North Central Regional Workgroup Executive Summary

Update on Coverage Expansions

Regional stakeholders discussed how health outcomes for the newly insured could be improved. After two years of successful open enrollments, enrollers believed that the majority of reachable uninsured have been enrolled. Now that the majority have healthcare, enrollees need to be educated on how the healthcare system works and what is the proper way to seek out care. Stakeholders also believe that there are not enough providers to ensure timely access for all the newly insured, especially those now enrolled in Medi-Cal. Some clinics are overworked, and challenged to meet the influx of newly insured. Some of the newly insured have previously unmanaged substance use and behavioral health disorders, so plans and providers will need to be prepared to meet their needs.

Enrollers also noted there were a number of challenges facing Covered California. Churn, as in other regions, is an issue for those with incomes right at the eligibility margins, leading to unpredictable coverage status shifting between Medi-Cal and Covered California. Consumers were also often frustrated over the differences between plans, which has been compounded by difficulties accessing care from overworked clinics at capacity. Some consumers feel they have gained coverage (i.e. bronze) that they don't need and cannot use. Like other regions, some consumers are balking at the cost of plans and choosing the cheapest possible option, possibly because they do not understand the value of healthcare benefits. The enrollment system has greatly improved, but many workarounds are still needed to process registrations and to override inaccurate Medi-Cal determinations. Stakeholders reported that Covered California plans do not always place safety net providers in their networks. Sacramento FQHCs would like to be part of the Covered California networks, but hospitals are not willing to craft new arrangements with new providers, effectively locking these FQHCs out of the network.

Payment and Delivery System Transformation

With the expansion, Medi-Cal Managed Plans that were formerly responsible for a largely healthy population of parents and children became responsible for the entirety of the community's low-income population, including many with substance use disorders, behavioral health conditions, and serious physical health conditions. The system must transform itself to adequately deliver care to this new population while also building up capacity to handle greatly increased demand.

Regional stakeholders said that local P4P reforms have been helpful in improving the quality of care, but were fearful that State P4P reforms could undo this work. They hoped that the State would consider and work with existing systems before creating new mandatory frameworks, especially when many regions already have capable P4P systems in place. Higher reimbursement rates would go a long way in making these systems even more effective, as shared savings are difficult to pass on when the reimbursement rate is so low. Some participants said that reimbursement rates were further cut in order to free up funding for P4P incentives, which frequently upsets providers. Better metrics for behavioral health and substance abuse treatment are also needed to better craft future incentives. Even so, stakeholders said that the lack of providers limits the effectiveness of P4P, as it cannot solve the underlying capacity issues that frequently impact quality of care. If the State would match Medi-Cal reimbursements to the Medicare level, the provider shortage wouldn't be so severe.

Some stakeholders expressed doubt that a free market approach to improving access might not work simply because there are too few providers (even outside of Medi-Cal) in certain portions of the region. Some hospi-

tals refuse to accept Medi-Cal all together, and that even increased rates wouldn't necessarily buy more access because of the inadequate provider supply.

Stakeholders asked for clarification of shared savings under the waiver. They warned that cutting rates based on projected savings would only disincentive cost reductions. Plans would like to retain the savings that can be achieved and re-invest them to meet local needs, but it was unclear if the State would keep the savings instead.

Behavioral Health and Expanded SUD Benefit

Regional stakeholders have struggled to define which entities are responsible for delivery of behavioral health care to the "mild-to-moderate" population and the "severely mentally ill" population due to ambiguity in the State definition. The resulting ping-ponging confusion when borderline patients are reclassified between the two levels has led to worsened access to care for the newly insured, who had greater clarity in accessing care when they were uninsured. There are also concerns that payments may be rescinded as patients are reclassified between severely mentally ill and mild-to-moderate. Provider participation and access was a major issue for North Central stakeholders. Because access is so poor, providers have undue leverage to raise their reimbursement rates.

Remaining Uninsured

Workgroup participants identified the undocumented and Covered California eligible but not enrolled as the main groups of concern among the remaining uninsured, since Medi-Cal enrollment is open year-round. These individuals are largely cared for by county health programs for the uninsured. Stakeholders said these programs play a key role for people in eligibility limbo while their eligibility status is being determined.

Stakeholders discussed options for providing care to the undocumented. Emergency Medi-Cal serves as the main funding stream for genuine emergency needs, but there are no clear funding streams to provide specialty care to the undocumented. Some suggested that LIHP could serve as a template for future efforts to care for the undocumented. Prop 99 funds could also be retargeted to fund community clinic care to the undocumented – a revived EAPC program.

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