%	23.00%	43.40%	88.00%	12.00%
Montgomery	MD	$110,865	6.80%	6.30%	11.50%	55.50%	89.50%	10.50%
Hennepin	MN	$80,972	11.60%	8.20%	9.40%	44.70%	90.10%	9.10%

Peer County Program Offerings

The types and structures of health care services provided by local and state governments are varied. In some communities, safety net health care services are provided almost exclusively by the private and nonprofit sector, while in other communities, including Fairfax County, the local governments provide or fund considerable direct care services to low income and uninsured residents. Among our study of six peer counties, the organizational and funding structures for publicly supported health care safety net services are quite different and include a variety of different models to review for potential ideas for implementation by Fairfax County.

Additionally, the review of services provided or funded by the local governments provides a type of benchmark and context from which Fairfax County can compare their own offerings to those of other counties around the Country. The chart below compare health care service programs paid for by local or state governments among the six peer counties identified for this study. It also compares a variety of service offerings sponsored, paid by, or connected with the local or state governments. [57]

57 Information on Fairfax County programs compiled from:
Fairfax County Health Assets and Resources – See Appendix 1
Information related to Montgomery County Programs complied from:
Primary Care Coalition of Montgomery County website: http://www.primarycarecoalition.org/
Phone Interviews with PCCMC staff
Montgomery County Department of Health and Human Services: Behavioral Health and Crisis Services Website:
http://www.montgomerycountymd.gov/hhstmpl.asp?url=/content/hhs/bhcs/index.asp
Montgomery County Disability Information and Services:
http://www.montgomerycountymd.gov/hhstmpl.asp?url=/content/hhs/ads/DisabilityServices/index.asp
Montgomery County Public Health Services: http://www.montgomerycountymd.gov/hhstmpl.asp?url=/content/hhs/phs/index.asp#ds
57 Information related to Hennepin County programs complied from:
Northpoint Health and Wellness Center: http://www.northpointhealth.org/Home/tabid/36/Default.aspx
Hennpein County website: Health:
http://hennepin.us/portal/site/HennepinUS/menuitem.c821986e7144921df8735443fbe06498/?vgnextoid=910e65c830fe1210VgnVCM10
0000c80f4689RCRD
Information related to Travis County Programs complied from:
Central Health: http://www.traviscountyhd.org/index.html
Austin Travis Health Department: http://www.austintexas.gov/department/health/services
Austin Travis County Integral Care: http://www.integralcare.org/
CommUnityCare: http://www.communitycaretx.org/
Information Related to Jefferson County Programs complied from:
Jefferson County Public Health Department: http://jeffco.us/health/index.htm
Information related to Cobb Programs compiled from Cobb and Douglas Public Health:
http://www.cobbanddouglaspublichealth.org/index.php
Cobb Community Services Board: http://www.cobbcsb.com/
Information Related to Wake County Programs Complied from:
Wake County Human Services: http://www.wakegov.com/humanservices/default.htm

Table 15 : Health Care Services Provided by Peer Counties	
Primary Care Adults	
Fairfax VA	Yes, Community Health Care Network which includes three primary care clinics
Montgomery MD	Yes, Montgomery Cares-County pays a flat rate per visit to private clinics for residents who qualify. Program is administer via contract with the Primary Care Coalition of Montgomery County
Hennepin MN	Yes, County Owned FQHC and Public Health Clinics. Minnesota also has an insurance program for the low income uninsured-converted though Medicaid expansion in 2011
Travis TX	Medical Assistance Program (MAP) for low income uninsured. Care though Contracted with clinics, affiliated FQHCs, county owned hospital and paid for by Central Health
Jefferson CO	Preventive Programs and services only (Colorado indigent care program reimburses providers with significance levels of uncompensated care).
Cobb GA	Yes, Health Department clinics provide personal health services. A federally qualified Community Health center is also located in the county
Wake NC	Referrals to private providers (clinics Federally Qualified Community Health Center FQHCs)

Table 16 : Health Care Services Provided by Peer Counties	
Specialty Care Adults	
Fairfax VA	CHCN utilizes a network of specialist and facilities willing to do a negotiated amount of services at free or reduced rates
Montgomery MD	Montgomery Cares utilizes an a network of 300 community providers, and the Archdiocese Health Care Network
Hennepin MN	Hennepin County Medical Center serves as a safety net hospital. Northpoint Health and Wellness center: optometry, sports medicine, OB-GYN services, Adult and Family medicine, Radiology, Mammography, Lab, pharmacy, behavioral health, Nutrition and Diabetes support
Travis TX	MAP program provides specialty care access
Jefferson CO	No, however, Navigator program to help Medicaid Recipients find providers and navigate the health system. Kaiser Connections
Cobb GA	N/A- other then what the CHC/FQHC may provide
Wake NC	Referrals from Wake Health Services, the local community health center

Table 17: Health Care Services Provided by Peer Counties	
Primary Care Children	
Fairfax VA	Yes, Medical Care for Children Partnership, combines county and private sector resources to place children with Kaiser or a private physician in the community
Montgomery MD	Care for Kids, Similar to (MCCP in Fairfax)
Hennepin MN	Pediatrics- North point Health and Wellness Center
Travis TX	MAP (see adults)
Jefferson CO	(S-CHIP) - Healthily communities combines CHIP coverage with additional services to best meet needs of low income children
Cobb GA	Yes, Health Department Clinics
Wake NC	Yes, county clinics

Table 18 : Health Care Services Provided by Peer Counties	
Specialty Care Children	
Fairfax VA	MCCP enrollees: referrals to specialists as needed, diagnostic testing, Laboratory services, Nutrition Counseling, Hospital Admission as needed
Montgomery MD	Care for Kids does not cover hospital care. State of Maryland has program for children diagnosed with a chronic illnesses
Hennepin MN	Same as Adults: see above
Travis TX	MAP (see Adults)
Jefferson CO	N/A
Cobb GA	Services for children with developmental delays, hearing and vision screenings, also a state program for children with chronic conditions is available
Wake NC	Children's Special Services: State level program for children with certain chronic medical conditions

Table 19 : Health Care Services Provided by Peer Counties	
Mental Health	
Fairfax VA	Yes, CSB- extensive services for the severely and persistently mentally ill Some additional services contracted though county. CSB and CHCN have a partnership for limited integrated care model
Montgomery MD	Montgomery Cares Behavioral Health- 4 major providers/ Clinics. Also a partnership with Georgetown is helpful to maintain specialized providers
Hennepin MN	Hennepin County Mental Health Clinic provides direct services. Front Door Access provides screenings and matches clients to public or private services. Northpoint
Travis TX	Austin Travis Integral County Care(ATCIC) Similar to CSB). Central Health also provides outpatient and short term inpatient services
Jefferson CO	Testing and referrals
Cobb GA	Yes, extensive continuum of treatment for children and adults provided by the Cobb County Community Services Board.
Wake NC	Yes, county clinics for adults, and school based mental health clinics for children

Table 20: Health Care Services Provided by Peer Counties	
Substance Abuse (SA)	
Fairfax VA	Yes, CSB, comprehensive services
Montgomery MD	Various levels of treatment for adults with dependence on alcohol or other drugs. Department collaborates with community providers for continuous and comprehensive treatment for consumers with co-occurring disorders (SA with Mental Health)
Hennepin MN	Chemical Health Services direct from county or referral to private health and social service providers- public funding for those who qualify
Travis TX	Yes, ATCIC
Jefferson CO	No, County has discontinued substance abuse services, provides list of Denver area service providers
Cobb GA	Adolescents and adults services provided by Cobb County CSB
Wake NC	Yes, in and outpatient treatment (county) adults, special services for pregnant women and HIV positive drug users. School based mental health and S/A services

Table 21 : Health Care Services Provided by Peer Counties	
Intellectual Disabilities /Developmental Disabilities	
Fairfax VA	Yes, CSB, comprehensive services
Montgomery MD	Services provided by Montgomery County Aging and Disabilities Resource Unit. Maryland also has several Medicaid waivers
Hennepin MN	MN has a variety of Medicaid waivers available. Also Hennepin County Aging and Disability Services Access & Initial Consultation
Travis TX	Yes, ATCIC
Jefferson CO	
Cobb GA	Intellectual disabilities /developmental disabilities provided by the Cobb CSB
Wake NC	Yes, wake local management Entity (LME) contracts for services

Table 22 : Health Care Services Provided by Peer Counties	
Dental	
Fairfax VA	Northern Virginia Dental Clinic- 2 sites, 1 in Fairfax County. County pays part of lease and other funding. Charge of $40/visit- 1,785 visits in FY2011
Montgomery MD	Health Department clinic and non-profit clinics with services for Adults, HIV, Maternity, Children
Hennepin MN	Health Department clinic and non-profit clinics with services for Adults, HIV, Maternity, Children
Travis TX	Clinics though Community Care
Jefferson CO	N/A
Cobb GA	Yes, public health clinic- exams, cleanings, fillings, x-rays, and sealants for adults and children
Wake NC	County clinic for children and pregnant women, also Adult Limited program through dental society -approx. 15 apt/ week (1400 request calls weekly)

Table 23 : Health Care Services Provided by Peer Counties	
Prescription Drugs	
Fairfax VA	Yes, CSB and CHCN. Also contract with American Laboratory Services
Montgomery MD	Montgomery RX - helps residents apply for programs by pharmaceutical companies, some formulary drugs for clinics
Hennepin MN	Pharmacy at Northpoint
Travis TX	CommUnityCare partnering with 17 pharmacies to fill and provide prescriptions at reduced costs. Direct Mail program for MAP card holders
Jefferson CO	N/A
Cobb GA	Pharmacy services for person's treated/seen in a health department clinic. Cobb County CSB also provides pharmacy services
Wake NC	Mental Health, and state program for children with chronic conditions

Table 24 : Health Care Services Provided by Peer Counties	
Maternal/Prenatal	
Fairfax VA	Health Department-1st two trimesters- last trimester and delivery though INOVA Fairfax
Montgomery MD	Three local hospitals, $450 fee
Hennepin MN	Yes, Northpoint has OBGYN services
Travis TX	Yes, MAP program and CommUnityCare
Jefferson CO	Pregnancy testing and referral
Cobb GA	Pregnancy testing and referral
Wake NC	Yes, at regional county clinics

Table 25 : Health Care Services Provided by Peer Counties	
STD Screenings/Treatment	
Fairfax VA	Yes, local health department clinics
Montgomery MD	Yes
Hennepin MN	Yes- though local health department clinics
Travis TX	Yes/ Austin Department of Health and Human Services $20 fee
Jefferson CO	Yes
Cobb GA	Yes, local health department clinics
Wake NC	Prevention, testing, education, counseling

Table 26 : Health Care Services Provided by Peer Counties	
HIV/AIDS	
Fairfax VA	Testing. Also treatment, dental, supportive psycho-social, housing, transportation, educational services provided to eligible individuals via federal grants to community based organizations
Montgomery MD	Testing
Hennepin MN	Yes, Public health clinic testing, treatment. Also- prevention programs. HIM (Health intervention for Men) and CAPS- Care Access and Prevention
Travis TX	Testing limited case management
Jefferson CO	Yes
Cobb GA	Yes, Anonymous testing, counseling, ongoing care for people with HIV
Wake NC	Prevention programs, testing and treatment. (Accepts Medicaid, Medicare, Private Insurance, sliding scale)

Table 27 : Health Care Services Provided by Peer Counties	
Cancer Screenings	
Fairfax VA	Yes, department of public health
Montgomery MD	Colorectal, prostate, oral, cervical, breast, (health Department or contractors)
Hennepin MN	
Travis TX	CommUniteCare
Jefferson CO	Yes, public health clinics. Breast and Cervical Cancer paid by grants from Susan G Komen Foundation
Cobb GA	Screenings for breast and cervical cancers
Wake NC	Yes, health department screening and treatment for breast and cervical cancer

58 Information on Fairfax County programs compiled from:
Fairfax County Health Assets and Resources – See Appendix 1
Information related to Montgomery County Programs complied from:
Primary Care Coalition of Montgomery County website: http://www.primarycarecoalition.org/
Phone Interviews with PCCMC staff
Montgomery County Department of Health and Human Services: Behavioral Health and Crisis Services Website:
http://www.montgomerycountymd.gov/hhstmpl.asp?url=/content/hhs/bhcs/index.asp
Montgomery County Disability Information and Services:
http://www.montgomerycountymd.gov/hhstmpl.asp?url=/content/hhs/ads/DisabilityServices/index.asp
Montgomery County Public Health Services: http://www.montgomerycountymd.gov/hhstmpl.asp?url=/content/hhs/phs/index.asp#ds
58 Information related to Hennepin County programs complied from:
Northpoint Health and Wellness Center: http://www.northpointhealth.org/Home/tabid/36/Default.aspx
Hennpein County website: Health:
http://hennepin.us/portal/site/HennepinUS/menuitem.c821986e7144921df8735443fbe06498/?vgnextoid=910e65c830fe1210VgnVCM100000c80f4689RCRD
Information related to Travis County Programs complied from:
Central Health: http://www.traviscountyhd.org/index.html
Austin Travis Health Department: http://www.austintexas.gov/department/health/services
Austin Travis County Integral Care: http://www.integralcare.org/
CommUnityCare: http://www.communitycaretx.org/
Information Related to Jefferson County Programs complied from:
Jefferson County Public Health Department: http://jeffco.us/health/index.htm
Information related to Cobb Programs compiled from Cobb and Douglas Public Health:
http://www.cobbanddouglaspublichealth.org/index.php
Cobb Community Services Board: http://www.cobbcsb.com/
Information Related to Wake County Programs Complied from:
Wake County Human Services: http://www.wakegov.com/humanservices/default.htm

Organizational Structures and Innovative Programs

In addition to comparing demographic information and service offerings provided by counties similar to Fairfax, the county can also learn from the structures and methods used by others to inform potential improvements (revisions) to the way that Fairfax County operates its health and social service programs. The review of the six counties above has uncovered several innovative approaches to services delivery. These approaches can be devised into categories including: governance models, integrated service and intake models, and contracting with the private sector to provide services to residents.

Governance

Currently Fairfax County governs most of its public health care services though standard county operations under powers granted to the County Executive from the elected Board of Supervisors. Over time, the county executive has developed professional staff to either administer and carry out programs with internal staff or utilize smaller numbers of internal staff to oversee programs operated through contractors. The county has several departments and offices in charge of various service lines related to health and/or social and economic services. The county conducts eligibility for a variety of federal, state, and local programs, but only has control over the eligibility rules for some of the programs. Because Virginia is a Dillon Rule state, the local governments must derive most of their powers directly from the Commonwealth by seeking permission from the legislature (through laws) or in some cases from state agencies. The powers to tax are limited by Virginia law and in some cases, such as a meals tax, must be approved by the citizens though a referendum on a general election (or special election) ballot.

Organizing health services through the alternative governance structures under local governments was found in our peer counties. In Travis County, Texas, most of the health care delivery functions of the local governments (combined Travis County and City of Austin), especially related to health care delivery for the low income and uninsured, were combined into a separate political entity which overlays with the geographic area of the county. The Travis County Healthcare district, known as Central Health, was created in 2004 by a vote of the residents of Travis County after a two year effort by community leaders including business people, community leaders, and elected officials who were "dedicated to improving access to and delivery of health care services in their community".[59] Central Health has limited taxing authority[60] to assess property taxes on residents of Travis County. The taxing authority of this separate political district creates a dedicated funding source and governance structure toward delivering health care services to the low income uninsured. Central Health is run by a board of managers. The board includes nine members with four appointed by the Travis County Commissioner Court and four by the Austin City Council. The chair is selected jointly by the Travis County Commission Court and the Austin City Council. The Board of Managers sets the direction of Central Health and approves programs that are carried out by professional staff. The ability to tax is derived from Texas law, and is limited to a

59 Central Health Website, About Central Health. Retrieved from: http://www.traviscountyhd.org/about_us.html
60 Central Health Website, About Central Health. Retrieved from: http://www.traviscountyhd.org/about_us.html

maximum of 25 cents per $100 of assessed property value. The tax rate is reviewed yearly, is subject to public hearings, and must be approved by the Travis County Commissioner Courts[61].

Central Health provides a wide range of services to the low income uninsured citizens of Travis County. As the ACS data above shows, Travis has an uninsured rate of 23%, and so Central Health has been working hard to improve access to care for the low income though its Medical Assistance Program (MAP).[62] The MAP program provides a full range of health services to uninsured low- income residents under 100% of poverty (200% if elderly or disabled). Uninsured individuals under 200% of poverty who do not qualify for the full MAP can receive primary care services on a sliding scale fee. Central health does not provide health services directly but contracts with affiliated FQHCs and other nonprofit and community providers. Central Health owns a local Trauma 1 hospital which is leased to and run by the Seton Healthcare Family. Central Health has been working with local clinics to develop additional capacity including infrastructure (appropriate physical space) as well as additional clinical capacities. Additionally, Central Health built and owns the recently opened North Central Health Center, which is operated by CommUnityCare, the local FQHC organization[63]. CommUnityCare operates 23 clinics in the Austin Travis area. It has a budget of $64.5 million and serves approximately 66,000 patients with approximately 220,000 medical and dental appointments annually. The majority of CommUnityCare's budget comes from Central Health and the Federal Bureau of Primary Healthcare.

Central Health has several other programs they sponsor including a low cost insurance plan for small businesses of 2-50 employees. [64] The plan called TexHealth Central Texas has a three -share plan for the $269 monthly premium which is split between the plan, employer, and employee for those making $15.62/hour or less. In 2011, the health plan paid $100 and the employer and employee each pay $84.50 monthly for the premiums. Business owners and employees making more than $15.62/hour are eligible for coverage but do not receive the $100 monthly premium subsidy. The plan does not cover dependents of employees.[65] It also has limited benefits including specific limits on the number of visits to physician offices and mental/behavioral health visits. This plan does include a waiting period for enrollees to receive services on certain pre-existing conditions.[66] TexHealth Central Texas is an innovative approach to provide access to some health insurance to employees of small businesses and nonprofits, which have been unable to provide health insurance in the past year for a community where nearly 1 in 4 people are uninsured.

The separate governance structure, with a dedicated funding source, has been effective at combining public and private resources to expand access to health care services in Travis County. In addition to paying for direct services for MAP enrollees, the ability to build infrastructure

61 Central Health Website: Finances and Funding. Retrieved http://www.traviscountyhd.org/finances_and_funding.html
62 Central Health Website, information about the MAP and other programs from: http://www.traviscountyhd.org/healthcare_services.html
63 Information on CommUnityCare from its website: http://www.communitycaretx.org/about_us.html

64 http://www.traviscountyhd.org/texhealth_central_texas.html

65 http://www.texhealthcentraltex.org/benefits/ There are several similar plans for various communities in Texas. TexHealth Central Texas covers a six county area including: Travis, Bastrop, Burnet, Caldwell, Hays or Williamson
66 Information obtained from the TexHealth Central Health website, "http://texhealthct.org/

for both existing clinics and expand to additional locations has increased the clinical capacity of these clinics and services. The model has also allowed for creation and implementation of innovative program offerings such as TexHealth Central Texas, and the current efforts to create a HMO, which will accept Medicaid.

Integrated Intake and Services

The Hennepin County Human Services and Public Health Department, (HSPHD), in Minnesota has created the "Client Services Delivery Model" which works to integrate health and social service intake, enrollment, and case management. [67] The model is used in a regional facility setting and is meant to view and treat the client holistically instead of in silos. The program created a horizontal management structure where services are provided by teams of specialists (social workers, nurses, eligibility specialists, etc.) working together to meet the needs of their clients. The model has three major integrated service tracks including: "initial contract and screening, eligibility determination and screenings, and case management and ongoing services and supports." (HSPHD new directions)[68] Upon seeking enrollment in a program, clients are asked to complete the, "Broader Needs Assessment" (BNA) which helps to identify if the client or client's family may need or be eligible for multiple services.

The BNA is a computer-based program, which asks approximately ten questions related to health, social services, mental health, housing and other basic needs. The software program maintains copies of the BNA reports and the dates in which they were completed. The BNA is connected to a database maintained by the state of Minnesota that holds information on a variety of public and private programs and resources available across a variety of service lines. Hennepin has the broader needs assessment search for resources based on distance from zip code of the client. The BNA creates a report listing all resources with description and contract information for the client. The intake worker can help the client to identify priorities and create a plan for enrolling in services. Also, the BNA report always lists resources related to safety needs first (such as court for restraining orders in cases of domestic violence). The BNA and CSDM were designed to break down barriers between service lines within human services and health needs and enhance the client experience as well as increase benefits gained from services or programs by combining multiple types of services to truly meet the client's needs.[69] As one director from the HSPHD department discussed, "in the traditional system used by Hennepin, if a client requested food assistance, the eligibility worker would screen for eligibility for food assistance, and not ask questions about other aspects of the person's life to see if other services could be provided. This was leading to diminishing returns as the county realized that clients' needs were not fully met in ways that helped improve client's lives."[70] The Hennepin model also includes software programs developed for use across the

67 Hennepin County Human Services and Public Health Department, "HSPHD's New Direction: Delivering Services in the 21st Century" April 2011: http://www.co.hennepin.mn.us/files/HennepinUS/HSPHD/Department/Cllient%20Service%20Delivery%20Model/Handout_V18_053111.pdf

68 Hennepin County Human Services and Public Health Department, "HSPHD's New Direction: Delivering Services in the 21st Century" April 2011: page 4 http://www.co.hennepin.mn.us/files/HennepinUS/HSPHD/Department/Cllient%20Service%20Delivery%20Model/Handout_V18_053111.pdf

69 Interview with Jen Castillo, Process Analysis Unit Supervisor, December 12, 2011, and from Demonstration document, "BNA_Demo_7, provided by Ms. Castillo.

70 Phone Interview with Rex Holzemer, Area Director, HSPHD

client services delivery model which reduces the need for clients to provide the same information repeatedly to multiple people, and allows case workers and other service providers to see information about services being provided to their clients by other providers. The software is available across the department and can be accessed outside of traditional offices.

Results Only Work Environment

The Results Only Work Environment, (ROWE), concept was started by Best Buy and other major businesses in Minnesota. One of the main incentives to develop this new business model was traffic congestion. In 2007, The HSPHD hired consultants to help develop a plan to convert the department to a ROWE. The conversion to the model came shortly after transitioning the department to an expanded regionalized office facilities structure. A goal was to make the department more accessible to the citizens of Hennepin County by moving program offices closer to where people live. The ROWE concept combined well with the regionalization model as it gave staff greater flexibility to meet the needs clients in streamlined processes and utilize flexible scheduling and office space. The staff is also required to maintain detailed records of their time spend in different tasks that are used to create benchmarks and meet goals. For example, the goal of 'percentage of time spent on direct client contact'.

Integrated Behavioral and primary Care services

Travis: E-Merge Program (Mental health assessment and short term treatment at CommUnityCare (FQHC) and the Austin Travis County Integral care network (Integral Care) active and Medical Assistance Program (MAP) card holders[71]. This program helps to provide primary care clients with access to Austin Travis Integral Care staff for a psychotic or behavioral health evaluation. The treatment begins with a 30- minute initial assessment that includes a clinical interview and a personal health questionnaire. Typically when needed the behavioral health team provides four to six brief follow-up visits.
The Health Integration Project, (HIP), provides CommUnityCare primary care staff to see Integral Care clients who do not have a primary care provider. The goal is provide access to primary care in the same location as the mental health services because many persons with mental health illnesses have often lacked access to primary care treatments. "HIP is a new evidence-based model that uses a person-centered approach developed from research supporting the integration of health care."[72] The program includes additional services such as: "Integration peer support programming, including 1:1 transportation and volunteer supports, peer led wellness group programming, integration of fitness and nutrition programs, community forum on Integral Cares programs, CPR and First Aid programs, and secured sharing of clinical records with local hospital systems."[73]

In Cobb County Georgia, the Cobb/Douglas Community Services Board and APS Healthcare Disease Management Georgia have formed a partnership aimed at "Enhancing positive health outcomes for clients with serious behavioral health

71 Austin Travis County Integral Care, retrieved http://www.integralcare.org/?nd=bh_emerge
72 Health Integration Project, Austin Travis County Integral Care, retrieved from: http://www.integralcare.org/?nd=bh_hip
73 Health Integration Project, Austin Travis County Integral Care, retrieved from: http://www.integralcare.org/?nd=bh_hip

disorders."[74] The structure of the program is a 'Virtual' Medical Home which links behavioral health and primary care providers though technology. The system uses claims driven data of services and medications, proprietary information systems [APS Healthcare Care Connection and CareLogic, best practice information, consumer empowerment strategies and human and social capital to improve the health of patients though coordinated care. Early metrics found that the project has momentum with "822 total shared members/clients, and a 104% increase in enrollment in the first two months."

Public Private Partnership Programs for Direct Care

Montgomery County has a unique program whereby the county contracts with the Primary Care Coalition of Montgomery County (PCC). The PCC worked with the county to develop a program to pay for and provide health care services for the uninsured with the county several years ago. The program, Montgomery Cares, provides health services to county residents at 11 different clinics (2 FQHCs and 9 nonprofit). The program works by paying a flat fee to the clinics for each office visit with a health care provider. Montgomery Cares also utilizes two networks of specialist providers willing to do specific amounts of services at negotiated terms, one is the in-house (PCC) network and the other is administered by the Arch-diocese health care network. The specialist care networks are similar to the specialist network created and utilized by the Fairfax County Community Health Care Network (CHCN). The PCC also provides various types of assistance to the clinics including Medication access program and management and other advising. The PCC also administers part of the Care for Kids program of Montgomery County, and a program to help county residents apply for assistance from the pharmaceuticals companies for specific medication needs.

The Cobb/Douglas CSB and APS Healthcare Disease Management, GA discussed earlier developed a partnership to integrate mental and medical healthcare shares several steps for they found were successful for their integrated care public-private partnership.[75] These steps include: establishing a shared mission and goals for the partnership, identifying a common language such as determining if the term clients, patients, or members be used. Third, It is important to maintain pacing, flexibility, and capacity as keep the process moving forward and be flexible in dealing with implementation challenges, including develop shared solutions, be open to new ideas, and avoid the blame game. Determine expectations, communicate individual and shared outcomes, address differences, and evaluate and adjust expectations. Developing trust though a variety of methods including though forums and significant face-time which will help to overcome expected conflict, and create empowerment from the bottom up and champions within all levels and solicit feedback from everyone simultaneously. Lastly, it is important, "establish outcome measurements early to universalize the

74 All information including quotations on the Cobb CSB and APS Healthcare partnership from: Climko, B, Strotz, D, Holt, C, "Integrating medical and behavioral healthcare poster presentation" presented at the National Council for Community Behavioral Healthcare, 40th National Mental Health and Addictions Conference & Expo, March 2010. http://www.cobbcsb.com/news2001.html

75 Cobb CSB and APS Healthcare partnership from: Climko, B, Strotz, D, Holt, C, "Integrating medical and behavioral healthcare poster presentation" presented at the National Council for Community Behavioral Healthcare, 40th National Mental Health and Addictions Conference & Expo, March2010. http://www.cobbcsb.com/news2001.html

partnership project" and to measure the outcomes.

Preparing for Health Reform

Counties and states are engaged in several types of programmatic planning and implementation related to health care reform. These efforts affect different areas of delivery and payment reforms. In Montgomery County, the Primary Care Coalition, is working with several of their private nonprofit clinics to become Medicaid providers and accept private insurance in anticipation of significant gains in their current populations gaining coverage though the expansion of Medicaid and subsides of private insurance[76]. Hennepin County is also in the process of working on a payment and delivery reform program for Medicaid clients by creating an Accountable Care Organization (ACO). Hennepin owns a hospital and other health care facilities, and has experience of running a Medicaid Health Maintenance Organization. Hennepin also has affiliated FQHC's. These make the county uniquely suited to pilot an ACO. The county plans to develop the ACO to serve about 12,000 Patients.

Lastly, Central Health is in the process of developing a Medicaid HMO plan, which is expected to become operational in March 2012.[77] A goal of creating a Medicaid HMO is that it will reduce the effects on individuals as they continually shifts between Medicaid and the MAP program for the uninsured. This is especially applicable with the health reform changes in eligibility in 2014. The press release also says "In conjunction with anticipated changes to the healthcare delivery system pursuant to the Federal Affordable Care Act, this new HMO will provide access and care to a population of individuals who otherwise would still remain without resources to obtain health insurance or find access to care."[78]

Overarching Observations

Governance, integration, cooperation, and comprehensive intake are important processes and goals, which have been described in the efforts reported from the peer counties. Aspects of these programs can be adapted to strengthen Fairfax County's current programs and efforts. From Travis County we learn that having a dedicated, separate organization to organize and finance health care services for the uninsured can be effective managing a revenue stream for safety net services and support establishment of public private service delivery partnerships. Using, an outside organization to help private clinics organize and grow in clinical and business abilities has been useful to help coordinate the private sector clinics and health services for the uninsured in Montgomery County Maryland.

From all peers, we learn that it will be important, for Fairfax County, to build information technology infrastructure that supports data sharing and integration across different units and programs. Such information access will help realize the goal of tracking clients across service/program lines and support assessment of the county's efforts in meeting resident's needs and assessing unmet needs. As discussed elsewhere in this report, it is clear Fairfax County does

76 Raskin, Barbara, phone conversation

77 Mike McKinnon, "Central Health Votes to Create HMO", Press Release, January 14, 2011, http://www.traviscountyhd.org/1-14_-_central_health_votes_to_create_hmo.html

78 Mike McKinnon, "Central Health Votes to Create HMO", Press Release, January 14, 2011, http://www.traviscountyhd.org/1-14_-_central_health_votes_to_create_hmo.html

not have the capacity to identify how many clients are being served by more than one department, or within different Health Department programs.. Fairfax County can look to Hennepin County, Minnesota, which has been working on integration of technology, services, and staff for advice on how to proceed. Efforts to work together exist, but are hindered by the current technology infrastructure, for example, the CSB and the CHCN have limited integration of primary care and mental/behavioral health services through sharing of staff and facilities but can only complete periodic hand checks of records to know which clients are utilizing both services. Although they are sharing clients/patients, they are unable to share medical records and may not know what services or treatments the other is providing unless told by the client/patient. The Health Access Assistance (HAAT) Team provides integration across the Department of Family Services and the Health Department through placement of staff at the CHCN clinics. A new team, the FAST team, provides access, eligibility and, insurance supports. The county needs to consider ways to integrate their best practices to reduce administrative overhead and expenses. While there is abundant evidence of Fairfax County programs working together to improve services and the quality of care to clients while leveraging available resources, such efforts could be enhanced by sharing data and through improved program integration, sharing infrastructure and managing limitations expenses. Fairfax County has some good service lines and excellent professionals providing services to its residents, however it can improve by better integration of service infrastructure and governance.

RECOMMENDATIONS

Challenges are inevitable, given the size, diversity and complexity of Fairfax County and its residents. The county's scope of operations, with varying access points to services and its vast array of strategic assets to employ and coordinate to make the Fairfax County safety net effective as it is today.

However, as the "facts on the ground" change, county government priorities are likely to change in the future. Local health care providers and clients themselves will be responding to and adapting to changing conditions that are viewed as both desirable and undesirable. Currently, the county makes resource allocation decisions in the absence of information that could be available if its authority and capacity to monitor and coordinate among various county agencies, programs and health care safety net partners were significantly enhanced. Therefore, improving the County's ability to make better- informed allocation decisions about program operations and impact in the future is an important consideration (principle 6) that cuts across most recommendations. To do so, recommendations involving three areas were developed. Those that support: Strategic planning, access to services and service/program alignment. Twelve recommendations were identified for the county's consideration. Each recommendation follows a description of the current and or future challenge that is addressed. Each recommendation is also cross-referenced to the Task Force Principles and Work Goals the recommendation *primarily* informs (we note that many recommendations are consistent with or cut across a number of principles and work goals presented in the report introduction).

Challenge: *The County does not have the capacity to identify health needs of low- income county residents and analyze the availability and effectiveness of extant safety net programs and resources to meet those needs. While a health needs assessment for the Fairfax community was recently completed (MAPP CHSA Report, Sept 2011), substantial information gaps to inform health planning and programs were also identified. Program data collection for operations and services provided, provider characteristics, productivity and longitudinal health outcomes (by population or special groups) are neither standardized nor consistent across county agencies and programs. As a result, data on cross cutting services and client coverage and care seeking is not adequate to identify service duplication or gaps. Currently, it is impossible to determine whether individual or aggregate program capacity is adequate to serve current needs or change in anticipation of PPACA impact after 2014, when the coverage expansion provisions of PPACA are scheduled to be implemented.*

Table 28 : TF Work Goals Addressed	
Principles /Planning Assumptions 4 and 5	• Identify known gaps in Fairfax County safety net; • Understand (fully) existing county programs and services and resident eligibility requirements and needs (including identification of those not served and why); • Identify available community and public sector primary and preventive services; • Analyze impact to the community on anticipated community practice changes

Recommendation #1: Leverage the Community Health Needs Assessment (CHNA) requirement for tax-exempt hospitals within PPACA to work collaboratively with Inova Health System on the development of a comprehensive Fairfax County health needs assessment and mutual identification of priorities for population health improvement. PPACA requires tax-exempt hospitals to not only assess the community's needs but to also devise a plan for meeting those needs or provide an explanation for why they cannot be met. Of course, it is not feasible for hospitals to be the sole providers of safety net services. But since PPACA and pursuant regulations require them to do a CHNA within a year of March 2012, and requires them to describe their methods and to accept input from persons who represent "the broad interests of the community" and /or who have "special knowledge or expertise in public health," it is appropriate for the County and its partners to work collaboratively with Inova to produce the first comprehensive CHNA required by PPACA for our area (and subsequent CHNAs, every three years). Because of the requirement to explain how the hospital will and will not meet the ongoing needs of the community, other safety net providers' capacities – public and private -- must be assessed as part of this process. This is an ideal opportunity to establish a comprehensive and shared framework for safety net analysis and public-private resource allocation. These efforts should build on and extend the Health Department's MAPP Strategic Planning process and Community Transformation Grant efforts, providing a platform for Inova to meet its obligations with full county engagement and leveraging extant, uniform public health planning data.

While IRS regulations on the CHNA requirement are not final yet,[79] published guidance makes clear the nature of the assessment and planning that must be undertaken to avoid penalties and loss of status. Several states already have exemplary CHNA requirements in place (the PPACA provisions were largely based on these, especially California's) so procedures and examples could easily be modified to fit Fairfax County's and other health care provider's planning needs/obligations.[80]

Challenge: *Challenge: The amount and types of community benefit provided by*

79 Internal Revenue Bulletin, 2011-30, July 25, 2011, Notice 2011-52, *Notice and Request for Comments Regarding the Community Health Needs Assessment Requirements for Tax-Exempt Hospitals.* http://www.irs.gov/irb/2011-30_IRB/ar08.html.

80 Government Accountability Office, *Nonprofit Hospitals: Variation in Standards and Guidance Limits Comparison of How Hospitals Meet Community Benefit Requirements.* September 2008 Report to the Ranking Member, Committee on Finance, US Senate.

not-for-profit and for-profit hospitals is voluntarily decided by each entity. This places the benefit outside the tax liabilities of the for-profit hospitals, which should be counted as community benefit in any comprehensive accounting, in our view).

We have a number of recommendations to respond to this challenge:

Table 29 : TF Work Goals Addressed

Principles/Planning Assumptions 2,4,5	Describe anticipated enrollment impacts and workload associated with new and expanded/changing health services ; • Connections to safety net providers (hospitals, FQHCs, local government, CBOs) • Recommend realignment of services to fill the gaps • Articulate public sector role in the health "safety net" • Identify steps to implement recommendations • Document and recommend options for uncompensated care populations; • Conduct planning and information sharing conversations with private providers on business models being developed by community providers (i.e. Inova, FQHCs, CBOs, etc.) Identify known gaps in Fairfax County safety net Understand (fully) existing county programs and services and resident eligibility requirements and needs (including identification of those not served and why) Identify available community and public sector primary and preventive services Analyze impact to the community on anticipated community practice changes

Recommendation #2: Develop explicit agreements or requirements, in conjunction with private providers (as feasible) for nonprofits and other partners, to help with the burden of caring for the uninsured and safety net patients. Part of the rationale of the CHNA requirement in PPACA is to standardize concepts and accounting for community benefits. But PPACA does *not* require nonprofits to provide specific amounts or percentages (of revenue, for example), just to assess need and explain what they will and will not do and why. Currently ten states have specific requirements for nonprofit hospitals' community benefits, but they vary considerably by amount.[81] To impose requirements on nonprofits, new state law or county regulation would be required. We would recommend pursuing non-statutory agreements if possible. This starts at a minimum, with developing a shared understanding of the County's needs (hence the CHNA recommendation) as well as the ability to anticipate the level of effort and what kinds contributions that can be expected from hospitals over the three year planning period of each subsequent CHNA. This will be an invaluable resource in helping the County perform its "general contracting" duties of ensuring access for those residents who have few or no options but the safety net. Analysis of remaining gaps in health needs not being met will also help County and Commonwealth officials evaluate the wisdom of more explicit requirements or contractual obligations on private health providers in the future.

81 Ibid.

Table 30 : TF Work Goals Addressed	
Principles/Planning Assumptions 3,4	Create medical home models - using primary provider/referral systems or network of linked providers in "managed care" settings; Identify new funding options, financial impact of reform and current county programs • additional costs to the county and sources of funding • sustainability of financing - models for consideration Identify available community and public sector primary and preventive services Analyze impact to the community on anticipated community practice changes

Recommendation #3: Develop a strategic and operating plan for centralizing county contracts with all health care and service providers (especially medical sub-specialists). Develop an evidence- based model for integrated service delivery in Fairfax County. At a minimum, the model and support system for care coordination and referrals should be developed and implemented across all county agencies and effectively support the continuum of services (diagnosis, treatment and long-term management) for primary care, medical homes, specialty care, behavioral and mental health care and oral health.

- As part of this system, establish a central, uniform contracting effort that serves all health recruitment and partner arrangements for service provision and revenue arrangements.
- Identify needs and organizing processes for meeting unique agency/program needs;
- Establish and implement uniform performance measures for contract providers, to ensure care, service quality and outcomes.

As part of the planning effort, review the scope of specialty provider needs for all county programs, the CHCN and CSB. Based on the critical mass of specialist needs across agencies, determine whether contract service providers or new cross-agency, county providers (full or part-time) will ensure the most effective balance of cost effective, high quality services combined with efficiently utilized specialty and managed care services that address agency/clinic needs.

Table 31 : TF Work Goals Addressed	
Principles/Planning Assumptions 2,4,5	Analyze managed care and potential partnership opportunities for low income, older adults, persons with chronic conditions, serious mental illness, etc; Recommend realignment of services to fill the gaps • Articulate public sector role in the health "safety net" • Identify steps to implement recommendations Document and recommend options for uncompensated care populations

Recommendation #4:
Continue to pursue "medically underserved population or area" (MUP/A)" Exceptional MUP Designation (also known as a "Governor's Special Designation") concurrent with efforts to establish a "New Access Point (NAP)" or expand existing Community Health Centers (CHC) in Fairfax , to enhance Medicaid and Medicare reimbursement under the "federally qualified health centers" (FQHC) benefit.

Table 32 : TF Work Goals Addressed	
Principles/Planning Assumptions 2	Describe anticipated enrollment impacts and workload associated with new and expanded/changing health services • how individual participants will be tracked/supported as income/eligibility fluctuates • cross system documentation of enrollment and health data exchanges

Recommendation #5: Expand use of existing streamlined eligibility systems. Support current efforts to expedite utilization of the new cross-program integrated eligibility system the Virginia Department of Health and Human Resources is currently developing to combine eligibility for multiple programs across the secretariat. To take full advantage of the new system, expected to be operational by July of 2012, create a uniform intake assessment questionnaire for use by all county units and health and social service organizations to determine a comprehensive set of client data including socio-economics, demographics and health status/needs. Data from the universal intake survey will establish a baseline to determine program match and eligibility for all available public and public/private programs (local, state, national), help prioritize needs, and ensure that clients are expeditiously enrolled in coordinate programs to address multiple and complex health and social service needs.

Table 33 : TF Work Goals Addressed	
Principles/Planning Assumptions 2, 3, 4	• documentation of enrollment and health data exchanges • electronic health records interfaces and state systems • connections to safety net providers (hospitals, FQHCs, local government, CBOs) • analysis of data exchange/electronic data needs and state plans for health insurance exchange data design review of state position regarding payment reform and monitoring state corporation commission regulations regarding insurance maximize use of existing and future data systems, (e.g. Electronic Health Records)

Recommendation #6: Invest in uniform and integrated information technology that supports a comprehensive array of clinical care and administrative functions (including billing) across all county health and human service agencies and programs. At a minimum, this system should be able to support or access state-sponsored enrollment data systems, electronic health records (perhaps from a health information exchange) and diagnostic test data among all system providers, by providing an interoperable interface between the CHCN, Health Department programs, CSB, and selected safety net programs, such as those for pharmacy assistance. Assessment of future opportunities and mechanisms (or limitations) to interface with electronic health systems utilized by hospitals and the Northern Virginia Regional Health Information Organization should be undertaken. At a minimum, a uniform data set should be adopted for all clinical care and administrative functions across all Fairfax health and human service agencies and programs. This data set should be established and implemented as a high priority.

Recommendation #7:
Continue to include dental care as a part of the safety net services and expand access to local dental service programs for more adults. Work with other safety net and community providers to achieve this expansion. This is particularly important as Medicaid does not cover dental care for adults.

Challenge: *Financing the necessary level of services in the anticipated budget environments will be extremely difficult.*

Table 34 : TF Work Goals Addressed	
Principles/Planning Assumptions 3	Identify new funding options, financial impact of reform and current county programs • available funding/financing, grants and sources to support services • additional costs to the county and sources of funding Sustainability of financing - model for consideration

Recommendation #8: Prepare the CHCN to accept an array of payer sources including self-pay, Medicaid, Medicare and private insurance, especially in preparation for expansion of coverage in both coverage types in 2014. Being able to collect money from newly eligible and enrolled Medicaid patients will be particularly important, as many patients who use CHCN now will likely become Medicaid eligible, and these resident will not likely find private sector providers eager to accept new Medicaid patients, due to historically low reimbursement rates. Therefore, it is even more incumbent upon the county to develop strategies for short and long term financing and reimbursement of primary and acute care services for these patients.

Challenge: *The number one reason people are not enrolled in Medicaid today even though individuals are eligible is they are not aware they, or their children, are eligible.*

Table 35 : TF Work Goals Addressed	
Principles/Planning Assumptions 1,3,5	Inform and educate community about ongoing and new coverage options • develop coordinated general and focused outreach plan • utilize existing resources, via reallocation, to maximize available private, public, nonprofit and not for profit health services

Recommendation #9: Develop an outreach campaign in 2013 to inform the community of the new coverage options and Medicaid expansion coming in 2014. Expand self-sufficiency services to support future Medicaid expansion. Develop technical interface with the health insurance exchange to augment insurance eligibility and referral coordination functions for eligible clients. The county might review and modify the strategies used to conduct the

successful outreach efforts utilized in Virginia when SCHIP was enacted in the mid 1990's.

Challenge: *Today, the Fairfax County safety net serves about 22% of the uninsured, but that is likely near half of those who actually seek care in a given year. Calibrating the scale of the safety net and the county's strategic support of it in the post-2014 environment where the number of uninsured is expected to fall by roughly half (with slightly more than half of those gaining private coverage, the rest Medicaid) requires balancing a number of considerations, some more easily managed than others.*

Table 36 : TF Work Goals Addressed

Principles/Planning Assumptions 2,3	Document and recommend options for uncompensated care populations Describe anticipated enrollment impacts and workload associated with new and expanded/changing health services • how individual participants will be tracked/supported as income/eligibility fluctuates • documentation of enrollment and health data exchanges Analyze managed care and potential partnership opportunities for low income, older adults, persons with chronic conditions, serious mental illness, etc; Create medical home models - using primary provider/referral systems or network of linked providers in "managed care" settings; Recommend realignment of services to fill the gaps • Articulate public sector role in the health "safety net" Identify known gaps in Fairfax County safety net Understand (fully) existing county programs and services and resident eligibility requirements and needs (including identification of those not served and why) Identify available community and public sector primary and preventive services Analyze impact to the community on anticipated community practice changes

Recommendation #10: Planning for some safety net reduction and/or consolidation is prudent, given the scale of the insurance coverage expansion in PPACA and the anticipated reduction in the uninsured population that will result over several years, following implementation of new coverage options and changes in resident's care seeking behavior. Take into consideration that the pace of Medicaid coverage expansion could be slowed by a reluctant state legislature in Richmond Virginia. Medicaid payment rates are likely to remain low relative to, and in comparison with private payment rates in Northern Virginia. As a result, it is important to anticipate that many newly eligible beneficiaries (maybe most) might have trouble finding private clinicians who will accept new Medicaid patients. Until it is clearer how PPACA and Commonwealth policy will evolve (and especially until the capacity of physicians accepting Medicaid improves) we do not recommend reducing the net commitments to the safety net, but we anticipate CHCN capacity could be scaled back by a quarter or even as much as a third by 2016. For these reasons and given the expected incidence of behavioral health (mental and substance abuse) conditions among the low income adult population

(who most likely will gain coverage through Medicaid), and the reluctance of the local private sector to accept low-paying patients with behavioral issues, we recommend keeping the CSB at least at its current scale until after 2016. At that time current, post-reform data can inform changes in local resource allocation. Part of the decision in changing programs support should consider current efforts by the CSB (yet to be realized) to integrate behavioral and primary/acute services.

Challenge: *Evaluating and coordinating the assessment and the service delivery quantity and quality, especially among the various nonprofit and for profit partners in service provision, can be problematic under present structures, due to a lack of centralized authority to quantify the demand for specialty services and to make allocation decisions in the future based on full information and consideration of different provider arrangements. Since centralized information and oversight/management authority are likely to be of higher value going forward, major changes in safety net arrangements may be more appropriate as health reform is implemented and amended over time.*

Recommendation #11: Create a new government entity and structure which will enable cross sector, cross agency integration, coordination, and planning in order to reorganize access to services through an authority that will manage and/or leverage resources and coordinate cross-agency/cross-sector services and programs. The statutory authority to take action is available to the County Executive under 15.2-5200 to establish a Fairfax County Health Commission or 32.1 to establish a Fairfax Health Partnership Authority (herein referred to as the entity). This entity would report to the Board of Supervisors but would have operational autonomy assuming Supervisor-determined objectives and priorities were being met.

This Entity will establish and define relationships between itself and various existing boards, authorities, and commissions, including but not limited to the Health Care Advisory Board (HCAB), Community Services Board, Advisory Social Services Board, Community Planning and Management Team (CPMT). Within 6 months of creation by the Board of Supervisors (BOS), the Entity will make recommendations to the BOS about the continuing roles of other boards, etc. Operational plans for implementation would be developed in the County's phase II health reform implementation efforts.

The primary goals of the entity will build on cross cutting County efforts (used for targeted purposes in the past) and implement a cross sector, cross agency planning and oversight mechanism to improve access to care and to reduce disparities and unnecessary health care costs. The primary tools the Entity will employ include strategic integration, resource management and evaluation, including the ability to effect operational changes at the program level, This relates to the direction and appropriate co-location of personnel and contractors providing primary care and specialty care (CHCN, private safety net providers, FQHC satellites and sites near the county, free

clinics, oral health and WIC), behavioral and mental health (Community Services Board: CSB and the Community Planning and Management Teams and various social services in areas around the county).

County legal counsel should be consulted on the feasibility and scope of the authority to act and establish the most advantageous entity feasible under the appropriate statute. While a Commission may be desirable for its flexibility, a Health Partnership Authority may have more influence to make and enforce decisions. *The most authoritative entity that is feasible to establish should be pursued.* The new entity must have authority to act and substantively influence health and related social service programs and resources across county agencies and between public and private sector collaborators and partners, to achieve the intent of the recommendation. We note that a similar entity established in Southwest Virginia appears to be a hybrid of these authorities.[82] See Appendix VI for a summary of the legislative provisions under each statute.

Recommendation #12: Develop a privately-funded evaluation program for the proposed Entity, wherein independent contractors conduct a gross and net impact analysis and report to the Board of Supervisors (BOS) every five years (however, the first evaluation should be initiated following the first three years of implementation). Evaluate the program by the priorities determined by the BOS. Private funding and independent evaluators will protect the process from the appearance and the reality of potential bias.

82 Southwest Virginia Health Authority
http://www.swvahealthauthority.org/about-svha

APPENDIX I: FAIRFAX COUNTY ASSETS AND RESOURCES

The following service information was collected during summer 2011 to catalog available health services to individuals residing in Fairfax County and in the cities of Fairfax and Falls Church. Health services were broadly defined to include those provided for primary medical, behavioral, oral care, pharmacy assistance, and related social service supports directly related to health and well-being of patients. Services listed include those financed through federal, state, local government, or private funding/in-kind services. In general, noted programs serve low income persons, special populations with chronic conditions and/or serve persons facing barriers to access to affordable health care. The list is not inclusive of all available resources, but does include county provided or county supported efforts, as well as local community resources that routinely share information regarding their programs and services to county residents. For corrections, updated data or additional information, please send inquiries to wwwahs@fairfaxcounty.gov.

<table>
<tr><th colspan="3">Fairfax County Health Assets and Resources
Existing Primary, Behavioral and Oral Health Services, Programs and Supports Available in the Community</th></tr>
<tr><th>Program/Service</th><th>Brief Description/Eligibility</th><th>Budget/Staffing</th></tr>
<tr><td>Auxiliary Grant program</td><td>Services Provided
Financial supplement to income for eligible persons living in assisted living or adult foster care. Eligible recipients also receive Medicaid. Eligibility is tied to Supplemental Security Income (SSI) levels and medical necessity criteria using an Uniform Assessment Instrument (UAI) screening tool. Local public human service workers assess for functional eligibility. Fairfax County Department of Family Services Self-Sufficiency staff determines individual client financial eligibility.
Population Served - In FY 11, an average of 201 people per month received auxiliary grants. Average payment was $1,279 monthly (incorporates a 15% differential for Planning District 8/northern Virginia residency- other Virginia payments at $1,112). A 20% local match is provided for the auxiliary grant.</td><td>FY 2011 expenditures:
$1,222,818

-$978,254 State
-$244,564 Local County share</td></tr>
<tr><td rowspan="2">Behavioral Health Services</td><td colspan="2">The Fairfax-Falls Church Community Services Board (CSB) serves the community as the public agency responsible for planning, organizing and providing services to persons who have a mental illness, intellectual disability, or a substance use disorder.
Services Provided
Services are provided to residents of Fairfax County and the Cities of Fairfax and Falls Church. The CSB’s Reimbursement for Services Policy ensures that every service has a cost and a source of funding. What a consumer pays depends on their ability to pay, based on the CSB’s Ability to Pay Scale and/or whether they have insurance.
Component descriptions begin below:</td></tr>
<tr><td>Emergency Services: Provide a continuum of emergency mental health and substance abuse services to ensure short-term safety for both the individual and the community, assess and stabilize crisis situations, and link individuals to services that address ongoing needs. Services are provided at three mental health centers, 24/7 at Woodburn Center and through the Mobile Crisis Unit. Countywide detoxification services are provided at the Fairfax Detoxification Center in Chantilly. The Diversion to Detox program assures in-community assessments of</td><td>Staff: 61.5 SYE:
-32 SYE Emergency mental health services including Mobile Crisis Unit
-25.5 SYE Fairfax Detoxification Center
-4 SYE Diversion-to-Detox Grant
FY 2011 Expenditures:
$7,921,715
• Emergency mental health: $5,028,186</td></tr>
</table>

Fairfax County Health Assets and Resources Existing Primary, Behavioral and Oral Health Services, Programs and Supports Available in the Community		
Program/Service	**Brief Description/Eligibility**	**Budget/Staffing**
Behavioral Health (cont.)	persons who are intoxicated in public. Hospital-based detoxification is provided for medically compromised persons, and methadone and Buprenorphine treatment is provided for those with opiate addictions. **Population Served -** Emergency Services were provided to 7,849 persons in FY 2010.	• Fairfax Detoxification Center: $2,609,262 • Diversion –to-Detox Grant: $284,267 Revenue/cost distribution: 54% State, 35% County and Cities funding 9% Federal, 1% Medicaid 1% Self pay and insurance
	CSB Mental Health Services **Services Provided** Service delivery at six directly-operated community outpatient mental health sites, more than ten 24-hour residential treatment facilities, and a 24-hour emergency services program. Recovery-oriented community based services include: day support, residential, individual and group treatment, case management, and assertive community treatment. **Population Served -**MHS served 11,447 persons in FY 2010, a slight increase over FY 2009 (n=11,318). The CSB is serving an increased number of persons with co-occurring and intensive mental health and medical needs. One in every four individuals receiving mental health services is over the age of 55.	**Staff: 426/423.5 SYE** **FY 2011 Expenditures*:*** $55,467,635 Funding sources: 66% County and Cities 16% State 10% Medicaid 3% Self pay and insurance 3% CSA fees 2% Federal *(note: figures above exclude emergency mental health services noted in previous section).*
	CSB Pharmacy services **Services Provided** Pharmacies within CSB centers: Local pharmacy option at the Gartlan and Woodburn Centers and medication pick-up services at outpatient sites – Reston, Chantilly and Springfield. Contracted vendor is QoL. Prescriptions filled for individuals with insurance, self-paying or for prescriptions for medications that are paid or subsidized by the CSB if a psychiatrist or nurse practitioner has determined that the individual is eligible. Eligibility: • Proof of Residency in Fairfax County, city of Falls Church or Fairfax, or towns of Vienna and Herndon. • No available funds or resources such as medical insurance with prescription coverage,	Medication cost avoidance far exceeded $4.0 million through the utilization of various Pharmacy Assistance Programs (PAPs) and a robust Medicare Part D Open Enrollment initiative. The CSB accesses PAPs for over 500 consumers.

Fairfax County Health Assets and Resources Existing Primary, Behavioral and Oral Health Services, Programs and Supports Available in the Community		
Program/Service	**Brief Description/Eligibility**	**Budget/Staffing**
Behavioral Health (cont.)	Medicaid or other financial resources. • Does not have access to a patient assistance program sponsored by a pharmaceutical company. • Meet the income requirement for the CSB's Ability-to-Pay Scale category of 10% or less **Population Served -** Over 6,900 CSB consumers received medication management services in FY 09.	
	CSB Infant Toddler Connection **Services Provided** Infant Toddler Connection- provides federally-mandated early intervention services to infants and toddlers as outlined in Part C of the Individuals with Disabilities Education Act (IDEA). ITC provides family-centered intervention to children ages birth to 3 years who need strategies to assist them in acquiring basic developmental skills such as sitting, crawling, walking and/or talking. Through public/private partnerships, ITC provides : physical, occupational and speech therapy; developmental services; medical, health and nursing services; hearing and vision services; assistive technology (e.g., hearing aids, adapted toys and mobility aids); family training and counseling; service coordination; and transportation. **Population served -** Families may receive a multidisciplinary evaluation to determine eligibility, service coordination, an assessment for service planning, and development of an Individual Family Service Plan (IFSP) free of charge. ITC served 2,697 infants and toddlers in FY 2010, a 13.6 percent increase over the FY 2009 level of 2,374. Over the ten-year period between FY 2000 through FY 2010, the number of kids and families served annually by ITC has grown at an average rate of 11.3 percent per year. During the most recent three-year period, the number of kids and families requiring services annually by ITC has increased at an	**Staff:** 57/57.0 SYE **FY 2011 Expenditures**: $9,184,334 31% County and Cities funding 25% Federal 11% State 8% Family pay and insurance 25% Medicaid

Fairfax County Health Assets and Resources Existing Primary, Behavioral and Oral Health Services, Programs and Supports Available in the Community		
Program/Service	**Brief Description/Eligibility**	**Budget/Staffing**
Behavioral Health (cont.)	average rate of 13.4 percent per year. Further, during FY 2010, ITC observed and sustained an acceleration of this unprecedented growth beginning in the summer of 2009. From August 1, 2009 to August 1, 2010, the state Part C office reported a 25% increase in the number of children served by ITC of Fairfax-Falls Church.	
Contracted Behavioral Health Services –CSA	**Services Provided** Comprehensive Services Act for At Risk Youth -Treatment services and supports for children and youth with complex and high risk needs at risk of out of home and/or out of community placement. Funds purchase services for youth requiring foster care services, private school special education, home-based intervention, and residential services for mental health treatment or other services. **Population served -**FY 2011: 1,100 children and families	**Staff:** 7 SYE **FY 2011 estimated expenditures:** $23.6 million *(Note: costs for in-home therapeutic, outpatient and residential services with 130 providers; excludes special education and social supports.* *Fund sources: state CSA, local match funds, Medicaid, 3rd party reimbursement and reflects $600,000 to FFXFC-CSB for group home and intensive care coordination*.)
Care Coordination/ Case Management for Older Adults and Adults with Disabilities **Intake** **Adult Protective Services** **Nutrition Services** **Volunteer Services**	**Services Provided** Through staff in Dept. of Family Services, provision of case management for older adults and adults with disabilities. Services include assessment of needs, care plan development, coordination of community and county services. Elderlink – Ongoing care coordination/case management services and specialty health promotion and disease care programs for older adults who need education and/or care coordination. Target population is persons over income for standard adult services case management. Staffing and support for the program provided by Inova through partnership with county via contract. Chronic disease self-management program and intake services are provided through state grant funds for *You can live well Virginia.*	**Care Coordination/Case Mgmt:** **Staff**: 65 SYE **FY 2011 Expenditures**: $3,267,997 Volunteers: 2,430 79,660 hours Value estimated at: $ 1.7 million (transportation, meals on wheels delivery and insurance counseling) Elderlink: **Staff:** 8 full time and

Fairfax County Health Assets and Resources Existing Primary, Behavioral and Oral Health Services, Programs and Supports Available in the Community		
Program/Service	**Brief Description/Eligibility**	**Budget/Staffing**
Intake **Adult Protective Services** **Nutrition Services** **Volunteer Services (cont.)**	**Population Served -** FY 2011: APS cases - 1005 investigations (suspected abuse/neglect/exploitation for at risk adults and case management) Long Term Care/Adult Services – 2,429 clients (combination home based care/mandated Medicaid preadmission screenings) Area Agency on Aging – Community- Based Services – assistance with transportation, information and referral, volunteer home services, insurance counseling. FY 2011 – 11,366 older adults served	2 part-time positions (funded through Inova Health Systems) **FY 2011 Expenditures:** $450,000 Volunteers: 2,838 68,380 hours Value estimated at: $ 1.5 million in FY 2011
Community Health Care Network (CHCN)	**Services Provided** CHCN offers primary health care to low income individuals and families residing in Fairfax County and the cities of Fairfax or Falls Church who lack affordable insurance. Established in 1989, three centers are currently operating in the southern, eastern, and northern areas of the County**.** CHCN is operated through contractual services. Three sites owned or leased by the County, are located in South, Central and North county areas. Services are offered to enrolled families and individuals, including primary health care services and referrals for specialty care. Pediatric services are provided by Health Department staff physicians and nurse practitioners, as well as residents through INOVA Health Systems, in partnership with several local universities. Health care services include: Well and sick care, Immunizations, physical examinations, referrals to specialists as needed prescriptions, diagnostic testing laboratory services, nutrition counseling, hospital admissions as needed. Follow-up care is offered through referrals for specialty care through partnerships with participating physicians at reduced fee or Medicaid rates. Pharmaceutical and laboratory work is provided through separate contract providers and accessed as needed. **Population Served -** In FY 2011, 26,588	**Staff**: 9/9.0 SYE **FY 2011 Expenditures:** $9,142,492

Fairfax County Health Assets and Resources Existing Primary, Behavioral and Oral Health Services, Programs and Supports Available in the Community		
Program/Service	**Brief Description/Eligibility**	**Budget/Staffing**
Community Health Care Network (CHCN) *(continued)*	children and adults were enrolled, of which 99% were adults. Of those individuals enrolled, 19,370 were seen at least once during FY 2011, with a primary care visit count of 56,108. All clients are uninsured and have gross family incomes of less than or equal to 200% of the Federal Poverty Level.	
Eligibility Staff – Department of Family Services	**Services Provided-** Medicaid application processing at county sites and three health sites; deployed staff at Fairfax Hospital, Mt Vernon Hospital and the Inova Cares Clinic for Women **Population Served** *See description of Medicaid below for client information*	**Staff:** 141.88 positions **FY 2011 expenditures:** $9,972,910: Formula distribution: -Federal $4,990,116 (50%) -State $3,436,994 (35%) -County $1,545,801 (15%) *(note: when reported salary expenditures reach state allocation levels, Fairfax County provides additional funding – match equates to approximately 35% of total costs)*
FAMIS/CHIP	**Services Provided** FAMIS covers uninsured low-income children under age 19 who are not eligible for FAMIS Plus (children's Medicaid) and whose gross family income is less than or equal to 200% of the federal poverty level (FPL) for the family size. Initial eligibility for FAMIS is determined by local DSS offices and out-stationed sites, or by the State FAMIS Central Processing Unit (CPU). Case management and ongoing case maintenance, and selection for managed care, are handled by the State FAMIS CPU. **Population Served -** 19,303 unduplicated count children for calendar year 2011 *(excludes city of Falls Church data).* Point in time count: 8,829 enrolled children as of 12/2011 *(excludes city of Falls Church data)*	**Expenditures:** $ 6.3 million (July -December 2011)
Health Access Assistance Team (HAAT)	**Services Provided** Provides one point of entry that connects people to State and local health care programs and supports optimal utilization of health care resources. **Population Served -** Fairfax County residents of all ages with incomes at or below the 200% of poverty.	**FY2011 Budget**: $631,045 –(NVFS contract - intake and case management) $15,921 - Adult Health Medical and dental program $158,329 – County staff

Fairfax County Health Assets and Resources Existing Primary, Behavioral and Oral Health Services, Programs and Supports Available in the Community		
Program/Service	**Brief Description/Eligibility**	**Budget/Staffing**
Health Department Maternity Services	**Services Provided** Prenatal care for income-eligible clients through the second trimester at four clinic sites (Falls Church, Herndon-Reston, Mount Vernon, and Springfield). Third trimester care is provided at Inova Health System OB/GYN Clinic. **Population Served -** Residents of Fairfax County, Fairfax City, and Falls Church City Income guidelines: Services are provided on a sliding scale based on the Federal Poverty Guidelines. During FY 2011, 2,926 maternity clients were seen for their initial appointment and 5,298 return appointments. In FY 2011, approximately 2/3 of all enrolled maternity patients were also enrolled in CHCN.	**Staff:** 6.0 SYE OB Physician 2.0 SYE PHN 4.0 SYE Family Assistance Worker 2.0 SYE **FY 2011 Expenditures:** Personnel Costs: $765,000 Operating Costs: $390,000 (genetic services, laundry, clinic/lab supplies, translation services/other operating costs).
Healthy Families Program	**Services Provided** Healthy Families Fairfax provides home-based parenting education, health information and community support to first-time parents from pregnancy until the child reaches age five. Services identify and reach expectant parents who are isolated within their communities and in greatest need of parenting education. Program is offered voluntarily to first-time parents, before the baby is born (or is no older than 3 months) up to age 5 of the child, to help prevent child abuse and neglect and promote child health. Services offered through Health Department, Dept. Family Services and nonprofits (NVFS, United Community Ministries and Reston Interfaith). **Population served -** FY 2011 - 633 children living in Fairfax County who are at high risk for abuse and neglect.	**FY 2011 budget:** $2.7 million Nonprofit partners supply 10% program match funds.
HIV/ AIDS/Ryan White Services (including Inova Juniper)	**Services Provided** Medical (testing/treatment), dental, supportive psycho-social, housing, transportation and educational services provided to eligible individuals via federal grant funds to community based providers.	**FY2011 Budget:** $124,500 (County contract/purchase of services with Inova Juniper Program)

Fairfax County Health Assets and Resources Existing Primary, Behavioral and Oral Health Services, Programs and Supports Available in the Community		
Program/Service	**Brief Description/Eligibility**	**Budget/Staffing**
HIV/ AIDS/Ryan White Services (including Inova Juniper) *(continued)*	**Population Served:** HIV infected individuals, with some financial eligibility requirements for some services: FY2011: 380 individuals served in the AIDS Drug Assistance Program; 605 individuals served in the contracted medical services program; 8,791 individuals received testing and prevention counseling via Fairfax County health Department programs; numerous at-risk individuals received counseling and testing via grant funded community based organizations . 2/3 of Inova Juniper services are with individuals who are uninsured. Of those, 30% are below 133% federal poverty levels, with remaining between 134% and 400% FPL.	County HIV/AIDs Personnel costs: $446,540 PHN 6/6.0 SYE PHN III (2) PHN II (4)
Home Based Care for older adults and persons with disabilities	**Services Provided** Purchased assistance with tasks of daily living for income and functionally eligible adults. Eligibility for services: • Home delivered meals – individual is home bound • Home health services –(housekeeping, bathing, laundry services) – individual is unable to perform daily living tasks as assessed through use of uniform assessment instrument) and has no other support available • Home based care- service limited to adults with annual incomes at or below 70% of Virginia gross median income **Population Served -** FY 2011- 970 clients	**FY 2011 Budget**: $2.5 million (contract/purchase of services)
Information and Referral Coordinated Services Planning	**Services Provided** Information, referral, linkage, and advocacy for Fairfax County residents seeking assistance. CSP staff assist/coordinate public/private partners for supports for basic needs, financial assistance, health care services and referrals to services and resources. Health and Wellness Intake and Screenings include initial screenings for home based care, Medicaid waivers and other services.	**Staff:** resources estimated at equivalent of 4 SYE for information and referral activities *(note: estimate based on 14% of all calls as health/medical information related)*

Fairfax County Health Assets and Resources Existing Primary, Behavioral and Oral Health Services, Programs and Supports Available in the Community		
Program/Service	**Brief Description/Eligibility**	**Budget/Staffing**
Information and Referral Coordinated Services Planning *(continued)*	**Population Served -** Calendar year 2011: Children -169; Adult referrals for minor children in the home – 19; Older Adults – 577	**FY 2011 Expenditures**: $351,000
Long Term Care facilities ***Lincolnia (26 units)*** ***Braddock Glen*** **(60 units)**	Assisted Living Facilities for the Elderly – licensed ALCs accessible units, providing 24 hour resident monitoring and resident assistant coverage; nurse on site 40 hours per week, meals, activities. **Population Served:** 62+ age and disabled persons aged 55-61 for low and moderate income individuals (auxiliary grant recipients, income ranges $36,250-$43,500 for sites)	**FY 2011 Budget:** Lincolnia: $2.4 million Braddock Glen: n/a Medicaid funded clients: 30
Medicaid	**Services Provided** Assistance to low-income, persons such as low-income children, pregnant women, older adults, persons with disabilities, and parents meeting specific income thresholds. Virginia Medicaid program covers federally mandated services including: • Inpatient and outpatient hospital services • Emergency hospital services • Physician and nurse midwife services • Federally qualified health centers and rural health clinic services • Laboratories and x-ray services • Transportation services • Family planning services and supplies • Nursing facility services • Home health services (nurse, aide) •Early and Periodic Screening, Diagnosis, and Treatment program for children (EPSDT) ***Optional*** programs include: Certified pediatric nurse and family nurse practitioner services, routine dental care, prescription drugs, rehabilitation services ((PT), occupational therapy (OT), and speech language pathology (SLP) services, Home health services (PT, OT, SLP), hospice, limited mental health and substance abuse services, home and	**FY 2011 Expenditures:** $120.4 million - children $282.4 million - adults $402.8 million total Federal/State funded (estimated share is 50% for both state and federal funding) *(note: these funds are directly paid to providers and are not captured as expenditures in county budget)*

Fairfax County Health Assets and Resources Existing Primary, Behavioral and Oral Health Services, Programs and Supports Available in the Community		
Program/Service	**Brief Description/Eligibility**	**Budget/Staffing**
Medicaid *(continued)*	community-based "waiver" services **Population served** 65,722 active cases as of December 2011 - 21,209 adults and 45,513 children 89,383 unduplicated recipients –7/1/2010-3/31/2011 - 28,322 adults and 61,061 children	
Medicaid Waiver Services	**Services Provided** **Alzheimer's Assisted Living (AAL) Waiver**—Participants live in a licensed Assisted Living Facility, meet criteria for nursing facility placement, and receive an auxiliary grant. Waiver is capped at 200 persons state-wide. Participants receive Medicaid funded health services. **Population Served:** FY 2010 - 1 Individual Screened	(see below)
	Services Provided **Elderly or Disabled with Consumer Direction (EDCD) Waiver** – Participants must meet nursing facility eligibility criteria. Services available include: adult day health care, medication monitoring, personal care aide, respite care, personal emergency response system, transition coordination, transition services. Local screening teams composed of Health Dept. nurses and Social Services (Family Services) social workers or hospital social workers conduct preadmission screenings. Family Services Benefits staff determined financial eligibility. **Population Served:** FY 2011 – 566 adults, 159 children 725 total (DFS screening data)	. **Staffing:** 2.0 SYE (Health Department PHN II to conduct screenings) **FY 2011 Expenditures:** Personnel Costs - $179,921 Operational Costs (mileage, equipment and supplies) - $2,049 *Note: There is no local match requirement for this Waiver*
	HIV/AIDS Waiver – for individuals with diagnosis of HIV or AIDS and symptoms requiring hospital or nursing facility care. Services include: nutritional supplements, personal emergency response system, transition services, private duty nursing, personal care, respite care.	Same as EDCD Waiver (see above)

Fairfax County Health Assets and Resources Existing Primary, Behavioral and Oral Health Services, Programs and Supports Available in the Community		
Program/Service	**Brief Description/Eligibility**	**Budget/Staffing**
Medicaid Waiver Services *(continued)*	**Population Served:** FY 2010-1 individual screened	
	Individual and Family Developmental Disabilities Support (IFDDS) Waiver— Provides services to individuals ages 6+ with a related condition such as Autism Spectrum Disorder, but who do not have a diagnosis of intellectual disability, and who have been determined to require the level of care provided in an ICF. Services include: assistive technology, attendant, companion, crisis stabilization, crisis supervision, day support, family and caregiver training, environmental modifications, in-home residential support, personal care, personal emergency response, prevocational services, respite care, skilled nursing, supported employment, therapeutic **Population Served:** 64 individuals screened (FY10)	IFDDS -- Functional screening is conducted by Health Dept. nurses and financial eligibility by Family Services Benefits staff. There is no local match. There is a waiting list. (see above).
	Intellectual Disabilities (ID) Waiver – Individuals age 6+ with a diagnosis of intellectual disability or under age 6 and at developmental risk. Services include: residential support, day support, supported employment, prevocational, personal assistance, respite, companion, assistive technology, environmental modifications, skilled nursing, therapeutic consultation, crisis stabilization, and personal emergency response, and support coordination. **Population Served:** n/a	ID Waiver -- Functional screening is conducted by Community Services Board staff and financial eligibility by Family Services Benefits staff. There is no local match. There is a waiting list
	Technology Assisted (Tech) Waiver – Children under age 21, who have exhausted available third party benefits for private duty nursing and are dependent on technology for a vital body function; must require substantial and on-going skilled nursing services. Adults age 21 + who are dependent at least part of the day on a mechanical ventilator or who have complex tracheotomy needs. Services include:	Same as EDCD Waiver (see also "Care Coordination") **Staffing and Expenditures:** Included in EDCD Waiver Budget (see above).

Fairfax County Health Assets and Resources Existing Primary, Behavioral and Oral Health Services, Programs and Supports Available in the Community		
Program/Service	**Brief Description/Eligibility**	**Budget/Staffing**
Medicaid Waiver Services *(continued)*	environmental modifications, personal emergency response system, transition services, personal care (adults only), private duty nursing, respite, environmental modifications, and assistive technology. **Population Served: -** 5 Individuals Screened (FY10)	
Medical Care for Children Partnership	**Services Provided** MCCP is a public-private program that combines County funding, medical, business and nonprofit support for comprehensive health and dental care to children of working poor families who do not meet Medicaid or FAMIS/SCHIP eligibility requirements. Covered benefits for those children enrolled with Kaiser Permanente include in center services – acute and preventive care, laboratory, pharmacy services, immunizations, x-rays, physical therapy, mental health, and eye refraction's. Children may receive care in Kaiser Permanente's Ambulatory Surgery Center, and Kaiser Permanente physicians provide services for children hospitalized at INOVA Fairfax Hospital at no cost. Hospitalization costs are not covered through MCCP. Private physician services include: office visits for acute and preventive care, immunizations, limited laboratory and x-rays, and specialty care such as pediatric cardiology, neurology, radiology, urology, and ophthalmology. Pediatric care is provided to uninsured County children, from birth to 18 years of age, who are not covered by private health insurance, not eligible for Medicaid/FAMIS and under 250% Federal Poverty Guidelines. **Dental Care** Covered benefits include comprehensive oral exams, x-rays, fillings, prophylaxis, sealants, crowns, root canals, and oral surgery.	**FY 2011 Expenditures:** MCCP Foundation - $507,243 Fairfax County - $237,000 Foundation funds: -$463,017 for dental care -$44,225 for private doctors and specialty care In-kind services provided by Kaiser Permanente *NOTE: refer to Health Access Assistance Team above – a substantial portion of the $631,045 for the NVFS contract for intake and case management positions is to support the MCCP program outreach and enrollment.*

Fairfax County Health Assets and Resources Existing Primary, Behavioral and Oral Health Services, Programs and Supports Available in the Community		
Program/Service	**Brief Description/Eligibility**	**Budget/Staffing**
Medical Care for Children Partnership *(continued)*	**Population Served -** As of Dec. 2010 - 246 children were served through private physician offices and 1,600 children through Kaiser Health Maintenance Services. Of children enrolled in private provider services, 84% were seen at least once by a physician during FY 10. Over 94% of the children served were between ages 6 and 18, and nearly 50% are below 150% of Federal poverty level.	
Nutrition Services and Programs	**Home delivered meals** – to frail, homebound low income residents age 60+ - 2011: 724 older adults and persons with disabilities, 179,057 meals - funds and administration in Dept. Family Services) **Nutrition Supplement Program** – low income and monitory at risk individuals with chronic disabling conditions, dementia or terminal illness - FY 2011- 71,453 meals provided to 419 individuals. **Congregate meals** – 29 congregate meal sites for senior and adult day health centers, private senior centers and partner sites (Alzheimer's Family Day Center and five senior housing complexes).). FY 2011 – 253,583meals provided to 2,617	**Staffing**: 8 SYE (DFS) **FY 2011 Expenditures:** $644,304 *(Note: includes food, mileage expenditures for volunteers)* **FY 2011 Expenditures:** $1.4 million
Program of All-Inclusive Care for the Elderly (PACE)	**Services Provided** For persons age 55+ who meet a nursing facility level of care, eligible for Medicare and Medicaid, are living in the community. Acute and long term care is provided by an interdisciplinary team through the PACE center. Services include: primary care, medications, OT/PT, personal care, durable medical equipment, hospitalization, companion care, and transportation. Care provided/contracted by medical organization (Inova for Fairfax PACE site). Local screening team determined functional eligibility; Family Services Benefits determines Medicaid eligibility.	Medicare/Medicaid funding. Costs: TBD *(new program in FY 2012)*

Fairfax County Health Assets and Resources Existing Primary, Behavioral and Oral Health Services, Programs and Supports Available in the Community		
Program/Service	**Brief Description/Eligibility**	**Budget/Staffing**
Head Start/Early Childhood Services	Provision of health screenings, including vision and hearing, are conducted on-site by Head Start/Early Head Start staff. There are a few children with no insurance whose screenings are paid for by Head Start.	*Note: expenditures not tracked by individuals.*
FASTRAN Medical Transportation	**Services Provided -** Fastran offers specialized transportation services for residents of Fairfax County and the Cities of Fairfax and Falls Church participating in human service agency programs. Fastran provides transportation for critical medical care appointments as well as essential shopping needs. An estimated 8% of all trips are medical related appointments.	**Staffing:** less than 1 SYE **FY 2011 Expenditures:** $66,311
Senior Center Services	**Services Provided** Senior Centers for active adults – 13 centers offering classes, health and wellness programs, computer and Internet access, trips and tours, and opportunities to socialize with others and stay connect with community. Health and Wellness screening services provided for basic health related issues such as high blood pressure, medicine review/regulation, flu shots. **Population Served**- Fairfax County residents age 55 and over may join any of the 13 senior centers sponsored by the Department of Community and Recreation Services.	**Staffing:** Volunteers run health screening seminars/workshops/lectures . **FY 2011 Expenditures:** $1,854,000 (all senior center programming; health related programming not tracked separately)
Senior Plus Program	**Services Provided** Senior Plus inclusion program for older adults with minor cognitive and physical disabilities for participation in health and wellness programs at the county Senior Centers. This program bridges the gap between programs for fully independent seniors and those who require some assistance, with the goal of enabling participants to remain in the least restrictive environment and maintain independence. The program is offered through the cooperative efforts of multiple county agencies as well as nonprofit providers, Easter Seals of the Greater Washington-Baltimore Region, Inc. Services include health and wellness intake/screenings for mental health, physical health. Provision of	**Staffing:** 14/13.33 SYE $833,307 **FY 2011 Expenditures:** $984,920 (contract)

Fairfax County Health Assets and Resources Existing Primary, Behavioral and Oral Health Services, Programs and Supports Available in the Community		
Program/Service	**Brief Description/Eligibility**	**Budget/Staffing**
Senior Plus Program *(continued)*	cross disciplinary services for geriatrics, therapeutic recreation services. Senior+ operates with 3 nurses, 3 mental health therapists, social workers, and 7 recreational therapists. 50% of all of this staff's time is spend working on the various health related assessments, the other 50% is spent doing direct services delivery of programs that support health and wellness of the members, developing and implementing individual wellness plans and participating in treatment team meetings.	
Adult Day Health Services (Health Department)	**Services Provided -** ADHC promotes the health and independence of frail elderly and adults with disabilities, while offering them an alternative to more restrictive and costly long term care options. Respites services offered for family caregivers. Adult Day Health Care Centers are operated at Lincolnia, Lewinsville, Annandale, Mount Vernon, Braddock Glen, and Herndon, offer a full range of services to meet the medical, social, and recreational needs and interests of the frail elderly and/or disabled adults attending these centers. **Population Served -** Adult Day Health Care Program participants- 342 in FY 2011	**FY 2011 Expenditures:** Personnel Costs - $3,357,623 Operational Costs (mileage, equipment and supplies) - $112,480
Health Department Communicable Disease Epidemiology Program	**Services Provided** The goal of the Communicable Disease Epidemiology program is to reduce illness and death from communicable disease in the community by identifying illness, investigating causes, and recommending actions to prevent transmission and spread. The Virginia Department of Health (VDH) established a Virginia Reportable Disease List identifying all conditions required to be reported to the local health department by state law (Section 32.1-36 of the Code of Virginia and 12 VAC 5-90-80 and 12 VAC 5-12-90 of the Board of Health Regulations for Disease Reporting and Control.) Physicians, laboratories, and medical facilities report directly to the local health	**FY 2011 Staffing and Expenditures:** State funding Personnel: $249,615 • 1/1.0 SYE • Epidemiologist • 1/1.0 SYE PHN • 1/1.0 Outreach Worker Coordinator • 2/2.0 Outreach Workers County Funding Personnel: $2,931,407

Fairfax County Health Assets and Resources Existing Primary, Behavioral and Oral Health Services, Programs and Supports Available in the Community		
Program/Service	**Brief Description/Eligibility**	**Budget/Staffing**
Health Department Communicable Disease Epidemiology Program *(continued)*	department. The Communicable Disease program includes HIV/AIDS testing, counseling and community education, Sexually Transmitted Disease (STD) confidential testing, treatment, follow-up and education, Tuberculosis (TB) prevention and control, adult immunizations, refugee services, disease investigation and surveillance and outbreak response. Services provided through the Communicable Disease Epidemiology program are mandated by the Virginia Department of Health and provided free of charge. Some adults in need of immunizations may be charged a fee. **Population Served (see HIV/AIDS section above as well) -** FY2011: 24,934 individuals served in TB screening, prevention and case management (including those screened with Refugee status); 2207 individual communicable diseases were investigated; 23 outbreaks of disease were investigated; 7776 individual evaluations for STD's; 39 cases of syphilis were investigated; 24 cases on new HIV infection investigated.	• 1/1.0 SYE Physician • 30.5/30.5 SYE PHN's
Health Department Homeless Medical Services Program	**Services Provided** The Homeless Healthcare Program (HHP) provides outreach to the unsheltered homeless with the goal of enrolling them into existing County programs including emergency shelters, alcohol and substance abuse treatment, Community Health Care Network (CHCN) and/or mental health counseling. Four mobile teams, comprised of Health Department nurse practitioners, a CSB psychiatric nurse practitioner, four nonprofit outreach workers, CSB PATH workers and a part time CSB psychiatrist provide physical and behavioral health care, as well as referral and transportation to medical care, mental health and alcohol and drug services to include detox services. Clients enroll in/provided transported to dental health services (preventative, acute	**Staffing:** 7.1 SYE **FY 2011 Expenditures:** Personnel - $380,000 • 4/3.0 SYE NPs (Health Dept.) - work with HHP, MRP and shelter clients. HHP program: • 1/1.0 SYE NP (CSB) • 1/.010 Psychiatrist (CSB) • 4/2.0 SYE Community based Outreach Workers • 4/1.0 SYE CSB PATH Outreach

Fairfax County Health Assets and Resources Existing Primary, Behavioral and Oral Health Services, Programs and Supports Available in the Community		
Program/Service	**Brief Description/Eligibility**	**Budget/Staffing**
Health Department Homeless Medical Services Program *(continued)*	and restorative) at the Northern Virginia Dental Clinic (NVDC). The Medical Respite Program (MRP) was implemented in October 2006 to provide respite care to homeless persons. Respite care was defined as "recuperative or convalescent services needed by homeless persons with medical problems- in essence providing sick or injured homeless a respite from the dangers of living on the streets." Persons eligible must be homeless and able to recuperate within 30 days of receiving medical and home health support. Departments of Health and Family Services jointly administer the program. DFS assumes the lead responsibility for the MRP; Embry Rucker Community Shelter (ERCS) hosts the program. The Health Department provides the nurse practitioner for the program. Four beds are dedicated to male patients, one bed for females and one for families. The Health Department also provides nurse practitioner and public health nursing services at each of the County's six adult and family shelters. **Population Served -** The Homeless Medical Services Program served a total of 1,420 clients in FY 2010: 264 duplicated in the shelters, 1,105 unduplicated in the Homeless Healthcare Program (HHP) and 51 unduplicated in the Medical Respite Program (MRP).	Workers (in-kind) Operating Costs for HHP - $300,000 • Community based contract - $200,000 • Dental Contract (NVDC) $30,000 • Detox Services/beds - $50,000 • Express Scripts - $10,000 • Other operating costs - $10,000
Community/Regional Resources (includes services with partial payment or in-kind by County)		
Adult Health Partnership	**Services Provided** AHP provides dental care and episodic medical care for families. Participants pay a portion of the care using a sliding scale based on the treatment costs. Providers discount their fees by an average of 52% before direct financial assistance is applied to remaining treatment costs. **Population Served -** Fairfax County residents up to 250% FPL Guidelines. Client served FY 2011: 625	**FY 2011 Expenditures**: $40,103 in county funds -$25,925 from DFS -$14,178 from CCFP -TANF funds (federal) County funds leveraged approximately $162,000 in provider discounts.

Fairfax County Health Assets and Resources Existing Primary, Behavioral and Oral Health Services, Programs and Supports Available in the Community		
Program/Service	**Brief Description/Eligibility**	**Budget/Staffing**
Alzheimer's Family Day Center	**Services Provided** Alzheimer's Family Day Center (AFDC) is a not-for-profit organization providing a wide range of services to people with Alzheimer's disease and their caregivers, including adult day health care, training for caregivers, support groups, preventative activities. AFDC is the only dementia-specific adult day center in the D.C. metropolitan area and the only center in Northern Virginia with programs for people in the later stages of Alzheimer's disease. **Population Served** - 61 participants	**FY 2011 Expenditures:** $300,000 *(funding source: Fairfax County Consolidated Community Funding Pool)*
Birmingham Green (District Home)	**Services Provided** Residential health and healthcare center including assisted living unit for 60 residents, and a nursing healthcare center serving 180 residents**.** Medical Care provided to residents includes: Personal care- including assistance with dressing, bathing, and personal hygiene. Nursing and Medical Care -Includes medications administered by licensed professionals according to physician order, skilled nursing care, and physician services. Therapeutic Services -physical, occupational, and speech therapies are provided based on individual need. Social, daily activities -crafts, exercise, movies, games, community outings, and religious services. **Population Served -** Admits residents who qualify for financial assistance from the Counties of Fairfax, Fauquier, Loudoun, Prince William and the City of Alexandria. Estimated 80% Fairfax County utilization rate for designated county placements**:** 32 assisted living beds 92 nursing home beds	**FY 2011 Expenditures:** $2.3 million (Fairfax County user fee, based on regional Memorandum of Agreement) *Note: participates in Medicaid and Medicare insurance for eligible clients/services*
Culmore Clinic	**Services Provided** Adult primary care, excluding pap smears. Accepts walk-ins, appointments preferred. Open	*FY 2011 expenditure information not requested.*

Fairfax County Health Assets and Resources Existing Primary, Behavioral and Oral Health Services, Programs and Supports Available in the Community		
Program/Service	**Brief Description/Eligibility**	**Budget/Staffing**
Culmore Clinic *(continued)*	on Thursdays. Most services free or at reduced charge. **Population Served -** No residency requirement. Income up to 250% FPL and no health insurance. FY 2010: 820 visits 373 unduplicated patients seen	
Hispanic Institute for Blindness Prevention	**Services Provided -**Preventive Vision Care Program provides free/reduced fee preventive and primary vision care. Professional members of Eye Care Network provide specialized services for free/ reduced fees for referred patients. Operates mobile clinic.	*FY 2011 expenditure information not requested.*
InovaCares Clinic for Women	**Services Provided** Comprehensive outpatient prenatal, obstetrical, gynecological and surgical services to high risk and third trimester patients. **Population Served -** 35,342 visits in calendar year 2011. Offers charity care to Virginia residents at 100% or less of FPL. . Reduced sliding scale fee for those patients from 101% to 300% of the FPL.	**Expenditures:** Net Cost-$4,616,333 for calendar year 2011 In-kind services provided by Inova Health Systems; County eligibility staff provide on-site services
InovaCares Clinic for Children	**Services Provided** Pediatric medical care to children whose families cannot afford the cost of health care. Children are enrolled in the Pediatric Center as a result of self-referral or through community referrals from service organizations. Eligibility screenings are conducted by Inova staff. **Population Served -**Children residing in Fairfax County, from birth through age 21, are eligible for enrollment in Medicaid or who are not covered by private health insurance and under 250% of Federal poverty guidelines. Some high risk children who do not live in Fairfax County and who cannot get necessary care may also be able to receive services. Calendar Year 2011 visits: 28,559 **Medical Care** Primary health care services are provided by Inova hospital staff. In addition, pediatricians and family practitioners affiliated with the	**Expenditures:** Net Cost-$2,048,178 for calendar year 2011 In-kind services provided by Inova Health Systems

Fairfax County Health Assets and Resources Existing Primary, Behavioral and Oral Health Services, Programs and Supports Available in the Community		
Program/Service	**Brief Description/Eligibility**	**Budget/Staffing**
InovaCares Clinic for Children *(continued)*	hospital provide volunteer services once every 12-18 months. Services provided include preventive health services, immunizations, school/sports physicals, sick care, and specialty services, including translation, health education, nutritional counseling, access to WIC program, treatment for sickle cell disease, social work services, treatment and counseling for sexually transmitted diseases, family planning, specialty care (such as treatment for orthopedic or cardiac conditions) and teen health services.	
Jeanie Schmidt Clinic	**Services Provided** Comprehensive primary care for adults with diagnosis of hypertension and/or diabetes; once enrolled provide all primary care, including medications and access to specialty care. Pediatrics: Comprehensive primary medical care while working with the HAAT team to enroll into permanent medical home. **Population Served** -Residents of western Fairfax County with household incomes 200% or less of FPL, and no health insurance or source of ongoing medical coverage. Approximately 70% served adults, 30% pediatrics. FY 2011: 1,534 unduplicated patients seen, 5,358 visits of which 20% were pediatric patients. 30% were below 133% of FPL, 70% under 200%.	**FY 2011 expenditures:** $820,041 (total organization expenditures) County support: $91,640 *Additional financial/in-kind support provided by Reston Hospital Center, Inova Health System, NOVA ScriptsCentral, community specialists, Northern VA Health Foundation, Kaiser Permanente, CareFirst BlueCross BlueShield, Virginia Health Care Foundation, No. Virginia Community Foundation, Kaiser Permanente, Graham Fund, Community Foundation of NCA, Va. Assoc. of Free Clinics, George Mason University*
Kaiser Bridge Program	**Services Provided** Kaiser enrollees receive comprehensive health care, hospitalization and dental. Enrollee pays a small monthly premium and is eligible for a maximum of 36 months. Program participation capped at 785. **Population Served-** Income up to 300% Federal Poverty Guidelines. February 2011 enrollment - 848 county	*FY 2011 expenditure information not requested* In-kind services provided by Kaiser Permanente. County staff and contract funded support provided for case management, referral

Fairfax County Health Assets and Resources Existing Primary, Behavioral and Oral Health Services, Programs and Supports Available in the Community		
Program/Service	**Brief Description/Eligibility**	**Budget/Staffing**
Kaiser Bridge Program *(continued)*	residents. During FY 2010, 1,639 visits for 280 patients. 100% are uninsured.	and intake support services.
Medical Supply Assistance Programs (financial and technology)	**Services Provided** Community and faith providers offering reduced/free medical supplies: ACCA, CHO, ECHO, Fairfax-Falls Church Comm. Svc. Council, Fairfax FISH, Herndon/Reston FISH, Link Inc., National MS Society –national Capital Area Chapter, SHARE Inc., St. Vincent De Paul Society, Washington Area Wheelchair society	*Note: Value of community in kind services not tracked on a system wide basis*
NAOMI Project	**Services Provided** Naomi Project provides free, confidential services to pregnant women and others to plan for healthy pregnancies and babies. Volunteers serve as mentors to high risk pregnant women and newly parenting mothers in the Northern Virginia area. Each mentor is matched with a client in a one-to-one relationship. Goals include good health and safety practices during pregnancy and for the newborn, information and referral, linkage to community services, and build on parenting skills. **Population Served -** 60 teens in FY 2010	*FY 2011 expenditure information not requested* Fairfax County pays a % share of lease expenses at Bailey's site.
Northern Virginia Dental Clinic	**Services Provided** Provides comprehensive oral healthcare services to residents from throughout the northern Virginia region. Referrals through a designated social service agency. Operates two clinic sites, one located in Fairfax County. **Population Served -** Residents of Arlington, Fairfax, Loudoun, and Prince William Counties, and the Cities of Alexandria, Fairfax, and Falls Church; age 18 or older; annual incomes at or below 200% of federal poverty level guidelines. Fairfax County residents in FY11: New patients: 297 Emergency: 43 Return Visits: 462 Total number of appointments: 1,785 Services offered at a flat rate of $40 per visit (additional charge for prosthetics & biopsies).	**FY 2011 Expenditures:** $36,000 (Fairfax County pays a % share of lease expenses at Bailey's site); and $148,000 (General Fund support through Consolidated Community Funding Pool and Fairfax County Health Dept.) Volunteer hours for clinic operations FY 11: dentists 1,468 hours, dental assistants/hygienists 555 hours

Fairfax County Health Assets and Resources Existing Primary, Behavioral and Oral Health Services, Programs and Supports Available in the Community		
Program/Service	**Brief Description/Eligibility**	**Budget/Staffing**
Northern Virginia Dental Clinic *(continued)*		
Northern Virginia Family Service Multicultural Human Services	**Services Provided** Behavioral health services for brief, solution-oriented mental health and social services. Trauma-informed services for adults & youth, acculturation & reunification, anxiety & depression. Programs for Survivors of Torture, domestic violence, anger management & parenting. **Population Served** Immigrant and ethnically diverse residents who face service barriers due to language and cultural barriers. Sliding fee scale; accepts Medicaid, private insurance	
Northern Virginia Family Service – Patient Assistance Programs	Accessible Medication Program and Medication Access Program (MH) – Eligibility and referral services for reduced fee and/or no cost prescriptions.	**FY 2011 Expenditures:** $ 37,500 Accessible Medication Program and $151,502 MH MAP
Northern Virginia Specialty Access Program	**Services Provided** Mission to expand availability of specialty care to low income, uninsured population throughout Northern Virginia with regional specialty care network. Project of the Northern Virginia Health Services Coalition.	Start-up funding provided through Kaiser Permanente
Ombudsman Services	**Services Provided -**Serves counties of Arlington, Fairfax, Loudoun, Prince William, and cities of Alexandria, Fairfax and Falls Church. Patient rights, complaints, counseling, negotiation and investigation services. Client/consumer education and technical assistance provided. **Population Served -** 10,933 residents in 103 nursing and assisted living facilities.	81 volunteers *Note: estimated value of in-kind services not requested*
Partnership for Healthier Kids (PHK)	**Services Provided** The Partnership for Healthier Kids program assesses whether children in public schools in Fairfax County have access to appropriate medical care. **Population Served** - Calendar year 2011: 3704	**FY 2011 Expenditures:** $436,238 (Inova Health Systems)

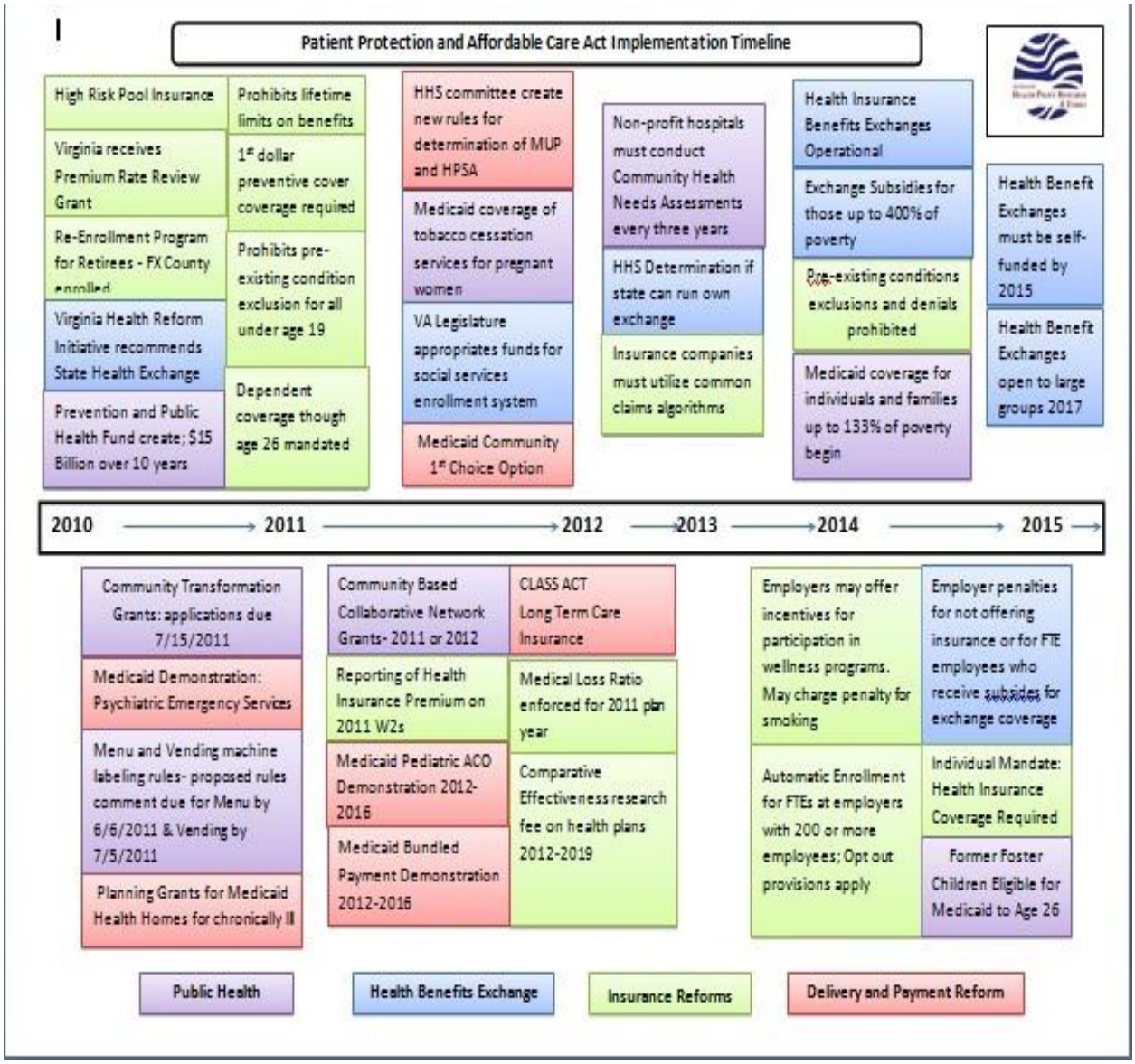
Fairfax County Health Assets and Resources Existing Primary, Behavioral and Oral Health Services, Programs and Supports Available in the Community		
Program/Service	**Brief Description/Eligibility**	**Budget/Staffing**
Prescription Drug Assistance – NOVA Scrips	**Services Provided** Medication access and pharmaceutical services to patients of Northern Virginia region safety-net primary care providers. Provides medications for over 35 chronic diseases. **Population Served -** Children and adult at or below 200% FPL and have no insurance for medications- Currently access is restricted to patients of safety net clinics.	*FY 2011 expenditure information not requested*
Resource Mothers Program	**Services Provided** Operated by the Urban League of Northern Virginia, the Resource Mothers program provides case management and mentoring, pre and post-natal intervention support services to pregnant/parenting teens living in Fairfax County. The goal of the program is to prevent low birth weight babies, infant death and to assist teens in remaining in school and move toward self-sufficiency. **Population Served -** FY 2011 enrollment as of January 2011 - 152 teens	**FY 2011 Expenditures:** $325,587 (funding Source: General Fund, Consolidated Community Funding Pool)
Transportation – medical	**Services Provided** Organizations offering transportation for individuals needing assistance to travel to medical appointments: American Cancer Society – National Capital Chapter, Corporate Angel Network, Inc. CHO, ECHO, Fairfax FISH, Herndon/Reston FISH, Shepherds Centers (Annandale-Springfield/Fairfax-Burke, Oakton-Vienna, McLean/Falls Church)	*Note: estimated value of in-kind services not requested*
Regional Providers located outside Fairfax County who do not have residency requirement and provide medical services to Fairfax residents		
Alexandria Neighborhood Health Services, Inc. (ANHSI)	**Services Provided** Provides primary health care services for newborn/well child exams, pediatric sick visits, family planning, general medicine, physical exams, immunizations, acute illness care, chronic disease management, mental health counseling, dental care, free/discounted medications. **Population Served -** Sliding Scale Fee for	**FY 2010 Expenditures**: $5.4 million

Fairfax County Health Assets and Resources Existing Primary, Behavioral and Oral Health Services, Programs and Supports Available in the Community		
Program/Service	**Brief Description/Eligibility**	**Budget/Staffing**
Alexandria Neighborhood Health Services, Inc. (ANHSI) *(Continued)*	Services. No residency requirement FY 2010: 33,500 visits, 11,700 unduplicated patients seen. Of those served, approximately 30% are Fairfax County residents (an estimated 3500 individuals.)	
Catholic Charities of Diocese of Arlington Family Services Department	**Services Provided** Outpatient mental health to individuals, families and children. Adjustment and mood disorders, Post-trauma recovery, marriage and family therapy **Population Served -** Sliding Scale Fee for Services. No residency requirement	*FY 2011 expenditure information not requested*
George Mason University Center for Psychological Services	**Services Provided** Intellectual, Cognitive, and Personality Assessment: Outpatient Psychotherapy. Anxiety, Depression, Relationship, and Co-morbid problems across the life span; Psycho educational groups. **Population Served -** Sliding Scale Fee for Services	*FY 2011 expenditure information not requested*
Greater Prince William Community Health Center	**Services Provided** Provides primary health care services for newborn/well child exams, pediatric sick visits, family planning, general medicine, physical exams, immunizations, acute illness care, chronic disease management, mental health counseling, dental care, free/discounted medications. **Population Served** Sliding Scale Fee for Services. No residency requirement FY 2010, 11,079 patients were seen, of which 6,212 were unduplicated patients. Of those, 70% are uninsured, and 90% are at or below 133% of federal poverty levels. 641 patients reside in Fairfax County. Of those, 50% were self-pay, and 50% were insured (including Medicaid and Medicare).	**FY 2012 Expenditures:** $2.4 million
Jewish Social Service Agency	Provides counseling, mental health, educational testing and supportive services. Early Childhood Development, Asperger's, ADD, ADHD, depression, anxiety, Senior Services	*FY 2011 expenditure information not requested*

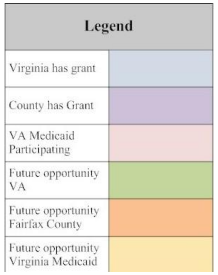
Fairfax County Health Assets and Resources Existing Primary, Behavioral and Oral Health Services, Programs and Supports Available in the Community		
Program/Service	**Brief Description/Eligibility**	**Budget/Staffing**
Jewish Social Service Agency *(continued)*	(case management), divorce/separation. **Population Served** Sliding scale fee for services	
Loudoun Community Health Center	**Services Provided** Provides comprehensive family practice, sick visits, screenings, chronic disease management, , well-child care, school physicals, pap smears, prescription assistance, case management, mental health/specialty/dental care referrals **Population Served -** Sliding Scale Fee. No residency requirement. Medicare, Medicaid, and private insurance accepted. Of patients seen, an estimated 20% live in Fairfax County. Two-thirds are uninsured, with 29% in Medicaid, 3% in Medicare. 90% of all patients are below 133% federal poverty levels. Total patients served: 5,600 unduplicated medical patients 21,000 medical encounters 471 mental health unduplicated patients	**FY 2011 Budget**: $4.2 million
Virginia Wounded Warrior Program	**Services Provided** Comprehensive assessments, care coordination, outpatient treatment, rehabilitative services, linkage to other services, and peer support for veterans and members of the Guard and Reserves - with stress-related injuries or traumatic brain injury resulting from military service - and their families. Funded by VA Dept. of Veterans Services. **Population Served** - Of the 1100 persons served annually in No. Va., approximately 20 percent are Fairfax County residents.	*N/A*
The Women's Center	**Services Provided** Mental health counseling, support and therapy groups, psychological assessment for children and adults, free domestic violence system advocacy, educational programs, career counseling, free individual financial counseling and financial literacy classes. **Population Served-**Counseling provided for	*FY 2011 expenditure information not requested*

Fairfax County Health Assets and Resources Existing Primary, Behavioral and Oral Health Services, Programs and Supports Available in the Community		
Program/Service	**Brief Description/Eligibility**	**Budget/Staffing**
	children age 4 and older and men as well as women. Accepts private insurance, Medicare, sliding fee scale.	
Other Community Resources		
Assisted Living Facilities	80 community assisted living facilities	*Not requested*
Nursing Homes	16 community nursing homes	*Not requested*

APPENDIX II: IMPLEMENTATION TIMELINE



APPENDIX III: PPACA GRANT OPPORTUNITIES



PPACA Opportunities for Fairfax County and Virginia Table 1 Appendix III							
PPACA Section	**Name of provision**	**Plain text/Summary**	**Amount available**	**Sub agency**	**Timeline**	**VA**	**County**
1002	Promoting Consumer Health Insurance Information	Grants to expand or establish health insurance consumer assistance and state health insurance ombudsman programs. Offices to assist with enrollment, grievances, and appeals, and track information on consumer problems with insurance companies.	$30M FY 2010/ additional years as appropriated	CMS, Center for consumer information and insurance oversight (CIIO)	awarded 10/19/2010	BOI Awarded $830,000	
1003	Health Insurance Premium Rate Review Grants	Virginia received a $1 million grant. The Commonwealth plans to use the funds to expand the information required to be filed by plans offering individual policies as well as audit the largest plans as well as those asking for the largest premium increases.	$250 million (round 1 provided $46 million in grants 8/2010) 5 year period for grants	OCIIO	round one announced 8/16/2010	$1 million to the Virginia Board of Insurance	

PPACA Opportunities for Fairfax County and Virginia Table 1 Appendix III							
PPACA Section	**Name of provision**	**Plain text/Summary**	**Amount available**	**Sub agency**	**Timeline**	**VA**	**County**
1101	High Risk Pools for Health Insurance through January 2014	This program provides for individuals to purchase health insurance regardless of the pre-existing condition. Eligibility rules include that the person has been without coverage for six months and that they providing documentation of a pre-existing condition. ACA rules supersede current state high risk pool programs. Virginia residents are eligible to apply to the program run directly by the federal government. On May 31, 2011, HHS announced that premiums will be reduced and the application process will be simplified beginning July 1, 2011. Premiums will be reduced 40.3% for Virginia participants. Press release available here: http://www.hhs.gov/news/press/2011pres/05/20110531b.html. Program website address is https://www.pcip.gov/StatePlans.html	$5 billion 7/1/2010-1/1/2014		7/1/2010-1/1/2014	Virginia is participating in federally run program. Qualified Virginia residents can apply for coverage.	
1102	Early	A program to help employer	$5billion	CMS		138 plans	

PPACA Opportunities for Fairfax County and Virginia Table 1 Appendix III							
PPACA Section	**Name of provision**	**Plain text/Summary**	**Amount available**	**Sub agency**	**Timeline**	**VA**	**County**
	Retirement Reinsurance Program (ERRP)	based health plans cover retirees who are at least 55 year of age and are not eligible for Medicare. Health plans must implement programs to reduce costs with respect to participates with chronic illness and/or other high cost conditions. The Federal Government will reimburse participating plans for 80% of claims for enrollees between with claims equaling between $15,000 and $90,000 in a plan year. The thresholds will be revised annually. The program will be in place until 1/1/2014. (This program is currently closed to new participating plans as the program estimates current participates will utilize all funds allocated to the program. Registration may open again, if funding levels or spending trends change.) Website for program is: http://www.errp.gov/	nationwide	(with use of contractors)		across Virginia including Fairfax County Government and FCPS were approved for participation as of 12/31/2010	
1201	Wellness Program	In 2014 HHS will conduct demonstrations in 10 states to				VA may choose to	

PPACA Opportunities for Fairfax County and Virginia Table 1 Appendix III							
PPACA Section	**Name of provision**	**Plain text/Summary**	**Amount available**	**Sub agency**	**Timeline**	**VA**	**County**
	Demonstration Project for Individual Plans.	allow health plans to offer wellness incentives in individual health insurance plans. Example of incentives include reductions in premiums, co-pays, and deductibles for participating in specified wellness programs. Group health insurance plans can provide such incentives under a different provision of PPACA.				apply for participation in this program likely in 2014.	
1311	Health insurance exchange planning grant	Grants to study and establish health benefit exchanges required in PPACA. First round grants were $1 million each and provided to all states which applied in 2010. The VA secretary of Health and Human Resources office is heading up the study to develop recommendations to the General Assembly of how to structure the Exchange in Virginia. Additional grant money may be available prior to 1/1/2015 when exchanges must be self operational. More information is available	Round 1- $1 million per state; Round 2 funds are available and states can apply as they reach certain thresholds in there Exchange planning are met.	OCIIO/ CCIIO		$1 million; Secretary of Health and Human Resources	

PPACA Opportunities for Fairfax County and Virginia Table 1 Appendix III							
PPACA Section	**Name of provision**	**Plain text/Summary**	**Amount available**	**Sub agency**	**Timeline**	**VA**	**County**
		here: http://cciio.cms.gov/programs/exchanges/index.html					
1311	Early Innovator Grants (for developing Enrollment HIT)	In February 2011 six states and a multi-state consortium received cooperative agreements from HHS to develop and implement Health Information technology to operate a state Health Benefits Exchange. Systems developed under this grant will be shared with other states. States can then utilize the technology in the operation of Exchange(s) in their states. The grantees include: Kansas, Maryland, New York, Oklahoma, Oregon, Wisconsin, and a multi-state consortium led by the University of Massachusetts Medical School will receive a combined total of approximately $241 million.	$241 million awarded 2/14/2011. 7 total cooperative agreements were awarded	OCIIO/CCIIO		did not apply.	
1561	Grants for Enrollment HIT	states and local governments can apply for funding to create, or adapt existing technology for enrollment.				Sec Hazel wants to create a single	State or sub-state governments may

PPACA Opportunities for Fairfax County and Virginia Table 1 Appendix III							
PPACA Section	**Name of provision**	**Plain text/Summary**	**Amount available**	**Sub agency**	**Timeline**	**VA**	**County**
		Grants can be used to eliminate legacy system, reduce maintenance costs, and collaborate with other entities in the state. HIT enrollment systems adopted under this grant must be made available to other state and local governments at no cost.				eligibility and enrollment system for all social service programs.	apply
2401	Community First Choice Option	This program will increase the FMAP by 6 percent for participating states for Home and Community based services for Medicaid enrollees who would otherwise qualify for Nursing or institutional care. The PPACA provision revising section 1915(k) to include home and community based attendant services. Patients must agree to utilize these services instead of institutional care. This program is optional for states and states must apply to participate. Proposed implementation rules for this program were published in the Federal Register February 25,		CMS		DMAS may apply for VA Medicaid to participate .	

PPACA Opportunities for Fairfax County and Virginia Table 1 Appendix III							
PPACA Section	**Name of provision**	**Plain text/Summary**	**Amount available**	**Sub agency**	**Timeline**	**VA**	**County**
		2011. The proposed rules do not create a new eligibility group for Medicaid and must apply statewide. Those rules can be found here: http://www.federalregister.gov/articles/2011/02/25/2011-3946/Medicaid-program-community-first-choice-option					
2403	Money Follows Person Long Term Care Demonstration (Medicaid)	Extends a current Medicaid demonstration program created under the Deficit Reduction Act (DRA) of 2005 to increase the use of Home and Community Based Services for individuals who otherwise qualify for long term nursing or institutional based care. CMS is providing Technical Assistance though contractors to states. States began transitioning individuals to community based settings in 2008. Virginia has been a participant in the program under DRA.	$450 million appropriated per FY2011-2016	CMS		Virginia Medicaid is a participant ; (DMAS)	
2703	Planning Grants for	Opened 1/1/2011; Planning grants for creation of Health	$25million	CMS/SAMHSA		States are eligible	

PPACA Opportunities for Fairfax County and Virginia Table 1 Appendix III							
PPACA Section	**Name of provision**	**Plain text/Summary**	**Amount available**	**Sub agency**	**Timeline**	**VA**	**County**
	Health Homes for Chronically Ill Patients	Homes. States can receive 90% FMAP for enrolled patients. States can participate by revising their Medicaid State plan, however, they must consult with SAMHSA as part of the process. A guidance letter to state Medicaid directors is available from CMS is at http://www.samhsa.gov/healthreform/health homes/healthHomesSMD.pdf. information from SAMHSA is available http://www.samhsa.gov/healthreform/health homes/				for participating by amending their state Medicaid plans	
2704 (Medicaid) 3203 (Medicare)	Bundled Payments	Medicaid demonstration projects to evaluate integrated care around a hospitalization. Projects to be awarded to up to eight states. Evaluation report due within one year of the conclusion of the demonstration. **When applying, State Medicaid programs will be able to propose to focus on individual diseases/conditions, category**	?	CMS office of innovation		State Medicaid programs may apply. Proposed programs may focus on geographic and or specific diseases	

PPACA Opportunities for Fairfax County and Virginia Table 1 Appendix III							
PPACA Section	**Name of provision**	**Plain text/Summary**	**Amount available**	**Sub agency**	**Timeline**	**VA**	**County**
		of beneficiaries and/or geographic areas. In selecting state proposals, the Secretary of HHS, must make sure that overall the projects will represent the national make up of Medicaid Beneficiaries A similar Pilot program is authorized for Medicare. The Medicare program will cover 3 days before hospitalization to 30 days after discharge.				or populations	
2707	Medicaid Emergency Psychiatric Demonstration Program	Three year demonstration program in which participating state Medicaid programs are required to reimburse certain institutions of mental disease (IMD) for services provided to Medicaid beneficiaries between the ages of 21 and 64 for medical services to stabilize the patient with an emergency psychiatric condition. In April 2011, CMS submitted to OMB a request for expedited approval of a form which will be used in this program to collect information. The	FY 2011 $75 million to remain available though 12/31/2015	CMS		Virginia Medicaid elegible (DMAS)	

PPACA Opportunities for Fairfax County and Virginia Table 1 Appendix III							
PPACA Section	**Name of provision**	**Plain text/Summary**	**Amount available**	**Sub agency**	**Timeline**	**VA**	**County**
		submission to OMB is an indication that the program is under development and therefore maybe open for applications soon. The program is possibly operational or open for application as it is published in the Catalog of Domestic Assistances as number 93.537. https://www.cfda.gov/?s=program&mode=form&tab=step1&id=21a6ba9d355770ad0d9791aca5e037aa					
2952	Services to individuals with a postpartum condition	Authorizes grants to establish and operate cost effective systems to deliver care to individuals suffering from or at risk of developing post-partum depressions. Support can also be provided to the families of such individuals. The Secretary of HHS may integrate activities related to postpartum conditions into other grant opportunities including those authorized under section 330 of the Public Health Services Act.	$3 FY2010; SSAN FY2011,2012	HRSA		Public or nonprofit entities, local and or state governments can apply. Primary care centers and others may be eligible as well.	

PPACA Opportunities for Fairfax County and Virginia Table 1 Appendix III							
PPACA Section	**Name of provision**	**Plain text/Summary**	**Amount available**	**Sub agency**	**Timeline**	**VA**	**County**
3504	Regional Systems for Emergency Care	Awards at least four multi-year grants (with matching) or contracts for pilot projects to improve regional coordination of emergency services.	$24 million each of FY2010-FY2014 for Title XII Parts A&B (sec 1201-1222)	Assistant Secretary for Preparedness and Response			
3510	Patient Navigator Program	Re-authorizes program which provides grants to fund patient navigators. Patient Navigators will assist patients in overcoming barriers to health care services. Funding period can last though 2015. Each patient Navigator must meet certain proficiencies and will coordinate health services. specifically the Navigators will provider referrals, assists community organizations in helping patients receive better care, identify and provide information regarding clinical trials for which the patient may be eligible. Patient Navigators will also conduct outreach to populations with health disparities.	$3.5million FY2010; SSAN FY2011-2015	HRSA		No organization in Virginia received funding in the 2010 competition	Public and nonprofit health centers can eligible to apply, as are hospitals and a number of other organizations

PPACA Opportunities for Fairfax County and Virginia Table 1 Appendix III							
PPACA Section	**Name of provision**	**Plain text/Summary**	**Amount available**	**Sub agency**	**Timeline**	**VA**	**County**
4002	Prevention and Public Health Fund	Fund amount increases each year from $500 million in FY 2010 to $2 billion in FY 2015 and beyond. Fund to support grants and activities in areas including but not limited to: HIV/AIDS Prevention and testing, Tobacco prevention and control, expand primary care to individuals with behavioral health disorders, obesity related programs. $100 million in grants awarded in September of 2010. A February 2011 HHS press release announced that the agency will invest $750 million in prevention and public health programs in FY 2011. The Press release from 2/9/2011 available online at: http://www.hhs.gov/news/press/2011pres/02/20110209b.html A variety of grant opportunities offered though this fund are expected over the next several years.	$15 billion over 10 years	CDC, HRSA, SAMSHA, (possibly others)		In FY 2010 Virginia received approximately $11.99 million in funding including $9.1 million in primary care training, $2.3 million in public health infrastructure, and $470,000 for HIV prevention and tobacco cessation programs	Various Grants will be announced over the next 10 years
4101	School Based health centers	Grants to fund management and operation of SBHCs	SSAN	HRSA			grant applicatio

PPACA Opportunities for Fairfax County and Virginia Table 1 Appendix III							
PPACA Section	**Name of provision**	**Plain text/Summary**	**Amount available**	**Sub agency**	**Timeline**	**VA**	**County**
	(SBHC)	which include comprehensive physical and behavioral health services to children and adolescents.					n deadline passed for 2011
4102	Oral Health Activities	5 year national oral health education campaign, and award grants for dental caries disease management programs and for other purposes; reauthorizes school based dental sealant program with grants to each state (no money authorized), and efforts to improve oral health infrastructure in the states.	FY 2010-CDC oral health $15 million-subject to appropriation	CDC		N/A	community based providers of dental services including public and private entities
4201	Community Transformation Grants	CDC to fund competitive grants for implementation, evaluation, and dissemination of evidence-based community preventative health activities. Current grant opportunities is open and includes the opportunity to apply for either capacity building ($50,000-$500,000) or implementation grants ($500,000 and up). Projects fuded by CTG must focus on reducing tobacco use, encouraging healthy eating and active lifestyles,	$100 million dollars available for first round of grants. Applications due July 15. CDC is hopeful that additional funds will be available over time for additional grant	CDC		state government eligible	local government agencies or nonprofit organizations, network of community organizations are eligible.

PPACA Opportunities for Fairfax County and Virginia Table 1 Appendix III							
PPACA Section	**Name of provision**	**Plain text/Summary**	**Amount available**	**Sub agency**	**Timeline**	**VA**	**County**
		and reducing the prevalence of high blood pressure and high cholesterol. Current grants open to counties over 500,000 residents, state - large counties, tribes, and U.S. territories. Project goals must focus on reducing health disparities as well as improving overall health of the population at large. Applicants who receive capacity building grants will be eligible to apply for implementation grants if money is available.	opportunities .				
4202	Community wellness pilot program	CDC to award five year pilot program grants for community prevention, interventions, screenings, and clinical referrals for individuals between 55 and 64 years of age.	SSAN; no further info available	CDC		state	local health departments
4204	Immunization programs	Provides authority for states to purchase vaccines at prices negotiated by the Sec of HHS. Reauthorized state immunization grants. Provides for new immunization demonstration	FY 2010 appropriation for PHSA section 317, vaccination program $559 million	CDC		state eligible	political subdivisions and are eligible for negotiated rates

PPACA Opportunities for Fairfax County and Virginia Table 1 Appendix III							
PPACA Section	**Name of provision**	**Plain text/Summary**	**Amount available**	**Sub agency**	**Timeline**	**VA**	**County**
		grants.					
4304	Epidemiology and laboratory capacity grants	CDC to issue grants to state and local health departments to assist public health agencies in improving surveillance for and response to infectious diseases. Grants would assist in strengthen epidemiological capacity to identify and monitor the occurrence of infectious disease, enhancing lab tests systems and ability to report results electronically, improving information systems and exchange, and developing and implementing prevention and control strategies.	Law Authorizes $190 million for each of FY2010-FY2013	CDC		Virginia Dept. of Health awarded $431,035 in 2010.	Counties were not eligible to apply in 2010. Future opportunities may be available
4305	Education and Training in Pain Care	Health profession schools, hospices, and other public and private entities can apply for money to provide training programs in recognizing the symptoms of pain, applicable laws and policies on controlled substances, and barriers to care in underserved populations.	SSAN-	HRSA			
5208	Nurse	Grants to Nurse Managed	$50Million	HRSA			

PPACA Opportunities for Fairfax County and Virginia Table 1 Appendix III							
PPACA Section	**Name of provision**	**Plain text/Summary**	**Amount available**	**Sub agency**	**Timeline**	**VA**	**County**
	Managed health clinics (NMHC)	Health Clinic to fund operation of NMHC that provide comprehensive primary care and wellness services regardless of income or insurance status. Nurses must provide the majority of the care and at least one advanced practice nurse must hold an executive management position.	FY 2010; SSAN FY2011-FY 2014				
5304	Alternative Dental Health Care Provider Demonstration Program	Program to train or employ alternative dental health care providers (community dental health coordinators, dental health aides) to increase access to dental health services in rural and other underserved communities.	SSAN (15 grants for 5 years of not less then $4 million)	HRSA			State or county public health clinics
5306	Mental and Behavioral health education and training grants	These grants are mostly for colleges and universities with programs in mental and behavioral health such as social work, psychology, etc. Grants will be targeted to schools which educate high numbers of minorities. However, a "state licensed mental health organizations to train professional child and	$35 million including $5 million for training paraprofessional child and adolescent mental health workers	HRSA		HBCUs, other minority serving institutions	state-licensed mental health organizations may be eligible to apply.

PPACA Opportunities for Fairfax County and Virginia Table 1 Appendix III							
PPACA Section	**Name of provision**	**Plain text/Summary**	**Amount available**	**Sub agency**	**Timeline**	**VA**	**County**
		adolescent mental health workers" may be eligible.					
5307	Cultural competency, Prevention, public health, disparities, and individuals with disability training	PPACA authorizes grants, contracts, cooperative agreements under Title VII for development and evaluation of research, demonstration projects, and model curricula that provide training in cultural competency, prevention, public health proficiency, reducing disparities, and aptitude for working with individuals with disabilities. Two components of section, one is specifically for nursing education	SSNA	HRSA		states and educational institutions can apply	local governments, and other public or private entities (or consortium) eligible to apply
5313	Community Health Worker (CHW) program	CDC to award grants to promote healthy behaviors and outcomes for populations in medically underserved communities. Programs to include training and supervision of CHWs.	SSAN	CDC		eligible to apply	health departments, free clinics, hospitals are eligible to apply
5314	CDC training fellowships	Expand fellowship in epidemiology, laboratory science, and informatics; the Epidemic Intelligent Service	$39.5 million for each year FY10-FY2013	CDC		states can get money to help with loan	Fairfax County has fellows

PPACA Opportunities for Fairfax County and Virginia Table 1 Appendix III							
PPACA Section	**Name of provision**	**Plain text/Summary**	**Amount available**	**Sub agency**	**Timeline**	**VA**	**County**
		(EIS). Fairfax County has fellows though this program.				repayment	though this program.
5405	Primary care extension program	Awards grants competitively to states to establish Primary Care Extension Hubs, constituting of state health departments and other entities. States must contract with county and local entities to service as extension agencies that assist primary care providers in developing patient centered medical homes	$120 million for each FY2011-FY2012; SSAN FY2013,FY2014	AHRQ		states and multiple state entities can apply	Potentially Fairfax County could be a "contractor" for Virginia.
5604	Co-Locating primary and specialty care in community based mental health settings	Demonstration projects to provide coordinated and integrated services to individuals with mental illness and co-occurring chronic diseases thought co-location of primary care at a community mental and behavioral health setting.	$50 million for FY2010; SSAN FY2011-FY2014.	SAMHSA		Many grants awarded in 2010, no recipients are in Virginia	It is unknown if additional funding opportunities will be available
10202	Incentives for states to offer Home and Community Based Services as a Long	This provision is to encourage states to increase their use of home and community based services for Medicaid recipients who otherwise qualify for long term nursing	$3 billion (for additional FMAP)	CMS		DMAS can apply for Virginia Medicaid	

PPACA Opportunities for Fairfax County and Virginia Table 1 Appendix III							
PPACA Section	**Name of provision**	**Plain text/Summary**	**Amount available**	**Sub agency**	**Timeline**	**VA**	**County**
	Term Care Alternative	home care. States will apply competitively to participate and receive an increase in their FMAP for covered services of 2 or 5 percent. Participating states who currently have under 25% of their long term service spending in HCBS will be required to reach 25%, states above 25% will be required to reach a 50% level during the increased FMAP period.					
10333	Community-Based Collaborative Care Network Program	Grants to support community based collaborative care networks (CCN). CCN are consortium of health care providers with a joint governance structure. CCN provide integrated comprehensive care for low income populations, CCNs must include a safety net hospital and all FQHCs in the community	SSAN	?		Program not believed to be operational at this time	
10410	Centers of Excellence for Depression	Competitive grants to entities to establish national center of excellence for depression. One grantee will be the coordinating center and will	$100 million each for FY 2011-FY2015; $150 million	SAMHSA		institutions of higher learning; public or private	institutions of higher learning; public or private

PPACA Opportunities for Fairfax County and Virginia Table 1 Appendix III							
PPACA Section	**Name of provision**	**Plain text/Summary**	**Amount available**	**Sub agency**	**Timeline**	**VA**	**County**
		maintain a national database. Grants up to $5 million ($10 for the coordinating center.	FY2016-FY2020			nonprofit research institutions	nonprofit research institutions
10412	Public Access Defibrillation Programs	Reauthorizes public access defibrillation programs including grants for equipment purchase and training.	$25 million each year	HRSA		states eligible	political subdivisions eligible
10501	National Diabetes Prevention Program	Grants for community based diabetes prevention program model sites. The Y (formally YMCA) has contracted with CDC and is offering programs in 21 communities around the county. By mid 2011 another 20 communities will be added to the program including Washington DC. No Communities are listed, and there is no Y in Fairfax County.	SSAN	CDC		Nationally the Y is conducting this program	
10504	Access to Affordable Care Demonstration Program	Three year demonstration program in up to 10 states to provide access to comprehensive healthcare services to the uninsured at reduced rates.	SSAN, up to $2 Million per state	HRSA		State based, non profit, public-private partnership	This program does not appear to be operational at this time

PPACA Opportunities for Fairfax County and Virginia Table 1 Appendix III							
PPACA Section	**Name of provision**	**Plain text/Summary**	**Amount available**	**Sub agency**	**Timeline**	**VA**	**County**
1322/ 10104	Grants/Loans for creation of Nonprofit Health Insurance Co-Ops	Consumer Operated and Oriented Plans (Co-Ops) can receive grants and loans to create nonprofit health insurers for the small group and individual market. Must be established after 7/16/2009. Priority given to applicants that will offer statewide plans, utilized integrated care models, and have private support. Both grants and loans must be repaid. Grants in 15 years and Loans within 5 years. Information available at: http://www.regulations.gov/#!documentDetail;D=HHS_FRDOC_0001-0151	$6 billion. Goal is creation of one CO-OP per state.	OCCIIO; The CO-OP Advisory Board announced in Federal Register 6/23/2010		nonprofit group's eligible	Government agencies may not be directly involved.
3502/ 3511	Community Health Team Grants to Support Medical Homes	Grants to support community based interdisciplinary, inter-professional health teams in assisting primary care practices.	SSAN	unknown		states or state designated entities	
3503/ 3511	Medication Therapy Management	Grants to support MTM services provided by licensed pharmacists to patients who at least four medications, take high risk medications, or have	SSAN	AHRQ			Entities that provide an appropriate setting

PPACA Opportunities for Fairfax County and Virginia Table 1 Appendix III							
PPACA Section	**Name of provision**	**Plain text/Summary**	**Amount available**	**Sub agency**	**Timeline**	**VA**	**County**
		two or more chronic illnesses, or are at risk for medication related problems for other reasons.					for MTM and have a plan for long term financial plan

APPENDIX IV: QUANTATIVE ANALYSIS

Statistical Details of the Quantitative Analysis

In this appendix we report the variables used in the quantitative analysis and the results of the statistical models that were estimated using our analytic combination of ACS and MEPS data for Fairfax County residents, both the individual coefficients and significance levels as well as overall goodness of fit or technical model accuracy results. Table 1 reports simple statistics for the variables of interest for the population of non-elderly (whom we modeled) in Fairfax County. Tables 2 and 3 report on the models that predicted Medicaid enrollment and are conditional on eligibility for children and adults respectively. These tables also report technical goodness of fit statistics. Table 4 does the same for those who are not Medicaid eligible, and simply estimates the probability of remaining uninsured, i.e. of not buying either individual or group insurance through one's employer.

Variable Description and Model output

Table 1 Appendix IV: Variable Description and Count

Variables	Pop Total	SE	Pop Mean	SE
AGE				
AGE: 0-19	285405	0.000	0.29	0.000
AGE: 20-34	197238	1653.737	0.20	0.002
AGE: 35-49	260091	1581.883	0.27	0.002
AGE:50-64	232703	1656.863	0.24	0.002
SEX				
sex1: Male	485253	308.871	0.50	0.000
sex2: Female	490183	308.871	0.50	0.000
RACE/Ethnicity				
race: White	637043	4719.725	0.65	0.005
race: Black	96589	2312.410	0.10	0.002
race : other	83299	4670.991	0.09	0.005

Variables	Pop Total	SE	Pop Mean	SE
race: Asian	158505	2672.945	0.16	0.003
hispanic1: Non-Hispanic	827814	2967.058	0.85	0.003
hispanic2:Hispanic	147622	2967.058	0.15	0.003
Employment				
employ1: No	6938	718.299	0.01	0.01
employ1: Yes	968498	718.299	0.99	0.01
Family Income				
fincome: Under $25,000	60489	3381.387	0.06	0.003
fincome: $25,000 to $49,999	106075	5126.928	0.11	0.005
fincome:$50,000 to $74,999	126507	5193.655	0.13	0.005
fincome: $75,000 to $99,999	117541	5061.226	0.12	0.005
fincome: $100,000 and over	564824	6805.655	0.58	0.007
Education				
edu: less HS grad	317021	2691.084	0.33	0.003
edu: HS.grad.GED.other	94311	2539.274	0.10	0.003
Education				
Edu: College.Ass.deg	166945	3666.450	0.17	0.004
edu: BAs.deg.or.Higher	397160	4119.525	0.41	0.004
Medical Expenditure				
totexp10 (Total Med Exp)	3880988533	104847385.860	3978.72	107.488
totslf10 (Out-pocket Exp)	880519086	20495296.739	902.69	21.011
Personal Asset				
asset0 (Non-accessible Asset)	106059	4143.302	0.11	0.004
asset1 (Accessible Asset)	869377	4143.302	0.89	0.004
Household Type				
htype: married couple	704437	6869.235	0.72	0.007

Variables	Pop Total	SE	Pop Mean	SE
htype:SP.Male/female	141543	6039.192	0.15	0.006
htype: Not.family	129456	4136.144	0.13	0.004
Health status				
health: Exc	387298	4175.296	0.40	0.004
health: V.Good	306825	3537.369	0.31	0.004
health: Good	218863	3811.758	0.22	0.004
health: Fair	57023	1755.046	0.06	0.002
health: Poor	5426	606.403	0.01	0.001
Family Type: With/Out Related Children				
ft type: WRC: Under 5	107502	3908.849	0.11	0.004
ft type: WRC: Under 17	458810	5006.839	0.47	0.005
ftype: NRC	409124	4773.746	0.42	0.005
Work experience of householder and spouse				
wkstat: Full.time	765690	5917.217	0.78	0.006
wkstat: Part.time	177807	5738.640	0.18	0.006
wkstat: No.time	31939	2319.845	0.03	0.002
Work status of householder or spouse				
wkstat2: H/W.LBF.EMP	810271	6338.526	0.83	0.006
wkstat2:H/W/M/F.LBF.UNEMP	10223	1810.159	0.01	0.002
wkstat2: H/W.NOT.LBF	18470	1583.449	0.02	0.002
wkstat2: M/F.LBF.EMP	119367	5445.956	0.12	0.006
wkstat2: M/F.NOTLBF	17104	1757.052	0.02	0.002
Food Stamp				
fs1:	32386	3617.481	0.03	0.004
Yes	943050	3617.481	0.97	0.004

Variables	Pop Total	SE	Pop Mean	SE
Marital Status				
marital: Married	43428	4804.925	0.45	0.005
marital: widowed	8046	831.601	0.01	0.001
marital: divorced	54616	2125.775	0.06	0.002
marital: separated	14601	1284.417	0.01	0.001
marital: Never married or under 15	460746	3953.328	0.47	0.004
Presence of persons 60 years and over in household				
r600: None	804512	4640.943	0.82	0.005
r601:One	115008	4355.151	0.12	0.004
r602: Two or more	55916	2510.026	0.06	0.003
Chronic Health Condition				
diabdx: No	917527	1852.845	0.94	0.002
diabdx: No yes Diabetes	57909	1852.845	0.06	0.002
coronary: No	953988	1164.303	0.98	0.001
coronary: yes Coronary Heart disease	21448	1164.303	0.02	0.001
asthdx: No	896559	1953.128	0.92	0.002
asthdx: Yes Asthma	78877	1953.128	0.08	0.002
Number of own Child				
nchld: None	446879	4504.495	0.46	0.005
nchld: 1-3	494385	5413.745	0.51	0.006
nchld: 4+	34172	3229.715	0.04	0.003
Disability				
dis1 : Yes	41781	1927.309	0.04	0.002

Variables	Pop Total	SE	Pop Mean	SE
dis2 : No	93365	1927.309	0.96	0.002
Does Employer Offers Ins				
oftemp531: Yes	588848	4204.797	0.60	0.004
oftemp531: No	386588	4204.797	0.40	0.004
Receive Public Assist Income				
pubassis0: No	964659	1083.750	0.99	0.001
pubassis0: Yes	10777	1083.750	0.01	0.001
Employment Status of parents				
pemploy: Both P Wk	613967	4099.610	0.63	0.004
pemploy: Only Father Wk	131673	3283.151	0.13	0.003
pemploy: Only Mother WK	5462	879.380	0.01	0.001
pemploy: Neither P WK	962	365.601	0.00	0.000
pemploy: Sngl.Father Wk	146164	2437.575	0.15	0.002
pemploy: Sngl.Father D'WK	946	450.700	0.00	0.000
pemploy: Sngl.Mother WK	71541	2463.793	0.07	0.003
pemploy: Sngl.Mother D'WK	4721	899.895	0.00	0.001
Number of Employees				
nemp1: <10	131673	3431.238	0.70	0.004
nemp1: 10-24	122964	2519.572	0.13	0.003
nemp1: 25-99	108556	2751.548	0.11	0.003
nemp1: 100+	65140	2098.491	0.07	0.002
Non-Group Coverage				
ngrp: No	861642	4657.469	0.88	0.005
ngrp: Yes	113794	4657.469	0.12	0.005
ESI				

Variables	Pop Total	SE	Pop Mean	SE
esi: No	266393	6604.497	0.27	0.007
esi: Yes	709043	6604.497	0.73	0.007
Employee Premium Contribution				
premctr	2376260278	25196364.981	2436.10	25.831
Self Employed				
selfemp0: No	913172	1686.4	0.936168	0.0017
selfemp0: Yes	62264	1686.4	0.063832	0.0017
Number of related Children				
nrchld : 1-3	514991	5805.8	0.527960	0.0060
nrchld : 4+	43879	4101.6	0.044984	0.0042
nrchld : None	416567	4485.4	0.427057	0.0046
Unmarried partner household				
partner: female-female UMP	1805.00	491.77	0.00	0.00
partner: male-female UMP	28935.00	3101.40	0.03	0.00
partner: Male-Male UMP	1966.00	509.17	0.00	0.00
partner: No UMP	942730.00	3305.72	0.97	0.00
Low Income Family Eligibility				
LIFCelg: Non Eligible	940316.00	3083.77	0.96	0.00
LIFCelg: Eligible	35120.00	3083.77	0.04	0.00
Children Eligibility				
CHLDelg: Non-Eligible	948592.00	2162.40	0.97	0.00
CHLDelg: Eligible	26844.00	2162.40	0.03	0.00
Number of Person in Family				
nperf: Two	248605.00	4693.72	0.25	0.00
nperf: 3-5	630784.00	6257.75	0.65	0.01

Variables	Pop Total	SE	Pop Mean	SE
nperf: 5+	96047.00	5053.58	0.10	0.01

Table 2 Appendix IV: Children's Medicaid Model

	Estimate	**Std. Error**	**t value**	**Pr(>|t|)**
(Intercept)	23.0545	3.9623	5.82	0.000
AGE7-10	-0.973	0.458	-.12	0.0480
AGE11-15	-0.9337	0.5295	-1.76	0.0948
AGE16-19	-0.6750	0.5746	-1.17	0.2554
sex2	0.4478	0.3777	1.19	0.2512
raceBlack	1.6124	0.9895	1.63	0.1206
raceother	0.4279	1.0503	0.41	0.6885
raceAsian	0.9386	1.1472	0.82	0.4240
hispanic2	1.7769	0.8178	2.17	0.0434
Employ1Yes	-18.7204	1.7200	-10.88	0.0000
fincome $25,000 to $49,999	-0.1874	0.7492	-0.25	0.8053
fincome $50,000 to $74,999	-0.1940	1.3498	-0.14	0.8873
fincome $75,000 to $99,999	0.4604	1.1531	0.40	0.6944
fincome $100,000 and over	-0.8441	1.0180	-0.83	0.4179
pov100-133 FPL	0.7058	0.5811	1.21	0.2402
pov133-250 FPL	4.5520	2.9829	1.53	0.1444
pov250-400 FPL	1.1093	1.7133	0.65	0.5255
pov400+ FPL	3.6872	1.5347	2.40	0.0273
pemployOnly Father Wk	0.4464	0.6248	0.71	0.4841
pemploy Sngl.Father Wk	-0.0790	1.3975	-0.06	0.9556
pemploy Sngl.Father D'WK	14.1706	1.5230	9.30	0.0000
pemploy Sngl.Mother WK	0.7605	0.9483	0.80	0.4330
pemploy Sngl.Mother D'WK	1.2149	1.3224	0.92	0.3704
psf1	-0.1983	0.8854	-0.22	0.8253
totexp10	-0.0000	0.0000	-0.63	0.5395
totslf10	0.0000	0.0001	0.30	0.7645
htypreSP.Male/Female	-6.3146	2.0209	-3.12	0.0059
htypeNot.family	-0.0007	1.4127	-0.00	0.9996
healthV.Good	-0.1027	0.4914	-0.21	0.8367

	Estimate	Std. Error	t value	Pr(>|t|)
(Intercept)	23.0545	3.9623	5.82	0.000
healthGood	0.4258	0.3879	1.10	0.2869
healthFair	0.4740	0.8939	0.53	0.6024
healthPoor	-1.1769	1.5463	-0.76	0.4564
ftypeWRC. under 17	0.2823	0.6392	0.44	0.6640
ftypeNRC	2.7093	2.2577	1.20	0.2457
wkstatPart.time	-0.6870	0.4570	-1.50	0.1501
wkstatNo.time	-2.5191	0.9534	-2.64	0.0166
wkstat2H/W/M/F.LBF.UNEMP	5.6537	1.5931	3.55	0.0023
wkstat2H/W.NOT.LBF	12.6595	2.5888	4.89	0.0001
wkstat2M/F.LBF.EMP	6.4855	2.0109	3.23	0.0047
wkstat2M/F.NOTLBF	8.2058	2.6154	3.14	0.0057
fs2	-2.5444	0.8792	-2.89	0.0097
pubassis1	0.5049	0.7353	0.69	0.5010
r181	3.6906	1.1977	3.08	0.0064
r601	-0.4938	0.8284	-0.60	0.5586
r602	0.6240	1.0357	0.60	0.5544
diabxYes	0.8816	0.5854	1.51	0.1494
coronaryYes	0.6004	0.9994	0.60	0.555
asthdxYes	1.5273	0.6380	2.39	0.0278
nchld1-3	-0.3110	1.6225	-0.19	0.8502
nchld 4+	0.6201	1.7044	0.36	0.7202
dis2	-2.2847	1.9943	-1.15	0.2670
ofremp532	-0.9841	0.3666	-2.68	0.0152
nemp110-24	-0.1853	0.6002	-0.31	0.7611
nemp125-99	-1.2078	0.4398	-2.75	0.0133
nemp1100+	-1.4023	0.7252	-1.93	0.0690
ngrp Yes	-4.0483	0.8745	-4.63	0.0002
esiYes	-7.0587	3.5146	-2.01	0.0598
premctr	0.0008	0.0010	0.88	0.3925
LIFCelg	-8.2418	2.7113	-3.04	0.0070
CHLDelg	-3.4498	1.5172	-2.27	0.0355

	Estimate	**Std. Error**	**t value**	**Pr(>|t|)**
(Intercept)	23.0545	3.9623	5.82	0.000

Goodness of Fit:

Children's Medicaid Model					
Optimizing Method	Threshold	PCC	Sensitivity	Specificity	Kappa
MaxSens+Spec[1]	0.55	0.91	0.92	0.90	0.82
MaxPCC	0.55	0.91	0.92	0.90	0.82
MinROCdist	0.55	0.91	0.92	0.90	0.82

The "Optimizing Method" is the criterion function used to solve the model. The "Threshold" is the predicted probability cutoff higher than which observations are labeled a "yes." PCC is percent of people correctly classified. Sensitivity is the percentage of true positives predicted by the model. Specificity is the percentage of true negatives predicted by the model. And Kappa reflects the consistency of each model's predictions, in that it records the percent of observations for which each model's specifications (within an optimizing method type) agreed.

1 Maximum sensitivity + specificity

Table 3 Appendix IV: Adult Medicaid Model

	Estimate	Std. Error	t value	Pr(>|t|)
(Intercept)	-3.0782	2.7692	-1.11	0.2818
AGE35-49	1.0753	0.6350	1.69	0.1086
AGE50-64	-0.1970	0.9008	-0.22	0.8295
sex2	0.3567	0.4633	0.77	0.4519
raceBlack	-0.5944	0.7650	-0.78	0.4479
raceother	0.1820	0.7409	0.25	0.8089
raceAsian	-0.6582	0.8582	-0.77	0.4536
hispanic2	-2.7376	0.7986	-3.43	0.0032
employ1Yes	-0.4182	0.8545	-0.49	0.6309
fincome $25,000 to $49,999	-0.6917	0.7048	-0.98	0.3402
fincome $50,000 to $74,999	-0.8816	0.9000	-0.98	0.3411
fincome $75,000 to $99,999	0.8592	0.9892	0.87	0.3972
fincome $100,000 and over	-0.0639	0.9420	-0.07	0.9467
eduHS.grad.GED.other	-2.1806	0.8289	-2.63	0.0175
eduCollege.Ass.deg	-2.7109	0.8737	-3.10	0.0065
eduBAs.deg.or.Higher	-2.6240	0.8919	-2.94	0.0091
totexp10	-0.0000	0.0000	-0.86	0.4043
totslf10	-0.0001	0.0000	-1.10	0.2877
asset1	-1.1641	0.7684	-1.51	0.1482
htypeSP.Male/female	-4.9127	1.4336	-3.43	0.0032

	Estimate	**Std. Error**	**t value**	**Pr(>|t|)**
(Intercept)	-3.0782	2.7692	-1.11	0.2818
htypeNot. family	-1.4299	1.1369	-1.26	0.2255
healthV.Good	-0.7612	0.6134	-1.24	0.2315
healthGood	-0.6411	0.7611	-0.84	0.4113
healthFair	-0.6915	0.7319	-0.94	0.3580
healthPoor	-1.9085	1.4089	-1.35	0.1933
ftypeWRC.under17	-0.7145	0.6883	-1.04	0.3137
ftypeNRC	-0.3907	1.4762	-0.26	0.7945
wkstatPart.time	0.2183	0.5683	0.38	0.7056
wkstatNo.time	-0.7462	1.2538	-0.60	0.5596
wkstat2H/W/M/F.LBF.UNEMP	5.6921	1.3791	4.13	0.0007
wkstat2H/W.NOT.LBF	0.1767	1.2057	0.15	0.8852
wkstat2M/F.LBF.EMP	3.5011	1.3674	2.56	0.0203
wkstat2M/F.NOTLBF	4.1577	1.9987	2.08	0.0530
fs2	-0.2409	0.5249	-0.46	0.6520
marital Widowed	0.7042	1.4419	0.49	0.6315
marital Divorced	0.9895	0.9058	1.09	0.2899
maritalSeparated	3.0631	1.2982	2.36	0.0305
maritalNever maried or under 15	1.0583	0.9334	1.13	0.2726
r601	1.1563	0.6917	1.67	0.1129
r602	0.8759	0.8548	1.02	0.3199

	Estimate	**Std. Error**	**t value**	**Pr(>|t|)**
(Intercept)	-3.0782	2.7692	-1.11	0.2818
diabdxYes	-0.4822	0.7075	-0.68	0.5047
coronaryYes	-0.5317	1.3111	-0.41	0.6901
asthdxYes	0.7813	0.7781	1.00	0.3293
nchld1-3	0.8723	1.2801	0.68	0.5048
nchld4+	2.5879	1.6754	1.54	0.1409
dis2	-0.6768	0.7739	-0.87	0.3941
ofremp532	-1.6634	0.6039	-2.75	0.0135
pubassis1	1.9255	1.3014	1.48	0.1573
nemp110-24	-0.1380	0.6688	-0.21	0.8390
nemp125-99	1.0669	0.8167	1.31	0.2089
nemp1100+	0.9515	0.8007	1.19	0.2510
ngrp Yes	-1.0190	0.6686	-1.52	0.1459
esiYes	-1.8627	2.2831	-0.82	0.4259
premctr	0.0002	0.0006	0.24	0.8107
selfemp1	-0.8016	0.8075	-0.99	0.3347
psf1	0.7576	1.1508	0.66	0.5191
partnerMale-Female UMP	13.6764	2.1697	6.30	0.0000
partnerMale-Male UMP	12.7990	2.8408	4.51	0.0003
partnerNo UMP	11.3662	2.0723	5.48	0.0000
LIFCelg	-6.2711	0.8804	-7.12	0.0000

	Estimate	**Std. Error**	**t value**	**Pr(>|t|)**
(Intercept)	-3.0782	2.7692	-1.11	0.2818
CHLDelg	9.8256	1.8084	5.43	0.0000
nperf3-5	-0.2817	0.6419	-0.44	0.6663
nperf5+	-0.9708	1.1553	-0.84	0.4124

Goodness of Fit:

Adult Medicaid Model					
Optimizing Method	Threshold	PCC	Sensitivity	Specificity	Kappa
MaxSens+Spec[1]	0.29	0.92	0.97	0.89	0.84
MaxPCC	0.31	0.93	0.96	0.90	0.85
MinROCdist	0.31	0.93	0.96	0.90	0.85

	Estimate	**Std. Error**	**t value**	**Pr(>|t|)**
(Intercept)	-2.5785	2.2009	-1.17	0.2520
AGE7-10	0.2441	0.3735	0.65	0.5191
AGE11-15	0.6929	0.3792	1.83	0.0792
AGE16-19	1.0236	0.3986	2.57	0.0163
AGE20-34	2.7846	0.3461	8.04	0.0000
AGE35-49	2.0503	0.3703	5.54	0.0000
AGE50-64	1.8475	0.4480	4.12	0.0003

	Estimate	**Std. Error**	**t value**	**Pr(>|t|)**
(Intercept)	-2.5785	2.2009	-1.17	0.2520
sex2	0.2643	0.1126	2.35	0.0269
raceBlack	0.7490	0.2753	2.72	0.0115
raceother	0.3072	0.3308	0.93	0.3616
raceAsian	1.0435	0.1747	5.97	0.0000
hispanic2	1.6828	0.2640	6.37	0.0000
employ1Yes	-0.4456	0.3552	-1.25	0.2209
pincome$25,000 to $49,999	-0.1534	0.1845	-0.83	0.4133
pincome$50,000 to $74,999	-1.0200	0.2542	-4.01	0.0005
pincome$75,000 to $99,999	-1.5236	0.4185	-3.64	0.0012
pincome$100,000 and over	-1.4298	0.2425	-5.90	0.0000
eduHS.grad.GED.other	-0.0689	0.2181	-0.32	0.7545
eduCollege.Ass.deg	-0.7491	0.1892	-3.96	0.0005

	Estimate	**Std. Error**	**t value**	**Pr(>|t|)**
(Intercept)	-2.5785	2.2009	-1.17	0.2520
eduBAs.deg.or.Higher	-1.1279	0.2103	-5.36	0.0000
totexp10	-0.0003	0.0001	-2.75	0.0108
totslf10	0.0002	0.0002	1.14	0.2665
htypeSPMale/Female	-0.2705	1.4251	-0.19	0.8509
htypeNot.family	0.0193	0.2965	0.06	0.9487
healthV.Good	0.5228	0.1324	3.95	0.0005
healthGood	0.4491	0.1400	3.21	0.0035
healthFair	1.9932	0.3255	6.12	0.0000
healthPoor	3.7019	0.9945	3.72	0.0010
ftypeWRC.under17	-0.6804	0.2956	-2.30	0.0296
ftypeNRC	-0.2730	0.3019	-0.90	0.3741
wkstatPart.time	0.3811	0.1593	2.39	0.0243
wkstatNo.time	-0.1734	0.5274	-0.33	0.7450
wkstat2H/W/M/F.LBF.UNEMP	1.1481	1.1999	0.96	0.3475
wkstat2H/W.NOT.LBF	-0.3051	0.5700	-0.54	0.5970

	Estimate	**Std. Error**	**t value**	**Pr(>|t|)**
(Intercept)	-2.5785	2.2009	-1.17	0.2520
wkstat2M/F.LBF.EMP	0.7054	1.4364	0.49	0.6275
wkstat2M/F.NOTLBF	0.7447	1.5228	0.49	0.6289
fs2	-0.7192	0.4813	-1.49	0.1471
maritalWidowed	1.0390	0.5650	1.84	0.0774
maritalDivorced	0.5964	0.3351	1.78	0.0868
maritalSeparated	0.4831	0.4124	1.17	0.2521
maritalNever maried or under 15	0.2197	0.2090	1.05	0.3029
r601	-0.1049	0.2318	-0.45	0.6547
r602	0.2671	0.3000	0.89	0.3814
diabdxYes	-0.7562	0.2325	-3.25	0.0032
coronaryYes	-0.5007	0.3157	-1.59	0.1249
asthdxYes	0.2662	0.3109	0.86	0.3996
dis2	-0.2897	0.2495	-1.16	0.2562
pubassis1	-0.0372	0.5555	-0.07	0.9472
selfemp1	0.4726	0.2401	1.97	0.0597
premctr	-0.0176	0.0010	-17.81	0.0000
partnerMale-Female UMP	0.3551	2.1099	0.17	0.8677
partnerMale-Male UMP	0.2959	2.5208	0.12	0.9074
partnerNo UMP	0.3455	2.1233	0.16	0.8720

	Estimate	**Std. Error**	**t value**	**Pr(>|t|)**
(Intercept)	-2.5785	2.2009	-1.17	0.2520
ofremp532	2.9765	0.1240	24.00	0.0000

Goodness of Fit:

Uninsured Model					
Optimizing Method	Threshold	PCC	Sensitivity	Specificity	Kappa
MaxSens+Spec[1]	0.08	0.94	0.98	0.93	0.70
MaxPCC	0.65	0.97	0.79	0.99	0.81
MinROCdist	0.16	0.95	0.96	0.95	0.75

[1] H/W = Husband or Wife, LBF = Labor Force, H/W/M/F = Husband or Wife, Male or Female Householder, NOTLBF, NOT.LBF = Not in Labor Force

APPENDIX V: SELECTED BEST PRACTICES

Continued on the next page

Program Name:	Community Based Facilitated Enrollment and Enrollment Center
Model:	Enrollment/Access
Location:	New York State

Brief Description of Services:

New York State funds more than 40 community based organizations, social service agencies others to assist New Yorkers with Child Health Plus, Family Health Plus and Medicaid enrollment and renewal. Through this program community enrollment counselors are available to determine program eligibility, help fill out the application, can help ensure applicants understand how managed care works, choose a health plan and even select a doctor. Facilitated enrollers offer culturally and linguistically appropriate enrollment in community settings like schools, day care centers and social service agencies during weekdays, evenings and on weekends. Also helps with self- employed applicants, such as food vendors, tuckers.

Just released an RFP in September 2011 to open an "Enrollment Center" where individuals can renewal Medicaid, FHP, over phone or web based – to decrease "churning"

Population Target:

Immigrant population, Underserved families, mostly targeting children

Funding sources

State budget – a little over $15 million allocated.

Governance/how is it operated:

New York State Department of Health; Office of Health Insurance Programs, Division of Coverage and enrollment

If this were implemented in Fairfax…..

Similar to Fairfax County's HAT team. This particular structure allows community based organizations along with government entities to assist in application and renewal. There is a large education focus in the model, and a "we will come to you" approach.

Program Name: Palm Beach County Florida Health Care District

Model: Governance/safety net model

Location: Palm Beach, FL

Population Target:
Community wide services- 300,000 Palm Beach County residents served each year

- 40,000 low income residents
- Health coverage programs for persons not qualifying for Medicaid
- Target : persons up to 150 percent of the poverty level (annual income of about $16,245 for an individual; $33,075 for a family of four)

Funding Sources:

Local tax district; the district has a $246 million budget and 1,000 employees, $100 million of total annual budget spent on health coverage to about 40,000 low-income residents

Governance/how is it operated:

Palm Beach County's voter-approved health insurance safety net established in 1988 - created the Palm Beach County Health Care District.

The district runs health clinics, the Trauma Hawk rescue helicopter, school nurse programs, a hospital in Belle Glade and a nursing home in West Palm Beach. One of its key duties is providing no-cost or low-cost health coverage to low-income residents. Palm Beach reviewing impact of federal health reform law – how to leverage funds to cover more residents and retain safety net of services Palm Beach County relies on remains in place.

"In addition to enabling more people to get health coverage, the federal program should help more Palm Beach County residents keep their coverage, Aaronson said. In coming years, the new national plan would prohibit private insurance companies from using pre-existing medical conditions to deny coverage.
The federal plan also creates safeguards to stop insurance companies from dropping customers who start racking up medical bills. Those protections, along with the new federal funding, could free up district to focus on its other duties, such as the school nurse program, Aaronson said. http://www.palmbeachpost.com/news/u-s-health-care-overhaul-could-alter-palm-464977.html

Program Name: Healthy San Francisco

Model: Safety Net/Governance

Location: San Francisco, California

Brief Description of Services:

Health San Francisco is designed to improve the traditional safety net by linking patients to primary care homes, providing transparent pricing, having a defined benefit package and offering an expanded network of care providers – does not consider themselves an insurance program, but rather a "program through which a specified group of providers within a local network deliver a specified package of services.

Population Target:

All uninsured adults 18-64; regardless of immigration status, pre-existing conditions or employment. Children are not eligible as the county operates a spate insurance program fro children who are not eligibile for state or federally funded health insurance.

Funding Sources:

Total cost of the program was $126 million (2008-09)

- $90 million County funded
- $19 million funded through California's Section 1115 Medicaid waiver agreement
- $3 million from participant enrollment fees
- $14 million from employers (through the implementation of an employers spending requirement program*)

During the 2008-09 period, there were 421,058 enrollee's, resulting in $298 per member per month cost. Only 5% of total costs goes towards Administrative expense

San Francisco employers with more than twenty employees must spend a specified among on health benefits for their employees who work at least eight hours per week; those with 20-99 employees were required to spend $1.31 per work hour per employee. (100 or more - $1.96 per work hour per employee) Employers may append the money to provide health insurance, create health savings accounts, pay health care claims ore contribute towards employee participation in Health San Francisco. Also included a provision that created a "floor" of health care spending that made it impossible for businesses to drop employment based insurance with the expectation their employees would be covered by Health San Francisco. (ACA will assess a fee for employers with 30 or more employees)

Program Name: Medical Home Portal

Model: Information Technology

Location: Utah Nine states funded so far: (Arkansas, Utah, Iowa, Kansas, Missouri, Nebraska, North Dakota, Oklahoma, South Dakota)
http://www.medicalhomeportal.org/diagnoses-and-conditions/diagnosis-prevalence-list

Brief Description of Services:

Information portal for: Services & Resources- locating community and professional services; Information, support, education materials for patients and families**;** Tools for clinical practice**;** Newsletters and conference calls; Registries and studies

Interesting program goals:

Most chronic conditions are uncommon or rare - for many diagnoses, primary care physicians are likely to have only one, or a few, patients; The cumulative prevalence of chronic conditions however is substantial - 13.9% of children meet criteria for classification as children with special health care needs (CSHCN) (see the diagnosis prevalence list); Maintaining current knowledge of medical information and community resources for each of these conditions is impossible; Families of CSHCN are motivated and may have more time than physicians to devote to learning about their child's condition and to finding resources; Families will soon learn to understand relatively technical language and will be better able to understand and communicate with professionals when they do; Numerous other professionals (therapists, dentists, care coordinators, educators, pediatric and adult subspecialists, etc.) could also benefit from information about various aspects of caring for CSHCN; Physicians and Families working together as partners in the Medical Home model will be best able to improve outcomes for CSHCN.

Population Target:

Physicians and parents care for children and youth with special health care needs (CYSHCN).

Funding Sources:

(Utah only) The University of Utah - Health Sciences Center, Centers for Medicare & Medicaid Services, Utah Department of Health, U.S. Maternal & Child Health Bureau , Utah Chapter, American Academy of Pediatrics, National Library of Medicine, Spencer S. Eccles Health Sciences Library , State 211 network, Family Voices

Program Name: Various

Model: Patient centered medical homes

Location: Various

Brief Description of Services:

A patient centered medical home is provision of comprehensive **primary care** using partnerships of individual patients, health care providers and patient's family - with goals to improve access to health care and overall maintenance of good health.

Accessible, continuous, comprehensive and coordinated and delivered in the context of family and community

For Fairfax County, would need to consider if this covers all aspects of health care…behavioral, dental, primary care….incorporating the full continuum of services strategies, from preventive care to end of life care

COMPONENTS of patient centered medical homes:

- **Access to care** -Patients can easily make appointments and select the day and time. Waiting times are short. E-mail and telephone consultations are offered. Off-hours service is available.

- **Patient engagement**- Patients have the option of being informed and engaged partners in their care. Practices provide information on treatment plans, preventive and follow-up care reminders, access to medical records, assistance with self-care, and counseling.

- **Clinical information**- systems support high-quality care, practice-based learning, and quality improvement. Practices maintain patient registries; monitor adherence to treatment; have easy access to lab and test results; and receive reminders, decision support, and information on recommended treatments.

- **Care coordination**- Specialist care is coordinated, and systems are in place to prevent errors that occur when multiple physicians are involved. Post-hospital follow-up and support is provided.

- **Integrated and comprehensive team care -** incorporating free flow of communication among physicians, nurses, and other health professionals. Duplication of tests and procedures is avoided.

Program Name: Community Care Organization

Model: A version of an Accountable Care Organization

Location: Washington State

Brief Description of Services:

This provides a "Healthcare Neighborhood" with coordination of services from the Community Services Board, the Health Department, Social Services, hospitals, Schools, housing providers. The purpose of the community care organization is to prevent admissions to nursing homes, hospitals, jails, and youth residential treatment facilities. Services include community health teams to "provide prevention, early intervention and care management services."

Population Target:

The "safety net population", persons who are low income who does not have access to health care.

Funding sources

Payers of safety net services – health plans, local government, foundations, the state

Governance/how is it operated:

It is designed by community residents and community partners and is made up of existing community service agencies.

If this were implemented in Fairfax…..

The governance, the extent of services, and the partnership expectations would need to be determined.

Program Name:	Columbia Basin Health Association – Community Health Center
Model:	Structure of EHR and practice management software
Location:	Washington State

Brief Description of Services:

CBHA has used EHR to enable improved continuity and coordination. In particular, CBHA has used practice management software to improve the quality and efficiency of patient care.

A "Leadership Team" began work in 1999 to establish a vision that consisted of 10 key elements, including improving proficiency, continuity of culture, education, tracking measuring, grant applications and pay for performance. The leadership team included CBHA medical staff to make the final decision on what software to purchase.

Used "practice management software" for measuring and managing processes. Wait time has decreased in waiting rooms. Patients have access to Web MD while they wait.

Able to produce Balance Scorecards with bonuses awarded to staff, nurses, providers, etc for top performance in specific areas such as percentage of co-pays colleges, number of patients enrolled in managed care, patient wait times.

Use of Practice Management Software allows dental appointments to be made 1 week in advance - they are able to fill 100% of the available slots and reduce the potential "no show" – averaging less than 7%. Staff no longer have to compete with other departments to share or view patients chart, improving moral and staff spending less time tracking down charts.

Population Target:

CBHA in particular serves a rural, lower income area in Washington State. – targeted at dental, prescription and variety of medical services. This one in particular serves 25,000 patients.

Funding sources

Financial impact is discussed in terms of ROI. For example their Pharmacy Management System was estimated at a 38% return on investment in their first year. The system paid itself back in 2004 –just three years later.

Barriers:

Expensive upfront costs.

Program Name: Wisconsin's Family Care Program

Models: Aging and Disability Resource Center and Managed Care

Location: State of Wisconsin

Brief Description of Services:

There are two organizational components:

1. Aging and Disability Resource Center (federal model, which is designed to be a single entry point where older adults and adults with disabilities and their families can receive information and advice about a wide range of resources available to them in their local communities. The Aging and Disability Resource Centers conduct the initial eligibility determinations for services.
2. Managed care organizations (MCOs), which manage and deliver the Family Care benefit, which combines funding and services from a variety of programs into one long-term care benefit, "tailored to each individual's needs, circumstances, and preferences".

For the MCOs in FY 2010, 55.7% of expenditures were for health and supportive services, such as assistance with daily activities, care management, and specialized transportation. 44.3% of expenditures were for residential services. For FY 2010, average monthly service costs ranged from $1,800 to $2,800 per participant with physical disabilities, and from $2,900 to $4,600 per participant for individuals with developmental disabilities.

Population Target:

Income eligible older adults and adults with developmental and physical disabilities in 53 Wisconsin counties. 60% of program participants reside in their own homes. Most others receive residential services in small, community-based facilities or adult family homes.

Funding Sources:

Medicaid, state of Wisconsin

Governance/how is it operated:

The Wisconsin Department of Health Services is responsible for oversight. Services are delivered under the direction of nine public or nonprofit managed care organizations. The managed care organizations contract with providers for the program services.

Program Name: Camden Coalition of Healthcare Providers

Model: Citywide Care Management System

Location: Camden, NJ

Population Target:

From the Coalition's website www.camdenhealth.org - In 2007, the Coalition began implementation of a citywide Care Management Project to intervene and direct appropriate outreach attention to Camden's most frequent utilizers of the city's EDs and hospitals. These patients lack consistent primary care, often suffer from chronic illness, mental illness, substance abuse, and as a result are the most frequent visitors to city emergency departments. Typically, these over-utilizers or 'super-utilizer" have complex medical conditions compounded by an array of social issues and problems.

Using an outreach team consisting of a social worker, a health outreach worker/medical assistant, and a nurse practitioner, the Care Management Project helps enrolled clients stabilize their social environment and health condition, with a goal of finding a long-term medical home. The team helps patients apply for government assistance benefits, secure temporary shelter, enroll in medical day programs, help coordinate primary and specialty care. Out of necessity, the staff is providing "transitional" primary care with a goal of moving the patients into a primary care setting that can meet their needs. With over 115 patients enrolled in the project, the staff is visiting patients in homeless shelters, abandoned homes, hospital rooms, ED gurneys, and street corners.

The advantage of the project's citywide scope is the ability to encourage collaboration between the hospitals, to share data, to identify common challenges, and to address the challenges with coordinated solutions. Monthly, the team coordinates a citywide Care Management meeting that allows providers and social workers from all of Camden's health institutions to present patient cases and discuss the systemic issues and barriers to care that each case addresses. Information and resource sharing are encouraged as providers and social workers develop collaborative strategies to make Camden's health systems more efficient and accessible for city residents. Participants have formed a coordinated network of social services, discharge planning, and health care delivery.

Program Name: Transitional Care Management

Model: Care Coordination

Location: Fairfax County

Brief Description of Services:

The purpose of this small pilot is to improve hospital discharge outcomes for patients with Obstructive Pulmonary Disease, Acute Myocardial Infarction, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease/Pneumonia, and Diabetes. It is a cooperation service model between Inova Health System, Fairfax County Department of Family Services, and George Mason University. Care transition services are initiated in the hospital soon after admission. There is an emphasis on medication review and education; support in helping the patient to develop a personal health record; education about warning signs; coaching about follow up with the personal physician; coaching and education of caregivers. Transition coaches make referrals to community services including the Department of Family Services.

There are different hospital to home care coordination models, and the Inova model combines aspects of those:

Care Transitions Intervention – A hospital transition coach helps patients and families learn self-management skills. The transition coach provides follow-up phone calls to review the patient's progress and to support the self-management skills.

The Transitional Care Model —A transitional care nurse visits the patient in the hospital to conduct an assessment, to plan with hospital staff, and to develop a plan of care for discharge. The transitional nurse conducts a home visit within 24 hours of discharge to recommend modifications to the home and to refer to community services. The transitional nurse accompanies the patient to the first physician visit and coordinates care with the physician, the patient, and the caregivers. The transitional nurse conducts weekly home visits for the first month.

Better Outcomes for Older Adults Through Safe Transitions – A standardized geriatric evaluation for development of a care plan is used. There is a standardized discharge process with a check list and educational material for all patients.

The Bridge Program – This model focuses on older adults. The hospital has an "Aging Resource Center" that offers information about community resources and health education materials. "Bridge Care Coordinators" meet with patients and families in the hospital and call patients two days and thirty days after discharge to assist with identified needs.

Program Name: Chronic Disease Self-Management Project and Independent Living Project

Model: Community Education and Prevention Programs

Location: Fairfax County, Virginia

Brief Description of Services:

ElderLink (partnership between Inova and Family Services) and the Fairfax County Health Department are partnering to provide the Stanford University Chronic Disease Self-Management Program. Free workshops are held each week for six consecutive weeks. Participants learn strategies and develop personal goals. Community volunteers are trained to lead the classes.

ElderLink, Family Services, and the Health Department, Fire and Rescue, Neighborhood and Community Services, Housing and Community Development, Libraries, Inova, businesses, community organizations, and faith communities have partnered to provide educational workshops to address risks to independent living (fall prevention, nutrition, and medication management), exercise classes, and to offer in-home safety assessments.

Population Target:

The Chronic Disease Self-Management Project targets older adults with diabetes, arthritis, hypertension, and lung disease.

The Independent Living Project targets older adults who can participate in community classes.

Funding Sources:

State grant, Fairfax County, and community partners.

Governance/how is it operated:

The Health Department, Family Services, ElderLink, and community partners.

If this were implemented in Fairfax…..

There is a need for: funding to sustain the projects, more community partnerships, and decisions about how these projects fit within to be developed health services projects.

Program Name: PACE (Program of All-inclusive Care for the Elderly)

Model: PACE is a community-based alternative to nursing home care for frail elders who qualify for both Medicare and Medicaid.

Location: Braddock Glen (4027-B Olley Lane in Fairfax) location for the Fairfax area.

Brief Description of Services:

PACE covers all services needed by participants including primary health care, hospitalizations, medications, home care, transportation, physical therapy, occupational therapy and nursing home care when needed. The only expense not included is housing. Most services are provided in an adult day health care setting, which is the core of the program to promote wellness.

Population Target:

Adults age 55 and over that qualify for Medicaid nursing home level of care.

Funding Sources:

Medicare and Medicaid pay the provider a capitated rate to cover all services a participant needs. For NoVa, the rate is about $5,000 per participant per month.

Governance/how is it operated:

The only eligible provider is a private, non-profit, which for NoVa will be Inova Health System. Inova assumes full financial risk for the services. The county has partnered with Inova by providing the space at Braddock Glen for $1 per year for 3 years. The program is authorized by Medicare (CMS) and approved by the state Department of Medical Assistance Services (DMAS).

If this were implemented in Fairfax…..

The continuum of services for frail elders will be significantly enhanced with a new, community-based alternative to nursing home placement.

Barriers to address?

Program expansion – Braddock Glen is limited to 50 participants in attendance per day. The program will have to expand in another location or locations. The county is exploring a partnership to provide adult day health care services at other locations for PACE participants as a means of providing service to those who live outside the transportable area of Braddock Glen.

Program Name: Aging/Living in Community

Model: Community based models such as neighborhood network, time Banking, or Village models, (Beacon Hill Village, Capitol Hill Village or Mount Vernon at Home), that enable community members to remain in the community for as long as possible, without moving to a nursing or assisted living facility.

Location: Any neighborhood or community, such as Reston, McLean, Lake Barcroft, etc.

Brief Description of Services:

The community decides how formal the alliance will be and what services will be provided. The range of services goes from informational programming of interest to the members, to volunteer transportation, volunteer chore or/or shopping services, to a concierge service for any in-home service to be provided by pre-vetted vendors at preferred rates for members.

Population Target:

Generally older adults, although individual communities have chosen intergenerational models when they feel it is appropriate.

Funding Sources:

Funding comes from member dues or fees and private fundraising.

Governance/how is it operated:

The community chooses the governing structure. Some are loose-knit neighborhood alliances, others are community associations or faith-based alliances, and the concierge (Village) model is a private, non-profit formed for this purpose.

If this were implemented in Fairfax… Individual communities such as Mount Vernon and Reston are already doing this to some extent; Mount Vernon at Home is the most advanced organization.

Barriers to address? The major barrier is funding. Organizations formed under these models usually require fund-raising beyond the simple dues or fees from members. Also, less affluent community members could be excluded unless the organizations agree to waive fees for low income members.

Program Name:	Minnesota Community Measurement
Model:	Minnesota Health Scores
Location:	Minnesota

Brief Description of Services:

MN Community Measurement is a nonprofit organization dedicated to improving the quality of health care in Minnesota by publicly reporting quality results.

Health Scores offers ratings that show how successful Minnesota physicians and other health care providers (clinics, medical groups and hospitals) are in providing high quality health care and can be held accountable.

Drives changes towards more safe, effective, patient centered, timely, efficient, and equitable care; be a resource used by providers to improve care and patients to make better decisions; catalyze our community to work together on health measurement and reduce administrative costs and maximize value

Includes an annual "Disparities Report" – based on 8 measures and compares results by race.

MN Community Measurement is a collaborative effort in our community among those who believe that you cannot improve what you don't measure. These stakeholders support the notion that greater transparency in our health care system will lead to better health outcomes for the people of Minnesota. MN Community Measurement's mission to accelerate the improvement of health by publicly reporting health care information is having a positive effect:

Population Target:

Community Partners, individuals, the hospitals themselves. Anyone who is receiving health care services.

Funding Sources:

For the first 3 years of the Minnesota Community Measurement coalition, health plans and the Minnesota Medical Association sponsored the bulk of the costs. In 2007, the coalition's funding included a mix of sponsor funding from the founding organizations, private grants, fee-for-service contracts, and federal contracts. The Minnesota Community Measurement board is developing a new long-term financing strategy.

Program Name: Missouri's Primary/Behavioral HealthCare Integration Initiative

Model: Integrated Care

Location: Missouri within FQHC (public sector primary care) and CMHC (community mental health)

Brief Description of Services:

Pilot program to integrate primary and behavioral health care systems with a bidirectional approach to assigning resources. The integration of behavioral health professionals into primary care settings and the integration of primary care directly into community mental health settings.

Population Target :

Users of the Missouri public health safety net.

Funding Sources:

State Department of Mental Health provided start-up funds of nearly $5 Million dollars shared among 7 FQHC-CHCN pairs as $100K for 1st 6 months and $200K per year for next 3 years ($700K total each). One time planning grants of $30K were provided to six other developing partnerships. Missouri Foundation for Health (a non-government funder of government and non-profit health initiatives with $900M in assets) funds the oversight team.

Governance/how is it operated:

Half-time State level "Technical Assistance Team" provides centralized training and on-site consultation. Technical assistance team also suggests changes in state policies and procedures to ensure sustainability of the initiative. Team consists of a Senior administrator in Missouri public mental health system, a clinical program manager from FQHC professional association, and a clinical psychologist with experience providing behavioral health in primary care setting.

If this were implemented in Fairfax…..

The lessons learned from this integration initiative should be considered to promote success of any integration of primary and behavioral health services.

Program Name: New York Medical Home models

Model: Medical homes (adults)

Location: New York State

Brief Description of Services:

Initiative to expand patient-centered medical homes to better control of home health care services and care management for individuals with complex and continuing health care needs.

Implementing new models of integrated care through ACO financing structures.

Pilots include:
Group Health and Health Plan of New York –"Medical Home High Value Network"
Adult primary care practices conversion to "Medical Home Practices". Patients will have electronic access to their providers via e-mail and appointment calendars. Participating physician practices will be separated into a support group of 25 primary care practices and a comparison, or control group, of 25 practices. Model testing revised payment methods, support for office redesign and care management.

The success of the Medical Home model will be measured through claims and performance quality measures for procedures and information including: Mammograms; Diabetes tests and cervical cancer screenings; Outcomes for diabetes and hypertension; and efficiency data and patient satisfaction scores.

The Ethel Donahue Center for Translating Research Into Practice at the University of California will assess the pilot, and results will be published at the end of the two-year project (Health Data Management, 1/10).

Funding Sources:

State Medicaid plan. Overall spending capped; future growth in Medicaid limited to the 10-year rolling average of the Medical CPI, currently 4 percent.

Governance/how is it operated:
Governor Cuomo established a Medicaid Redesign Team (MRT). Tasked with identifying ways to provide critical health care services at lower costs and control unsustainable growth. Participants included health care providers, labor, government and Medicaid stakeholders.

MRT recommended a series of proposals to fundamentally restructure and reform New York Medicaid program. Commissioner of Health delegated cost containment responsibilities.

APPENDIX VI: VIRGINIA CODE SECTION COMPARISON

Comparison of a Local Healthcare Authority and a Healthcare Commission under Virginia Laws is summarized as follows: The Authority focuses on working with community partners to organize and encourage care for those who need it in the community, and the Commission's authority appears to provide for building, operating, enlarging, up keeping, a hospital or health center type of entity. The Commission may have more 'powers' when it comes to financing/funding abilities such as bonds and loans; additionally the Commission may have property exemption from foreclosure or execution sale and judgment lien, and has eminent domain authorities. The Commission also has authority to develop stock and non-stock companies. An advantage of the Authority is that it has a liability clause proving some exemption of volunteer providers from civil claims for non-invasive and limited invasive procedures. The Southwest Virginia Health Authority (§15.2-5368) appears to be a hybrid between the two sections of the law described in the table that follows. The Virginia Code is available online at: http://leg1.state.va.us/000/src.htm

Title	**Authority- Local health partnership authority**	**Commission**
Virginia Code Section	§32.1-22.10:001 though §32.1-122.10:005	§15.2-5200 Though §15.2-5219
Code Goals	Allow communities to coordinate, across jurisdictions and with private providers of health care services to encourage the use of services delivery that might otherwise might have required government funding or programs, or allow for innovative funding mechanisms to leverage public funds, and other activities which bring together public and private resources to meet the health care needs of the community.	The governing bodies of one or more political subdivision may declare the need for a hospital or health center and may adopt by resolution for the creation of a commission if they find that the public health and welfare, including the health and welfare of persons of low income in such subdivisions and surrounding areas require the acquisition, construction, financing, or operation of a hospital or health center.
Formation requirements	The governing body of a locality may create an Authority by ordinance or resolution, or when two or more localities are members, by concurrent	Local governing body resolution, if multiple localities are involved, each locality must pass the resolution. A copy of the resolution, certified by the clerk of

Title	**Authority- Local health partnership authority**	**Commission**
Virginia Code Section	§32.1-22.10:001 though §32.1-122.10:005	§15.2-5200 Though §15.2-5219
	ordinances or resolutions, or by agreement. A public hearing must be held at least 30 days after advertisement of the hearing.	the locality by which it is adopted, shall be admissible in evidence in any suit, action, or proceeding.
Bonds	May not issue bonds or other forms of indebtedness	Bond issuing allowed only for acquiring, constructing, furnishing, etc. buildings for use as a hospital or health center- bonds issued by the authority shall be payable only from revenues and receipts from the hospital or health center. The bonds may and other obligations of the commission shall not be a debt of any locality or the Commonwealth, or the personal debt of a Commissioner. Political subdivisions may issue general bonds in the manner under the public finance act §15.2-2600 in furtherance of establishment, construction, or enlargement of a hospital or health center.
Other regulation/compliance	Must comply with COPN laws and regulations	Comply with US and Commonwealth laws, rules, and regulations
Reporting requirements	Annual report on programmatic initiatives to Joint Commission on Health Care (JCHC). Annual fiscal year including complete operating and financial statement covering the year to JCHC and to each member locality.	The Commission shall keep and preserve complete records of its operations and transactions, and records shall be open to inspection by participating subdivisions at all times. Annual reports are required.
Board of Directors/ Commissioners	Membership determined by participating locality(ies) – must include at least one of each; local elected official, health care industry representative, business community representative, non-	Number of commissioners is based on number of participating localities 1 locality = 5 members 2 or 3 localities = 6 members 4 localities = 8 members

Title	**Authority- Local health partnership authority**	**Commission**
Virginia Code Section	§32.1-22.10:001 though §32.1-122.10:005	§15.2-5200 Though §15.2-5219
	governmental human services agency; also sufficient citizen members to constitute the majority of board who may not be employed or financially linked to any patterning organizations.	More than 4 localities= 1 member for each locality Quorum= a majority of the members in office shall constitute a quorum
Board member terms	Board member terms are four years and a person may serve no more than two-consecutive full terms.	
Compensation of board members	Reimbursement of actual expenses incurred in performance of duties from available funds- specific policies determined by board	Up to $50 for attendance at each commission meeting, not to exceed $1,200 per year, and shall be paid their actual expenses incurred in the performance of their duties
Staff	Professional staff may be hired and paid from funds received by the authority	Technical experts and such other officers, agents, and employees as may be required, set the hiring requirements, compensation, and remove such employees at pleasure
Office	Physical office must be established in one of the participating localities, all property must be titled to the authority for the benefit off all its members	Locate office(s), and transact business directly or thought domestic or foreign stock or non-stock corporations, LLC Partnerships, associations, foundations, or other supporting organizations, joint ventures or other entities.
***Powers of Authority*- body corporate, separate and legal entity**	1) Authority is vested with powers of body corporate including: power to sue and be sued in its own name, adopt a seal, make contracts and other instruments to carry out duties, make amend and repeal bylaws, rules and regulations, not inconsistent with law, to carry into effect the powers and purposes of the authority.	Commission is vested with powers of body corporate including: power to sue and be sued in its own name, adopt a seal, make contracts and other instruments to carry out duties.

Title	**Authority- Local health partnership authority**	**Commission**
Virginia Code Section	§32.1-22.10:001 though §32.1-122.10:005	§15.2-5200 Though §15.2-5219
Powers of Authority (continued)-	2) To foster and stimulate the cooperative assessment and provision of healthcare in the community by local governments, private entities, and volunteers.	Power to acquire by lease, purchase, gift, or otherwise, land, buildings or structures, within the territorial limits of the political subdivisions involved to establish, construct, enlarge, or maintain and operating one or more hospitals or health centers, and any other facilities and services for the care and treatment of sick persons. The commission may also sell, lease, or transfer any real property when the transactions will further the purposes of the commissions charter.
Powers of Authority (continued)-	3) To cooperate with local and state health care planning entities, and local, state, and federal governments in the discharge of duties	Make and enforce rules and regulations for the management and conduct of its business and affairs, and for the operation of facilities. Make rules and regulations for governing admission, care and treatment of patients in such hospital or health center, classify patients as to charges to be paid by them (if any), determine the nature and extent of services rendered to patients. Contract for the management and operation of any hospital or health center subject to the control of the commission.
Powers of Authority (continued)- **Grants and gifts**	4) Solicit and accept grants or donations from local, state, federal governments, private entities, or any other source public or private for or to aid in any project of the authority to provide health services as defined in subsection A of § 21.1-122.10:001	Accept gifts and grants, including real or personal property, from the commonwealth or any political subdivision, and from the US Government, and accept donations of money, personal or real estate property, and take title from any person.
Powers of Authority (continued)-		Assist in the creation of domestic or foreign stock or non-stock

Title	**Authority- Local health partnership authority**	**Commission**
Virginia Code Section	§32.1-22.10:001 though §32.1-122.10:005	§15.2-5200 Though §15.2-5219
Creation of corporations and other entities		corporations, limited liability companies, partnerships, associations, foundations, or other supporting organizations and to purchase and hold stock and dispose of stocks other organizations. Assist entities owned all or in part by the facilities owned by commission with loans, employee time, and other appropriate assistance to carry out the duties of the commission under the chapter.
Powers of Authority (continued)		Participate in joint ventures, with individuals or organizations for providing medical and related services.
Licensed agents; liability	No volunteer or participating entity who is duly licensed to provide health care services shall be liable for any civil damages for any act or omission resulting from rendering such services are provided free of charge and are within the volunteers authority to practice. This provision is limited to noninvasive and minimally invasive procedures limited to finger sticks and injections performed as part of health care services.	The commission may procure insurance, participate in insurance plans, or provide self-insurance or any combination thereof. Participation in insurance shall not be deemed a waiver or relinquishment of any sovereign immunity to which the hospital, or health center commission or its members, officers, directors, employees, or agents are otherwise entitled.