



Highlights
from the
BSCF County Coverage
Expansion Planning Workshop
March 11, 2011

The View from Washington, DC

*Andy Schneider, Consultant and Former Chief Health Counsel
House of Reps Committee on Energy and Commerce*

- This kind of federal funding (\$8B – only in CA) will not happen again for a very long time – will not be repealed.
- Differences of LIHP (vs. 2014 Medicaid):
 - Allowance of wait list
 - Variability in eligibility across counties
 - Narrower scope of benefits, esp. for behavioral health
 - Closed systems will have to function as a Medicaid MCO
- Federal statute allows clinics to agree to alternative payment model—not PPS rate.

County Coverage Initiatives 1.0: Lessons from HCCIs
UCLA Center for Health Policy Research

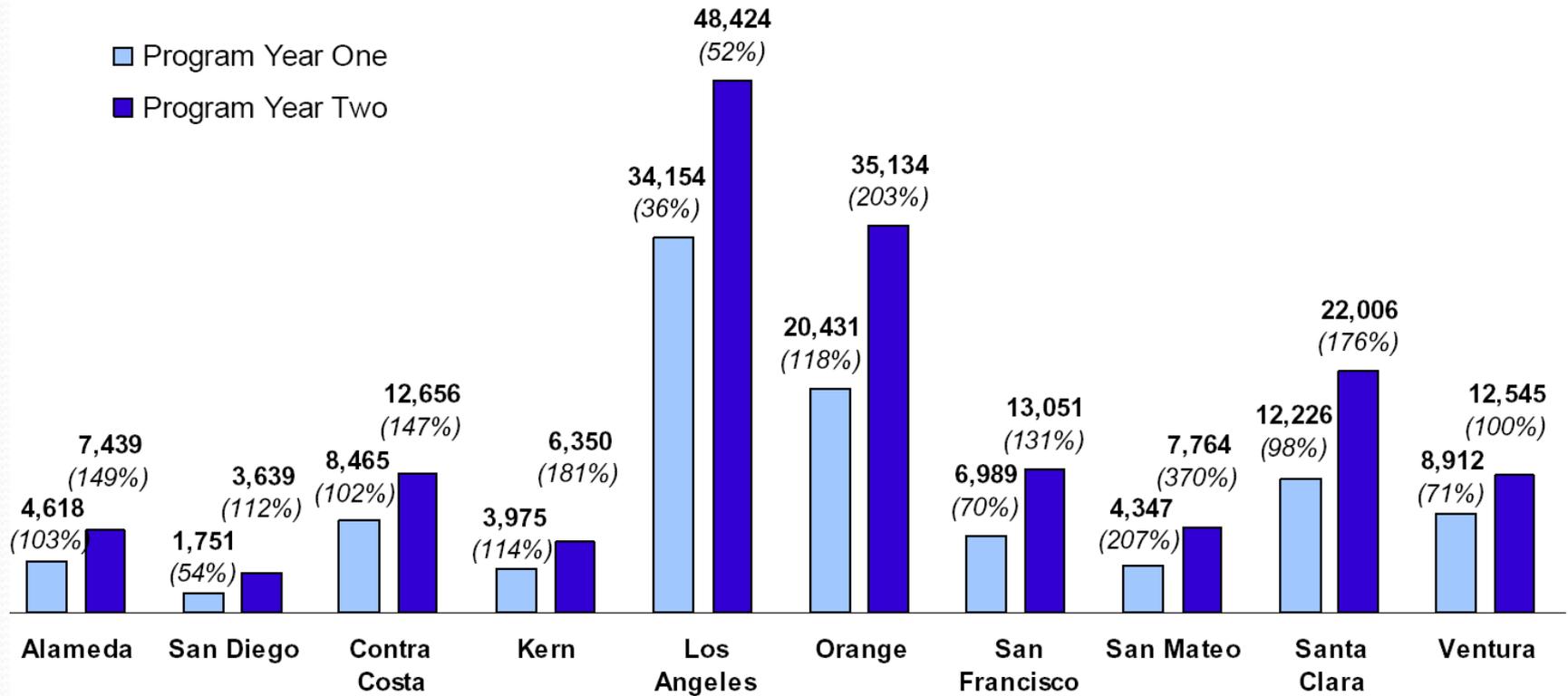
- Review of 2 year period of 10 HCCI County programs
- Significant variations in each county program
 - Additional eligibility requirements from some counties:
 - Chronic condition diagnosis (Alameda, San Diego, LA)
 - Urgent or emergent condition (Orange)
 - Variations in covered services (80% covered dental care)

UCLA: Provider Network Best Practices

- Telemedicine, mobile clinics
- Pharmacy benefit management
- Referral management policies
- Clinical care guidelines
- Training to extend primary care provider scope of practice
- Third party administrator

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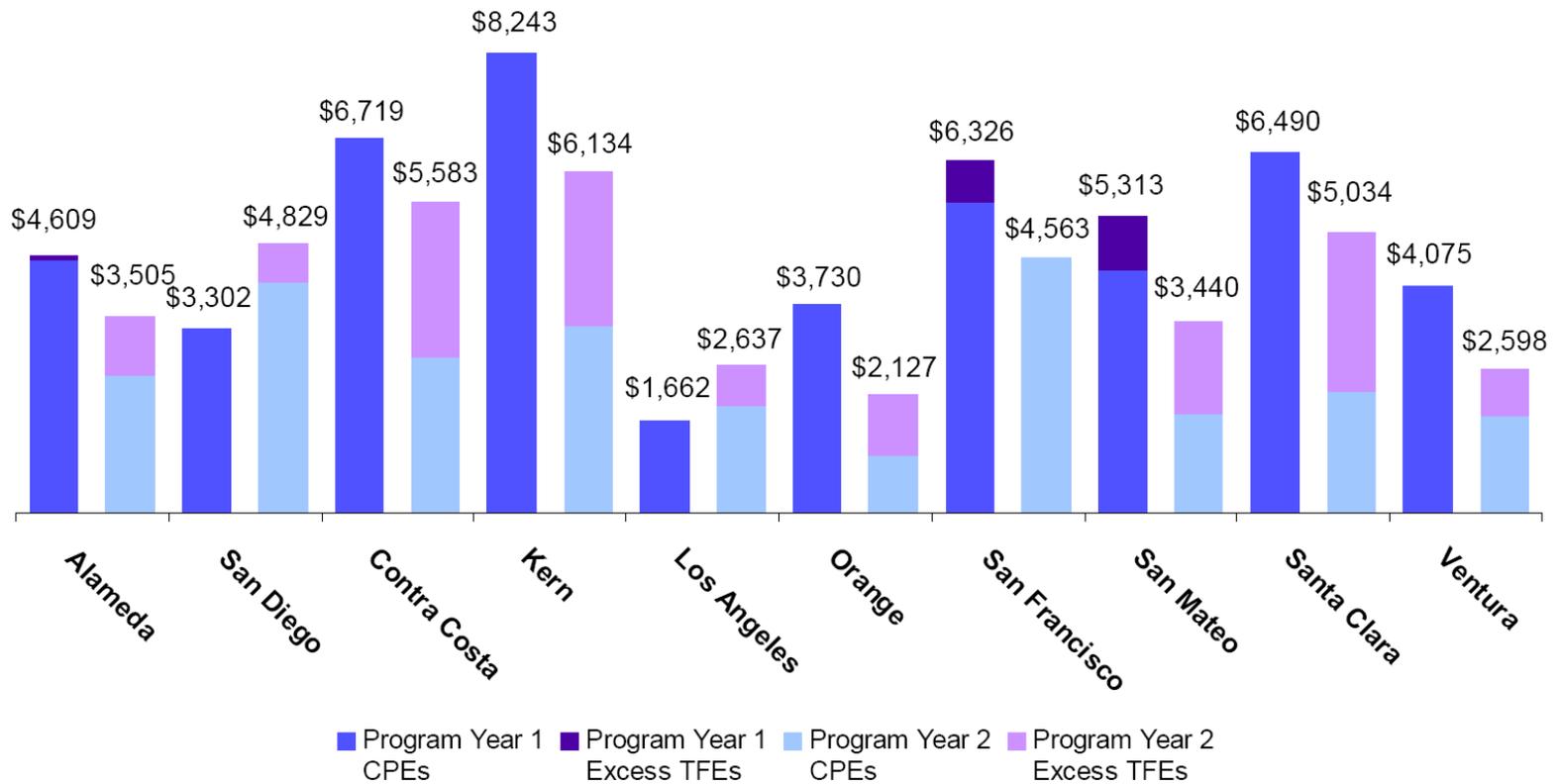
Exhibit 5: Annual Enrollment and Percent of Target Enrollment, by County Years 1 and 2.



Source: Years 1 and 2 revised county progress reports to DHCS.

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Exhibit 13: Total Estimated Average Annualized Cost per Enrollee by Expenditure Type, Program Years 1 and 2 by County.



Source: Years 1 and 2 revised county progress reports to DHCS; DHCS personnel.

Note: Expenditure data should be interpreted as estimates. Final reconciliation of costs will be conducted after August 31, 2010.

Lessons from Orange, Santa Clara and Contra Costa Counties

- Strongly emphasized medical home – no payment if person went to ED rather than medical home.
- Use of a point system – shared risk with hard cap for each sector; e.g., ED, inpatient, primary care
- IT system very important for enrollment – able to merge or retain separate MIS/SP
- Outreach not needed – “build it and they will come”

Lessons from Orange, Santa Clara and Contra Costa Counties, continued

- Increased utilization: Integrated with medical home/providers—diagnostic tests ordered and discovered health conditions, which then must be treated.
- Don't use existing MISP data for utilization estimates—utilization will be much higher because services no longer just episodic. In old system the other health conditions were not discovered or treated.
- Higher utilization rates initially—then decreased over time.

LIHP Eligible Population

- LIHP eligibility handout
- Pooled estimate using CHIS 2007 and CHIS 2009
 - Pooling method improves statistical stability but leads to under-estimate of 14% at the statewide level. Eligible population is also likely to have grown since 2009.
 - MCE: estimates do not account for possible participation by individuals with third party coverage (STC page 25).

i. **MCE Applicants** – are non-pregnant individuals between 19 and 64 years of age who are not enrolled in Medicaid or CHIP and who appear to have family incomes at or below 133 percent of the FPL (or less based on participating county standards) who have completed an application in a participating county and who have not had an eligibility determination.

Q& A with Department of Health Care Services:
Jalynne Callori & Bob Baxter

- New STCs will be released sometime in April and will reflect MOE is based on FY 09/10 and include MOE calculation method.
- DHCS understands LIHP applications were your first best guess—there's lots of flexibility in this authorization process for changes.
- Confirmed that federal Title XIX allows for negotiated rates with FQHCs. DHCS is looking into how to assist in PPS rate negotiations between counties and FQHCs.

Q& A with Department of Health Care Services:
Jalynne Callori & Bob Baxter, continued

- Must have a contract with the provider in order to count CPE.
- DHCS hopes to transition counties to MEDS system in 3-4 years. In meantime, would like to offer a system by June that will at least access SS#. CALWin interface is 3-5 years away.
- No answer yet on what DHCS will charge counties for administration. Likely similar to MAA @ 0.5% of all claims
- There is no asset test for LIHP applicants.