

ITUP hosted two North Central Regional Workgroups in 2010, one in Yolo and one in Napa. The North Central region includes Yolo, Sacramento, Napa, Placer, El Dorado, Solano and Sonoma Counties. Topics covered in these workgroups included data on North Central's uninsured, the Exchange, the §1115 waiver, electronic health records, and ACOs. Workgroup participants provided overviews of topics and shared their thoughts, concerns, and suggestions.

Data on North Central's Uninsured

Between 2006 and 2009, there was a 4% increase in the uninsured, from 14.4% to 18.1% (500,000 uninsured) in the North Central region. The number of uninsured has decreased in Napa but significantly increased in Yolo from 13.2% in 2006 to 20% in 2009. Statewide, the number of uninsured has risen from 20.2% to 24.3%. Federal reform is estimated to expand coverage to close to 100,000 uninsured in the North Central region.

Other significant trends include the decrease in county funding due to the recession and reduction in realignment funding. North Central also experienced an increase in Medi-Cal enrollment and a small decrease in Healthy Families enrollment (most likely due to lack of CAA funding, enrollment caps, premium increases, and/or the bad economy leaving more eligible for Medi-Cal). North Central has a higher HFP enrollment than the rest of California. Care to the insured (including Medi-Cal) is rising in North Central community clinics, whereas care to the uninsured is falling. Revenues are down for EAPC and net operating revenue is getting worse (down 4.1%). North Central hospitals are experiencing an increase in bad debt and charity care (up 35%), but North Central has better county funding than the rest of the state.

The Exchange

Forty percent 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 feel that the counties should have roles in offering local-level help with processing of applications. There should be a combination of local and state enrollment where community leaders will play a key role. They feel the counties have the resources and knowledge to help applicants. Participants suggested OERU funding for counties to do enrollment (similar to CHI outreach).

There are questions as to whether programs that are currently offering coverage to individuals between 133% and 400% FPL, such as ADAP, Healthy Families, 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 50% of the cost of these programs whereas the federal government will pay 100% of Exchange subsidies. Participants feel that rolling programs into the Exchange will interrupt niche services and that it is important to keep programs in place so that the undocumented can access care. They support merging HFP into the Exchange so that kids and parents have the same types of coverage (HFP funding as wraparound to maintain benefits).

§1115 Waiver

County Updates

Representatives from each county provided updates in terms of county coverage and preparing for the waiver. Placer has identified the MIA population and but has not yet identified potential funds that will be freed up. Yolo recently stopped covering the undocumented because of funding issues. Sacramento had to begin applying DRA rules because of rising costs and can no longer cover the undocumented. All counties' current priority with new funding is paying bills.

Sacramento also hopes to start re-operating clinics and Contra Costa/Solano will invest in specialty care. CMSP counties have similar structures to what is required under the waiver.

Managed Care for SPDs

Under the waiver, some counties are mandated to move SPDs into managed care. Larger counties with organized systems of care will be easily assimilated while those with health professional shortages will have challenges. Some counties will remain fee-for-service. County representatives shared what this would mean for their counties: Napa and Yolo are COHS counties that already cover the SPD population; Contra Costa does well contracting with providers seeing SPDs; Colusa will be challenged since they do not currently have managed care in the entire county and there are not enough physicians to take on this population; Yuba is rural and therefore does not have the population or infrastructure for managed care; Placer has unsuccessfully tried to switch to managed care three times over the past eight years; Most of Sacramento's SPDs are already in managed care plans (mostly urban area).

Waiver Funding Opportunities

In Napa county, \$5.3M was spent on 1300 MIAs in one year, 34% of whom were under 100% FPL. This money could potentially be doubled under the waiver, freeing up funds for the county's spending on the uninsured. Napa counties priorities include filling up the \$1M shortage, expanding Partnership Health Plan, creating a uniform eligibility process, investing in mental health services and integrating mental and physical health, and creating a wellness and recovery model.

Electronic Health Records

Approximately 150 techs are needed to implement EHR in North Central. Rural counties have seen more success in implementing EHRs in community clinics and FQHCs than in hospitals because they have designated individuals dedicated to implementing new systems. HIPAA confidentiality rules make EHRs difficult. Solano County is the furthest ahead in terms of EHR. Community Health Centers have been early adopters (they received funding before others) but physicians see electronic records as very high tech and contrasting the terms of meaningful use. Participants feel that IT techs and physicians need to collaborate to create an efficient system. In Yolo, clinics have implemented EHR and communicate with UC Davis. Napa County has it's own IT system that is used by Aldea Children and Family Services.

Accountable Care Organizations (ACOs)

An ACO is a team of providers that manage and coordinate care for patients across different care settings to improve outcomes and share cost savings. The ACO concept creates an organization that is rewarded for improving quality of care, where providers are paid in a way that influences them to work together to improve health care outcomes. The goal of an ACO is to contain costs through better integration among health care providers, where delivering high quality of care is encouraged through financial rewards based upon performance measurement. If the ACO meets its performance and savings guidelines, the members receive a portion of these savings as an incentive for successful collaboration.