Health Care Services Master Plan Task Force

Issue Meeting Minutes: Health Care Finance

December 22, 2011 – 2 pm to 4:30 pm, San Francisco City Hall, Room 305

Key themes and potential recommendations from Task Force discussion:

- Health care finance impacts delivery of and access to quality health care services.
- Nearly half of all San Franciscans will be age 50+ by 2030, highlighting the importance of addressing the needs of the city's aging population. Concerns include cuts to In-Home Supportive Services, and a potential lack of gerontology providers.
- Prioritize meeting the service needs of San Francisco's vulnerable populations, focusing on services for Medi-Cal beneficiaries and the uninsured. Potential recommendations include incentives for new or expanded facilities to serve a certain percentage of Medi-Cal and uninsured patients and instituting an "impact fee" designed to address known gaps in San Francisco's health care services.
- Be mindful of social determinants of health when identifying and addressing health care access issues. Possible recommendations include incentivizing the construction of new facilities that promote prevention and overall wellness.
- People with mental health care needs often face challenges accessing health care services. Specialty mental health services are carved out of the Medi-Cal Managed Care system, creating a more fragmented health care system that separates mental health from primary and acute medical services. One potential model is a 24-hour mental health care provider serving as the medical home with access to adjunctive onsite primary care services.
- Health care access may be more significantly impacted by extending hours of operation versus increasing the number of facility locations. The availability of primary care services outside traditional business hours would expand access for working individuals and families.
- Culturally competent services are important for all San Franciscans and will be especially important for those transitioning to Medi-Cal Managed Care from the Medi-Cal Fee-for-Service system. Consider land use incentives for providers that demonstrate the ability and commitment to provide specialized care for underserved populations. Consider policy recommendations related to California's essential health benefits for populations with special needs, such as increasing the cultural competence of the existing health care workforce.
- Collaborations are important in the current climate of declining resources. The Task Force may wish to emphasize partnerships among schools, the medical community, and/or community-based organizations.

1. **Opening remarks** from Roma Guy Task, Force Co-Chair. Dr. Tomás Aragón was unable to attend.

2. **Agenda review: Clare Nolan, Harder+Company.** Ms. Nolan reviewed the agenda.

3. **Overview of Health Care Finance: Lori Cook, Department of Public Health.** Ms. Cook provided an overview of health care spending trends and factors that drive health care costs, explained the basic structure of Medi-Cal, described Health Reform's impact on the health care reimbursement structure and how those changes may impact access to care, and initiated a discussion of land use-specific and other policy considerations.

4. **Task Force Discussion: Clare Nolan, Harder and Company.** Ms. Nolan requested that Task Force members to start with clarifying questions about the presentation before moving on to a broader discussion:

Q: What are the implications of the 1915(i) for mental health and long-term care?
A: Four states have implemented 1915(i), but they did so before changes made by Health Reform. It is unclear whether California will opt into 1915(i) because it requires a degree of "statewideness," meaning that counties would not be able to tailor 1915(i) services to their needs – covered services and eligibility requirements would have to be the same across counties. Under the old 1915(i), beneficiaries had to qualify for an institutional level of care before they could receive home- and community-based services. Under Health Reform, this provision has been eliminated; beneficiaries are no longer required to quality for an institutional level of care.

Q: How will the uninsured be impacted by Health Reform?
A: There are two ways standard measurements of the uninsured: (1) everyone who is uninsured at the time they are surveyed; and (2) everyone who has been uninsured at any time during the year preceding the survey. Based upon the latter measure, 64,000 individuals are expected to be uninsured post-Health Reform. Two-thirds are expected to be undocumented, and the remaining one-third is expected may not comply for other reasons, including because it is not financially feasible or because they are unaware that they are eligible.

Q: Will carve outs undermine the advancement of the Patient-Centered Medical Home (PCMH), particularly among those entities that service Medi-Cal recipients? Might we need a recommendation about what PCMH should consist of as well as potential barriers?
A: The PCMH model encourages care coordination among interdisciplinary teams led by the primary care provider. Under the Medi-Cal Managed Care system – in which San Francisco participates – patients already have a medical home, which will remain the case despite the existing carve out system.

Q: Are medical homes under Medi-Cal Managed Care struggling with these changes?
A: There has been no specific indication that this is the case; however, an estimated 30,000 people will enroll in San Francisco's Medi-Cal program under Health Reform, and it is unclear whether existing providers have the capacity to meet the expanded need for Medi-Cal-covered services. Task Force member Brenda Storey noted that Mission Neighborhood Health Center, along with other consortium and public health clinics, is striving to meet the criteria to become a patient-centered medical home, noting that those criteria consist of 127 different factors. She said that the carve outs have integrated mental health services broadly – but not specialty mental health care, adding that some diagnoses are more complex and require more intensive services.

Q: Do the national spending trends in Ms. Cook's presentation include specialty care?
A: Yes.

Q: Can high-utilization patients opt out of managed care? If so, how will the managed care program save money if the high-utilization population stays in the fee-for-service model?
A: Only certain populations may opt out of Medi-Cal Managed Care at this time (i.e., individuals who are dually eligible for Medi-Cal and Medicare, those in foster care, those who pay a portion of their Medi-Cal expenses, and persons in long-term care). However, managed care "opt outs" pose an additional challenge to the already strained Medi-Cal system. San Francisco's Long-Term Care Coordinating Council has just begun to address this issue for the long-term care population.

Q: Is San Francisco considering adopting an Accountable Care Organization (ACO) model?
A: As part of its 2011 negotiations with area health plans, the City and County of San Francisco (CCSF) Health Service System requested proposals from health plans willing to provide care to CCSF employees using the ACO framework. As a result, CCSF partnered with Blue Shield of California and five major health providers – Brown & Toland Physicians, California Pacific Medical Center Medical Center, Hill Physicians Medical Group, Catholic Healthcare West, and the University of California - San Francisco – to create two ACOs with the aim of providing more cost-effective, high-quality care to CCSF's 26,000 employees. San Francisco's ACO initiative, effective July 2011, will continue for at least one year and is expected to save CCSF a projected $10 million to $15 million annually.

Q: Will newly covered enrollees in the health exchange have the same reimbursement rate that Medi-Cal enrollees have for FQHCs?
A: Under Health Reform, private health plans participating in a health benefit exchange may not reimburse FQHCs at a rate below that which they receive from Medicaid. As noted by Brenda Storey, however, private plans could theoretically contract with only one FQHC and still meet Health Reform requirements as currently written.

Q: Which definition of "medically underserved population" is being used?
A: The Task Force has not specified a definition, but should plan to do so.

Common themes that emerged from the Task Force member discussion include:

Health Care Finance

- ACOs could serve as a guide to integrate more services and provide better, less duplicative care.
- Care coordination and integration are one piece of a larger puzzle – financing strategies are also important in creating change. As a counterpoint, under Health Reform, finance has the capacity to drive integration, coordination, and continuity of care. Payers are trying to formulate reimbursement methodologies that will drive providers to improve quality. The question is how to incentivize health care in a different way that addresses financial realities and includes prevention, mental health, substance abuse, elder care, etc.
- The elimination of siloed funding would allow San Francisco providers to have maximum flexibility in program design.
- The FQHC model requires the inclusion of consumers in clinic governance to ensure that services are responsive to patient need. The Task Force may wish to consider encouraging the use of consumer advisory boards by providers.

- Access to pharmacy services is an important consideration for many low-income patients. This could lead to increased unnecessary emergency room utilization. The rules for the federal 340b Drug Pricing Program create barriers to low-cost medications.

Services for the Aging

- In-Home Supportive Services (IHSS) may get incorporated into Medi-Cal, which is a concern given the program's importance in enabling seniors to age at home and avoid unnecessary institutional care.
- It is not clear whether San Francisco has a sufficient number of gerontology providers to address the needs of the aging population as existing providers retire.
- Projections indicate that by 2030, half of San Francisco's population will be over 50. While the Task Force has discussed the importance of support services (e.g., escort needs) the Task Force is interested in learning what planning the the Municipal Transit Agency (MTA) may be engaged in to address the needs of the growing aging population. Ms. Nolan noted that this and related topics will be covered in the "connectivity" issue meeting. She added that a representative from MTA was invited to sit on the Task Force and will ask the co-chairs to reach out to that individual.
- Another challenge is the lack of optometry and dental care coverage provided by Medi-Cal.

Safety Net and Service Gaps

- Not all providers in San Francisco participate in the safety net system. The Task Force should consider incentives for these providers, or San Francisco's underserved will continue to have access problems.
- Land use projects that serve some threshold of Medi-Cal beneficiaries, the under- and uninsured should be incentivized. For example, a recommendation could mandate that new and/or expanded facilities serve a certain percentage of Medi-Cal patients.
- While land use incentives are important, the Task Force may want to recommend the use of mandates (e.g., Medi-Cal patients must constitute "x" percent of a Medical Use's patient base) to ensure access to care for underserved populations.
- Community benefits are required of new developments in the form of impact fees, but they are not specifically related to health care or the health of the community. The Task Force could consider fashioning that concept into a recommendation, such as filling known gaps(e.g., prenatal care in specific neighborhoods).

Health and Wellness

- The Task Force should highlight the importance of the social determinants of health. Ms. Nolan noted that the Task Force's scope does go beyond Medical Use projects and some recommendations on the inventory already address social determinants.
- The City could include a "Health Element" to the San Francisco General Plan, which would promote a lens of healthy eating and active living when making land use decisions. Several other jurisdictions have taken a similar approach.
- There is a tension between the provision of medical services and overall health (i.e., wellness and the health of citizens). A land use recommendation could be to incentivize construction of new facilities that promote prevention activities and overall wellness, such as publicly available space for walking, exercise equipment, etc.

Mental Health

- California has committed more than other states to providing high quality, comprehensive mental health services to those with behavioral health issues – a financial challenge to an already-fiscally-strained state. This challenge is of particular concern given that specialty mental health services are carved out of the managed care system, creating a more fragmented health care system that separates mental health from primary and acute medical services.
- National discussions have explored alternative patient-centered medical home models for patients with high mental and physical health needs. For example, one potential model is a 24-hour mental health care provider serving as the medical home with access to adjunctive onsite primary care services. San Francisco should explore this model in the context of Health Reform and the needs of this vulnerable population, which often struggles with access to care.

Location and Hours of Services

- A tension exists in holistic, cohesive planning between "downstream" solutions (e.g., escort services) and "upstream" solutions (e.g., bringing services to those who need them) and the question of what should be local.
- San Francisco is relatively small compared to other communities and it may not be feasible or advisable to locate every service in every neighborhood.
- Primary care services should be available beyond traditional business hours. Public comment presented at the two neighborhood meetings – as well as Task Force representation of the small business community – affirm that this is a critical issue.

Access to Culturally Competent Services

- The transition from fee-for-service Medi-Cal to Medi-Cal Managed Care may be particularly difficult for patients who need specialized care and who have long-standing relationships with their existing providers. There may fewer specially-trained health care professionals and fewer ADA-compliant facilities available through the existing Medi-Cal Managed Care system, which could disproportionately impact certain populations, such as persons with disabilities and transgender people. The definition of "culturally competent" should be broadly defined to include the needs of transgender people, persons with disabilities, and other special populations. The Task Force may consider recommending land use incentives for providers that demonstrate the ability and commitment to provide specialized care for underserved populations.
- The federal Centers for Medicare and Medicaid Services recently announced that states will have flexibility in determining the essential health benefits that will be required of all plans offered on a state health benefit exchange. The Task Force may wish to consider policy recommendations related to California's essential health benefits for populations with special needs and/or related to improving the cultural competence of the health care workforce.

Collaboration

- Given that many young children are in the San Francisco Unified School District (SFUSD) system, SFUSD should be considered as a partner in health promotion and prevention. The Task Force may wish to emphasize the importance of collaborations and partnerships among schools, the medical community, and/or community-based organizations in this era of declining resources.

Task Force members also made suggestions regarding the Task Force process and approach to developing recommendations:

- Task Force members acknowledged that the health care system will change greatly with the implementation of Health Reform in 2014 and that the full extent and impact of those changes will not be known until that time.
- Unfortunately, the City and the Task Force are limited by a lack of available data, for example there is no reliable and comprehensive source of information that identifies the location of specialty care services. The Task Force may wish to consider a recommendation for improved data collection for local health care services.
- Community-identified service gaps should be validated by follow-up searches of available data. For example, the Task Force could look to the Comprehensive Perinatal Services Program (CPSP), which has county-level delivery data by Zip Code, to verify public testimony about the lack of perinatal care in certain neighborhoods.
- The Data Advisory Committee is looking at indicators in compliance with National Association of County and City Health Officials (NACCHO) domains as explained in the memo to Task Force members dated August 15, 2011. Because this is a large amount of data, a subset was selected for presentation at community meetings. Complete data will be part of the full Health Care Services Master Plan and will be made available to Task Force members in early 2012. Suggestions about data should be made to Ms. Nolan, Ms. Chawla, Ms. Cook, Ms. Guy, and to the Data Advisory Committee, which includes Erika Takada from Harder+Company as well as the following Task Force members: Claudia Flores, Lucy Johns, Barry Lawlor, Ellen Shaffer, and Abbie Yant.
- Data is one element of the Health Care Services Master Plan process. Task Force members also bring their experience and expertise to inform the process.
- Task Force leadership may wish to consider small committees to focus on specific areas and formulate recommendations.
- As it formulates recommendations for SFDPH consideration, the Task Force may wish to consider how it can build on the work being done (or already completed) by other San Francisco health planning bodies.

5. **Task Force Updates.** There were no Task Force Updates.

6. **Public comment.** No one asked to make public comment.

7. **Closing comments and next steps: Roma Guy and Clare Nolan.** Ms. Guy reminded the Task Force that, per San Francisco Ordinance 300-10, the Health Care Services Master Plan must be updated every three years; the current Plan will lay the groundwork for future efforts. Ms. Guy addressed the importance of framing recommendations for decision makers (e.g., the Mayor and Board of Supervisors) in a holistic and synthesized manner, and she emphasized that it is the responsibility of Task Force to represent consumers. Ms. Nolan asked members to complete a meeting evaluation and reminded members that the next neighborhood meeting will focus on the Inner Richmond, Japantown, Sunset, and Western Addition, and will take place on Thursday, January 26th, from 5 to 7:30pm at The African American Art and Culture Complex (762 Fulton Street), Hall of Culture (3rd Floor).

Evaluation Results

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
The meeting was a good use of my time.	5	6	-	-	-
The purpose of the meeting was clear.	2	7	1	-	-
The meeting topic was important to the HCSMP.	7	4	-	-	-
The meeting materials (e.g., agenda, briefing paper) were useful.	7	4	-	-	-
The presentation was helpful.	5	6	-	-	-
The meeting was well facilitated.	7	3	1	-	-
I felt comfortable sharing my ideas with the group.	5	4	2	-	-
SFDPH and the Task Force Co-Chairs will use my contributions to the discussion.	3	7	1	-	-
The meeting format was effective.	3	6	-	1	-
I am likely to come to future HCSMP Issue Meetings.	7	2	2	-	-
I am committed to the HCSMP Task Force.	8	2	-	-	-

Task Force Members

Members in Attendance

Name	Representing
Roma Guy, Task Force Co-Chair	At-Large Seat
Margaret Baran	Long-Term Care Coordinating Council
James Chionsini (alternate: Donna Shellmont)	Planning for Elders in the Central City
Anson Moon	San Francisco General Hospital and Trauma Center
Masen Davis	Transgender Law Center
Regina Dick-Endrizzi	Small Business
David Fernandez	LGBT Executive Directors Association
Steve Fields	Human Services Network
Stuart Fong	Chinese Hospital
John Gressman	San Francisco Community Clinic Consortium
Jay Harris	UCSF Medical Center
Lucy Johns	At-Large Seat
Mary Lou Licwinko	San Francisco Medical Society
Ellen Shaffer	At-Large Seat
Christina Shea	Asian Pacific Islander Health Parity Coalition
Brenda Storey	Mission Neighborhood Health Center
Kim Tavaglione	California Nurses Association
Dr. Steven Tierney	San Francisco Health Commission
Maria Luz Torre	San Francisco Health Plan Advisory Committee
Eduardo Vega	Mental Health Association of San Francisco
Elizabeth Ferber (Permanent alternate for Randy Wittorp)	Kaiser Permanente

Members Not in Attendance

Name	Representing
Dr. Tomás Aragón, Task Force Co-Chair	San Francisco Department of Public Health
Brian Basinger	AIDS Housing Alliance
Michael Bennett	At-Large Seat
Kathy Babcock	San Francisco Unified School District
Aine Casey	Independent Living Resource Center
Eddie Chan	Northeast Medical Services
Linda Edelstein	Human Services Agency
Steve Falk	San Francisco Chamber of Commerce
Claudia Flores (alternate: Elizabeth Watty)	San Francisco Planning Department
Estela Garcia	Chicano/Latino/Indigena Health Equity Coalition
Dr. Michael Huff	African American Health Disparities Project
Paul Kumar	National Union of Healthcare Workers
Perry Lang	BCA/Rafiki Wellness, African American Leadership Group
Barry Lawlor	Sister Mary Philippa Health Center, St. Mary's Medical Center
Judy Li	California Pacific Medical Center
Le Tim Ly	Chinese Progressive Association
Timothy N. Papandreou	San Francisco Municipal Transit Authority
Roxanne Sanchez	Service Employees International Union Local 1021
Ron Smith	Hospital Council of Northern California
Randy Wittorp	Kaiser Permanente
Abbie Yant	St. Francis Memorial Hospital