

Topics covered in the San Diego Regional Workgroup included data on San Diego's uninsured, early implications of reform (high risk pool, the Exchange, young adult coverage, clinic funding, EHRs, ACOs, the undocumented, and children's coverage), and the §1115 Waiver (updates from Bay Area counties, updates from San Diego, challenges moving forward, managed care expansion, and health portals). Workgroup participants provided overviews of topics and shared their thoughts, concerns, and suggestions.

Data on San Diego's Uninsured

Kamal Muilenburg (San Diegans for Health Care Coverage) presented data on San Diego's Uninsured. After 2014, 25% (100,000) of San Diego's current uninsured population will remain uninsured (including immigrants). Assuming all legal permanent residents (LPRs) and U.S. citizens who are eligible for Medi-Cal expansion and subsidies in the Exchange participate, only 4% of legal San Diegans will remain uninsured. SDHCC predicts that the private sector will pick up more of the uninsured population than the public sector because of the number of Exchange subsidies. A local task force is addressing SD impacts of federal reform, including the waiver, enhanced public/private communication, and systematic changes to ensure a smooth transition.

Early Implications of Federal Reform

High Risk Pool

Cliff Sarkin (ITUP) explained the High Risk Pool. 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. The state might eventually supplement these still-high premiums. California will receive \$761M for this program (\$5B allocated nationally). There are concerns about MRMIB running the pool given the challenges they faced with Healthy Families program. Outreach is extremely important; SD should target hospitals and those who work with high-risk populations.

The Exchange

The Exchange is quite possibly the most complex element of federal reform. States will either have their own exchanges, multi-state (regional) exchanges or statewide exchanges with premium variations by region. California has decided to create its own exchange and currently has two bills that set the framework (AB 1602 and SB 900). ITUP uses workgroups as an opportunity to get stakeholder feedback on the formation of the state's Exchange. San Diego participants feel that local navigator roles should be strong to ensure community feedback gets back to the Exchange. They feel a mix of government and the private sector should run it to ensure transparency and flexibility. Participants also believe that it is important to separate Northern California from Southern California so that there are regionally subsidized rates, implementation and responsiveness and for the Exchange to be an active purchaser. Small businesses and individuals should be in the same pool, but treated differently.

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 undocumented immigrants. 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 within as the system changes, possibly as wraparound coverage in the Exchange and as residual programs for those who fall between the cracks.

Young Adult Coverage

Ashley Cohen (ITUP) presented information regarding the expansion of young adult coverage. Young adults (ages 19-29) have the highest uninsured rate compared to any other age group

(30% in U.S., 26.4% in CA, 25.5% in SD) and nearly half of uninsured young adults report problems paying medical bills. Federal reform expands coverage to young adults both directly and indirectly via including childless adults in the Medicaid expansion (53% in the U.S. have incomes below 133% FPL), small business tax credits (35% in the U.S. work for small businesses), the high-risk pool (14% in the U.S. have a chronic illness, 15% of which will qualify for the pool), dependent coverage extension up to age 26 (1.2M estimated to benefit in CA, 650,000 of whom are currently uninsured), and subsidies in the Exchange (5.5M (41%) of uninsured fall between 133% and 400% of FPL in the U.S.). Outreach to this age group is important and can include social media, peer groups, and schools.

San Diego Clinics

Gary Rotto (Community Clinic Consortium) explained that \$1B in clinic funding will be allocated by the federal government in September/October. That funding will escalate over the next 5 years. The funding will go to established clinics to expand and continue current work and to new projects at sites that are deemed eligible for funding. San Diego believes they have a competitive chance at getting a share of funding due to the urgent need in the county. Safety net clinics will have to contract with successful networks to be a part of the Exchange. They are predicted to do well if they successfully identify newly eligible populations via both in-reach and outreach (only 3-5% of current clinic patients are between 200-300% FPL).

Electronic Health Records

A few SD County clinics are utilizing EMRs; safety nets have MOUs and are in the testing phase. For the most part, the County is behind and having issues catching up to where they should be (not in a position to take advantage of federal funding). Providers feel that EMRs lead to increased competition. SD is one of 14 counties selected for the Beacon project and received \$14M in technology grants (ARRA funding).

Accountable Care Organizations

ACOs are important in transforming the system to gain better value and SD County is ahead of the curve in the thought and development process. The ACO target population is Medicare beneficiaries. The ACO model might also work well for the Medi-Medi population (high percentage of chronically ill with poor coordination between the two programs). Participants wonder if the state will keep the savings rather than giving it to providers as incentives. Many questions remain regarding ACOs, including governance, funding, leadership, and physician participation. SD's current system is unique in that there are no county hospitals so the county contracts with medical groups and integrated systems that communicate. They count on private physicians, health plans and private hospitals.

Children's Coverage

Since there are many unknowns with the Exchange, the federal government decided to authorize CHIP funding through 2019 with a block grant that expires in September 2015. Pros to folding the Healthy Families Program (HFP) program into the Exchange include 100% federal funding, best elements of both programs can be combined, and parents and kids can be on the same plan. Cons include the current consumer satisfaction with HFP and lower copays, deductibles and premiums than the Exchange might offer.

§1115 Waiver

The renewed waiver will put CCS children into pilot programs, provide matching funds for all counties to cover their medically indigent, mandate some counties to put SPDs into managed care, and fund hospitals for delivery system reform.

Updates from Bay Area Counties

Representatives from four Bay Area counties, including San Mateo (Srija Srinivasan), Contra Costa (Wanda Sessions & Cathryn Taub), San Francisco (Tangerine Brigham) and Alameda (Vana Chavez) joined the meeting via conference call to provide updates on their current Coverage Initiatives and plans for the next waiver.

San Francisco's efforts have been focused on standardization and eligibility. Their one-way interface with the Medi-Cal eligibility system determines if individuals are eligible for Medi-Cal and electronically sends the application to Human Services for processing. They are awaiting clarification from CMS to find out if the CI provisions will be required of Healthy San Francisco since the program does not always match Medi-Cal. Most CI enrollees are between 35-55 but they have seen an increase from 5% to 11% of 18-24 year-olds over time. The majority of enrollment sites are medical homes (county and community clinics, doctor's offices) and they find that some beneficiaries only enroll when they need a service. The average program costs are \$300ppm.

San Mateo's enrollment is currently on hold since their demand has exceeded their county and federal funds. They have future plans to participate in other pilot projects within the waiver centering on behavioral health, Medi-Medi integration and long-term care integration. San Mateo also has a one-way interface with the Medi-Cal eligibility system, and works as an "add-on" to Social Services in terms of benefits (not a one-stop shop for coverage). Their only community health center is a CI provider.

Contra Costa has an electronic system that assigned enrollees to a PCP as a medical home (primary care is provided at FQHCs). They currently get the California Birth Index to align with enrollment but are hoping to do Social Security matching with grant money. The County met and exceeded its target enrollment for every year of the three-year grant. The CI provides most benefits (not mental health) and is managed through the Contra Costa Health Plan.

Alameda recently submitted a grant application to fund enhancements for their current records system so that they can appropriately categorize applicants. They will be hiring consultants to do actuarial work relative to CEED reimbursements and to do needs assessments for the current provider network. In year one of the CI, the County did not reach their enrollment goal. They exceeded their enrollment goals in years two and three. The County has been successful in providing medical homes. They maintain a separate system from the county and contract with clinics that are already FQHCs.

Updates from San Diego

The County maintained a CI enrollment of approximately 3,000. They have begun engaging stakeholders in planning and designing the new expansion. The new CI would increase the total projected enrollment to 21,000. These enrollees will be designated to medical homes and behavioral health integration will be a large priority. The County wants to work with safety net providers in the CI expansion and build on existing success. The current cost of the program is high, \$400ppm, because of disease management. The County is trying to have Alta-Med do e-eligibility. Under the new waiver, SD will have more of an SF model in which it will be open to all medically indigent and not just high-risk patients.

Challenges Moving Forward

The County is unsure if local health plans are ready to move seniors and persons with disabilities (SPDs) into managed care by January 2012. The County also experiences a lack of provider participation. Although they can mandate patients to move into managed care, they cannot mandate health plans to participate.

Health Portals

Clovis Honore (Congregations for Change) described a statewide project that focuses on prisoners facing re-entry. The organization has asked for increased public health funding to meet the needs of 44,000 people returning from prison due to overcrowding. They support health portal demonstration projects as a part of the §1115 Waiver. Because health portals are clinics, waiver funds may be available to pay for direct medical services. There are also talks of creating a primary care organization targeting this population, who suffer from very poor health (diabetes, hypertension, oral health issues).