

ITUP hosted two Regional Workgroups in the Bay Area. The region consists of Alameda, Contra Costa, Marin, San Francisco, San Mateo, and Santa Clara Counties. During the second Workgroup, ITUP received up to date information on the region's implementation of the §1115 Medicaid Waiver, discussed priorities for transforming the Medi-Cal program in preparation for 2014, and informed participants of the ongoing development of the California Health Benefit Exchange. This summary will provide an overview of thoughts, concerns, and recommendations from the region.

§1115 Medicaid Waiver

Low-Income Health Program

The Low-Income Health Program (LIHP) provides an opportunity for counties to cover indigent populations and receive a 50/50 federal match for care delivered under the program. LIHP consists of the Medicaid Coverage Expansion (MCE), which covers individuals with incomes up to 133% FPL and the Health Care Coverage Initiative (HCC), which extends up to 200% FPL. Maximum FPLs for enrollment were left to County discretion, as neither component of the coverage initiative was mandatory.

The feasibility of many LIHPs was threatened when uncertainty surrounding the payor of last resort surfaced. There was question as to whether the AIDS Drug Assistance Program (ADAP), a federally matched program run by the State, or LIHP was responsible for the care not covered by other county programs, Medi-Cal or private insurance. The federal government deemed Counties payor of last resort by insisting that LIHPs are equivalent to Medi-Cal. As a result, individuals in the Ryan White program became LIHP eligible and the responsibility and cost of care to these individuals shifted from the state to the county.

Participants discussed the implications of this funding shift. San Francisco County lowered its upper FPL for LIHP to 25% and San Mateo County anticipated losing \$500,000 in funding. Alameda County had not yet lowered its FPL, but participants reported that the County is considering a separate coverage initiative for the HIV/AIDS population. Continuity of care and access to AIDS providers and specialty care continues to be of concern as Ryan White patients transition into LIHPs.

Seniors and Persons with Disabilities (SPDs)

In managed care counties, SPDs were required to enroll in managed care. Enrollment occurred on a rolling basis with SPDs transitioning during their birth month. Participants in San Francisco and Alameda Counties reported a smooth transition of SPDs, which they attributed to the extensive outreach and patient education they conducted before the change.

Medi-Cal Transformation

In 2014, 3M Californians will be newly eligible for Medicaid expansion. Currently, California's Medi-Cal program serves 7.5M individuals. In order to accommodate the influx of new beneficiaries and ensure quality of care for all those enrolled, the program will need to undergo a number of transformations, namely in simplifying and streamlining enrollment processes, increasing provider reimbursement rates, and improving payment methods. The following will discuss the outreach efforts of each County and provide recommendations for program simplification:

Alameda: The County has partnered with the Department of Social Services and included on-site enrollment workers at community clinics to help improve outreach and enrollment strategies. Since the County's MCE population is tracked by the one-e-app and its managed care plan serves a large portion of those who will be newly eligible for Medi-Cal, Alameda anticipates a smooth transition come 2014.

The California Family Health Council, an organization that works to broaden access to health education, information and services, maintains a website (*teenSource*) to help inform youth about health-related decision making. Alameda may utilize the website as a source for educating parents about future coverage expansions through their children. Participants strongly suggested that counties expand traditional outreach methods to include a variety of venues, such as faith-based organizations and unemployment offices, in addition to medical homes, clinics, school-based health centers, and public health centers.

Contra Costa: The Community Clinic Consortium in Contra Costa convened a Patient Education and Outreach Stakeholder group to help think through effective outreach efforts. Stakeholders were first briefed on existing health programs offered at community clinics, then informed of future outreach plans of the County. Ideally, these individuals will be an extension of the County's patient education and outreach efforts.

Enrollment & Eligibility Redetermination

The current enrollment process for Medi-Cal can be slow and cumbersome, and the redetermination process tedious. Workgroup participants recommend simplifying the language used on Medi-Cal applications and redetermination forms. This would help improve retention rates and decrease application errors. To simplify the redetermination process, participants suggest only updating changes to information, such as address and income, annually rather than the ten-day period that is currently required.

California Health Benefit Exchange (HBEX)

Visions and Design Options

The California Health Benefit Exchange will be a virtual marketplace where 4M Californians will be eligible to purchase health coverage. Participants discussed the four visions for the Exchange as outline by the California HealthCare Foundation, including the Exchange as a price leader, service center, change agent, and public partner.

As a price leader, the Exchange would offer the most competitively priced coverage by selectively contracting with plans that offer the lowest coverage. As a service center the Exchange would provide a great consumer experience by offering options, clear information, and high quality customer support to draw in consumers. As a change agent, the Exchange would initiate delivery reform by driving innovation, while as a public partner; HBEX would coordinate with Medi-Cal to guarantee continuity of care.

Participants also discussed design options and the development of the Exchange's IT system. Options include a distributive, partially integrated, fully integrated, or integrated partnership design. The Exchange Board will determine if and how to best integrate state and county IT systems, which will be responsible for assessing an individual's eligibility for Medi-Cal, the Exchange, or other health programs.

Basic Health Plan (BHP)

The ACA allows states to develop a Basic Health Plan for individuals with incomes between 133 and 200% FPL. BHP would be reimbursed by the federal government at a lower rate, allowing consumers to save on premiums and out of pocket cost. Participants were concerned that lower co-pays and deductibles could imply lower reimbursement rates for providers. There was also question of whether the Exchange would administer BHP and the participants emphasized the need to merge risk pools. Despite concerns, participants favored BHP for its ability to protect continuity of care and create seamlessness.

The Exchange and the Undocumented

Currently, undocumented individuals are not eligible to purchase health coverage through the Exchange. Participants discussed how this restriction could discourage individuals in mixed status families from seeking coverage for their citizen children if citizenship is crosschecked with federal immigration agencies. They suggested the Exchange consider re-directing undocumented individuals to other sources of care or to marketplaces where they would be able to buy coverage.