



San Francisco
Behavioral Health Services System

**Primary Care Integration
(Behaviorists in PC)
and Health Reform Preparation
(LIHP)**

February 8, 2012

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Milestones:

- 2005-Mayor Gavin Newsom call for Universal Healthcare
- 2006- SF Health Care Security Ordinance
- Jan 2007- HCCI application submitted
- July 2007-Healthy San Francisco launched
- July 1, 2011- Dec 31, 2013- LIHP in effect

Healthy San Francisco (HSF)

- HSF is PC Medical Home-based care, not insurance, for services in SF for residents 18-64 with income/assets up to 500%FPL who are ineligible for public coverage such as MediCal
- **Initial Service sites-** PC-SFDPH & SFCCC, Hospital-SFGH, MH/SA- Community Behavioral Health Services
- **One-e-App-** assess eligibility/enroll in HSF, ID'd HCCI
 - Unique Client ID
 - Preliminary eligibility determination for other public programs
 - Verification of residency, etc. (document imaging)
 - Current enrollment status
 - Rapid renewal process
 - Routing eligibility to registration and billing
- HSF Quarterly Income-based Participant fee & POS fee
- Phased enrollment to reach to 500% FPL
- **Later** Phases- network expanded significantly – addt'l PC (N=37) and all hospitals except Veterans Admin



HSF: What's Covered

- preventive and routine care/primary care
- specialty care
- urgent care
- emergency care
- ambulance services
- hospital care
- alcohol and drug abuse care
- laboratory services and tests
- mental health care
- family planning
- durable medical equipment
- prescription medicine
 - *Referral, Prior Authorization and Medical Necessity required for most specialty services

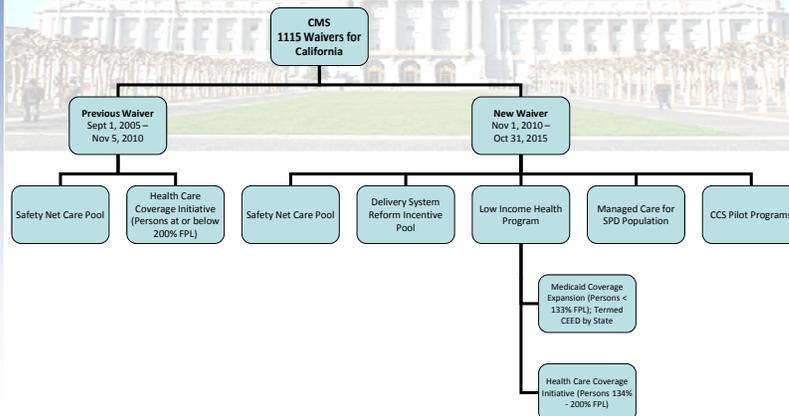


HSF: Mental Health and Substance Abuse Services

- INTEGRATED CBHS system- extensive network of DPH, private providers, and contract programs
- STANDARD REFERRAL PROCESS
 - Access phone-line and walk-in Behavioral Health Access Center- "BHAC" August 2008-
 - Screening, assessment, need for treatment, authorization, placement control (residential, methadone), referral, pre-treatment services
 - Centralized Opiate Program Evaluation- COPE
 - Integrated Buprenorphine Intervention Services-IBIS
 - CBHS Pharmacy, Office Based Opiate Tx NTP dispensary
- Full range of MH/SA services- outpatient, detox, opiate treatment, residential, crisis, ADU, medication, prevention and wellness services
- Some access direct through community providers
- INTEGRATED PC Medical Home & Behaviorists- Step Up, Step Down (2010 initiative)
- *Funding stream essentially invisible to treating clinician*



California's 1115 Waivers Supporting Coverage Expansion



Prior 1115 Waiver - Health Care Coverage Initiative (HCCI)

- HCCI goal was to provide roughly 100,000 uninsured California adults with comprehensive care and access to a primary medical home
- Competitive State application -- 10 counties selected (including San Francisco)
- In San Francisco, HCCI was not a separate and distinct program
 - HCCI served as one funding source for Healthy San Francisco
 - HCCI reimbursement was limited to HSF participants who met the following federal criteria:
 - **Uninsured adult aged 19 – 64**
 - **San Francisco resident**
 - **Income at or below 200% FPL**
 - **2005 Deficit Reduction Act docum. (identification&legal status)**
- San Francisco's HCCI provider network was the SFDPH health care delivery system (SFDPH, SFGH, CBHS)
- DPH had over 10,000 HSF participants with HCCI-eligibility
- HCCI was in existence from September 1, 2007 to June 30, 2011₇



New Waiver - Low Income Health Program (LIHP)

- Component of California's "Bridge to Reform" Medicaid 1115 Waiver (2010-15) and the Special Terms and Conditions (STCs)
- Specific goal of LIHP is to "expand coverage to low-income Californians"
- County participation in LIHP is voluntary – with exception of 10 HCCI counties
- California estimates LIHP enrollment ≈ 500,000 low-income adults statewide
- **LIHP began July 1, 2011**
- LIHP is time limited – ends on Dec. 31, 2013
 - Timed with January 1, 2014 implementation of individual mandate under Affordable Care Act



LIHP is Expansion of HCCI – But Critical Differences

- LIHP differs significantly from HCCI in that it:
 - Creates two different coverage populations and set of benefits based on FPL
 - **Medicaid Coverage Expansion (MCE) for those with incomes between 0% - 133% FPL**
 - **Health Care Coverage Initiative (HCCI) for those with incomes between 134% - 200% FPL**
- Offers a range of benefits for low-income population that are similar to Medi-Cal
- Identifies two different enrollment levels, funding streams and reimbursement potential for each population
- Standardizes various aspects of the program for all participating counties
- Imposes managed care provider network requirements and clinical access standards – imposes financial penalties for not meeting provisions
- Increases county costs above and beyond costs currently incurred by county to provide services to population



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LIHP Eligible Population

- LIHP covers individuals who are:
 - Between the ages of 19 and 64
 - U.S. citizens or qualified immigrants
 - Have U.S. government identification
 - Residents of the program county
 - Not pregnant
 - Not eligible for Medi-Cal or S-CHIP
 - Between 0% and 200% FPL
 - **MCE is between 0 and 133%**
 - **HCCI is between 134 and 200%**



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Prioritization of Lower Income Individuals

- Counties must prioritize lower income patients
 - May not operate a HCCI without having a MCE up to 133% FPL
- To reduce its enrollment cap/lower its program FPL cap, counties must go through a public process which includes obtaining a County Resolution and DHCS Director approval
 - Incentive to start modest with MCE population and expand up
- Counties must consider what the highest % FPL cap will be given the estimated number of people it will be able to cover based on expenditure projections
- Counties can grandfather enrollees who continue to recertify, even if the LIHP FPL cap is lower than an enrollee's FPL



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LIHP and Ryan White

- Post-implementation: Center for Medicare and Medicaid Services (CMS) and the Health Resources and Services Administration (HRSA) determination re: LIHP and Ryan White (RW)
- Decision: All current RW clients who are eligible for the LIHP must be enrolled in the LIHP program
- Rationale: Under current law the RW must serve as payer of last resort
- Aftermath:
 - LIHPs assume financial responsibility for RW funded services for eligible clients
 - A direct cost shift from the State/federal government to counties
 - Displaces the uninsured from LIHP
 - Continuity of care concerns for RW clients



SF PATH – San Francisco’s LIHP

- “San Francisco Provides Access to Healthcare” or SF PATH
 - Grandfathered Enrollees (transferred effective 7/1/2011): Former HCCI with incomes 0 %-200% FPL
 - New Enrollees (enrolled between 7/1/2011 – 11/10/2011): incomes 0% - 133% FPL
 - New Enrollees (on or after 11/14/2011): incomes 0 – 25% FPL (due to absorption of eligible Ryan White population)
- Provider network is SFDPH – same network as previous Health Care Coverage Initiative (HCCI) under old waiver:
 - 16 SFDPH primary care clinics (all FQHCs)
 - 12 community oriented primary care clinics
 - 4 hospital-based primary care clinics
 - San Francisco General Hospital
 - Community Behavioral Health Services- MH & SA services
 - Laguna Honda Hospital (short-term rehabilitation)
- **Continued coverage of MH & SA- Non-tiered system of care**
- Reviewed and approved by State DHCS and federal CMS
- SF PATH implemented on July 1, 2011
- Currently over 11,000 enrollees



SF PATH – Eligibility, Enrollment & Billing

- SFDPH continued use of One-e-App to determine eligibility for SF PATH and a range of other health programs (e.g., Healthy San Francisco, Medi-Cal, etc.)
 - Uninsured adult resident does not have to apply to any specific program – SFDPH uses a “no wrong door” approach
- Enrollment into SF PATH is based on
 - meeting federal eligibility criteria
 - applicant selection of a SFDPH primary care medical home
- SF PATH enrollment can only be done by SFDPH employees
- Billing SF Path is done monthly through IT/billing department after the service is provided
 - Clinician not focused on funding source, but on care
 - Eligible clients and services are billed to LIHP
 - Not all BH services are billed to or paid by LIHP



SF PATH ENROLLEE GUIDE TO MENTAL HEALTH & ALCOHOL & DRUG ABUSE SERVICES

Minimum:

- Up to 10 days per year of acute inpatient hospitalization in an acute care hospital, psychiatric hospital, or psychiatric health facility
- Psychiatric medication
- Up to 12 outpatient encounters per year.
- Additional MH and SA services available from SF PATH Medical Home or San Francisco Community Behavioral Health Services.

SF PATH Enrollee ID Card:

- Telephone # of SF PATH Medical Home
- Telephone #s for Community Behavioral Health Services – Central Access line for direct access to behavioral health services, available 24/7



Behavioral Health Services at Medical Home

- Confidential mental health services on site
- Individual to group therapy for mental health needs such as depression or anxiety.
- For access to behavioral health services (mental health and/or substance abuse) that are not provided at SF PATH Medical Home, primary care provider will refer to San Francisco Community Behavioral Health Services for care.
- Or if not comfortable discussing mental health and/or alcohol and drug abuse care needs with primary care provider, enrollee calls San Francisco Community Behavioral Health Services directly. No referral needed from SF PATH medical home provider to access services from Community Behavioral Health Services.



Behavioral Health Services through SFDPH Community Behavioral Health Services (CBHS)

SF PATH enrollees access comprehensive community-based services offered by CBHS, including, but not limited to:

- Information and referral services.
- Prevention services.
- A full range of voluntary behavioral health services, including
 - self-help
 - peer support
 - outpatient
 - case management
 - medication support
 - dual diagnosis treatment
 - substance abuse services
- 24-hour psychiatric emergency services-includes inpatient
 - crisis hotline
- Enrollee calls CBHS through Central Access phone (BHAC)
- Staff match enrollee with a network provider who has the needed expertise, skills and language capability



PC Behaviorist Initiative (2010): Screening Strategies

- Routine Outcome Tools (Age Appropriate):
 - Duke Health Profile
 - Pediatric Symptom Checklist
- As Indicated Screening Tools:
 - Depression-PHQ -2 or 9
 - Geriatric Depression Scale
 - Anxiety- GAD 7
 - ADHD- Vanderbilt Tool Kit
 - PTSD- PC-PTSD
 - Domestic Violence- IPV Screen
 - Pain- Wong-Baker Faces Pain Scale
 - Substance Abuse- CAGE-AID
 - Overall Health- Healthy Days Measure



Referrals to Behaviorists in PC (all referrals)- Client Demographics: Nov 2011-Jan 2012

- Care notes recorded in the Coordinated Case Management System (CCMS) Beginning Nov. 2011
- Average 643 UDC BH referrals per month
 - 40% Male
 - 44% Female
 - 16% Decline/Not stated
- Age- Average 52.4
 - 1% 18 or under
 - 9.4% 20s
 - 9.4% 30s
 - 16.4% 40s
 - 28.8% 50s
 - 24.7% 60s
 - 9.8 % 70s and above



Referrals to PC Behaviorists: Demographics Continued

- | | |
|---|---|
| <ul style="list-style-type: none"> • Ethnicity • 25.5% African American • 8.8% Asian • 3.1% API • 7.5% Filipino • 11.9% Latino • .1% Native American • 18.5% White • 22.4% Decline/ Not stated | <ul style="list-style-type: none"> • Preferred Language • 8% Cantonese • 54% English • .1% Mandarin • 3.3% Other • 2.4% Russian • 5.5% Spanish • .3% Tagalog • .1% Vietnamese • 26% Decline/ Not stated |
|---|---|



Primary Reason for Referral to PC Behaviorist

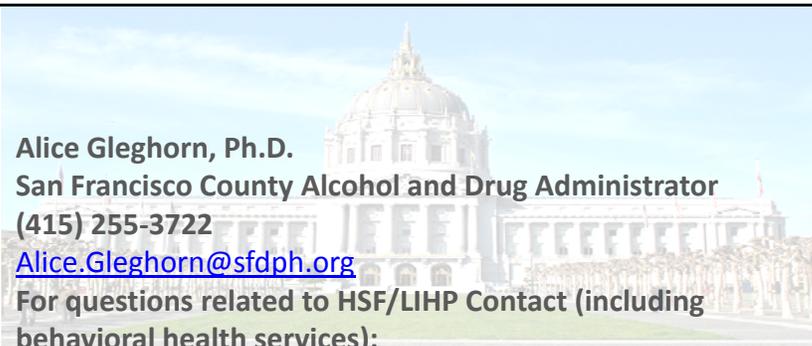
- **Mental Health Issues**
 - .9% Anger
 - 11.4% Anxiety
 - 6% Chronic Pain
 - 25.2% Depression
 - 1.9% Grief
 - 6.4% Disease Mngmt
 - 4.5% Sleep
 - 6.9% Stress
 - 2.1% Traumatic Stress
 - 4.1% Weight Mngmt
- **Substance Abuse Issues**
 - 4.7% Alcohol Abuse/Dependence
 - 3.4% Drug Abuse/Dependence
 - 6.5% Tobacco
 - 0% Gambling
 - 0% Other Addiction



Ongoing Issues/ Reminders

- **Issues:**
 - Meeting timely access standards
 - Monitoring enrollment and expenditures
 - Formalizing Step up, Step down procedures between PC and CBHS
 - Absorption of Ryan White eligible population
 - **Communication to providers and clients**
 - **Continuity of care**
 - **Capacity**
 - **Cultural competence**
 - **Transition plan**
 - **Efforts to obtain fiscal relief from federal government**
- **Reminders:**
 - LIHP assists clients into appropriate use of a Primary Care Home-based prevention and treatment service system, and reduces dependence on Emergency/Urgent/Crisis care
 - LIHP activities lead provider systems to organize functions (eligibility, enrollment, access, authorization, fees, billing etc.) in preparation for implementation of the ACA in 2014
 - In San Francisco, clinician's focus is on providing care
 - Integrated systems (BH, PC) ease necessary transitions





Alice Gleghorn, Ph.D.
San Francisco County Alcohol and Drug Administrator
(415) 255-3722

Alice.Gleghorn@sfdph.org

For questions related to HSF/LIHP Contact (including behavioral health services):

Tangerine M. Brigham
Dep. Dir. of Health & Dir. of Healthy San Francisco
415.554.2779

tangerine.brigham@sfdph.org

For Primary Care Behaviorist questions:

David Silven, Ph.D.

(415) 255-3626

david.silven@sfdph.org

