San Diego Regional Workgroup Executive Summary

Update on Coverage Expansions

San Diego stakeholders reported significant success in enrolling Medi-Cal and Covered California eligibles. In 2013-14, they exceeded projections for Covered California enrollments by 300% and increased market share in year two. Participants emphasized that CECs and Navigators played a key role in outreach, responsible for 25% of enrollments. San Diego enrollers began their efforts very early, gaining a headstart over other counties, and worked in tandem with brokers to ensure good reach through the community. Clinics also played a key role, helping coordinate minority community outreach. Although Covered California does provide in-language materials, San Diego enrollers elected to create their own materials instead, finding that they were able to better communicate key messages on affordability and how enrolling in Covered California would not endanger family members with immigration enforcement actions. These materials directed individuals to contact local agencies rather than Covered California in the event of needing assistance. Enrollers also developed unified messaging that emphasized that the penalty for not getting coverage is the cost of uncovered care, not merely a tax penalty, and were careful to walk potential applicants through the financial breakdowns.

A side-effect of the increase in newly insured is that emergency rooms have experienced surges in usage, despite the presence of a well-developed clinic network. Stakeholders pointed to poor clinic capacity and patient unfamiliarity with primary care. Clinics will need to shift to team-based care in order to better use their existing resources. Stakeholders pointed out that the lack of patient understanding about primary care is unsurprising, given the complex nature of most available resources and the lack of post-enrollment education on how to actually utilize benefits. Enrollment efforts should include linking people to primary care after receiving coverage. Plans should also incentivize providers to link patients to primary care, rather than just letting them seek care through the emergency room.

Behavioral Health and Expanded SUD Benefit

The County of San Diego's Mental Health agency and its community clinics are strongly committed to behavioral health integration. Although integration efforts are hampered by the presence of 6 MCOs covering the county, stakeholders have made significant progress in advancing behavioral health. The county has opened new regional crisis treatment centers, expanded its support for Alzheimer's caregivers, improved intensive case management for the homeless with co-occurring behavioral health conditions and introduced linkages to subsidized housing, and implemented some measures to divert the mentally ill with Medi-Cal away from ERs into psychiatric ill.

Because treatment of mild/moderate-classified patients is handled by one of six MCOs while the county handles treatment of SMI-classified patients, careful coordination is needed to ensure care continuity for patients in the grey zones. Cooperation can be challenging due to the high number of plans. Even so, there is broad support for collaboration and behavioral health integration, with a monthly convening of clinics, plans, and county stakeholders that helps organize the necessary collaboration between entities. Clinics and the county are working to co-locate and integrate behavioral health in the primary care setting. The county still needs to resolve confidentiality issues and move their HIE to an opt-out system to ensure all the necessary linkages are present to support increased integration and collaboration.

Payment & Delivery System Transformation

In order to standardize care quality, 11 San Diego clinics have formed a unified collective that will provide uniform care and no-wrong-entry to its patients. Once they fully develop their system, they will have global capitation covering all services. Efforts to vertically integrate are mostly hindered by hospital access, as most clinics only have relationships with one or two hospitals.

Although there has been movement towards implementing an alternative payment methodology in the State, many clinics are uncomfortable with giving up federally-set PPS rates despite the advantages APM offers (eliminates 3-year turnaround, allows for alternative charges, movement away from visit-based reimbursement). Regardless of how clinics feel, stakeholders acknowledged that the window of opportunity is closing as the ACA's clinic funding augmentations will sunset in 2020.

Specialty Care access remains challenging for Medi-Cal patients, even in life-threatening situations. For these patients, the ER is most reliable way to access specialty care. Because many clinics did not have the capacity to build up specialty care, San Diego stakeholders attempted to create a central hub for specialty care, but it was shut down by CMS, who stated that any such hub would have to be based in a FQHC. Many FQHCs dislike this approach, as it would give the specialty hub FQHC an advantage over other clinics. Other approaches to building up specialty care were discussed, including working with other larger providers to augment local MMC networks and to contract with specialists directly to provide services in the FQHC setting.

Remaining Uninsured and Premium Assistance

San Diego's success in outreach during open enrollments has made a significant dent in the remaining uninsured. However, stakeholders noted that due to San Diego's proximity to the border and a high number of people who spend large amounts of time on both sides of the border, there need to be more plans with comprehensive cross-border coverage.

Enrollers reported that due to the entry of several new plans, the cost of the second-lowest cost silver plan in San Diego has sharply dropped compared to other plans, reducing the amount of premium assistance for the subsidy-eligible. Stakeholders expressed concern that this may lead to many people dropping coverage in response to a sudden increase in premiums. There is some interest in providing supplemental premium assistance to mitigate these effects. Covered California has indicated their support, but is unwilling to modify their computer systems to implement any changes, so any program would need to operate completely at the county level. The county is waiting on IRS to issue clarification on how supplemental premium assistance should be implemented.

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