

ITUP hosted three North Rural Regional Workgroups, one in Mendocino County, one in Humboldt County, and one in Shasta County. The North Rural region is made up of 16 counties, including Butte, Del Norte, Humboldt, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Siskiyou, Sutter, Tehama (includes Colusa, Glenn and Lake), Trinity, and Yuba. Topics covered in these workgroups included data on North Rural's uninsured, implementation of health care reform (the Exchange, the High Risk Pool, clinic updates), the §1115 Waiver, electronic health records, accountable care organizations, and a presentation from Aligning Forces For Quality (Humboldt).

Data on North Rural's Uninsured

North Rural experienced a large increase in the uninsured from 2006 to 2009 (19.7% in 2006 to 26.9% in 2009). One fifth of the region's population is enrolled in Medi-Cal and Medi-Cal enrollment increased slightly from 20.3% to 21.7% between 2006 and 2009. Statewide, Medi-Cal enrollment has increased from 18.2% to 19.2%. North Rural also experienced 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). Clinics in the region have experienced a drastic decrease in state and county funds and a large increase in federal funds, patient fees, and private funds.

Implementation of Health Care Reform

The Exchange

In 2014, 3.3M Californians will be eligible for subsidies through the Exchange. Forty percent (2.3M) of those currently uninsured in California will be eligible and subsidies will be based on Adjusted Gross Income with no asset tests. These subsidies will be tied to the second lowest cost silver plan. Participants feel that local support will be necessary to assisting with enrollment. They believe that brokers should not be the only navigators and that the locals are better positioned to identify and educate eligibles. Language in the reform bill states that hospitals can make initial eligibility determinations and North Rural clinics want similar authority. Participants also support a local advisory board to assist with Exchange enrollment.

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 feel that the Exchange should consider some successes amongst public programs such as simple applications, low copays, low premiums and good benefits in HFP, the privacy and instant enrollment in FamilyPACT, and the better reimbursements in CCS.

The competition in the Exchange will be highly beneficial for North Rural residents who currently face high premiums due to a shortage of plan options. Mendocino and Shasta are considering creating Co-Ops, however the size requirements might be an issue in Mendocino.

Pre-Existing Condition Insurance 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 but only 500 people have applied. Potential reasons include high premiums (\$400-\$900/month depending on age and geography) and lack of outreach.

Clinics

Mendocino is in the process of merging all clinics in the county. With possible federal clinic funding over the next five years, participant priorities include funding to give FQHC status to tribal/native corporations and look-alikes, better transportation within the county, and expanding telemedicine. Humboldt clinics are concerned about undocs and those who will not be eligible for coverage under reform. Over the past three years, two clinics have closed in Shasta.

§1115 Waiver

All North Rural counties are considered CMSP counties. Since CMSP already looks a lot like Medi-Cal, it will be easy for counties to draw down matching funds under the waiver. Participants like that CMSP is a locally-run program and do not want too many restrictions. With the extra waiver money, participants suggest counties invest in mental health, drug and alcohol abuse, prevention/wellness, outreach, case management, care coordination (especially for SPDs), specialty care access (increasing payments to providers), a 3-month retroactive reimbursement, dental benefits, medical homes and doing annual determinations.

Once these individuals move into Medi-Cal under federal expansion, participants suggest using the savings on a local safety net infrastructure for those who fall through the cracks, capacity building (provider recruitment and retention), telemedicine, increasing provider rates, case management, better reimbursement for primary care, support for local programs, dental benefits, and local substance abuse treatment.

Electronic Health Records

Shasta clinics have strong EMR systems, but they are all different and therefore health information exchange might be difficult. They plan on doing an EMR inventory to determine who is using what. Telemedicine is popular, but limited by who is providing the service on the other end. 50% of all patients in Humboldt are in EHR systems (mostly clinics and IPAs). Almost all clinics have at least one contract. There is some communication between clinics and hospitals, but it is unidirectional (clinics can tap into hospitals, but not vice versa). Participants feel that electronic referrals might be the best way to strengthen those communications. Mendocino has EHR systems, one of which (NextGen) is aligned with the County.

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. Shasta is interested in exploring the ACO model. Community players have been very involved in the discussion. Mendocino would be interested, but feel that geographic isolation would create too big of a barrier.

Aligning Forces for Quality (AF4Q)

At the Humboldt workgroup, AF4Q members presented on their Robert Wood Johnson Foundation initiative to address health care quality. They explained the “rural conundrum” of a great medical system and poor community health. The three AF4Q focus areas include ambulatory care, in-patient care and consumer engagement. Their goals are improving health



North Rural Regional Workgroups

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Executive Summary

Insure the Uninsured Project

care quality and reducing disparities in health care. They develop and implement a high-quality, engaged and coordinated network of care that links primary care and hospitals. AF4Q encourages people to become their own advocates and co-managers of health care using patient empowerment and self-management skills.