**Shasta Regional Workgroup Executive Summary**
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## *Update on Coverage Expansions: Medi-Cal & Covered California*

Although Northern California as a whole greatly exceeded CalSIM enrollment predictions, northern frontier enrollers reported mixed success, finding that many people would rather pay for care in cash on a sliding fee schedule. There were also many who claimed religious exemptions or refused to enroll out of political opposition. Nonetheless, Shasta County's total share of statewide enrollment did increase in 2015, and clinics have seen a 360% increase in their Medi-Cal Managed Care visits and a 50% drop in their uninsured visits.

Enrollers credited coordination by the Shasta Health and Human Services department for ensuring handoffs between enrollers and county social services went smoothly. A Blue Shield grant provided funding to train enrollers. Partnership Health Plan also worked with its members and providers during enrollment, assisting the county. Likewise, clinics also took a part, making sure to get as many of their patients enrolled as possible. Enrollers also suggested that the prior transition to managed care taught stakeholders the necessary systems discipline to work together during open enrollment.

## *Payment & Delivery System Reform*

Since the expansion, ED usage has increased. Because many providers treat the ER like a clinic, Partnership is trying to educate their providers about when it is appropriate to send a patient to the ER. Even so, unless the clinician shortage is addressed, ER usage will remain high.

The high cost of medical school discourages many physicians from working in as primary care physicians in rural areas like Shasta. Although there are loan forgiveness programs for those who commit to a certain number of years in underserved areas, many leave as soon as their loans are forgiven. Additionally, large medical groups have pulled many physicians away from the area. Rural areas will likely have to rely more on physician's assistants and nurse practitioners, but there need to be more opportunities to provide these caregivers with sufficient clinical expertise.

Although alternative payment methodology pilots are now on the table for FQHCs, local clinics are skeptical that these will benefit them due to their constrained patient volume that is limited by low capacity, which will cut into their capitation rates. An effective funding methodology needs to be sensitive to the realities of clinics operating in a shortage environment where low visit volumes are not a result of poor demand.

## *Behavioral Health Integration*

The waiver offers some opportunities to advance behavioral health integration, but DHCS needs to remove the single-visit restriction on FQHCs, who desperately need the potential savings they could achieve from providing multiple services during a single visit. The whole person care element seems promising, and could help break down heavy siloing among existing services, which have resulted in an inflated budget to provide services to the homeless. Its potential may be constrained by the local county's lack of ability to provide a county match.

## *Drug Medi-Cal Waiver and SUD Treatment*

Local stakeholders believe that Partnership Health Plan is in a better position to administer the Drug Medi-Cal benefit under the new waiver than the county. Given the sparse condition of current SUD treatment networks, the waiver could help develop the necessary infrastructure needed to provide this critical care.

## *Remaining Uninsured*

In May 2016, undocumented youth will become eligible for full-scope Medi-Cal. Providing care to the remaining uninsured remains challenging, but there are some options – CMSP is considering funding additional specialty care, and possibly even workforce development. There is also local legislative support for providing coverage to the undocumented, despite the area's conservative politics.

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