

The Bay Area region includes Alameda, Contra Costa, Marin, San Francisco, San Mateo, and Santa Clara Counties. Topics covered in the Bay Area Regional Workgroup included early implications of federal health reform (early expansion options, Medicaid managed care for the MIAs), important decision areas (the Exchange, §1115 waiver, and high risk pool), and long-term issues (the undocumented, workforce capacity, and other issues). Workgroup participants provided overviews of topics and shared their thoughts, concerns, and suggestions.

## Early Implications of Reform

### *Early Expansion Options*

Starting in October 2011, FQHC clinics will receive \$11B in federal funding over 5 years, 10-15% of which California will receive. This money can be used for clinics who transition to FQHC status. There is a possibility that most or even all counties in California will be willing to participate in the renewed §1115 waiver.

### *Medicaid Managed Care for the SPDs and MIAs*

Participants recommend preparing safety net plans and providers to attract and retain patients, however there is concern regarding a limited supply of providers in the Bay Area. The following are county-level updates on managed care for the MIAs:

- **San Mateo:** The County already has SPDs in its managed care plan and the County and plan (Health Plan of San Mateo) are working aggressively on a full long-term care integration effort for SPDs through an amendment to the §1115 waiver. The County and HPSM are also exploring a pilot for CCS integration and are pursuing behavioral health integration through the MIA coverage component of the waiver. They have expanded primary care partnerships to serve the indigent population and will need to continue to work closely with provider partners and consider expanding county operated primary care in order to meet the needs of an expanded CI and Medi-Cal population. The TPA arrangement with HPSM for the MIA population has also allowed the County to better identify disabled individuals who qualify for Medi-Cal.
- **Contra Costa:** The §1115 waiver allows a third county alternative plan for SPDs, but the County requires aggressive funding for primary care.
- **San Francisco:** The County wants to improve access to primary care by improving transportation for individuals to access the services. However, the County has a limited supply of providers.

## Important Decision Areas

### *§1115 Waiver*

Participants look at the waiver as an opportunity to slow spending growth and receive significant enhanced federal funding. The goal is to have fully Medicaid compliant systems in place for enrollment of MIAs under federal reform on January 1, 2014. In addition, the transition period should be spent identifying those newly eligible for Medi-Cal and reconfiguring local safety nets towards a competitive managed care model. Participants support standardizing the enrollment process across all counties using e-application, auto-enrollment and re-determination (i.e. Massachusetts – enrollment connected to payment of taxes). It is important for counties to communicate with each other and maintain benefits for people who move between counties.

Counties must identify their IGTs and CPE that can be matched under the waiver. Following are updates from each county:

- **San Mateo:** Looking at all unmatched funding sources

- **Santa Clara:** Undecided what funds will be used. The county has a large safety net hospital and must consider impacts of waiver.
- **Contra Costa:** Concerns about financial ability to maintain expansion of care.
- **Alameda:** Still in the process of identifying CPEs.

County mental health opportunities still need to be clarified under the waiver. San Francisco is already coordinating with behavioral health, but unsure if waiver funds can be used for behavioral health services.

#### *The Exchange*

Some of the challenges of the Exchange which the participants discussed included the need to move certain Medi-Cal eligibles into the Exchange. The state is working on who would administer this shift and deciding who will administer the Exchange (possibly MRMIIB).

Thoughts on the Exchange included simplifying eligibility for Medi-Cal, moving to adjusted gross income for both Medi-Cal and the Exchange, centralizing and simplifying Medi-Cal eligibility determination, state/federal consolidated matching rate (combining new and existing eligibles), determining an IRS/Exchange relationship, and determining administration of job, income and status changes between Medi-Cal and the Exchange.

Participants recommended that in order to ensure access, the Exchange must have cultural appropriateness, affordable cost sharing, sliding scale premium subsidies, incentives for improved health outcomes, subsidies only available through the Exchange, effective risk adjustment, and program simplification. San Francisco Health plan is likely to participate in the Exchange.

#### *High Risk Pool*

Participants expressed concerns with California's new high risk pool, such as the risk of exhausting funds early and requiring people to be placed on wait lists, complicated enrollment based on disparities between the two programs, their pricing, and benefits, and the issue of affordability which has not yet been clarified.

### **Looking Forward**

#### *The Undocumented*

Since most undocumented will remain uninsured, counties will need to mix and match existing funding care to the undocumented (DSH funds, some community clinic primary care funds, some county funds, emergency Medi-Cal).

#### *Workforce Capacity*

When counties reach their limits, there are talks of enlarging "Operation Access," a private physician volunteer program. The goal should be to raise Medi-Cal reimbursements up to Medicare level. Alternative compensation models include moving away from fee for service, better utilizing nurse practitioners and other health professionals, preventive services, and partial capitation.

#### *Other issues*

Additional concerns with the new health care legislation included:

- Despite policy for guaranteed issue, there is no guarantee of affordability (especially for those just over 400% FPL).
- Challenges in explaining complex new policies to the general public.



-There will be negative impacts of DSH payment cuts, which begin in 2014 - Safety nets will need continued funding to take care of residual insured (possible federal funding redistribution for those with greatest burdens of care to residual uninsured).