



Merced County Health Care Consortium

**Affordable Care Act Readiness Project
Thursday, May 23, 2013
Meeting Summary**

Attendees:

Representatives from Member Agencies: Steven Slack, Jan Wolf and Jennifer Mockus, Central California Alliance for Health; Christine Bobbitt and Corrina Brown, Merced County Human Services Agency; April Brewer, Dignity Health; Christine Noguera, Golden Valley Health Centers; Lori Norman, Merced County Department of Child Support Services; Sharon Robinson, Merced County Mental Health Department; Steve Roussos and Paul Brown, University of California, Merced; Chrisy Muchow, Merced Mariposa Medical Society; Cindy Valencia, and Kathleen Grassi, Merced County Department of Public Health.

Consultants and Support Staff: Rafael Gomez, Pacific Health Consulting Group; Joel Diring, Diring and Associates; Karl Stahlhut and Sarah Baker, Merced County Department of Public Health.

Agenda Items	Discussion Summary	Resources / Action Items
<p>Welcome and Introductions</p> <p>Joel Diring Diring and Associates</p>	<p>Joel facilitated introductions.</p>	
<p>Policy Updates on ACA and Local Implementation Activities</p> <p>Joel Diring</p>	<p>Joel provided the following ACA updates:</p> <p><u>Covered California</u></p> <ul style="list-style-type: none"> • Covered California announced the qualified health plans and the rates for each plan. Region 10 - San Joaquin, Stanislaus, Merced, Mariposa, and Tulare Counties - will have the following health plans: Anthem, Blue Shield, Health Net, and Kaiser Permanente. Merced County residents will be able to choose from Anthem, Blue Shield, and Health Net. • Each plan must provide the 10 essential health benefits. There is no pre-existing condition exclusion or caps on benefits. The only difference in premiums is based on age and residency. California did not opt to have a premium differentiation for smokers. Preventive services will not be subject to co-pays or deductibles. • Individuals at 138% FPL who are documented and children under 250% FPL will qualify for Medi-Cal. There will be individuals whose income fluctuate around 138% FPL – falling below 138% FPL qualifying for Medi-Cal and above 138% FPL requiring purchase from the Exchange. A Bridge Plan is under development to allow these consumers to remain in Medi-Cal plans with the same provider network up to 200% FPL and, therefore, to maintain provider continuity, when they move from Medi-Cal eligible to the Exchange. 	<p>Materials Provided:</p> <p>Press Release- <i>Covered California Announces Plans and Rates for 2014</i></p> <p><i>Affordable Care Act Implementation Updates Power Point</i></p>
<p>ACA Outreach and Enrollment</p>	<p>Joel provided an update on current outreach and enrollment issues:</p> <p><u>Outreach and Education Grants</u></p> <ul style="list-style-type: none"> • Covered California announced outreach and education grantees on May 14th. Grantees who will be working in Merced County are: the California NAACP; School Health Centers Association; Central Valley Health Network; Planned Parenthood; United Way; U.C. Berkeley School of Public Health, Health Initiative of the Americas; and U.C. Davis, Center for Reducing Health Disparities. 	



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	<ul style="list-style-type: none"> • Jennifer Mockus - agencies that were funded to do work in Merced County should be developing or have developed a scope of work. She suggested that the Consortium ask for that information and/or ask if these organizations would like to participate in this group. • Joel - Covered California is assigning staff to coordinate within counties. The Consortium could reach out to Merced's assignee and invite them to the next meeting. • Christine Noguera - Golden Valley did not apply for the Covered California grant because it was specifically for the Exchange, not Medi-Cal, and it's was about outreach, not enrollment. However, they are part of a grant to the Central Valley Health Network. Jan Wolf - Santa Cruz and Monterey Counties applied together for the Covered California grant to build the infrastructure, relationships, and messages would be beneficial for both the Exchange and for the Medi-Cal expansion. • Joel - there is no current funding for Medi-Cal expansion outreach activities, although, The California Endowment has approached the state with a proposal to fund \$37 million for Medi-Cal outreach and to draw down federal match. <p><u>Draft Applications</u></p> <ul style="list-style-type: none"> • Joel shared the California Healthcare Eligibility Enrollment Retention System (CalHEERS) processes. He also shared draft applications for enrollment. There will be three sets of applications – individual w/subsidies; families' w/subsidies; and applications without subsidies. When fully operational, CalHEERS will be able to verify information provided through other government agencies such as check immigration status with Homeland Security, verify social security numbers through Social Security, and check with the IRS to verify reported income and household size. <p><u>Community Activities</u></p> <ul style="list-style-type: none"> • Christine Noguera - the U.S. Health Resources and Services Administration provided local Federally Qualified Health Centers additional funding for outreach and enrollment. Golden Valley already has certified assistors on their payroll. • Corrina Brown – Merced County HSA is pulling lists to determine potentially eligible individuals such as those who were denied Medi-Cal in the last year. • Joel - the Public Health Department's Medical Assistance Program could also track clients that apply. Kathleen - MAP currently serves about 1,400 individuals but there are estimates of 12,000 medically indigent in Merced County that could be Medi-Cal eligible with expansion. Karl Stahlhut - MAP only covers people that have a current medical need so those numbers could be accurate. Corrina Brown - at the present parents of children transitioning from Healthy Families are not requesting Medi-Cal; however, they are potentially eligible under the expansion. • Christine – Golden Valley is developing lists of patients identified within their system in the last 24 months. All agencies conducting in-reach should have similar messages. Golden Valley will do in-reach and outreach and the new HRSA funding is specifically for outreach for both Medi-Cal and the Exchange. • Kathleen Grassi - the purpose of this grant is to identify these activities and coordinate where possible. 	
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	<ul style="list-style-type: none"> • Corrina - the streamlined Medi-Cal application are to identify those who are Medi-Cal eligible but the Exchange will enroll some of these individuals into Advance Premium Tax Credit (APTC) plans, “the metals”, while their Medi-Cal determination is in process. State DHCS has indicated that share-of-cost Medi-Cal does not meet the essential health benefits coverage so these individuals would have to purchase coverage from the Exchange; an individual could have share-of-cost Medi-Cal and APTC. • Jan Wolf – Can an individual could be in an Exchange plan and have Medi-Cal as their secondary coverage? Corrina Brown - that could only happen with share-of-cost Medi-Cal. • Joel - there is potential for a lot of crossover/dual-eligibility. A person could have employer coverage but the Medi-Cal coverage may be wider so they could have both with Medi-Cal as the payer of last resort. • Jan - the Governor’s May revise included pregnancy-only Medi-Cal beneficiaries, 100% to 200% FPL, would go into the Exchange but the state would pay their subsidies. Essentially, they would have zero cost coverage but their enrollment would be done through the Exchange with a silver plan. The state would cover anything that their tax credit didn’t cover including their co-pays and deductible. 	
<p>Medicaid Expansion Update</p> <p>Kathleen Grassi Merced County Public Health Department</p>	<p>Kathleen provided an update of the Medicaid expansion:</p> <ul style="list-style-type: none"> • The Governor’s May Budget Revise has dropped the county option for Medicaid expansion and has committed to state-administered Medi-Cal expansion for the medically indigent in January 2014. • The state has determined that counties would have significant savings; therefore, the state will “take back” county health realignment funds - \$300 million in 2014, \$900 million in 2015 and \$1.3 billion thereafter. • Counties will continue to be responsible for the indigent population not be eligible for Medi-Cal expansion. Each county has different rules for their indigent care program so their residual obligation for the medically indigent will vary. Merced County’s MAP has set eligibility at 100% of FPL, county resident, U.S. citizenship, and a health condition requiring medical attention. Public Health has estimated the remaining population who will be served through MAP will primarily be immigrants who have been in the country less than five years. • Since the May revise came out three groups of counties have organized with the California State Association of Counties (CSAC) to negotiate with the state on the “take back” provision. These are: 1) counties with hospital and clinic systems; 2) small counties that are administered through the County Medical Services Program (CMSP); and 3) 12 counties are neither hospital counties nor CMSP counties. Merced County is part of the 12 county-group. • The State Department of Health Care Services and Department of Finance are moving quickly to put the Governor’s proposal into legislation to accompany the state budget vote in June. Counties have a small window to counter the current proposal. • Joel - realignment doesn’t just fund the medically indigent; it is core public health funding. Kathleen - the formula for county health realignment, made up of sales tax and vehicle license registration fee revenues, 	



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	<p>was developed in 1991-92 and proportioned between medically indigent programs and public health programs. The current proposal would take both portions of realignment; counties are negotiating to limit the “take back” to just those funds allocated for indigent health care programs.</p> <ul style="list-style-type: none"> • April Brewer - what percentage of the Department’s budget comes from realignment funds? Kathleen - \$8 million of the Department’s \$20 million budget is derived from realignment funding for both the MAP program and core public health programs. The balance of the \$20 million budget is derived from categorical funding allocations and grants. It is the only discretionary funding available to cover core public health programs not funded by other sources. • Jennifer Mockus - is there was a formula in the May revise to demonstrate actual costs? Kathleen - the state’s current formula would have counties go back four years for a historical accounting of what has been spent on the medically indigent as a baseline. Going forward, each year the county would be audited by the state to determine the difference between the baseline and current expenditures for this population; this would constitute the county’s savings. It will take several years to identify what the true savings will be but the state plans to “take back” funds right away and then “true up” in five years when actual data is available. • Kathleen - the May revise also included a proposal to move California Children’s Services Program to state administration, likely under Medi-Cal managed care, but not for several years. 	
<p>ACA Presentation</p> <p>Paul Brown, Ph.D. U.C. Merced</p>	<p>Paul Brown went to Washington, D.C. in September of 2008 when health economists were being retained because it was expected that Barack Obama would win the election and health care reform would come. Paul shared how health economists view what is happening now with health care reform.</p> <p><u>Introduction</u></p> <ul style="list-style-type: none"> • The current major health care challenges are uninsured/lack of care, greater need for clinical and fiscal accountability, expenditures/cost of health care, technology, chronic health conditions, healthcare delivery changes, and lack of a coordinated system. Health economists are talking about the ACA, the move towards capitation and bundled payments (paying a certain amount for an individual rather than fee for service) moving people to medical homes, and electronic medical records. • The ACA poses three questions. Will the insurance mandate work? What is the likely impact of health outcomes and health spending? Where will the gaps be? He summarized what is known about the international experience and what has happened in Massachusetts and Oregon to try to answer these questions. • There are four types of health care systems in the world: 1) insurance-based systems like Germany where everyone is required to buy private insurance: 2) government-run systems like the U.K. where the government runs the hospitals; 3) government reimbursement systems like Canada; and 4) a pay as you go system as seen in developing countries. The United States is unique in that it has elements of all four types. The result of the ACA is that it will be closer to the German system. Everyone is required to have insurance and the government strongly regulates the health insurance market. This type of system provides good coverage for individuals but it struggles with healthcare costs. 	<p>Materials Provided:</p> <p><i>Health Economist’s Review of the ACA Power Point</i></p>



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	<p><u>International</u></p> <ul style="list-style-type: none"> All countries have some type of private providers. Where the government is the payer, it increases the level of responsibility including identifying groups with unmet needs, prioritizing what will be purchased, contracting with providers, contracting in ways that will encourage hospitals to talk with primary care providers, and monitoring skimming and cost shifting. <p><u>Massachusetts</u></p> <ul style="list-style-type: none"> The Massachusetts plan is similar to the ACA. It has an individual mandate, employer mandate, government subsidies for low income, and a single market in the state. The results show that both the public and providers are in favor of the plan. Following the implementation of health reform, the uninsured rate dropped by about half. Unmet need also experienced a significant drop. Not surprisingly, it has had limited success with vulnerable populations which suggests that special effort is required above and beyond just offering insurance. Impact on medical expenditures increased 7.5% from 2006 to 2008. Most of that is related to price increases but they associate 2% of that with greater insurance coverage. This suggests that this won't solve our health expenditure crisis which is what we should expect when giving people access but not doing anything to limit costs. <p><u>Oregon</u></p> <ul style="list-style-type: none"> In 2008, Oregon increased enrollment in Medicaid by 30,000. 90,000 applications were received; so individuals were randomly selected to enroll. The results of Oregon's efforts are now becoming available. Health care usage increased by 35% across all categories, such as physician services, prescription drugs, and hospitalizations. One of the big outcomes was that individuals' financial strain was greatly reduced. Depression rates after two years were reduced by 30% for this group compared to the control group. Health care costs did increase but there was some indication of better control of chronic conditions. It didn't translate into better health outcomes but considering the short frame and a small sample size this outcome can be debated. <p><u>Results</u></p> <ul style="list-style-type: none"> Looking at Massachusetts, the Exchange should work. With a Medicaid expansion more people will use healthcare. Healthcare costs will go up but not dramatically, as seen in Massachusetts and Oregon. If people have access to healthcare, it doesn't necessarily mean that they will use it, or that it will be good healthcare, or that it will be seamless. An issue that isn't addressed by the ACA is the delivery of healthcare services. Health economists say that healthcare delivery will look very different five years from now. Another issue not addressed is prevention services. Overseas, where a medical home model has been used, healthcare providers have the big picture view of prevention services and some don't, so sometimes good preventive care is not being provided. In these cases, government has had to step back in and set up separate prevention services for certain groups. Coordination of care is another issue not addressed by the ACA. Who will ensure that seamless healthcare delivery is provided? In other countries, there are government organizations responsible for 	
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	<p>monitoring these issues and the overall health of the population. Finally, cost of care is not addressed in the ACA. Choices like whether or not to use incentives to avoid unnecessary tests or treatments and all those cost control measures are not required.</p> <ul style="list-style-type: none"> • Moving to these types of enrollment systems tend to raise the potential for cream skimming or cost shifting. Moving towards medical homes may address the lack of coordinated care. Electronic medical records are good for internal quality control, like flagging when a patient needs to have a test done. However, a lot of money is spent setting up technology but overall it has had a minimal effect on decreasing costs or moving towards better care. • Other changes include capitation and bundling of payments. Something of interest is the way the ACA changes hospitalization reimbursements. A second admission within 30 days will be treated as a re-admission. One way to look at it is hospitals incentive will be to work with clinics so patients won't be re-admitted. It's like giving a capitated payment to the hospital. • Dr. Slack - the Alliance was paying its providers under capitation. However, under the ACA, the federal government increased certain codes for primary care physicians. In order to demonstrate that the increase in reimbursement is going directly to the primary care provider, the federal government is requiring that it be recognized as fee for service. Therefore, as of January of this year, the Alliance pays its primary care providers under a fee for service system. • April Brewer - the hospital and other local clinics use NexGen but HIPAA restricts their ability to communicate and share information. • In other countries, government agencies usually take responsibility for the big picture issues. In a place like the San Joaquin Valley, it will most likely fall on public health departments but they may not get funding to support that effort. Public health departments will have a reduced role in healthcare services. Whether or not they remain a provider of services is yet to be seen. 	
<p>Other Business</p> <p>ACA Topics for Future Meetings</p> <p>Rafael Gomez, Pacific Health Consulting Group</p>	<ul style="list-style-type: none"> • Rafael Gomez - These meetings are a great opportunity for the group to stay informed about of policy updates as well as to get to know each other and the departments/organizations represented. It's also a great opportunity to dig deeper into some topic areas to develop a shared understanding of what the community context is, what the current state is and what to expect in the future. These goals could be common messaging, coordinated outreach services, or something broader. The Consortium's input around prioritizing topics for the next couple months is important. The group will hopefully identify some gaps/opportunities that they can work on together. • Jan Wolf - would like to know what the current inventory/capacity of enrollment assistors is now in Merced County and who is thinking of adding to that. Should Merced County have a centralized support for the assistors to ensure consistent messaging and training? • Jan - at some point will there be an interest to put together a speaker's bureau? The group could share presentations that have already been developed and messages that are delivered. 	<p>Materials Provided</p> <p>Discussion Topic Options:</p> <p>Merced County ACA Readiness Project</p>



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- Christine Noguera - there was a question raised about provider access at the Alliance board meeting. She thinks that it might be helpful to see what the access issues are in a more defined manner.
- Jan - that at the Alliance's last meeting Phase 3 of the Healthy Families transition was discussed. Healthy Families members who are currently getting care from Anthem Blue Cross or Health Plan of San Joaquin will transition into Medi-Cal/Alliance. The Alliance presented Merced County provider network information to the state as did Anthem and San Joaquin. The state reported back that there is only a 6-9% overlap in the provider networks. This means that these children are getting health care in other counties, so the Alliance may need to contract with providers out of Merced County to allow those children to maintain continuity of care.
- Kathleen Grassi - this low overlap could be related to patterns of usage; if Merced County residents live close to the Stanislaus County line they could be routinely getting care in Stanislaus County. It could also related to whether the providers in Merced County will accept Medi-Cal, or it could be that there is just not enough providers in general to support the Medi-Cal population.
- Jennifer Mockus - for the purpose of this group, this would be an interesting conversation to have, not only the pediatric issues but our patterns of care for PCP coverage within the community. Perhaps even a conversation about specialty care access, which may be more of a regional question.
- Kathleen - the list of discussion topics is open so topics can be added along the way.

Other Items for Discussion

- Joel - for the next meeting, a speaker from the Central Valley Health Network, who has an ongoing project on healthcare access in the Central Valley, has been arranged. He also suspects outreach and enrollment will be addressed as well.
- Kathleen - let her know if there is someone they think should also be included in these meetings.

Next Meeting: June 27, 2013



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