

The Inland Empire Region encompasses Imperial, Riverside, and San Bernardino Counties. ITUP hosted two Inland Empire Regional Workgroups in 2010, one in San Bernardino and one in Riverside. Topics covered in these workgroups included implementation of federal reform (updates from IEHP, overview of the current system, Medicaid expansion, mental health, the future of the safety net, electronic health records, and the undocumented), important decision areas (the Exchange and high risk pool), and the §1115 Waiver (identifying matching funds, managed care for MIAs, and community clinics). Workgroup participants provided overviews of topics and shared their thoughts, concerns, and suggestions.

## **Implementation of Federal Reform**

### *Inland Empire Health Plan*

IEHP currently enrolls over 400,000 Medi-Cal members and just under 60,000 Healthy Family members. Through health care reform, approximately 220,000 currently uninsured will obtain coverage through Medi-Cal and over 300,000 through the Exchange, covered by IEHP, Molina, and commercial health plans. As of 2014, IEHP will cover 20% of the Inland Empire population, requiring significant increases in primary care and specialty capacity not only for IEHP but for all of the other health plans covering the newly insured individuals and families. They expect to have over 850,000 members by the end of 2014. IEHP currently has a ratio of 40 primary care doctors for every 100,000 individuals. They added 6,400 new Medi-Cal members in August 2010 and 100,000 over the past two years. More doctors have been willing to work with IEHP due to increasing membership and some shift of commercial patients to Medi-Cal coverage due to the recession. Community clinics and FQHCs are the backbone of the plan and will act as medical homes under federal reform.

### *Current System*

Medi-Cal reimbursement rates are extremely low in the Inland Empire and a priority is to get those rates up for specialists. Riverside has been seeing an increasing number of Medi-Cal and self-pay patients in emergency departments over the years because people find that there is no copay in the ER and it is more convenient. IE is looking at ways to create financial disincentives to visiting EDs. IE also faces challenges creating public-private partnerships, however it will be crucial three years from now and the waiver is an opportunity to begin collaboration.

### *Medicaid Expansion*

Medicaid eligibility will be based on modified Adjusted Gross Income (mAGI) with no asset tests. This will simplify the current system, which has hundreds of categories in Medi-Cal and a confusing structure that leads to many denials. IE participants feel that the program should have a lot of local, county flexibility with local offices where eligibles can enroll. Patients are currently able to apply for Medi-Cal in IE doctor's offices, but many patients are illiterate. San Bernardino plans to purchase kiosks to put in community so that people do not need to come into an office. Other suggestions include CAAs/Navigators, promotion in school districts and community clinics, a "no wrong door" policy, and peer advocates.

### *Mental Health*

IE participants feel that FQHCs should be able to provide and bill for both physical and mental health. Borrego is looking into providing psychiatrists via telemedicine and currently relies on teleconferencing for mental health because of their rural location. Participants believe that good pilot programs should be developed for mental health integration. Currently, Medi-Cal mental health is carved out and the region is strapped for resources.

### *The Future of the Safety Net*

There is a concern that the newly insured will shift away from county services to places like Kaiser, which has a strong reputation in the area. IE aims to work together to improve county care

to the uninsured and create a more integrated system that is not siloed in its payment structure. Community clinics will definitely be a part of Medi-Cal and the Exchange in 2014, but unlike public hospitals, there is a shortage of clinics in the IE area. Private physicians see a significant number of Medi-Cal patients due to the low number of FQHCs and other clinics in the IE, but are challenged by Medi-Cal reimbursement being lower than commercial or Medicare payment. Loma Linda is in the process of building more clinics and accepting more Medicaid patients.

#### *Electronic Health Records*

Riverside is a C4 county. Borrego is improving their documentation and coding. Hospitals are “energetically” adopting EHR. A Local Extension Center (Inland Empire EHR Resource Center), funded by ARRA funds through CALHIPSO, is currently assisting physicians in selecting, adopting and reaching meaningful use utilizing an electronic health record. Also, the Inland Empire is in the final stages of forming a Health Information Exchange (called Inland Empire Health Information Exchange (IEHIE) and is exploring start-up funding and building a self-sustaining financial model. HIE will provide for the secure exchange of health data amongst healthcare provider and patients and will increase the quality and outcomes of that care. Due to the costs of an EHR there is resistance to adoption among some physicians.

#### *The Undocumented*

Emergency Medi-Cal, DSH, county funding, and community clinic funding, First 5 (for Healthy Kids) currently fund the undocumented. Participants feel that hospitals and community clinics should share information to better coordinate care for these patients.

### **Important Decision Areas**

#### *The High Risk Pool*

California’s current High Risk Pool, MRMIP, costs \$30-\$40M and premiums are set at 125% of those of the private market. California decided to start a new, statewide High Risk Pool for individuals with pre-existing conditions who have been uninsured for 6+ months. Premiums will be set at 100% of the premiums of private, individual coverage with no annual or lifetime limits. California will receive \$761M for this program. There are 23,000 spots available in California. IE participants suggest targeting physician specialty practices in order to identify potential enrollees.

#### *The California Health Benefit Exchange*

40% of those currently uninsured in California will be eligible for premium subsidies through the Exchange and subsidies will be based on Adjusted Gross Income with no asset tests. Participants predict that one of the biggest challenges will be getting people into the system. They believe that much of the success of the Exchange will depend on employer participation for currently insured employees. The minimum essential benefits do not include adult dental and in order for it to be required in the state, it must be 100% funded by the state.

One of the reasons PacAdvantage had adverse selection was because plans could be inside and outside the market, and there were different prices and underwriting rules in the outside market. In the Exchange, plans have the same rules inside and outside the market and “risk adjustment” will deter cherry picking. IE’s goal is to keep the Exchange simple for the subscriber without too many confusing options, including a single point of entry for the Exchange, Healthy Families, and Medi-Cal. They also feel that there must be working relationships between local plans for individuals who seek care in bordering counties.

There are questions as to whether programs such as ADAP, CCS, and AIM should be folded into the Exchange, kept separate, or phased down as residual coverage. Pros to keeping programs separate are low copays, specialized services, and availability to undocs. The downside is that the state is paying for these programs whereas the federal government will pay 100% of

Exchange subsidies. Participants suggest that we decide what program elements to keep as the system changes, possibly as wraparound coverage in the Exchange and as residual programs for those who fall between the cracks.

IEHP would face competition with commercial plans if they joined the Exchange, however they would have the advantage of their current expertise with the low income. Their costs would be lower because they do not pay shareholders. However the quality of care in the region must be drastically improved and primary and specialty care capacity must be expanded as 400,000 new patients are expected. IEHP would likely tailor its marketing strategy to attract the population they service (200% FPL and below). If IEHP joined the Exchange, they would have a very different role than they have now.

### **§1115 Waiver**

IE's goal of the waiver is to put individuals in an organized system of care. Riverside County is trying to work more closely with public health clinics and look for opportunities to better integrate services and improve information sharing. They feel that their current system cannot cover all the uninsured in the community, so community partners are essential for expanding the workforce. San Bernardino County has a good relationship with the hospital and is looking into co-locating services before 2014. The CI will be extremely important to the hospitals in the county. Currently, about half of San Bernardino County's population is either uninsured or on Medi-Cal; 20% of the uninsured are undocumented.

#### *Identifying Matching Funds*

IE counties have not yet addressed how to manage their budgets. In the past, counties have capped enrollment. Riverside County finds it challenging to determine exactly how much is spent on MIAs that can be matched and from which revenue streams these funds are being spent because federal dollars cannot be matched with federal dollars. The County puts MIA dollars into clinics and hospitals and also covers care for MIAs outside of the county system. Riverside County will need to broaden their network in order to draw down a match. IEHP might serve as a third party administrator (TPA) under the waiver. San Bernardino has no new general county funds other than realignment, Prop 63, and funding that already goes to the uninsured.

#### *Managed Care for SPDs*

SPDs who move into managed care already have issues with access to specialists. Current reimbursement structures drive the wrong behavior and participants feel that care coordination and patient education are crucial to driving down costs and promoting healthy outcomes. They hope that ACOs will streamline the care and payment process.

#### *Community Clinics*

Participants feel that the waiver should include community clinics so that they can begin putting a primary care network in place (the approved waiver says counties must contract with at least one FQHC at FQHC rates). Both San Bernardino and Riverside Counties are expanding the structure of FQHC clinics.