City and County of San Francisco **Department of Public Health**

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Director of Health

M E M O R A N D U M

DATE: March 23, 2004

TO: President Edward A. Chow, MD
and Members of the Health Commission

FROM: Mitchell H. Katz, MD
Director of Health

RE: **FY 04-05 Health Department Budget**

In last week's budget hearing several issues were raised by the Health Commission. This memo presents new information where available on these issues.

A. Additional information on the rationale for charging a copay for pharmaceuticals to patients with incomes greater than 100% of the Federal Poverty level and the proposed level of the copay

As you know, other county health systems charge a copay for pharmaceuticals and if our clients were to become insured (a major goal of the Commission), the clients would have to pay a copay. Clients in Healthy Workers, Healthy Families, and Healthy Kids all pay pharmaceutical copays along with employees of employers subject to the Health Care Accountability Ordinance. The following compares the copays for these programs to the proposed copay schedule for clients at greater than 100% of poverty.

	Generic	Proprietary
Healthy Workers	$3.00	$5.00
Healthy Kids and Healthy Families	$5.00	$5.00
Health Care Accountability Ordinance (Minimum Standards)	$15.00	$25.00
Proposed copays for clients at greater than 100% of poverty	$5.00	$10.00

B. Status of MediCal funding for OBOAT and the Methadone van

At this time there is no reimbursement from MediCal for either the OBOAT or Van. The status of each program with respect to MediCal reimbursement is described in more detail below.

Both OBOAT and the Van were implemented as the result of Federal grants, and officially operate under a pilot program with the State. To end the pilot status and be able to claim MediCal, the following actions need to occur:

1. Enabling legislation must be passed at the State level authorizing the provision of OBOAT and Van services
2. Development of State regulations pertaining to these services
3. Approval of the regulations by the Governor
4. Application for MediCal reimbursement

<u>OBOAT</u>

Steps 1 and 2 have been completed. Assuming that the Governor approves the regulations despite likely strong objections from the Narcotic Treatment Providers (NTP) who do not all support competition for the provision of Methadone, it is estimated to take up to 12 months for the MediCal certification to be in place.

The OBOAT program currently has 35 enrollees, of which 24 are being seen in community - based sites, and 11 are being seen by OTOP at SFGH. Of the 24 clients, 17 are receiving Methadone and 7 are receiving Buprenorphine. In FY 2004-05, it is expected that this program will reach full enrollment of 200 clients, of which 55 clients will receive Methadone and 145 clients will receive Buprenorphine.

Of the 35 current enrollees in OBOAT, five of the clients, or 15% are MediCal eligible. Although the process for OBOAT MediCal certification is 50 percent completed, once the MediCal certification is finalized, it will still not apply to Buprenorphine. This medication is currently not regulated by the State, and would require both State and Federal legislation to regulate. The reasons the Department is projecting the FY04-05 expansion of OBOAT to be mostly for clients on Buprenorphine, which isn't MediCal eligible, include the following:

1. Less restrictive Federal guidelines for dispensing this medication, which will make it more practical for physicians to dispense through their office (the goal of OBOAT).
2. Less restrictive guidelines for the client, e.g. there are no counseling requirements, and the limitations on take-home quantities are less than Methadone.
3. Less side effects and clients report higher functioning.
4. Medication is targeted towards new users, so there is a greater possibility of breaking the cycle of heroin addiction with an earlier intervention.
5. There is no street value.

Methadone Van

Enabling legislation for the Methadone Van will occur during the current legislative session. From start to finish, it is estimated to take from 12 to 18 months for the certification to be in place.

Impact of MediCal certification

Although our goal is to obtain MediCal certification for both OBOAT and the Methadone Van, the lack of certification will not have a material affect on our budget. As a point of context, of a total of approximately 12,700 unduplicated substance abuse clients, approximately 20 percent are MediCal eligible, or 2,500 clients. Of these clients, approximately half receive Methadone, and the rest receive other MediCal eligible services. Annual reimbursement for a Methadone slot is approximately $4,000 annually. To maximize revenues MediCal eligible clients will be assigned to MediCal reimbursable slots, and we will use the General Fund to support methadone related treatment strategies for indigent uninsured persons.

C. Status of the Mentally Ill Offender Crime Reduction Grant

As part of the jail report, we highlighted a program provided by the Citywide Forensic Team (Team) that is currently partially funded by the State Board of Corrections Mentally Ill Offender Crime Reduction Grant. The Team has been serving severely mentally ill offenders who suffer substance abuse disorders since January 2000. During this time the program has amassed considerable expertise and resources enabling the treatment of clients who are high users of both mental health acute services and the criminal justice system. In particular the program has been shown to produce a substantial decrease in recidivism back to jail, resulting in a major savings for the City.

The FY 2003-04 budget is $1,128,767, of which $533,113 is funded by the grant, $464,388 is matched by the federally funded portion (FFP) of MediCal and the remaining $131,266 is Realignment and General Fund. There are 100 treatment slots.

The grant expires in March 2004. The cost of maintaining this program in FY 2004-05 is $533,113. We are currently discussing with the Mayor’s Office potential methods for maintaining this program.

D. Proposal to consolidate the Southeast Mission Geriatric and Team II Mental Health clinics with OMI Mental Health Clinic and impacts this relocation will have on the clients

The goal of the proposal is to create a comprehensive family clinic that serves children, adults and geriatric clients and is a more functional operating unit. Currently, the Team II and the SE Mission Geriatric Services are small programs that have difficulty meeting all the demands of the system. For example, clinicians may need to serve as receptionists when their clerk is out on sick leave or vacation. The Geriatric program also has difficulty meeting the system's advanced access standard of assessing clients within 24-48 hours of request for service. Because staffing is so skeletal at these small programs, any staff vacancy or leave creates major problems in meeting service demand. By consolidating the three programs,

there would be a greater mass of staff to be able to cover the variety of functions of an outpatient service and to meet requirements and standards.

The Department does not believe that the impact to the clients will be significant. However, if there are individual cases of hardship, the Department will work with these clients to reassign them to a different clinic. All three of the existing clinics are located in the same area of the City, while the clients are spread throughout the City. The OMI clinic is located directly on a MUNI train line. Additionally, a significant number of clients served by the South East Mission Geriatric clinic receive their services in their homes, so there would not impact to these clients.

E. Additional information and resolution of issues involving Walden House

It was the goal of the Department to avoid cuts to residential substance abuse programs in the base budget. Nonetheless, we proposed two cuts to Walden House residential programs. One eliminated funding for the Walden House Intensive Treatment Services program (WHITS), and the second reduced funding to their residential program by $292,212, a 10% reduction.

Following last week's Health Commission meeting and public testimony heard at the meeting, Barbara Garcia met with Walden House leadership, and I spoke with them by phone. We were able to make the following agreements:

Walden House Intensive Treatment Services (WHITS) - This 5-bed residential program serves clients with co-occuring mental health and substance abuse issues. The program reduces homelessness, and is a cost effective alternative to psychiatric emergency and inpatient services. The program provides assessment, medication services and stabilization.

In our budget presentation, we proposed an elimination of $191,554, comprised of a 100% reduction of funding for WHITS of $274,887, offset by an $83,333 allocation of funding to Walden's residential program. This reduction was proposed based on the belief that the WHITS program was located at a facility that was not licensed or licensable. However, since the base budget was prepared, Walden was able to identify a new site at a licensed facility and consolidate the WHITS program with two other programs also located there. Walden believes that efficiencies associated with the relocation and consolidation will allow them to achieve a General Fund savings of $33,000 without any reduction of service. We are therefore revising our base budget to restore funding to WHITS, less a $33,000 reduction.

Residential Program Efficiencies – Walden House believes that they can absorb the baseline reduction of $292,212 in their residential program without a decrease in the unduplicated number of patients served by working with Behavioral Health to reduce length of stay. Therefore our proposed reduction to this program is unchanged.

Financing the restoration of funding to WHITS – To prevent a reduction of residential beds at WHITS, the Mayor's office has allowed us to bring in $158,554 of surplus carry-forward from the current year to fund the restoration to Walden House. Because this funding is one-time funding, they have been reluctant to allow rollover funding into the base, preferring to hold current year surplus for inclusion in the contingency plan. Nonetheless, they have

agreed to make an exception in this case. Following is the composition of the funding restored:

Restore WHITS program funding	$274,887
Withdraw additional funding for the residential program to serve displaced WHITS clients	(83,333)
Reduction for administrative efficiencies	(33,000)
Total Restoration	$158,554

F. Dealing with the decrease in administrative positions in Primary Care

In our budget presentation, we proposed eliminating a total of 9.7 FTEs in Primary Care. This decision was made because there is a tremendous demand for primary care services and we did not want to make any direct service cuts in the primary care area. In terms of the responsibilities of the primary care medical director, we will ask the nine medical directors of the different health centers to take on increased responsibilities to handle the issues that have been performed by the 0.5 FTE primary care medical director. I will be meeting with the primary care medical staff tomorrow at 5:30 to discuss these issues in greater depth. In terms of the administration of each center, we will be asking that each of the center directors, each of the nurse managers, and each of the principal clerks manage two health centers. We recognize that this will place an increased burden on remaining staff but we believe it is the only way that we can maintain direct services in primary care within the base budget. Community Programs will continue to provide administrative support to Primary Care.