

## Affordable Care Act Readiness Project Thursday, March 28, 2013 Meeting Summary

## Attendees:

Representatives from Member Agencies: Alan McKay, Jan Wolf, and Jennifer Mockus, Central California Alliance for Health; Christine Bobbitt, Merced County Human Services Agency; Christine Noguera, Golden Valley Health Centers; Ed Lujano, Castle Family Health Centers; Leslie McGowan, Livingston Medical Group; Manuel Jimenez, Merced County Mental Health Department; Paul Brown and Steve Roussos, University of California, Merced; Tim Livermore, Jane MacLean and Kathleen Grassi, Merced County Department of Public Health.

Guests: Deidre Kelsey, District 4, Merced County Board of Supervisors; Jim Brown and Stephanie Dietz, Merced County Chief Executive's Office; Sharon Wardale-Trejo and Lori Norman, Merced County Department of Child Support Services.

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

Agenda Items	Discussion Summary	Resources / Action Items
Welcome and Introductions  Joel Diringer  Diringer and Associates	Joel asked those present to introduce themselves and to answer the question:  What Affordable Care Act (ACA) issues are you most focused on at your organization?	See Attachment #1 for detailed responses
ACA Readiness Project  Kathleen Grassi Merced County Department of Public Health	<ul> <li>Kathleen provided an overview of the ACA Readiness Project:</li> <li>The ACA Readiness Project is funded by The California Endowment, Building Healthy Communities Merced. The eighteen month project will provide resources and support for the Health Care Consortium to identify opportunities and challenges that the Affordable Care Act will present to Merced County to expand quality, affordable health care access to more residents.</li> <li>ACA is very broad and the Consortium should identify other potential community members to join this effort. Potential topics for discussion may include Medi-Cal expansion for various populations; in-reach and outreach to move new Medi-Cal eligible into medical homes; Medi-Cal, Covered California, and employer-based health insurance and the coordination across these health care coverage networks; provider network adequacy issues; health care access issues (i.e., transportation); prevention models (i.e., Stanford's Chronic Disease Self-Management Program), etc.</li> <li>The project will support 15 monthly meetings of the Consortium over the next 18 months. Proposed project outcomes: recommendations for action; new or expanded partnership efforts to increase health care access and enrollment, policy briefs for stakeholders, consumer information and a community convening.</li> </ul>	Materials provided:  Merced County ACA Readiness Project Abstract  Merced County Health Care Consortium 2013-14 Meeting Schedule







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	<ul> <li>The project is supporting assistance from consultants Bobbie Wunsch and Rafael Gomez, Pacific Health Consulting Group, and Joel Diringer, Diringer and Associates. Both consulting firms and their principals are familiar with the Central Valley's health care delivery issues, have assisted Valley counties, including Merced County, on previous health care projects and have prepared reports that examine various aspects of health factors and health care delivery systems unique to this area.</li> <li>The Merced County Public Health Department is the fiscal agent for the project and will provide staff support to the Consortium.</li> </ul>	
Affordable Care Act Issues	Joel provided an abbreviated overview of the ACA:	
Joel Diringer  Bobbie Wunsch, Pacific Health Consulting Group  Alan McKay, Central California Alliance for Health	<ul> <li>The ACA was passed in 2010; and implementation has begun with some aspects of the Act including - eligibility for coverage for children under parents' policies until the age of 26 and a new Pre-Existing Condition Insurance Program.</li> <li>Funding for community health centers increased for capital improvements, about 11 billion dollars over five years was added to the federally qualified health centers (FQHCs).</li> <li>The largest coverage components of ACA won't go into effect until January 2014 including an emphasis on prevention services and payment reform as well as broader health care coverage.</li> <li>In 2014, everyone in the country that is here legally and can afford coverage is required to have health insurance. Medicaid will be expanded to all low income adults up to 138% of federal poverty level.</li> <li>For the medically indigent, childless adults, the Governor has prompted discussion about whether this will be a county-based expansion or whether it will be a statewide expansion. There are concerns about separate county-based Medi-Cal programs and also about how much the state wants to claw back from the counties to expand coverage through the state-wide Medi-Cal option.</li> <li>Individuals will get insurance through Medi-Cal expansion if below 138% FPL. If above 138% FPL, they will either be covered through their employer or they will purchase insurance through a marketplace.</li> <li>Large employers, more than 50 employees, will have a mandate to either provide affordable coverage with minimum requirements or they will have to pay a \$2000 fine</li> </ul>	Materials provided:  Affordable Care Act: What Californians Should Know, California HealthCare Foundation, July 2012  The Affordable Care Act: An Implementation Timeline for California, California HealthCare Foundation, November 2011  Thinking Ahead – High Priorities for ACA Implementation in California, Lucien Wulsin, ITUP, January 2013  Federal Health Care Reform, power point, Central California Alliance for Health, March 28, 2013
	per employee annually (except for the first 30 employees).	







- The Health Benefits Exchange, known as Covered California, is a marketplace that
  individuals or small businesses can go through to purchase insurance. It will provide
  consumers apples to apples comparisons of the plans. Federal subsidies for
  premium assistance for lower income individuals will flow through the Exchange.
- Covered California will open for enrollment in October 2013 for coverage beginning in January 2014. There will be an open enrollment period from October 2013 through March 2014, then it will close until the following October when enrollment will only be available October through December thereafter.
- Outreach and education efforts will commence this summer in advance of open enrollment in the fall for Medi-Cal or Exchange expansion in January 2014.
- If low income, up to 138% FPL, you go into Medi-Cal, assuming you are documented. If income is between 138% FPL and 400% FPL, and you don't have employer provided insurance, you go through Covered California to purchase federally subsidized insurance. If above 400% FPL, you still have an obligation to purchase private insurance. All insurance products offered through Covered California will provide, at a minimum, 10 essential health benefits so that consumers are provided with a cost comparison. What we don't know is the affordability of these plans.
- The Covered California consumer website has a insurance premium calculator that
  will provide premium costs and the cap on the share-of-cost. For a family of four
  making about \$30,000 a year, the monthly premium is about \$120. However, the
  out-of-pocket maximum is over \$4,000. So these are high deductible plans.
   Prevention and wellness visits are not subject to the deductible, but treatment will be.
- Paul Brown asked how much freedom insurers will have to set premiums within the
  exchange. Joel insurers have to offer the same benefits so if they want people to
  sign up, they have to offer competitive prices. There is no regulation of premiums by
  the Exchange or the Department of Insurance, but the theory is that the market will
  force the premiums down.
- Paul is there any talk with the state about letting consumers buy into Medi-Cal. Joel no. Medicaid expansion is 100% funded by the federal government, gliding down to 90% by 2020. Bobbie Wunsch the exchange will choose health plans in each region of the state. The companies that want to offer an exchange product will not have free reign. There will be a certain number of plans chosen in each region and the exchange will negotiate with them about rates. There will only be a handful







of companies offering plans on the Exchange in Merced County.

- Paul the worry is that people with diabetes will be priced out of the market and that will leave the County to care for them. Joel there will be no medical underwriting allowed in 2014. Insurance companies must take everyone. The age banding is narrowed in which prices can differ. One option that California did not take was having a different premium pricing for smokers.
- Ed Lujano employers will be responsible for their employees coverage but not for their dependents. The employee would have to pay out-of-pocket to take care of their dependents. Joel - dependents would have to go on to Medi-Cal or on the Exchange.
- Lori Norman will there be dependent only plans. Joel yes.

Bobbie Wunsch presented an overview of the impact on Merced County.

- Most of the rules for Medi-Cal expansion and the Exchange have not been agreed on yet. Every day new regulations are coming out. The Federal government first waited on the ACA Supreme Court decision in June 2012. Then the Presidential election stopped most of the ACA development until the election outcome was known. It wasn't until after the election that the pipeline for developing federal regulations began.
- Bobbie there is no exact number for the uninsured, new or current, but not enrolled Medi-Cal eligible or the undocumented. It is also unknown how many eligible in these categories will actually get enrolled. These numbers only represent people under 65 years of age because 95% of people over 65 are covered by Medicare.
- The best estimate is that about 21-24% of people who live in Merced County under the age of 65 are uninsured. That is about 50,000 60,000 people. There are two categories of people eligible for Medi-Cal. About 13,000 16,000 individuals will be newly eligible for Medi-Cal. These people are eligible because the rules are changing. The income level is going up and the asset tests will no longer apply for these individuals. There are many young adults in this group under the age of 35, homeless people who currently do not qualify, and more than half of the people in the Family Pact program would fall in this group.
- The newly eligible are the people for whom, in the first three years (2014 2017), the federal government will pay 100% of their Medi-Cal costs, not their enrollment







costs, but the cost of their benefits. This will reduce to 90% by 2020.

- Currently, the Medi-Cal program cost is a 50/50 split between the federal and state
  governments. About 40% of the people currently eligible statewide for Medi-Cal are
  not enrolled in the program. Why? There are many possible reasons it's difficult to
  apply and to get services in some communities, they aren't sick, or they don't think
  they need health insurance. Alan McKay estimated this population to be about
  12,000 people for Merced County.
- Federal participation for these currently Medi-Cal eligible people does not change. The state and federal governments both pay 50 cents on the dollar for their costs. The state is worried because there will be a lot of publicity starting in July 2013 when outreach efforts begin for the Exchange, when there will be a mass community education campaigns, plus grants for community outreach and enrollment. Because of this, these currently eligible folks may now decide to enroll and since the cost of these individuals is 50/50, it could cost the state a lot of money.
- There is a large number of possibly eligible for Covered California. The estimates range dramatically. Merced County's 21-24% uninsured could go down to as little as 5% of the population, if everyone signs up that is eligible.
- The 5% would represent the undocumented individuals who today are not covered by the ACA and new immigrants, who are legal but not in the United States legally for five years.
- The first job of the Consortium members is to get the Medi-Cal newly eligible, coming to the health centers as uninsured, converted to Medi-Cal as fast as possible.
- The largest groups are those that are not eligible for Medi-Cal but will be eligible for the Exchange. They will have to be identified, informed, educated, and helped to enroll. The plans have to be affordable. There is a lot of concern about the affordability. The Exchange has calculated that in the first two years maybe 40% of people will get enrolled and by the end of 10 years maybe 80%. This will be a steep hike to get these people enrolled because there is so little information available to consumers. They just assume that there won't be anything for them if they even understand what the purpose of health insurance is.
- What happens to the Indigent Health Care Program/Medical Assistance Program
  (MAP) in Merced County? The MAP program covers about 1,200 individuals. They
  have to be at or below 100% of the federal poverty level and legal residents.







- Based on the Medi-Cal eligibility for the newly eligible, all those people should be
  eligible for the Medi-Cal program. So another first step should be to convert all the
  MAP clients into Medi-Cal. What does that do to the MAP program? That will be
  something the County will be evaluating.
- The funds that the County spends on the infrastructure to run the MAP program and the funds spent on the care of the MAP patients will change dramatically over the next couple of years. The state says that in order to cover the former medically indigent through Medi-Cal, the state will need to take a fair amount of counties' realignment money, even though the federal government will pay 100% of costs the first three years. The Legislative Analyst Office recommends taking 50% of realignment that currently pays for the medically indigent from counties. This is a big debate between the counties and the state.
- What happens to those that are left uninsured? They will be left uninsured because they don't qualify, they do qualify but can't afford the Exchange, or they are ready to sign up but have to wait until open enrollment. This leads to other issues that the Consortium should pay attention to. How do we educate consumers? What does that mean about access? Having insurance doesn't mean you have access to care. What do we need as far as capacity in three or five years? This is what we don't know yet and what the providers are struggling with. We also don't know how quickly the ramp up will be. The conversation this group is having is happening throughout the state.

Alan McKay provided a brief overview from the Central California Alliance for Health's perspective:

- The Alliance is looking to work with their counties on the new frontiers that the ACA
  is providing. One issue that doesn't get talked about is the current public demand for
  services for chronic disease conditions.
- Chronic disease is about 60% of the 2.7 trillion dollar healthcare spending in the U.S. Most chronic disease has a behavioral health component to it, whether that is diet, activity level, or safety practices.
- The second issue relates to the culture of the delivery system which is that all the
  financial incentives are related to sickness. Providers get paid more for healing
  complex conditions rather than for keeping people healthy. The Alliance identifies an
  important structural reform challenge around payment reform. There should be
  rewards for keeping people healthy and in good condition.







	• The question with ACA is, is it a train wreck or a transformation? The train wreck side of ACA is finding federal and state tax dollars to finance a lot of new coverage. California is looking to insure another 6 million people. Clearly there is a challenge in front of us to get everyone covered and in a health oriented program that will maintain their well-being. The Alliance wants to get everyone covered but also would like to look at the way care is delivered and the way people take care of themselves as well.	
	• The proposed "narrow bridge" plan is related to the idea that people in Medi-Cal will flip in and out of the Exchange. Would people have to change their health plan every time they do that? They may not. If Medi-Cal health plans, like the Alliance, participate in the Exchange's "narrow bridge" plan there is a potential to provide continuity of care for as many as 30% of members flexing out of the Exchange into Medi-Cal.	
	• There are plenty of obstacles for the "narrow bridge" plan to become a reality. It needs federal approval and there are financial underwriting issues that are problematic, but certainly in terms of the goal of continuity of care and being able to stay with your health plan, the "narrow bridge" plan could be a good thing.	
	Bobbie – what is the timeline for the implementation of the bridge if it is approved?  Alan - It may be a couple months into 2014. But he thinks that the risk factors around the viability of the "narrow bridge" concept are pretty strong so that would just be a rough guess. There may be a delay in Medicaid expansion so some of this is tied to the realignment dollar negotiations between counties and the state.	
Group Discussion	<ul> <li>Joel - MAGI represents modified adjusted gross income, a new standard for determining income for Medi-Cal.</li> </ul>	Recommendations:
Joel Diringer	Joel - Covered California's Request for Proposals (RFP) for outreach and education, did anyone in Merced apply? Livingston Medical Group and Golden Valley Health Centers applied as a part of the Central Valley Health Network application. Jennifer - the Office of Education and the United Way had applied.  Christing No. funding was really forward on the exchange if related to Medi Cal.  Christing No. funding was really forward on the exchange if related to Medi Cal.  Christing No. funding was really forward on the exchange if related to Medi Cal.  Christing No. funding was really forward on the exchange if related to Medi Cal.  Christing No. funding was really forward on the exchange if related to Medi Cal.	<ul><li>1. Develop a unified message</li><li>2. Invite –</li><li>Christine Munchow, MMMS;</li></ul>
	Christine N funding was really focused on the exchange, if related to Medi-Cal, there would have had a larger response to the RFP.  Rephie responding to Time shout how to advection consumers, deliver small.	<ul> <li>School and Business Reps;</li> </ul>
	<ul> <li>Bobbie – responding to Tim about how to education consumers - deliver small pieces of information now. Start telling patients that more insurance coverage will be available. Tell them that if they have questions once they start hearing more about</li> </ul>	BHC Community Rep.
		X.





with prevention.



it, that you're the place to come for answers. She said the hardest part will be finding how to reach the uninsured. Community organizations will be a good resource.

- Joel the exchange has put out a \$45 million RFP the allocation for Merced County applicants is about \$300,000. There will be a 2<sup>nd</sup> round.
- Joel there doesn't appear to be a coordinated effort in Merced; this may be the role
  that the Consortium may want to take on, a coordinated effort using disparate
  funding sources for outreach, education and enrollment.
- Joel responding to Christine N. outreach and education RFP separate funding stream for actual enrollment for the Exchange. There will also be paid assistors that will get \$58 per completed new application and \$25 on renewals. Assistor position applicants would have to go through background checks, fingerprinting, and six week training courses. There will also be assistors who can do applications but would not be paid, like insurance agents they will get commission from the health plans. Starting in January 2014 when the Exchange has some money from the health plans, there will be grants to community based organizations for enrollment.
- Bobbie the Endowment will match the assistor fees for Medi-Cal application assistance.
- Joel What does the Consortium want to work on locally? What other information does the Consortium need? Who else should be at the table?
- Christine N. Consortium partners should have a unified message to the community.
- Kathleen what does Merced County have for specialty services? Jennifer the Alliance had done some analysis and it would be something they could offer.
- Stephanie the County needs to know about how to increase capacity, how to increase access, or how to build in preventative structure around what public health will look like.
- Jennifer Christine Munchow from the Merced Mariposa Medical Society (MMMS) is very concerned about the age of existing provider network re: retirement.
- Tim MMMS understands that Merced does not have enough primary care providers or specialty care providers. They are concerned that many providers don't accept Medi-Cal and with the implementation of ACA, there may be fewer that don't

Recommendations (con't):

- Identify who is doing outreach, education and/or enrollment activities with the Medi-Cal population already.
- 4. Alliance provide list of available specialty care providers in area.
- Paul will put a list of questions together to identify what issue areas should be addressed and when.







because Medi-Cal reimbursement doesn't cover costs. U.C. Merced and Mercy Family Practice may be able to help keep graduates here, but they need to be more prevention oriented. Christy Munchow should be invited.

- Jan the Consortium could get a handle on who is currently doing outreach and enrollment for Medi-Cal now and look to increase that. Perhaps having a convening to make sure there is capacity throughout the County for enrollment assistance.
- Joel how many clinics at the table do Medi-Cal enrollment or facilitate it. The clinics, Human Services Agency, Public Health, and the hospital all assist.
- Steve schools present a huge dissemination source. Christine B. Kelly Bentz from the Merced Union High School District has been increasing activity around health and wellness. Jennifer developing new relationships with the middle schools, we can present to the nurses. Bobbie keep in mind that the focus will be on the parents of the children. The key is to use the schools to educate the parents. Jennifer include Merced College, Adult Education.
- Christine N. small business would be good to include, there are several chambers in Merced County. Joel United Way, is that someone to add?
- Jennifer Merced is one of the 14 counties funded by TCE through Building Healthy Communities, it would be good to have community presence.
- Bobbie the group may want to organize the work in phases and then make sure the right people are included in the different phases so the discussions are more targeted.
- Joel asked what should be the focus of the next meeting. Outreach and enrollment
  is certainly Phase 1 and understanding how to do that is important. Bobbie the
  Exchange grants would have been announced so we could talk to whoever those
  grantees are.
- Steve Merced Organizing Project (MOP) might be good to contact.
- Joel immigration reform is a big issue now and health reform is not working without immigration reform. Kathleen – need estimates on the new legal permanent residents. Stephanie - need to know who that 5% are that will be without insurance after ACA. Joel and Bobbie - they would research that.







	<ul> <li>Paul - offered to develop a list of questions to present to the Consortium so they could determine what still needs to be addressed. The group was receptive to this idea.</li> <li>Kathleen - counties that did implement the Low Income Health Program (LIHP) are having a hard time with retention, the same difficulty may present with newly Medi-Cal eligible. Joel - to focus on long term prevention, we must focus on retention.</li> </ul>
Other Consortium Business	Kathleen - another funding opportunity from Blue Shield of California Foundation is focused on strategies to transition the medically indigent population into Medi-Cal.  The strategies to transition the medically indigent population into Medi-Cal.
Joel Diringer	<ul> <li>Funding decisions are expected in July.</li> <li>Kathleen - if the others have related projects they are working on that they want on the agenda, let her know before the next meeting.</li> </ul>
	Next Meeting - April 25th at the Central California Alliance for Health at noon.







## Attachment #1: What Affordable Care Act issues are you most focused on at your organization?

Bobbie Wunsch - preparing briefs on ACA issues that the group decides to work on.

Manuel Jimenez - how ACA will look in January 2014.

Jane MacLean - how the ACA will change the Maternal and Child Health programs.

Tim Livermore, M.D. - what the future might hold for ACA and what Public Health can take advantage of for our own accreditation process.

Stephanie Dietz - how ACA will impact all the County Departments that deal with health care.

Jim Brown - the delivery system and how it will impact our communities.

Karl Stahlhut - how the Medical Assistance Program clients will transition to Medi-Cal.

Kathleen Grassi - Medicaid expansion and what Public Health's obligation is to move clients to Medi-Cal and what remaining population the county will be responsible for as a provider of last resort. The evolution of the role of Public Health as we move away from being a direct service provider and assisting consumers with access to medical homes and providing prevention services.

Leslie McGowan - how ACA will affect their staff and how it will affect their payor mix and how people will be moving from the classes that they are in now.

Ed Lujan - determining who in their current population will be affected by the change and how they will inform and educate these clients. Also is trying to determine what their staffing and facilities needs will be to care for new clients.

Chris Bobbitt - expansion for new Medi-Cal enrollees and call center needs. The Human Services Agency will be a regional host for eight other counties in Region V in California so they are will be securing a location, hiring staff, and training.

Jennifer Mockus - the Alliance is assessing its organizational structure. In their tri-County region, they may be accepting up to 49,000 newly eligible or new currently eligible Medi-Cal enrollees. The Alliance is trying to keep up with the changes and information that come from the state as far as the potential for their benefit packages, the modified adjusted gross income (MAGI) and currently enrolled folks and making sure their systems will







work for the new members. They are interesting in having a better understanding of the newly eligible population since they will be a group of folks the Alliance has not worked with. Some newly eligible will be childless, some may have part time work, or be enrolled in college. They want to know how to inform these communities and how to help get them into services.

## Attachment #1 – con't

Christine Noguera – the impact to those currently coming to Golden Valley clinics and how they can make sure the clients are well informed about the changes and what benefits will be there for them. They are also focused on how they can improve access through expansion of facilities and programs and services.

Lori Norman - how the ACA will change Child Support Services' enforcement activities.

Sharon Wardale-Trejo - the newly eligible Medi-Cal recipients will be a huge change to the Child Support Services program and also from a state perspective, they will be finding out whether or not Child Support will still have a role in medical enforcement. They also believe that the more information about ACA they can receive as an organization, the better they can educate their customers.

Steve Roussos - as a public health researcher focused on disparities in medicine, he is interested in finding out how they can be of help since the new population is known to have experienced disparities in health. He also thinks that there is a great opportunity for students to be involved, graduate students and researchers, to help in whatever way the community thinks is worthwhile, such as making sense of data, how to use data effectively to know what is working.

Jan Wolf - the Alliance is interested in knowing what their role will be as far as outreach, making sure people get enrolled and that they are able to serve them, that there is provider capacity, then also looking at how people may move between the Medi-Cal expansion and the "Narrow Bridge" program and what this Exchange product will look like.

Alan McKay - there is a lot of uncertainty at the state about how and when the Medicaid expansion will take place. Will there be a delay? Will it be a statewide approach or a county based approach focused on low income health programs and MIA programs? Counties are in dialogue with the state administration about it. Secondly, on the clinical care side, the Alliance is a big fan of the patient center medical home model. It is a more efficient, patient sensitive way to deliver care. Want to make sure we use all the resources available in our communities so factoring that into our thinking about Medicaid expansion is key. Something that they discovered which was quite shocking was that 8% of their members account for 75% of cost within the Alliance membership. So there is a huge cost concentration for a few enrollees so the Alliance is working to find way to better serve those members, to improve quality and lower cost. All these things are part of the Alliance's thinking about federal health reform.











