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Briefing on the ACA in California: Year One and Beyond

Kaiser Family Foundation
May 28, 2015

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RICHARD THOMASON, MPA: Good afternoon. We'd like to get started if I can have your attention please. I'm Richard Thomason, Director of the Healthcare and Coverage program for Blue Shield of California Foundation. I want to welcome you all to today's briefing on the Affordable Care Act in California: Year One and Beyond. We're here today to present the results of the California sample of the 2014 Kaiser Survey of Low-Income Americans and the ACA, which was funded by Blue Shield of California Foundation. This is the second year that we've supported the California sample of this national survey, which looks at how low-income Americans are taking up health insurance coverage, how they're using care and experiencing barriers to obtaining care, and the impact of coverage on their financial security.

We think it's really important to stop and look at how the ACA is fairing in California because our implementation of the law is so important for the national conversation. California has embraced the law by expanding Medicaid, by creating our own marketplace, Covered California, to provide subsidized coverage to individuals. Over 4 million Californians have gotten coverage through the ACA. We continue to be a bellwether for the nation to see the impact of the ACA on the health of our residents.

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Before we get started, I wanted to thank the staff of Kaiser Family Foundation and Blue Shield of California Foundation who created the terrific research you'll be hearing about today. First I'd like to thank the report's authors from the Kaiser Family Foundation, Rachel Garfield, Melissa Majerol, and Katherine Young. On my staff, Rachel Wick, Program Officer for Blue Shield of California Foundation who helped to shape the California results. I'd also like to thank Rakesh Singh from KFF and Christine Maulhardt and Kimberly Weber from Blue Shield of California Foundation for their work in putting today's briefing together.

Today's briefing is not only live here in Sacramento, California but it's also being webcast and live streamed on Periscope, which you can find in the KFF Twitter feed, so good luck with that. First today, we'll hear results from the survey from Rachel Garfield of the Kaiser Family Foundation. After Rachel we'll be joined by Jennifer Kent, Director of the Department of Healthcare Services for her observations about how we're doing in the second year of this historic coverage expansion. Jennifer has to leave a little early, so we're going to make time for Q&A with her after her remarks. Following the director, we'll have a panel discussion about California's successes and challenges with ACA implementation with a great group of folks. For more information about the survey results, I'd like to introduce Rachel Garfield. She's a

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Senior Researcher and Associate Director at the Kaiser Commission on Medicaid and the Uninsured where she's responsible for directing data analysis on insurance coverage and access to care for low-income populations. She'll walk us through some of the detailed findings and highlights in the report which is being released today. Rachel?

RACHEL GARFIELD, PhD: Thanks so much, Richard. I'm really pleased to be here today to present some of the findings from our survey of what's been happening to individuals in California during the first year of the ACA, or what happened to them during the first year of the ACA. What survey results are really wonderful for is illuminating broad patterns in what's been happening and helping us move beyond some of the anecdotal evidence that was popping up during the first year of coverage, but it's really up to the people on the ground who are implementing this law to help us interpret those findings. My role today is to present those patterns as a setup for our speakers who will come later on and talk about what it means for ongoing policy implementation in the state.

For those of you who may not be familiar with the Kaiser Family Foundation, we are an independent health policy research organization, and in the words of our President, Drew Altman, we're really in the information business. One of the challenges we identified when we were thinking about how to study the ACA was the lack of timely information on people's

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experiences under the law. We wanted to undertake original data collection to try to capture this information, and our goal was really to move beyond the enrollment numbers. There are other excellent sources of how many people enrolled in either Medi-Cal or Covered California, specifically the administrative data that the state collects. We wanted to be able to get some data that told us how are people fairing, how are they using the healthcare system, what impact has coverage had on their lives? For those that remain uninsured what's been happening to them? And so you can see on this slide some of the broad aims of the study.

As Richard mentioned, the California sample that I'll be talking about today is part of a broader effort at the Kaiser Family Foundation that includes a national sample as well as some other state-specific samples. We were in the field in the fall of 2014 with most of the interviews done before the start of the second enrollment period so we could really ask people about that first year of coverage. In California, we had a very robust sample with over 4,500 non-elderly adults participating in the survey.

There are several reasons why the Kaiser Family Foundation was really interested in doing a California-specific survey, and it's not just because California is our home, we're based on Menlo Park, but it's really because, as most of you know, the ACA is really being implemented at the state level

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and so you need that state-specific policy context to understand the findings. We chose California because it really is a bellwether state for ACA implementation. I'm sure most of you are familiar with the specific steps that the state has taken to really be quite aggressive in implementation of the law, and while the state did experience some of the glitches that were experienced nationwide during that first year, the state showed remarkable enrollment numbers during that first year. I think they were pretty unexpected and it leads it to be a wonderful case study for examining what happened under the law.

Let me get into some of the findings. The findings that I'm going to be presenting today are part of a broader report. There is an excerpt from that report in your packets, and the full report is actually available at KFF.org. We also have a few copies available for people to pick up on their way out if they like. I'm only going to be able to really skim the surface today, so I would encourage you to take a look at that if you have a chance.

One of the first things we were interested in was who are the people who gained coverage in 2014 and who are the people who were left behind and remained uninsured. On many important measures that we looked at, specifically income, age, and health status, as I'll talk about in a second, these groups were very similar to each other actually. But there were some

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differences between these populations, some of which I've highlighted here in this slide. You can see that while the majority of both groups are in families with a worker, the newly insured are actually less likely to be in a family with a full-time worker than the remaining uninsured. As you know, the ACA opened up new coverage options for people outside of employment, people who had primarily part-time employment before the ACA had a few coverage options, and so perhaps that has changed under the law.

Importantly, we see some differences in race ethnicity of the two groups. I know there's been a lot of attention to this issue in this state, and while Hispanics had large coverage gains under the law, we do see that the remaining uninsured population is disproportionately of Hispanic race ethnicity and this is self-identified by the respondents in the survey. There are several possible explanations for this. One is limits on eligibility related to immigration which affect primarily people of Hispanic origin, but others are barriers related to language access or cultural barriers to coverage that I'm sure our panel will talk about.

Last, we saw some differences by gender and these actually reflect some long-standing patterns of women being more likely to have coverage than men, and we actually see that in the population that gained coverage versus those who did not. When we dug a little deeper into the data on that, we

think that some of this may be related to actually Medi-Cal eligibility which is still higher for women, for some women, specifically pregnant women, and a lot of people who gained Medi-Cal in 2014 were actually still qualifying under those old eligibility pathways that were in place. Many were newly eligible, but people are still coming in under those new pathways.

As I mentioned, we also looked at health status and I wanted to drill down to these results just for a second. There is a lot of data on this slide and I want to highlight two take-away points for you. The first is that there was a big concern before implementation that there would be selection among the newly insured, that is that the sickest people would be the ones to sign up for coverage. When we looked at the data we actually did not see significant differences between those who remained uninsured and those that took up coverage in the share that say that their health is poor, either their overall health or their mental health. This leads us to think that perhaps selection wasn't as big an issue.

The second major take-away from this slide is that we find that there is still a great need for coverage among the remaining uninsured. Many of them are telling us that they are in poor health and so that would indicate a need for some kind of coverage and health services. Notably, they're also less likely to tell us that they have either a diagnosed illness or

are taking a prescription. Based on other research, we think this means that people are less likely to be linked to care and there are possibly high rates of undiagnosed illness among this population.

One of the most interesting questions that people were asking before implementation is what's going to happen to care patterns. This was really a big unknown– what people would do once they got their coverage– and we asked a host of questions about where people go for care, what their utilization was. And what we found was that most people who have a usual place that they go for care tell us that they did not change where they went for care once they got their coverage. We see that just under one in five of the newly insured say they did change their source of care. In followup questions, most people said this was related to insurance, but that still means that about 80-percent stayed with their previous provider. When we look at who that provider was, we can see the ongoing important role that clinics and health centers are playing in caring for this population. The majority of the uninsured population and a plurality of the newly insured population tell us that they rely on either a clinic or a health center for their ongoing care. These providers are continuing to play a very important role in caring for both the uninsured and low-income insured population in the state.

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On most measures of access that we looked at we actually find that those who gain coverage did better than the uninsured. This is not a surprising finding, as anyone who's familiar with the past 30 years of research in this area knows, but it's nice to see that the law's working as planned.

That said, we did identify some areas for policy makers to perhaps pay attention to moving forward. When we ask people did you postpone care and if you postponed care did you ever get it, we actually find that the uninsured and the newly insured are reporting similar rates of having those challenges and that these are higher than those who have been previously uninsured. I'm sorry, I should have defined earlier, the previously insured are people who had coverage before 2014 and continued to have coverage afterwards.

There are several reasons why we may see these patterns. Most of the newly insured are lower income, and there are barriers to accessing care for people who are lower income related to traveling to care or getting time off of work, all sorts of things like that. It could also be related to more complex health needs among the lower income population. That is to say if you have more potential encounters with the healthcare system there's a higher likelihood that one of those may be potentially problematic for you.

In addition, we also identified some system challenges and you can see these in the results on the right-hand side for

which we don't see differences by insurance. It looks different, but they're not statistically significant. We actually see similar rates of people telling us they have problems either getting appointments or had to wait longer for appointments among the newly insured and those that had coverage before. These may be indicative of just larger challenges in the healthcare system, not related necessarily to the coverage that people have.

The last set of outcomes that we wanted to focus on were related to financial security. Health coverage has two major goals, one is to help you access coverage and the other is to provide financial protection from that coverage, and we find that health insurance is working in this capacity. Both the newly insured and the previously insured tell us that they have fewer problems with medical bills and greater financial security against future medical bills than those who remain uninsured.

That said, there are some areas to pay attention to moving forward, specifically nearly half of the newly insured population told us that they believe it's either somewhat or very difficult to pay their monthly premium. Most of these individuals are in Covered California since Medi-Cal enrollees generally do not pay any premiums for their coverage, and although there are affordability provisions in the law, perhaps

some ongoing attention to the suitability of those provisions is warranted.

Last, I just wanted to reiterate that the financial concerns that we raised are really the ongoing challenge that the uninsured in the state are facing. There was a lot of attention in 2014 to implementation and the need to get it right to get people coverage, but when we asked folks who remain uninsured why they remain uninsured, very few people indicated that it was some sort of logistical challenge in actually getting enrolled. Very, very small shares said they either didn't want coverage, they opposed the law, or they were against the idea of the ACA. Some did tell us that they sought coverage but were told that they were ineligible or that they knew they were ineligible because of their immigration, but the most common reason people tell us that they don't have insurance coverage is that they simply can't afford it. Given the availability of financial assistance for most people who remain uninsured, perhaps some ongoing help in helping people be aware of these new options or making sure that they are affordable to them would be important.

In conclusion, I just wanted to leave you with some of the policy implications that we drew in the survey. In the name of time I won't read these to you. I'll just leave them to you to peruse, and most of them I've already touched on in my previous comments. In summary, I think I'll just say that

while there were significant coverage gains under the ACA and the newly insured population is faring better than they were before, that is to say they have better access to care, better financial security, there are some ongoing areas to pay attention to and I look forward to hearing from the panel about some of the things that the state has done in 2015 to continue its progress. Thank you.

RICHARD THOMASON, MPA: Great. Thank you, Rachel, for sharing those interesting findings. In the interest of having Jennifer Kent here and out on time, we're going to hold questions for Rachel Garfield until later on in the session so that we can bring up Jennifer Kent who is the Appointed Director of the California Department of Healthcare Services as of January of 2015. She oversees a staff of 3,700 people at DHCS, and among other things is responsible for the operation of Medi-Cal, the state's Medicaid program that supports the health of more than 12 million Californians, so a big job. We are so pleased that Jennifer can join us today.

JENNIFER KENT, MPA: Thank you. It's good to see you and thank you for having me. What's really phenomenal when you think about a program such as Medi-Cal in California, obviously it's the largest Medicaid program in the country, but when you sit, at least this is what I do when I sit at home by myself at night, and think that there's 12 million Californians that are out there that are better because of what you and your

department and the administration and policy makers are doing for them. Then it's also the same thought which is oh my gosh, there's 12 million people that rely on this state to help provide coverage for them and their families which is a really amazing both opportunity and challenge.

In preparation for this discussion, I think it's really important that we take a look back just for a little bit to understand where Medi-Cal was prior to the Affordable Care Act and where it is today, which I think coming to this department for the third time, I served in 2004 to 2007 and then basically for a little bit in 2011 and then I'm back for my third tour of duty. I got to see both the pre-ACA department as well as the post-ACA department, and I think it's just really phenomenal to think how the program has changed as well as the department itself. Kudos to our Research and Analytics Division who gave me some of these facts, but when Medi-Cal was taken in October of 2012, it was 7.6 million individuals and then today we stand at 12.3 million individuals, which is a 62-percent increase in enrollment in essentially two and a half years. I think when you, just from an operational standpoint, think about how you added 62-percent of an increase to a system that is very complicated and extremely diverse with a very challenging set of populations, it really is stunning that we were able to both grasp and embed the Affordable Care Act into our state program the way that we did, especially on such a short amount of time

that we had and given the state's resources when we were doing such an implementation.

The other thing that I want to highlight, and it's not a fact that has changed before and after the Affordable Care Act is that we, in Medi-Cal today pay for approximately half the births in the state of California, so there's approximately 550,000 children born in California every single year and we provide coverage to the moms and babies that are about half of those born under Medi-Cal coverage and payment scheme.

Today, about 50-percent of all the children in California are on Medi-Cal, so if there's, according to the Department of Finance, approximately 9.6 million kids in California, we have just a shave under 5 million of those children with us. That is both important to know but also key to some of the decisions and policies that we want to think about which is if these are children that otherwise wouldn't have coverage with us, what are we doing to make sure that they are healthy and obviously able to go to school, learn, get their education because you want them to go on. Hopefully, you don't want them on Medi-Cal, you want them on their own and supporting themselves either with employer-based coverage or other types of coverage.

Lastly, the Affordable Care Act in an enrollment setting, children dropped by 10 percentage points, so the program before the ACA and after the ACA, children made up

about 55-percent of the overall population in Medi-Cal, and then after the ACA where we stand today they've dropped down to 45-percent and adults have increased up to 55-percent of the program. I think, obviously, as many of you know, that comes as a result of the adults that had no other linkage to Medicaid, otherwise not eligible for the program, becoming eligible. I think many of you were aware of the waiver that we had in 2010, that the Medi-Cal program had in place, to provide an early expansion of coverage to uninsured adults. I'm looking out there if anybody knows about the LIHP program, and I know the Foundation certainly supported a lot of the counties and their local health programs. This was coverage to about 660,000 adults as an early part of the expansion of the ACA, and when we transitioned them on a single day, how many of you remember the press coverage around that transition? Well, Norman does because he works at the department, so that doesn't count, but most people don't remember seeing that transition in the press and the reason they didn't see it in the press was because it was a resounding success and it is something that we are really proud of as we look forward to the next five years of the waiver that we are seeking with the federal government is the ACA and the waiver that we got in 2010 as a department and as a program was all about the early implementation of the Affordable Care Act. What can we do as a state to make sure that we put this program into place and provide coverage to the

millions of Californians that need it and that early wave of individuals on January 1 of 2014 were transitioned into coverage and pretty seamlessly and it was a remarkable both early adoption of the ACA from a state perspective– no one else flipped 660,000 people into a program on a single day– but also to the fact that they had already been receiving care through an organized delivery system also spoke volumes as to how those people found their medical home, how they already had a provider established, and that many of them were already under treatment which I think is also remarkable and that probably helped the overall health delivery system absorb them better because they had been in coverage that previous two years.

Then lastly, the largest transformation of Medi-Cal, again, prior to the ACA, and it has been a slow and steady phased-in approach, has been the increasing number of individuals that are enrolled in managed care versus fee-for-service. Today, about 80-percent of our population is in managed care, 20-percent is in fee-for-service. Back in 2007, it was 50/50, and really what we've got left now is about 9.2 million individuals in Medi-Cal managed care plans throughout the state, a little around 3 million in fee-for-service. Those individuals that are in fee-for-service by and large are individuals without full scope coverage either due to their lack of documentation status, so they may be with us through our emergency Medi-Cal program. They may have limited

benefits. They may be there for a pregnancy-only coverage. They may be populations that are exempt from Medi-Cal managed care because they've received what we call a medical exemption request from managed care. A lot of those individuals may also be dually eligible, so individuals with both Medicare and Medicaid coverage if they're not in one of our coordinated care initiative counties. That, I think, is kind of the challenge going forward as a state as we look into this next year or so with the Affordable Care Act, which is how do we ensure that the coverage individuals are receiving in managed care is both accessible and meaningful. But then I look to the fee-for-service system and say what are we doing for those individuals because they have coverage through Medi-Cal, but it is obviously not the same as our managed care plans. To the extent that individuals enrolled in a Medi-Cal managed care plan are entitled to certain things that our state has in place– a regulatory and legal scheme in terms of plans have to have primary care providers assigned to all of their beneficiaries, we have time and distance standards in this state that plans are held to which as far as I'm aware no other state has timely access standards the way we do– I think that that is a completely both appropriate and measurable system that we are really both continuing to refine but also incredibly comfortable with and that we feel that is the better way to provide care to people in an organized delivery system.

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The next challenge that is see both as a department and as a program is what do we do about our remaining fee-for-service population because their care is truly unmanaged and that presents a lot of challenges both for their own health status as well as the financial ramifications of having individuals without any kind of either regular or comprehensive benefits afforded to them.

The last thing I want to note, as we are getting ready to engage with the federal government in negotiations over our next five-year Medicaid waiver is the waiver expires on October 31. It was sold as the Bridge to Reform to the federal government, meaning help us do an early adoption of the ACA and provide us the federal funding, which was approximately $10 billion in federal funds, to show you how we can do this. I think we have absolutely delivered on that promise, but what we're talking to the federal government about now which is we need another five years to fully embed this law into California and to really transform the delivery systems that these millions of Californians rely on. I'm also mindful of the fact that it's not just Medi-Cal beneficiaries that rely on the Medi-Cal program, in a lot of different settings, the funding that Medi-Cal provides to certain facilities and to certain providers benefit all of us and so I look to some of you who are experts more than I in this area in terms of our safety net, financing, to our UC hospitals, to our tertiary care

centers, to individuals that are familiar with our California Children Services program. If you look at the Children's Hospitals in the state of California, if you've ever visited UC or had any kind of interaction with our academic research facilities, a lot of those programs, those facilities, that funding comes as a result of what Medi-Cal is able to do as one of the largest purchases not only in this state but also the country. Our story to the federal government as we look to this next five-year waiver is we have done a really good job with the first five years of this waiver and we need another five years to transform the system, but watch what we can do to better integrate care for individuals in our program. I have my May is Mental Health Awareness pin on if any of you are tracking this, but I think the next five years for our waiver is really kind of making sure that individuals have coverage that is fully comprehensive and is not just about their physical health is that for a lot of individuals, when they see a provider, they may be also struggling with behavior health issues, mental illness or substance use disorders. I think that that's really what we're trying to tell the federal government that if we don't look at the whole person when they come into a provider's office, be it a behavior health provider or a physical health provider, if we're not providing them a comprehensive benefit across the spectrum, they will continue to have poor health and they will continue to cost the system

money that otherwise could be used for other purposes. I really am impressed with what we've done as a state, but I think we have set a real benchmark for the rest of the country. More on this as we negotiate the next waiver with the federal government and I'm going to stop for questions, comments. Don't be shy. Yes?

RICHARD THOMASON, MPA: I will start off and then we'll take some questions from the audience. There's a microphone over there if folks want to come over to the mic and ask a question. We'll ask you to state your name and your affiliation if you have one for the webcast. Jennifer, you were appointed director of the department near the end of the second Affordable Care Act period. I'm wondering from the department's perspective, how did that go and how are you thinking about enrollment and retention issues this year because last year there was quite a backlog of Medi-Cal applications that I think you've worked through. How's it going this year and how are you seeing the enrollment and retention question?

JENNIFER KENT, MPA: Interesting question. I think like all things, when you do a big implementation in California the way that we did, there are certain things and certain circumstances that you can control and certain things that you can't. The IT system that we built in about two and a half years in California is really a testament to the fact that it

was an IT system that we built from scratch to do really complicated things that no one in the country actually knew what they were building too. You saw a lot of state exchanges in other states fundamentally fail in their ability to deliver the needed IT system to get the job done and we did that in California which was pretty phenomenal. I see one person in the audience that has way more knowledge on this than I, but I think that when people flipped the switch on October 1 of 2013 to see if it would even turn on, I think there was maybe a little bit of nervousness. That being said, I think that the system we built, otherwise known as CalHEERS in California certainly was new and immature as a system, and as a result we had a lot of IT challenges between us as the state and the county consortium of eligibility systems. That unfortunately led to a pretty significant backlog. We have worked through that backlog, but I think that eligibility enrollment still continues to be a challenge in large part due to the fact that we just have a significant volume of individuals that are on this program and Medi-Cal eligibility being what it is, a lot of those individuals have to be annually redetermined for coverage, so when you think about it there is maybe 15,000 to 17,000 eligibility workers in the state spread through the various 58 county welfare director offices. Those 15,000 to 16,000 individuals have to annually determine basically 12 million Californians and just think about how much of an

intensive workload that is because these are individuals that have changes in circumstance, changes in family size, their income is probably not as easy as some of us in terms of they may have three or four different jobs, they may have income that is self-produced or produced on an hourly basis that may be temporary, it may be short-term. I think trying to make sure that these individuals are entitled and found eligible for the program has been a really, really challenging thing, so that needs continued refinement. That system has about a two-year roadmap that we have developed that says all of these functionalities still need to be refined and improved and I'm hoping that at the end of two years, this is an easier process than it has been in the last couple of years.

I would also say that the churn factor is just going to be one of those things that we have not reached a steady state of enrollment in California yet as far as Medi-Cal. We still are seeing increases every month in our enrollment which means that there are individuals for a variety of reasons that are still finding their way to our program. That is also starting to show. The data on the Covered California side is how are we doing the transition between Covered California, which is most likely where they individuals are bouncing in between which is subsidized coverage, heavily subsidized coverage because of their low income status, and if they lose a job or they lose a few hours on the job that will all of a sudden make them

eligible for Medi-Cal. Those transitions and that churn that we refer to is going to continue to be difficult to fully process in another year and so I'm hopeful that we will have a better handle on what that actually looks like, but I think that's one of the more significant challenges that we, as a state and a country, still have is understanding that transitory population and how they move so quickly between coverage. That does pose its own challenge for continuity of care and other things.

RICHARD THOMASON, MPA: Great. Thank you. Question over here.

GABRIELLE LESSARD: Yes, thank you. This is Gabrielle Lessard from the National Immigration Law Center. At the last stakeholders meeting, you hadn't had a response from CMS on the waiver proposal and I'm wondering if you've received a response since.

JENNIFER KENT, MPA: No. That's a great question. We have had unofficial conversations, because we talked to CMS for a lot of things. They are hoping to get waiver comments to us probably in the next week or so. I think that they had wanted to do it sooner. There are two states that are up for major waiver renewals this year, us and Florida, and two different states we could not more be. What's happening in Florida is very different than what's happening in California, but the same people at CMS that are working on Florida also have to

work on our waiver and so I am hopeful that we probably get some pretty detailed questions and comments and then we can just start to march through it. They have been really receptive in the first opening discussion that we had with them. They like the fact that we are continuing to talk about value-based purchasing, they like the fact that we are incorporating a comprehensive proposal to address individual's needs on the spectrum of physical, behavioral, social need. They haven't said what they think about our housing proposal, but I think that that's one of those revolutionary concepts that if an individual doesn't have a stable housing situation, how are they expected to be on top of all of their healthcare needs as well? I think it's going to be a fairly productive conversation with the federal government and certainly very, very different than what's happening in Florida which is Florida says give us a bunch of money for the uninsured and CMS is saying you could expand your Medicaid program, so why would we give you money to cover your uninsured costs when you could just increase your Medicaid population. We obviously have a completely different situation in California which is we've increased and so we just continue to need help to refine what we've already built.

LOLA ACOSTA: Hi, I'm Lola Acosta of Healthcare for All Sacramento Valley. I am really interested in Senator Laura's bill, Senate bill four. Should it clear both houses of the

legislature and be signed by the governor, I wonder what challenges that would pose for implementation?

JENNIFER KENT, MPA: Like any kind of population change or beneficiary change in the state, and I think you just heard a little bit from me in terms of how we implemented the Affordable Care Act, there are so many different things that we, as a state, have to do when you add a population. There are systems changes, there are a lot of state plan amendments or waiver changes that we have administratively with the federal government. We have an increasingly complicated financial arrangement between us and the counties for purposes of sharing costs associated with the Medicaid program, so I actually am breaking out in a sweat starting to think about how complicated it would be to add a completely new population to the state in terms of both the systems and the programatic and the financing. That being said, I would just note that our budget allowed for a certain increase in funding related to the DACA and DAPA immigration changes issued by executive order under President Obama, and that was built on an estimate of our best guess as to should that be done. How many individuals in California do we think would fall under that particular immigration declaration as well as how many do we think would actually take up the rate? I think anything related to both Senator Laura's bill or other proposals is it's always very complicated for us to understand the behavioral patterns of

whether individuals would actually seek care or not. I think the costs associated with a complete expansion of individuals that are not currently served today would be challenging just for us to financially understand how they would behave, especially if their immigration status is still unknown. I think there are individuals in Medi-Cal today that receive emergency Medi-Cal coverage on a month-to-month basis. Some individuals may not even come into that program because they're worried about what happens to them on an immigration change or status or coming into a system that would otherwise try to track them. We do not have an official position on that, but there are a lot of programatic and administrative changes that the department would have to make both from a benefit standpoint as well as just accepting new beneficiaries.

BEN AVEY: Hi, my name is Ben Avey and I'm with the California Primary Care Association. Today's report spoke to the importance of community clinics and health centers in the post-ACA world, and I was just wondering if briefly you can talk about where you see community clinics and health centers moving forward and as a part of the post-ACA world?

JENNIFER KENT, MPA: Great question. I think that when you think about all the different ways that individuals seek care in California and especially low-income populations or a minority population where they may not be comfortable seeking care through the more traditional coverage sites, I look at our

FQs and our community-based clinics and you look at the different ways in which they serve their local populations, and our numbers in California and in the Medi-Cal program show how many individuals actually rely on FQs and rural health clinics for their care. I think it is one of the ways in which we are keeping an actual network together in California. I know that the health plans rely on those FQs and RHCs and community clinics as well in part because individuals are comfortable receiving care in health clinics. Often times, there are providers there that speak the language that they speak and that makes them more willing and able to seek the care and I know that the data that was presented earlier was that there were some individuals were like I am not wanting to seek care because I don't feel that the provider can talk to me in my own language or I'm uncomfortable in the waiting room or something. I think that the FQs and clinics have gone a long ways in really adapting their modalities to reach out to those hard-to-reach populations and make them feel as if they have a place to go. I think the data just supports that. Those individuals that were getting care in clinics before the expansion, and that are still there after, they may have been uninsured in your clinics before 2014 and now they're actually with a coverage card, but they're still in your clinic and I think that that speaks volumes to the fact that they made their medical home there and that's where they continue to receive

it. Especially in rural areas, sometimes the FQHC is the only provider and that's a really important foundational key linkage to care in communities that don't otherwise have other providers up there and so we would see them as being a fundamental partner going forward as well as what they have done for us in the past.

RICHARD THOMASON, MPA: Thanks. I'm afraid this will have to be the last question for Jennifer.

HUGO MORALES: Hello, my name is Hugo Morales and I'm the Executive Director of Radio Bilingue for Latino Public Radio Network, nonprofit community radio. I'm also commissioner of First 5 Fresno County. I wanted to ask you, we're the only ones that have a statewide interactive radio show dealing with health in California, so we are monitoring for several years the ACA. One of the things that we've been hearing last year was the long waiting periods for enrolling in Medi-Cal. I have three questions, the waiting period this time for that. Also we are hearing that folks continue to not know what is covered under Medi-Cal. Then another is that there is a lot of misinformation, or maybe not, about some of the consequences of enrolling and benefiting from a coverage under Medi-Cal. I have a concrete example. A former employee who for years waited not to enroll, and I'll tell you the reason why, and finally she did enroll and right now she's diabetic and has a foot infection and so she's bedridden. One of my

managers visited her last week and asked her what worries her and she says besides the ailment is that she's fearing Medi-Cal will take away her home. She lives in [inaudible 00:43:45] in Fresno. These are my questions.

JENNIFER KENT, MPA: First I'm trying to remember the enrollment question and it goes back to some of my comments earlier as to the volume and the vast uptake at the beginning of the Affordable Care Act in California certainly not only overwhelmed the IT system, but it also just overwhelmed all of us both from a workforce standpoint as well as from a state program standpoint. We have worked mightily, and kudos to the county eligibility workers that also had to work that backlog because they were, I know, pulling in a lot of manpower and overtime to make sure that individuals that wanted coverage could actually get coverage. I know that that was their first priority as well as it was ours.

I think that there are still some delays but probably not as many as people would think. I believe that a lot of delays in eligibility enrollment these days are from individuals that may not have all the right pieces of information that they have to provide and if they are waiting for either an income or a documentation status, those are sometimes reasons why their eligibility is delayed. I think there also still continues to be some systems challenges. I do know that we have a lot of duplicate applications where someone

will send in an application through our system electronically, and I'm making up a name Bob Smith, and then if he doesn't hear back from the county whether he's been found eligible or not he may submit another application entitled Robert Smith. Then if that doesn't get a response then Robert Smith might be Robert R. Smith. There's a lot of duplicate applications and we know that's a problem that we have to fix and that just adds to some of the county's workload as they have to sort through some of these duplicate workloads and make sure they are working on the one person that has actually applied.

I think that your example of someone having delayed onset challenges related to their diabetes is a classic case for why we were so proud of the Low-Income Health Program under the waiver is that we believed, and I think this bore out, is that individuals with chronic conditions, if they don't receive treatment in a more appropriate and timely manner hopefully through a primary care home, that it worsens and we are left with a condition that is far worse in terms of outcome as well as cost to a system where those otherwise could have been avoided through a better provider in a lower level of setting.

I think that we try as much as we possibly can with beneficiaries in their own language, so we translate all of our applications, all of our documents, all of our welcome packets, into all of our Medi-Cal threshold languages. Don't quote me on the number but I think it's somewhere between 13 and 18 are

our threshold languages in California for how we communicate with recipients. The plans, if an individual's enrolled into their Medi-Cal managed care plan, they receive a welcome packet from the plan which is both their card, which entitles them to see that they have coverage and they can show it to a provider, but the welcome packet also includes the list of benefits that are available to them in Medi-Cal. To the extent that you have information that you want to provide to us after this for individuals that say we don't know what those benefits are or we're not sure what Medi-Cal can do for us, I think that we are always looking for ways to better communicate what Medi-Cal is, how we provide coverage, and doing it in a way that is responsive to the recipient's cultural and linguistic needs because not everybody receives information in a certain way. I know Richard had done a study a few years ago on seniors and persons with disabilities and we talk about ways in which they preferred to receive information and a lot of them said we don't want to get a call, we want to see it in the mail. Then if you talk to other populations in Medi-Cal, they say well we don't want to get it in the mail, we want to get a call or could you text us, could you e-mail us? Each segment of our Medi-Cal population prefers different communication strategies and we are always endeavoring to do that in a better way. Again, it's a program with 12-plus million people and so every day is a challenge. Thank you.

RICHARD THOMASON, MPA: Great. Thank you, Jennifer. Now let's turn to a panel of dynamic leaders who've been deeply involved in Affordable Care Act implementation and get their observations on the study and how the ACA is going in California. I'd like to call them on up here. Joining us are Genoveva Islas, the Program Director of Cultiva la Salud, an organization dedicated to creating healthier communities in the San Joaquin Valley. As of March, she was also appointed by Governor Brown to be a member of the Covered California governing board and is, I'm sure, on a very steep learning curve there about how that works. Also joining us is Carmela Castellano-Garcia, the President and CEO of the California Primary Care Association which has a membership of more than 1,100 nonprofit community clinics and health centers serving more than 5.6 million patients a year. Then finally Sarah de Guia, the Executive Director of the California Pan-Ethnic Health Network, which is a multicultural statewide advocacy organization that works to improve the health of communities of color in California.

First off, let me turn to Genoveva. Since you've come to the Covered California board with a strong history of working to improve the health of low-income and Latino communities, especially in the Central Valley, I'm wondering from your perspective both where you work and as a board member

how successful was the second open enrollment season and what challenges are on your mind looking forward?

GENOVEVA ISLAS, MPH: Thanks, Richard. First before I begin my remarks I just want to say that it's always been my dream that Latinas would be recognized for their brilliance and happily I'm on a board, a panel today, of all Latinas, so I just want to say we're making progress. Secondly, I want to thank you for recognizing that I've only been on the board since March and really only have about two board meetings under my belt, so yes I'm on a very steep learning curve and I'm really still trying to learn the history and some of the decisions that have been made before my appointment.

As a broad-sweeping statement, I want to say that there are many successes to celebrate with Covered California and I can think of 1.3 million. 1.3 million is the number of consumers that have active health insurance as of March 2015, and to date, Covered California has served 1.8 million Californians since it began offering coverage in January of 2014. During the second enrollment period, Covered California covered nearly half a million people and the mix of enrollees are definitely more diverse and younger. New enrollment of subsidy-eligible Latinos surged 6 percentage points from 31-percent to 37-percent this year, and that's in alignment with the Cal-Sim estimates of Latinos at 38-percent. Similarly, African American enrollment also rose from 3-percent to 4-

percent and that's also in line with Cal-Sim estimates. Also finally young adults surged from 29 to 34, so 5 percentage points surge. I think at Covered California we understand that we're not done and that we've certainly learned a lot during the first and second enrollment periods, but I think it's fair to say that we're headed in the right direction.

In terms of challenges, I think that we need to continue to keep costs down. I see that as one of the foremost challenges. Covered California now is going into negotiation with health plans for 2016 and we'll be announcing carriers and prices in late July. This is incredibly important because as an active purchaser, we're looking to hold their feet to the fire, so to speak, not only to provide consumers with the best prices but also with the best access to doctors and hospitals.

I think one last remark I want to say in terms of challenges overall that speaking as a Latina and speaking as a child of farm laborers, I'd be remiss if I didn't call out that one of the greatest failings of our system is that it doesn't allow the enrollment of all Californians specifically undocumented immigrants into the Covered California. To be clear, I don't want to imply that this is failing of Covered California, again, I think it's a larger failing in terms of the designing of the system and as we sit here, my mind is definitely on the 3 to 4 million Californians that remain uninsured and my mind is also on the fact that in

appropriations we're hearing a Senate bill for today. My wishes are that we create a system that is fair and accessible to all Californians.

RICHARD THOMASON, MPA: Thank you. Next let me turn to Carmela. The report clearly highlights the importance of clinics and health centers are core providers for low-income Californians, so from your perspective, how are clinics adapting to attract and retain Medi-Cal and Covered California enrollees by being their provider of choice?

CARMELA CASTELLANO-GARCIA: I want to start by saying I'm having a good day. I heard SP4 did pass out of appropriations, the coverage for the undocumented as well as CP's other bill, so I'm feeling good. I walked in here, before I knew that, really feeling good about this report because I can remember back in 2011, sat on a lot of panels with Anthony Wright and [inaudible 00:54:37] doing the rounds of people asking about what was going to happen to the community health centers as a result of the ACA. Being the eternal optimist that I am and knowing my constituency well, I predicted very consistently that community health centers where not only going to retain their population, but they are going to grow. I am very pleased about the results of this report because it confirms with hard data what I predicted would occur.

Why has that happened? Why are we providers of choice? I think we've achieved that; the data shows. I think for years

we've been actively transforming ourselves so that we can deliver the quality care that our patient deserve in the manner that they prefer. We are seeing the results. Another study that Blue Shield released in January about advances in health care for low-income Californians showed that there was a significant increase among low-income communities in terms of patient satisfaction with the care they're receiving at community health centers, so the data shows the kind of efforts that we have made. It's everything from the fact that we have a focus on whole-person care. There was just an article yesterday in the *Public News Service* about that showed that at community health centers, it goes well beyond primary care into mental health, dental, counseling, eye care, and even further referrals for domestic violence, food and shelter all happening under one roof. For low-income Californians, that's extremely valuable. We want them to stay healthy.

Our patient-centered approach is, of course, critical which means that we have providers on our team, not just physicians, but nurses, care coordinators, promotoras, outreach workers and more standing alongside the providers to meet the diverse needs of our population. Certainly, the data also shows for the Medi-Cal new enrollment, they do have important healthcare needs and so it's critical that we're able to provide this kind of services.

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Certainly, when it comes to advances in technology, 95-percent adoption of the electronic medical record for community health centers in California and nationally, so staying at the cutting edge of technology, adopting patient portals, being involved in health information exchange. These are the ways we show our patients that they can connect to us. Certainly, on the legislative front, we are really looking at changing our reimbursement methodology so that it actually incentivizes alternative approaches in things like e-mail and phone and group visits and the kinds of things that our patients want. We are going to continue to innovate, we are going to continue to be leaders and therefore I think we will continue to be providers of choice which we have also packaged into our branding imitative, which is California Health Plus and that is the name of the statewide network of community health centers that take their obligation to see the newly insured very seriously, are committed to high quality care for their community and California Health Plus is the brand that we are adopting statewide to really showcase the plus in healthcare that we provide, that I just really shared that makes us the provider of choice.

RICHARD THOMASON, MPA: Great. Thank you, so now onto Sarah. From your perspective as an advocate for consumers and ethnic communities, what did the second enrollment season look

like to you and what are you hearing from communities around the state?

SARAH de GUIA, JD: Yes, just as a comparison from the first and second enrollment period, as the report shows there were some communication issues and also from the enrollment figures we know that the enrollment wasn't as great, particularly for the Latino and African American communities. Thanks to support from the Blue Shield of California Foundation, we were able to work really closely with a number of certified enrollment entities who worked first-hand at enrolling people and could communicate those challenges directly to Covered California and the Department of Healthcare Services, so things like the web site glitches, long wait times, inaccurately translated materials, they were all able to address those pretty real-time and that was able to help enrollment along the way. I think that served as a platform for lessons learned as Covered California move forward into the second enrollment period. On the positive side, I think we saw that the targeting of outreach and marketing materials to the Latino and African American communities really did pay off. As Genoveva showed, the numbers for African American/Latinos was really close to what the Cal-Sim estimates were. We also know that there's still a lot of work to be done.

Three things that I think I would really point out that are very tangible things that we can be working on is, number

one, really acknowledging the role of the certified enrollment counselors and navigators, that they provide much more than just enrollment assistance. They are there for all the followup calls and questions. We have CECs who have spent up to 11 hours with one consumer helping them work through enrollment, making sure that their getting enrollment, making sure that they understand their plans because a big part of this is people enroll in a plan but they don't know how to utilize the system. They really don't understand the difference between co-insurance and co-payments, and so these are the folks on the ground without a lot of funding and resources who are able to help translate that information and they are literally translating that information and interpreting that information from languages that are up to 13 Asian languages in some cases. I think we really need to make sure that we understand that we're undercompensating those individuals who are helping.

We also notice that there's a real need for desegregated data, so it's great that we're breaking it down by race/ethnicity, but we need to go even further. We really picked the low-hanging fruit in the first round of enrollment. We saw 1.3 million enrolled individuals and I think in the second round and the second and third series of enrollments, we're probably not going to see those sheer numbers because these populations are going to be harder to reach. Again,

languages besides English, individuals who, again, may not have any real understanding of how to use the system, they're farther away. They need greater touches along the way and I think the desegregated data would really help us where to target the resources to be making sure that we're enrolling those eligible populations. Also, just to note that enrollment in the API, the Asian Pacific Islander community actually went down from 23-percent in first enrollment to 18-percent in the second.

Tied to my first point is that we do need to continue to invest in enrollment and assistant, that what we're seeing is a disinvestment in outreach and enrollment from $30 million to $10 million in the year 2015/2016 enrollment period. Again, with the harder populations to enroll, knowing that we need to actually provide that greater material in other languages that these are going to be populations that just need that greater assistance, we can't afford to disinvest, in this enrollment period we really need to ensure we're continuing that level of investing in the infrastructure that can help people who are already enrolled understand their coverage as well as get those harder-to-reach populations.

RICHARD THOMASON, MPA: Great. Thank you. My next question is for Genoveva, although I invite the other panelists to chime in as well. The survey shows that 44-percent of Covered California enrollees are still reporting difficulty

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paying their monthly premium as compared to, say, a quarter of adults with other types of coverage. Are you concerned that people gaining coverage now will be losing it in the coming years because of cost and what are your thoughts about how this could be addressed?

GENOVEVA ISLAS, MPH: I think that this is a larger societal issue in terms of equitable pay and am really happy about the progress in trying to increase the minimum wage. More specifically in terms of Covered California, I think it is vital that we work to try to keep costs down. Covered California does fight, we do negotiate on behalf of our members with insurance companies and I think through our combined membership with have a very large purchasing power. One person perhaps can't do a lot to affect this, but 1.3 million is power and can, so I think that's one thing.

We're unique in that most of our consumers receive financial assistance to bring health insurance within their reach, and in fact about three quarters of all subsidized enrollees, that's roughly 912,000, pay less than $150 per member per month for health coverage and some 120,000 pay less than $10 per member per month. That is good news. We do understand that healthcare in this country is still very expensive and it's going to take time to bring down those costs, and while subsidies are important, this survey released validates the fact that healthcare costs are a challenge for

many Covered Californian consumers as they are for many with private healthcare coverage and through their employer. In fact, as mentioned in the report, Covered Californian enrollees face costs that were higher than expected which compares to 29-percent in the other private market, so I think definitely work to do there.

CARMELA CASTELLANO-GARCIA: Definitely concerns around the affordable issue and the way it plays out in our health centers is to see folks with a Bronze plan coming in and trying to use the slide fee scale. It really is an issue we're seeing. Our clinics are telling us it's a problem and challenging. We're pleased to see progress made at the exchange last week on the prescription drugs issue and we would just encourage more consideration on these matters.

SARAH de GUIA, JD: In terms of affordability, I applaud Gevoveva's comment. There's definitely an equitable pay issue obviously, and I think there are also some changes that we should be pushing on the federal government as well to be looking at. For example, the family glitch which is that employers, whether or not an individual in the employee market can receive family coverage is based only on the individual, so if you as an individual can afford, if it's below the 9-percent of your income you can afford it, it doesn't take into consideration the cost of dependent coverage. That's a challenge for a lot of families because that makes them

ineligible for Covered California. I think in terms of some affordability issues around, there is some work to be done on the ACA, which we all knew.

The other piece of it, I think, is also going back to the health literacy issue which is that, again, people are not really understanding what their coverage is and that maybe issues such as preventive care. We understand maybe what preventive care is, but somebody who maybe thinks that their preventing care by going to get actual care from their doctor, like an eye infection or things like that, that actually isn't covered, that isn't free. People may not understand those differences, so I think a lot of work needs to be done about really helping people understand what their coverage is.

There continues to be, I think, two miscommunications between providers and their patients as well. If a provider doesn't understand what a patient has coverage for, they may recommend a series of tests that the individual doesn't have coverage for as well or that they don't understand what their procedures are. I think both the provider community, the plan community, as well as consumers all need to be on the same page about the type of care that people can get. You can't have an activated consumer if your plan and your provider aren't also a part of that conversation, so I think there really needs to be more engagement with the government entities as well as the

provider and plan community to help people navigate the system as well.

I think last but not least, of course, health for all. We absolutely have to do something in California about covering individuals, SP4 has passed through appropriations. It's going to cover all kids, which is great, and it's going to cover eligible adults, or at least the proposal is to cover eligible adults as funding is available. Again, there's the idea out there that we definitely want to cover people, but we really haven't stepped in fully to make sure that that is a reality here in California.

RICHARD THOMASON, MPA: Great. Thank you, Sarah. I think now I'll open it up to some questions from the audience, and there's the roving microphone. If you have a question, raise your hand. Again, please state your name and affiliation if you have one.

KEVIN HAMILTON: My name is Kevin Hamilton. I'm with Clinica Sierra Vista. We're an FQHC here in California. We probably are a blip on the enrollment radar as well having enrolled over 30,000 people here in the last year and I think we've got some very unique things going on with our county government as well and Department of Social Services and some new experimental enrollment models and partnerships there.

However, we've got a couple of things. First of all, Covered California and CalHEERS are two separate entities and

they talk separately, yet both are troubled by the churning issues at the income breaks. This needs to be incentivized from both directions, I wish the director was still here, but to seamlessly join those two systems not just at that enrollment level, but the majority of providers of managed care are also providing coverage in Covered California. There is no reason not to have the plans migrate these folks back and forth and have that be transparent to the enrollee. The problem becomes when you get the enrollee involved in that part of the conversation, they lose it immediately, and why wouldn't they? We don't understand it ourselves half the time and we're supposed to be fairly knowledgeable about these things. That's one thing that I would suggest that we keep our sights on in the future.

The other thing is when we're talking about deploying CECs and deploying eligibility workers, again, we have about 35, well we have more than that. I guess we have closer to 50 of them now in three counties. The funding that comes through for that, especially again on the Covered California side, is very numbers-driven, and we talked about this a few years ago. I talked about this a few years ago, and it was addressed initially, though I thought poorly, in the original outreach grants, the ones that are coming out now are still very numbers-focused. The folks who live in central California, the 4 million of us, and those of us who live in eastern

California, the couple of million people there, and those in northern California, we've got some significant geography issues. We talked about this then that geography should be considered at the same level as the numbers of people enrolled as a deciding point for how you're funding these things and the cost associated with that. If I have to send somebody 40 miles out to a town of 400 people, is that less valuable then sitting in an urban center enrolling 4,000? It isn't to them and it isn't to us, so and it shouldn't be to us as a state. We really need to fix that. It is interesting because I just sent her a letter of support that I got from somebody for our new navigator grant, but again, targeted at numbers. How many people can we enroll in Covered California? I get it; I know you need the numbers, but it's not meeting the needs of these communities.

Then the last thing is the cost issue. We have discovered, and you should be informed by this conversation, as Carmela so eloquently stated a few minutes ago, in that range of people in health centers and sliding scale, when you're at 150-percent of the federal poverty line, given the cost of housing and utilities and groceries and you're sitting there making maybe take-home $1,500 a month, $1,600 a month, you're rent for a two-bedroom apartment, and if you got a couple of kids you've got a two-bedroom apartment, in Fresno, not in a nice part of town by the way is going to be $600 to $800 a

month. Your utilities are going to cost you, by the way, that apartment doesn't have all the great insulation and the triple-pane windows and the low energy footprint that newer places have, so again, we need to fix that. That's a huge problem and we appreciate the subsidies. I think it's great at a certain point, but we either really need to raise that level or as a state decide we're going to raise the Medi-Cal minimum wage for qualifications. That's pretty much about it. I would appreciate any comments about that.

RICHARD THOMASON, MPA: Thank you, comments, reflection?

CARMELA CASTELLANO-GARCIA: I'm not going to argue with that because that's certainly the kind of information we are hearing from our health centers. It's certainly the rule, folks, and not just in the Central Valley but up north have been saying all along that the funding formulas do not take into account the challenges that we have with outreach enrollment on the rural side.

GENOVEVA ISLAS, MPH: It's kind of hard to have anything to address because I agree with everything that Kevin said. Definitely it is something of concern to us, the churning issue, and I think we're trying to be as proactive as possible to try to create a system that is seamless. It's not a quick fix, but I think we're looking in that direction.

I've heard from a number of advocate organizations that are not in good situations in relation to how the initial grants were set up. I do think it's unfair and I think there are conversations to be had in terms of how we fix it going forward. As someone who's been born and raised in the Central Valley, yes, those 400 people in a rural community matter, they matter to me, and we want to make sure there's service to them and so whatever we can do to improve it and fix it I'm for it.

RICHARD THOMASON, MPA: Thank you. Question over here?

RICK JOHNSON: Yeah, hi. Rick Johnson, ZeroDivide. Question for you who work with navigators and enrollees. What, if anything, could Covered California do from a technology perspective to make the web site easier for your navigators to enroll people into Covered California?

SARAH de GUIA, JD: Translate them into other languages. I think the paper application, which was translated into, I think it was, up to 13 languages. I think the sense was that the paper application was a little bit discouraged and that the online application was definitely encouraged. Again, having folks being able to do it at their homes but also working with other individuals who can help them enroll if that translation is done and they can look at it real-time, it's much quicker to be able to enroll people in the coverages.

I think the other piece was that there are, Asian Americans Advancing Justice, for example, my colleagues down in

LA, who received, I think, $500,000 this year to enroll a number of people, it was really numbers-focused and they didn't meet their targets and so I think this year the number is going to go down, but they've actually took it upon themselves to translate materials into 13 different languages. That's on their dime or money that they have to put out-of-pocket in order to help the communities that they're serving. Again, going to Kevin's point, I think all of the points, which is making sure that we're really investing in that infrastructure of people who are already helping to get people information about enrollment, but then again who keep coming back to those communities to understand. I think that point has definitely been made over and over again today.

I think in terms of also working with individuals, I think there are ongoing systems such as making CalHEERS a little bit more accessible, the glitches that were happening at the web site. The other point that I saw as I was looking through some of the stories is that not only do the CECs and the navigators have long wait times with Covered California, but they also have long wait times with the plans and so they could be spending two hours just getting information from Covered California but also from the plans. I think, again, looking at the plans and the provider community to say there are several language access laws that are already on the books and so it's just really making sure that those plans and

providers understand what their obligations are and that their infrastructure is in place to be able to meet the needs of their current enrollees but also their potential enrollees as well.

RICHARD THOMASON, MPA: Thank you. Other questions? The microphone's coming.

EVO MORALES: Yes. Evo Morales [inaudible 01:16:46] First 5, Fresno Commissioner. As Carmela was alluding to the changes in the clinics, I was thinking about some of the challenges that the families face. There's 25-percent of California's families who do not have broadband at home. As we, how do I say, upgrade and so on, our facilities, 10 million California without broadband at home. I am calling this up because there is an opportunity to address this. Right now, in the next few days, there will be an opening opportunity to support the idea of providing Lifeline and refining Lifeline, which is subsidized service that has been just for telephone and finding out do we include broadband. There's a real opportunity here for those of us in the health field to support the introduction of broadband to 10 million Californians, which is the population that all of us here in this room are supporting. I hope that you can do that by going to the web site, internetforallnow.org and registering there. I just thought I would link people to that opportunity.

RICHARD THOMASON, MPA: Thank you.

CARMELA CASTELLANO-GARCIA: Can I just comment that certainly the digital divide is an important issue that needs to continue to be considered. I really think one of the successes of the community health centers, what is our role in providing that one-stop-shop to the families with over 2,000 certified enrollment counselors placed at community health centers throughout the state really played a critical role for the folks that could not take care and do this at home and plus needed all the assistance with language and the complexity and everything else. I think that is one of the important ways that we are helping to overcome that digital divide with community health centers serving several million Latinos in the state of California and certainly Spanish-speaking and half our patients speaking a language other than English, so these issues are critical for our population. That is why having those certified enrollment counselors in the place where folks are receiving their care and being able to help them through that process and to have the laptop at our end and not theirs really made a huge difference. It's something I'm very proud of. It was such a wise decision to make sure that the health centers not only, certainly in Medi-Cal, but in the exchange as well because there was even a question at one point early on, you might recall, about whether health centers could be enrollers and be compensated for that, but wisely that decision

was changed. Then it showed the success of meeting that assistance for the very issues that you mentioned.

RICHARD THOMASON, MPA: Thanks. Other questions? Just wanted to then ask one question of my own for Carmela to start with, but for the whole panel. According to the survey, it did show that about 19-percent of newly insured adults who have a usual source of care reported that they changed the place they usually go for care since gaining their coverage. Most of the newly insured adults who changed their site of care reported that it was due to their insurance. I am wondering, Carmela, what are your health center members experiencing in terms of churn and patients shifting to or away from the health centers because of their coverage? The other panelists, if this is an issue that you are seeing as well in the communities that you're talking to.

CARMELA CASTELLANO-GARCIA: I think that what the data shows is that for community health centers is that folks stayed with the community health centers, so we had excellent retention of our patients and we were also attracting new ones. I think these enrollment efforts that I mentioned were absolutely key to our success in being able to do that. I think it was very helpful to the patients; it made a lot of sense. It's all the changes that I already discussed that we had made that have certainly made the community health centers providers or choice. That is another reason why we were able

to do so. I think it just shows too the wise decisions that Congress made and the President when passing the ACA, when they made an $11 billion investment in the expansion of community health centers because I think it was predicted that this would be a model of care that the patients would choose, particularly the Medi-Cal population which the data fully supports as well as recognizing that we were going to continue to play a significant role in care to the uninsured, which is another piece that is very strongly coming out of this data with 60-percent of the uninsured getting their care at community health centers. We have 100 new access points in California as a result of this federal investment, so there has been a great expansion in our capacity. It doesn't mean though that we're not stretched thin to keep up with this increased demand, so one thing about being popular is that you got a lot of demand to meet and you also have to keep up with patient expectations around access. There was a data point on wait times. The wait times is something that needs to come down and has and needs to continue to do so. We are going to need to continue to transform and make the changes to attract and retain those patients. Out of the gate we are doing well, but in order to sustain it, community health centers are going to have to continue to innovate, continue to have to focus on patient engagement, patient satisfaction, care transformation, so

nobody is resting on their laurels. We are looking at how we build on the success into the future.

SARAH de GUIA, JD: I think the majority of individuals who enrolled either through Medi-Cal or Covered California were from communities of color, and so as we looked at the findings, and I definitely talked with Rachel too, is what role is language and culture playing in people's choices as well? We know that the community clinics often provide some of the best culturally competent care and that there are other providers in networks that are also providing that culturally competent care. As Director Kent mentioned that we still have 20-percent of Medi-Cal beneficiaries that enrolled in fee-for-service, we're starting to find that some of those may be staying with their fee-for-service providers because they're getting care from their providers who speak their language. They don't want to shift into a Medi-Cal managed care plan because they're not sure that they're going to be able to get those same doctors who speak those same languages. I really think that language and culture plays a huge role in who people choose to be their providers, whether or not they stay, or whether or not they change their providers.

We also have seen a little bit that people are delaying care to get services as well because they can't access those providers too, that the networks are very slim in terms of having providers who speak those languages. I think that plays

a really key role and I would love to see future iterations that sort of teased out a little bit more and just really helping us understand how can we ensure going forward that we really do have those services for those who are newly enrolled.

GENOVEVA ISLAS, MPH: I'm not sure exactly the proportion, but I'm sure, to some degree, part of that shift in terms of where they're seeking care could be as a result of change of circumstance and moving from Medi-Cal to Covered California. To the point that was raised earlier, it does need to be seamless so that people aren't faced with those changes in their life circumstance changing who their healthcare provider is or where they routinely go for care. That is a concern to us.

When I think about some of this challenge, certainly in my geography, it does have a lot to do with an upstream issues and that's how do we draw more providers? How do we create a sufficient pool of providers to give our consumers the right care at the right time that they need? Again, I feel like that is part of the larger challenge and that we need to think about how we are working in concert to make sure that everybody has access to the right providers.

An interesting tidbit from Covered California is that in terms of the evidence and the data that we're seeing, the difference between Covered California and those with employer-based coverage are not statistically significant and what this

truly, I think, underscores is that too many Californians of all types with employer-based coverage and Covered California sometimes struggle to get the care in a timely way. Important good news here is that over 90-percent of both Covered California and employer-covered Californians report that they have locally accessible care, so I think that's a positive.

RICHARD THOMASON, MPA: Great, thanks.

CARMELA CASTELLANO-GARCIA: I am so glad you mentioned workforce because I was so remiss not to, because I think that is the next phase of the major, major challenge that not only the community health centers, but the entire health industry, is currently facing and is going to continue to face and is really getting to crisis proportions. In particular, the primary care provider shortage, going well beyond physicians because, again, with the team approach we've got physician assistants and nurses and nurse practitioners and many others. Particularly when it comes to culturally linguistic competent care, so the statistics that Latinos are 5-percent of physicians, which is what it was, if I'm not mistaken, 25 years ago when I first got involved in healthcare, is indicative of what is a very serious crisis we're facing. That'll be the next slew of panels I expect to be on going forward.

RICHARD THOMASON, MPA: I think we have time for one more question over here.

SAM COLE: Sure, my name is Sam Cole. I'm with Keenan [misspelled? 01:27:02]. The question that I have is we saw over the two open enrollment periods a growing market of individuals who are small business owners, self-employed individuals, farmers, who's income did not qualify them for a subsidy under Covered California and we were directed to enroll them into Medi-Cal. When they go to Medi-Cal they are declined because they own assets of some form and so they're pushed out into the open market and literally cannot afford it because of their financial situation. I'm curious to see if there's any kind of a program involved, I've heard this is now up to about 1.2 million people in California who are falling into the chasm, and I hope that at some point one of the agencies would try and address it.

RICHARD THOMASON, MPA: Any comments on that?

GENOVEVA ISLAS, MPH: This is, I think, indicative of my learning curve still because I know that there is what used to be called the SHOP Program, and I think it's been renamed recently to [inaudible 01:28:11] Covered California for Small Business. I'm not specifically clear on the eligibility for that, but my hopes are that some of these people falling through the crack as described, they're not able [inaudible 01:28:28].

SARAH de GUIA, JD: We also know that there are a number of small business owners who are immigrants and who are

communities of color and so it really is a huge issue and I think a population that tends to get overlooked. I think we definitely look forward to continue working with Covered California and also with DHCS and the state to see if there are individuals who are income eligible, but because of the assets if there is a way to look at state policy to make sure that these individuals are not penalized for doing what they need to do but you can't unfortunately afford health insurance.

RICHARD THOMASON, MPA: Thank you. Our time is up, so join me in thanking our panel. What we've heard today really shows progress in improving health coverage and access for low-income Californians, but as you've heard there remain significant issues with enrollment and cost and we still have a lot of work to do. This report helps show us where to focus our efforts in the months again, so again, I'd like to thank Rachel Garfield and the Kaiser Family Foundation staff for all the hard work they put into this report and into this briefing as well as thank Rachel Wick in and the Blue Shield California staff for helping to shape the report and the briefing today. I would like to thank DHCS Director Kent for her comments and our panelists for giving us a lot of great things to think about, so thank you all for coming.

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[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.