



San Luis Obispo County Public Health Department

MEETING MINUTES

Low Income Health Program (LIHP) Planning Project Stakeholder Work Group Tuesday, October 25, 2011, 3:00 p.m. – 4:30 p.m.

The meeting convened at 3:10 p.m.

Attendance

Stakeholder representatives in attendance: Tracy Buckingham, SLO County Dept. of Social Services; Jean Raymond, County Health Commission; Theresa Merkle and Marina Gordon, CenCal Health; Lorincio Bacus, Kena Burke, John Khan and Bob Lotwala, Community Health Centers of the Central Coast (CHC); Cathy Lewis, AIDS Support Network/SLO Hep C Project; Abby Lassen, CRLA volunteer; Sue Andersen, Catholic Healthcare West; Carsten Zieger, ED Physician; Biz Steinberg, CAPSLO; and Betsy Umhofer, Office of Congresswoman Lois Capps.

Others in attendance: SLO County Health Agency: Jeff Hamm, Diane Jay, Gloria Gonzales, Kathleen Karle, Penny Borenstein, and Jennifer Shay; and Joel Diring, Diring & Associates.

Handouts provided: SLO County LIHP Planning Project PowerPoint presentation.

Welcome and Introductions

Joel Diring, of Diring & Associates, welcomed the stakeholder representatives and began introductions followed by a review of the meeting Agenda.

State LIHP Update

Mr. Diring began the statewide update by presenting a map of the counties color-coded by their common LIHP categories. The County Medical Services Program (CMSP) consortium of 34 small counties are designated in red, the 10 legacy counties, which the original Health Care Coverage Initiative pilot program counties are commonly referred to, are in green, and the remaining 14 counties are white. While 58 counties are represented on the map, there are just 27 LIHP programs. The CMSP consortium will operate under a single LIHP program and two non-county entities have submitted LIHP applications as well: the City of Pasadena and the California Rural Indian Health Bureau (CRIHB).

Mr. Diring explained that the legacy counties were able to implement their LIHP programs in September with a July retroactive effective date because of their existing Coverage Initiative programs and because the state prioritized their LIHP implementation. The new LIHP counties/programs are in various stages of planning and implementation. Riverside,

Sacramento, San Bernardino, and Santa Cruz counties have made great progress and are nearing implementation. While the CMSP program is making good progress, Santa Barbara, Stanislaus, Tulare, and Yolo Counties have paused development of their programs, and Fresno County has withdrawn its LIHP application at this time.

Mr. Diringler concluded the state update by noting that some big questions are being asked by counties regarding what will happen in 2014 when the LIHP programs end and the Affordable Care Act begins. Since there will most likely be documented and undocumented people not enrolled in private or public insurance, or in the exchange, will counties need to continue some kind of medical services plan for the residual uninsured? Will counties still be responsible for these people under the existing Welfare and Institutions Code 17000 or will that go away? What about state funding for indigent care? Will the state take back realignment funds, and if so, how **much and based on what? These are critical questions for all counties' fiscal planning, and** the good news/bad news is that officials at California Health and Human Services are just now thinking about these questions.

Jeff Hamm, Health Agency Director, added that most counties assume nothing will happen to the W&I 17000 requirement and that few if any documented people will remain uninsured in 2014.

SLO County LIHP Update

Dr. Penny Borenstein, County Health Officer, began the LIHP update by stating that there is no slam-dunk answer here and that the state and federal rules keep changing. Recently, though, we have nailed down some major issues and made good progress. Estimating and managing enrollment numbers begins with determining eligibility criteria, such as setting income limits within a percentage of the federal poverty level (FPL) and capping the number of enrollees. Our percentage of FPL originally began at 200%, until we realized how expensive that would be. Then we reduced it to 133%, then down to 50%, and now we are considering reducing to 0% to only include those with no income. At any given point in our CMSP program, we have roughly 1,000 clients enrolled with zero income. If our LIHP set income limits at 50% of FPL with an enrollment cap of 1,600 clients we could fill up immediately and potentially leave out the poorest of the poor. Approval to reduce our FPL must come from the feds, CMS, and could take 120 days, which is too slow to respond effectively. The state, however, recently announced a fast-track approval of 15 days for requests to increase FPL. Therefore, if our FPL is set at or near 0% and we find we still have enrollment slots available, we may easily increase FPL to broaden eligibility and increase enrollment.

Dr. Borenstein continued by telling the group that we have met with provider groups to propose the general concept of an alternative payment model, which was discussed in detail at previous stakeholder meetings. We are asking providers to share the financial risk with the county. The most likely scenario, based on historical utilization estimates, is that all providers would benefit from implementing the LIHP.

Financial assumptions, continued Dr. Borenstein, include the additional costs for medical and pharmaceutical services previously funded by the Ryan White and AIDS Drug Assistance

Program (ADAP) for HIV/AIDS clients enrolled in LIHP. Well into the LIHP planning process, HRSA ruled that Ryan White funding must be the payer of last resort and that this must now be a county expense under LIHP. This means millions of dollars of additional cost for some counties and has forced many to further limit enrollment and remove optional benefits. The **majority of the expense is from pharmacy and based on data provided by the state's Office of AIDS and ADAP**, the estimated additional cost for our county, fortunately, is not a deal breaker. Other financial considerations include updating expenditure projections based on finalization of the County-CHC contract, the absence of a definitive answer from the state on our proposed alternative payment model, the impact to County cash flow from historically slow payments from the state, and our pending grant request to Blue Shield Coverage Foundation to fund the implementation of our LIHP program.

Dr. Borenstein noted that progress has been made in our authorization process with the state Department of Health Care Services (DHCS). We have submitted to DHCS 14 of the 25 deliverables with much assistance from Marina Gordon and others at CenCal Health. Lots of work remains with the development of additional policy and procedures and other operational items. The latest DHCS draft boilerplate contract is currently being reviewed by County Counsel. DHCS recently released a draft policy and procedures letter regarding local and state inmates and LIHP. LIHP benefits for inmates are limited to hospital inpatient services. Inmates are **enrolled into the LIHP of the inmate's county of last residence. There will be no LIHP expense** to counties for medical services provided to state inmates enrolled in LIHP. The state will use local LIHPs as a claims pass-through entity only. The upcoming prison realignment should have minimal effects on our LIHP program. Parolee applications for LIHP will be processed the same as non-incarcerated residents.

Dr. Borenstein stated that our previous estimated date for implementation of January 2012 is now more like the end of March or early April. We will present a report on the LIHP project at the Board of Supervisors public meeting on November 15, and we should have a firm decision about our LIHP participation around that time or soon after. We plan to have completed and **submitted all outstanding deliverables to DHCS by December 15. Based on DHCS's timetable**, we should then be ready to enter into a contract with DHCS at the end of March.

Dr. Borenstein concluded her presentation by summarizing some of the reasons why we are considering a LIHP program. Most importantly, we could provide improved, comprehensive care for some of our most vulnerable residents. Furthermore, LIHP could add \$4 million dollars into our local economy from the federal funds match, not including the multiplier effect of an additional \$2.38 for each new dollar. LIHP could also result in better utilization of ED and hospital resources by instructing the newly insured how to use the program and through medical home management. Finally, the overall federal and state reason for LIHP is to create a bridge to reform by preparing for Medi-Cal expansion and other components of health reform in 2014. Efforts to date with DSS, CenCal, and others are advancing that objective, regardless of ultimate participation in LIHP.

General Discussion

Mr. Diring opened up the meeting for questions and general discussion. Dr. Borenstein was asked if we should set the income limit higher than 0% FPL so we may include those very poor who receive County General Assistance income of \$200-\$300 dollars a month. Dr. Borenstein appreciated the insight and agreed that we should consider an FPL above 0% for that reason.

Someone asked what are the decision points for moving ahead or not with LIHP? Dr. Borenstein responded that we need a definitive answer from the state on our proposed alternative payment model and we also need to further refine our cost estimates and determine a worst case scenario. Mr. Hamm added that since the County and CHC are partners in indigent care, and LIHP requires higher payments to FQHCs such as CHC, perhaps we could work together and create some negotiating room for primary care expenses within the grant amount.

Someone asked why Santa Barbara County paused development of their LIHP. Dr. Borenstein responded that their financial issues include significant costs for Ryan White/ADAP services and the greater complexity of assessing costs for mental health services which resides in a separate county department.

Mr. Hamm asked Jennifer Shay, based on her interactions with other county representatives at the recent statewide LIHP conference, how likely is it that DHCS will be able to review all new LIHP deliverables and other tasks by the time counties are ready for implementation. Ms. Shay replied that while it is true that the state has not provided timely follow up to several important issues, they did manage to pull off implementation of the 10 legacy counties by their September target date. Ms. Shay added that unlike the legacy counties, which were all launched in September, the new LIHP counties will launch at different times. Mr. Hamm noted that the later it takes the state to approve programs, the shorter the life of these programs. We have to consider the term of the program and ask ourselves if it is worth all this work for a year and a half or less.

Mr. Diring thanked everyone for attending and mentioned to the group, that although we do not know today if we should hold a meeting next month, please consider keeping this time open for November 22. The meeting was adjourned at 4:30 p.m.