The Latino Coalition for a Healthy California

Latino Policy Priorities for an Effective & Equitable Health Benefit Exchange in California

Introduction:

In October 2011, the Latino Coalition for a Healthy California convened a Blue Ribbon Panel of experts in Latino health (Appendix 1) to consider California's implementation of the Patient Protection and Affordable Care Act (ACA) and its potential impact on the health of Latinos. The proceedings of that meeting lead to the development of this document. Blue Ribbon Panel proceedings are also reflected in our seminal document, "***A Framework for Implementing the Patient Protection & Affordable Care Act (ACA) to Improve Health in Latino Communities***."[1] We aim for *Latino Policy Priorities* to be used by advocates for health and equity to inform the Health Benefits Exchange Board and other decision-makers about implementation of the ACA in California.

Even though it falls short of assuring access to health care for every California resident, the ACA promises unprecedented advancement in the reform of our healthcare system and presents new opportunities to place a high priority on prevention and to improve community health. The planning, development and implementation of an effective Health Benefits Exchange for California demands engagement and vigilance from the Latino community. LCHC is prepared to be the leading voice for Latino health on California's implementation of the ACA.

The Health Benefits Exchange merits scrutiny because; 1) California is a majority-minority state where more than half of the population are people of color[2], including 38% or 14 million Latinos; 2) Latinos constitute 59% of California's uninsured population, including about 48% of the uninsured who are eligible for subsidies through the Exchange; 3) An estimated 31% of those eligible through the Exchange are Limited English Proficient; and, 4) Due to limitations of the ACA, millions of Latinos will remain without coverage and will continue to depend on Community Health Centers, other safety net providers, and charitable programs for their health care.

At the outset, of particular importance are those pieces of legislation that implement the Exchange provisions in California, SB 900 (Alquist) and AB 1602 (Perez) which established the structure of a health Benefits Exchange Board and its authority. In passing these bills, California has committed itself to an undertaking of historical importance. Information gathered from the Blue Ribbon Panel serves as a guide for our comments on the federal Proposed Regulations on the Establishment of Qualified Health Plans. Blue Ribbon Panel input also serves to guide the policy priorities provided herein. As a matter of clarity, our statutory comments relate to California's Health Benefit Exchange enabling legislation as recorded in Title 22 of the California Government Code § 100500 et seq.

[1] Latino Coalition for a Healthy California: *A Framework for Implementing the Patient Protection & Affordable Care Act (ACA) to Improve Health in Latino Communities*. October, 2012. Available at : www.lchc.org

[2] Courtesy of California Program on Access to Care, UC Berkeley School of Public Health from California Department of Finance 2011 Projections for Percent of Total California Population by Race/Ethnicity based on US Census data where people of color constitute approximately 58.5% of California's total population.

The Priorities for an Effective and Equitable Health Benefits Exchange address five primary areas of concern, all bearing on California's enabling legislation:

1. The Exchange, in its executive Board composition and its staffing, should represent the diversity of California.

2. The policies instituted regarding education and outreach should take into consideration the cultural and linguistic needs of California's diverse population.

3. Community based providers, including FQHCs, should be mandatory partners with any plan seeking qualified status through the exchange.

4. The Board should establish polices that ensure a no wrong door and no deterrents approach to enrollment.

5. The Board should support community level prevention and health promotion measures aimed at improving health outcomes.

I. THE EXCHANGE'S EXECUTIVE BOARD COMPOSITION AND STAFFING SHOULD REPRESENT THE DIVERSITY OF CALIFORNIA.

Background:

California's population diversity is sufficient justification for diversity within our government and its processes. This fact is perhaps the impetus for the language of AB 1602 where diversity is called out as an important consideration to be made by those responsible for appointing Exchange Board members and for those who hire the Exchange staff. The Health Benefit Exchange Board, as well, has indicated in its Level 1 grant that it will dedicate a full time Exchange staff person to ensure Exchange services are culturally and linguistically appropriate for the individuals likely to be enrolled in coverage through the Exchange.

Recommendations:

- *While the appointment of its own membership is not within the purview of the Health Benefit Exchange Board (Board) and since the Board does not currently reflect the diversity of California, it should take care to ensure that the policies, over which it does exert control, reflect the need for diversity at the decision making level as reflected in statute.*

- *The Board should urge legislation to expand the membership of its body to reflect consumer and population diversity interests, consistent with the enabling statutes; until such legislation is adopted, the Board and its Executive Director have in within its power to establish an advisory body (similar to that for Healthy Families) which reflects a wide range of stakeholder interests including the provider and health plans currently active in providing services to publically subsidized clients.*

- *The Executive Director of the Exchange should regard as first priority the need for diversity when considering candidates for Exchange staff, particularly management and senior level staff. Moreover to be consistent with the demographics of the state, the Exchange's recruiting polices should be constructed in a manner that candidates are drawn from the largest most diverse pool possible. This should include partnership opportunities with statewide and community based organizations with ties to communities of*

color to assist in the recruitment process. LCHC does not regard the exclusive use of State Personnel lists as meeting the imperative for a diverse Exchange staff.

- *The need for a diverse, dynamic, qualified Exchange staff should be the operating principle and value in Exchange hiring practices.*

II. THE POLICIES INSTITUTED REGARDING EDUCATION, OUTREACH AND ENROLLMENT SHOULD TAKE INTO CONSIDERATION THE CULTURAL AND LINGUISTIC NEEDS OF CALIFORNIA'S DIVERSE POPULATION AND BE INFORMED BY ROBUST STAKEHOLDER INPUT.

Background

California's enabling legislation provides for the establishment of a navigators program.[3] The Board needs to institute policies that ensure consumer focused navigators. The primary focus should be on those entities that have an established trust within the communities they serve and a demonstrated ability to effectively communicate with them. This being the primary criteria, those entities providing navigator services could themselves be diverse.[4] As well section 100503 (k)[5] requires that the Board establish an enrollment process that addresses the needs of hard to reach populations including limited English proficient populations. To assist in this work, the Board is required to engage consumer stakeholders who include consumers and advocates[6]. Moreover, the Board is required to, "provide oral interpretation services in any language for individuals seeking coverage through the Exchange" and "written information made available by the Exchange is made available in prevalent languages".[7] A robust stakeholder engagement process will maximize the effectiveness of education, outreach and ultimately enrollment efforts focused on traditionally hard to reach ethnic populations. California's Community Health Clinics have a history of serving these populations in a manner that is community based and linguistically and culturally appropriate.

Navigators

Navigator entities must demonstrate expertise and linguistic and cultural competency in assisting populations served by the Exchange or by public health coverage programs, including communities of color and vulnerable populations, such as low-income families, individuals who are not functionally literate or have low-English literacy, families of individuals with special health care needs, individuals with physical or mental disabilities, and individuals with substance-abuse issues.[8]

California is expected to provide care for an estimated 3-4 million individuals through the Exchange, many of whom are hard to reach, underserved populations who have never accessed a regular source of care. Utilizing the successful networks of the state's community and consumer-focused non-profit organizations will help to ensure that those entities that have the most experience working with this population are able to adequately assist bringing those individuals into care in 2014.

---

[3] Ca. Gov. Code (CGC) §100502 (l) Establish the navigator program in accordance with subdivision (i) of Section 1311 of the federal act. Any entity chosen by the Exchange as a navigator shall do all of the following
(5) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange.
[4] Statewide Guiding Principles for Consumer-Focused Navigators in California, October, 2011
[5] CGC § 100503(k) Undertake activities necessary to market and publicize the availability of health care coverage and federal subsidies through the Exchange. The board shall also undertake outreach and enrollment activities that seek to assist enrollees and potential enrollees with enrolling and reenrolling in the Exchange in the least burdensome manner, including populations that may experience barriers to enrollment, such as the disabled and those with limited English language proficiency.
[6] CGC §100503(t) Consult with stakeholders relevant to carrying out the activities under this title, including, but not limited to, all of the following: (1) Health care consumers who are enrolled in health plans. (5) Advocates for enrolling hard-to-reach populations.
[7] CGC §100503 (y)
[8] Statewide Guiding Principles for Consumer-Focused Navigators in California, October, 2011

California's Community Health Clinics are an essential provider and should be looked to when exploring Navigator models. For example, CCHCs provide successful enabling services including: transportation, translation, interpretation, patient and community education, disease management, outreach and enrollment, and linkages to other community organizations, in a culturally and linguistically competent manner. Over the years, CCHC's community-based outreach efforts have successfully enrolled hundreds of thousands of children in the Healthy Families Program, and should serve as a model for the Navigator in the Exchange. Further, the state and regional associations have an established network of disseminating information to its member CCHCs, and are in an ideal position to inform their members of the plan, benefit, enrollment and eligibility information developed, enabling California's CCHCs to effectively conduct the necessary outreach and enrollment activities that are vital to bringing the hardest to reach individuals into care.

Further, the timeframe for the establishment of the Navigator program should occur well in advance of the open enrollment period of the Exchange, October 2013. While it will be critical to have Navigators available to individuals on Day One to assist them in the enrollment process, it is even more critical that these individuals be notified and educated about their options well in advance of enrolling into programs. Given that the majority of individuals that will be accessing care in 2014 will be doing so for the very first time, the amount of education, notification and assistance that will be required will be significant. Additionally, Navigator grantees will need the time and resources necessary to be educated and trained on the options available to the uninsured population in order to adequately assist them.

Lastly, we have significant concerns around the restriction of funds to be used for the Navigator program. Given that the Exchange is established with Federal funds, and the Navigator program is not only critical to its success but a required element of it, being unable to utilize Federal establishment funds may significantly limit the robustness of this program. Further, given the economic climate of most states, particularly California, utilizing "other non-Federal sources" to fund this program will prove to be extremely difficult.

Recommendations:

- *Given California's geographic size and estimate of individuals accessing the Exchange, many more than two Navigator entities are required. Selected entities must be primarily community and consumer-focused non-profit organizations.*
- *The Board should designate CCHCs, as well as their state and regional associations, as Patient Navigators.*
- *The Board should build on lessons and models from existing or past community and consumer-focused non-profit organizations, programs, and grants that have successfully enrolled individuals into health care programs. Many of these programs already have successful training models that can be adapted for the Navigator program in the Exchange.*
- *The Board should begin the process of establishing the Navigator program by awarding grants a year to six months in advance of the open enrollment period in the Exchange to ensure that they are able to receive adequate training of the options available, and will have sufficient time to disseminate that information into the communities that will be accessing care.*
- *The Board should push CMS to re-evaluate the financing restriction for the Navigator program and develop specific funding for this program in order to ensure that the most critical individuals, the individuals the ACA was designed for, will be informed and able to access their needed care. Should CMS maintain its stance on the restriction of Federal funds, LCHC suggests that the Exchange Board consider utilizing the QHP user fees to fund the Navigator program.*

The Stakeholder Process

Stakeholders from hard to reach communities need to be included in the process. This means organizations that reflect the racial and ethnic diversity of California. The populations that need to be reached coalesce not only around economic lines but racial/ethnic lines as well. The ability to speak English fluently is also a factor in economic status. In California, minority and limited English proficient populations tend to reside within the same communities and often times reside at the lower end of the economic scale. So while there is a correlation with race and economic status, addressing economic status alone is inadequate.[9]

Recommendation:

- *The Board and Exchange staff should establish and monitor measurable targets to include ethnic and community-based organizations in the stakeholder process particularly because these are the very populations that stand to benefit most from ACA implementation.*

Limited English Proficient

An estimated 31% of those expected to enroll in the Exchange will be limited English proficient. The Exchange should establish standards and definitions with regard to this population that will realize maximum effect from education, outreach and enrollment efforts undertaken by the Exchange and its agents.[10]

Recommendations:

- The Board should apply the following definition of limited English proficient: "speaks English less than very well" when developing outreach policies focused on LEP populations.
- The Board should designate a language threshold standard similar to Health and Human Services (HHS) LEP Guidance for determining the translation of written documents: "500 LEP individuals or 5% of those eligible to be served by an Exchange, whichever is less."

III. COMMUNITY BASED PROVIDERS, INCLUDING FQHCS, SHOULD BE MANDATORY PARTNERS WITH ANY PLAN SEEKING QUALIFIED STATUS THROUGH THE EXCHANGE.

A. Essential Community Providers

Background

The creation of the essential community provider designation provides a significant opportunity for FQHCs to serve more communities. However, the requirement in the Exchange for qualified health plans to reimburse FQHCs their PPS rate may cause health plans to limit contracts with FQHCs or limit assignment of lives in contracts. To assist in mitigating this issue, the statute does require that qualified health plans develop provider networks that include those essential community providers who serve predominantly low-income individuals located in medically underserved areas. Given that FQHCs are located in these underserved areas across the state, and the care they provide is focused primarily on at-risk, low-income populations, LCHC interprets this language to require FQHC participation.

[9] California Pan-Ethnic Health Network: *Comments on the Federal Notice of Proposed Rule Making on Health Insurance Exchanges*. September, 2011
[10] Id.

LCHC is mindful of the unique PPS reimbursement provision that applies to FQHCs. We are mindful, as well, that this provision may be seen as a financial disadvantage to plans to contract. However, it must be noted that through the unique PPS rate, health centers are able to consistently provide high quality, cost-effective health care services. This reimbursement provides for comprehensive, bundled "Health Center Services," which include dental, mental health, pharmacy, primary care, immunizations, chronic care management, care-coordination, interpreters, and much more, thereby keeping patients out of the emergency room and preventing hospitalization.

Health centers are true health care homes where individuals can access a broad array of both primary and specialty care, and without the PPS rate, health centers would not be able to fill this vital role for millions of patients. Further, each individual health center's PPS rate ensures that FQHC grant revenues can be dedicated to care for the uninsured rather than subsidizing care for Medi-Cal and Healthy Families patients. Without the PPS rate, inadequate payment for the fee-for-service Medi-Cal and Healthy Families patients combined with extremely limited to no payment for the patients who are uninsured, would quickly cause health centers to lose viability and be unable to serve as a health care home for over twenty million patients nationwide, 4.7 million in California, or save the health care system $24 billion annually in reduced emergency, hospital, and specialty care costs.[11]

Under Federal law when a Managed Care organization reimburses an FQHC for a visit at less than their full PPS rate, the state must make a supplemental or "wrap-around" payment to make up the difference. This policy provides for a more stable cash flow to health centers, while decreasing the administrative burden for the plan and the FQHC. Having the Exchange Board implement a similar model and pay a wrap-around for FQHC services provided by Qualified Health Plans (QHPs) would mirror the practice established in the Medi-Cal program, and remove the responsibility that the ACA creates by requiring QHPs to pay each health center their PPS rate when contracting.[12]

The mission-driven nature of FQHCs combined with the bundled services they provide, their payment structure and placement in their communities allows health centers to provide this invaluable care. We must acknowledge that even when fully implemented, the federal reform legislation will leave millions of children and families, uninsured. In order to ensure that health plans do not minimally contract with FQHCs due to the payment provision, regulations and the actions made by the Exchange Board must expressly require health center participation in the Exchange.

Recommendations:[13]

- *The Board should increase the QHPs user fees that are already required to be paid into the Exchange in order to pay an FQHC wrap-around payment, thereby removing the burden from QHPs to be exclusively responsible for providing this subset of providers more than the QHPs' generally applicable payment rate.*
- *The Board should push HHS to require that in order to provide care to critical populations, QHPs must contract with all willing essential community providers and at a minimum, FQHCs that serve populations located in the highest need areas.*

B. Qualified Health Plan Certification Network Adequacy Standards

Background

As the Exchange Board works to implement pieces of the Exchange, such as certification of the qualified health plans, it will be important for the Board to establish key metrics that all plans must adhere to in order to ensure that those individuals that utilize the Exchange have adequate access to the care they need.

[11] California Primary Care Association*: Policy Priorities for Ensuring the Success of Community Clinics and Health Centers' Expansion in the Exchange*. September, 2011
[12] California Health Care Foundation: *Federally Qualified Health Centers and State Health Policy: A Primer for California*. July, 2009
[13] Id. at footnote 11 supra

One example of a metrics model that has been successfully instituted is the Community Provider Plan utilized in the Healthy Families Program. The success of this model is based upon the ability to bring low-income underserved populations into care through the incentive of discounted premiums, and the relationship that has been strengthened between health plans and traditional safety-net providers such as CCHCs.

Each year, the Managed Risk Medical Insurance Board designates one plan in each county as the Community Provider Plan based on their inclusion of the greatest number of traditional safety net providers in its network. In California, the majority of local health plans are recognized as the Community Provider Plan in their county because of their commitment to the community and their strong alliances with safety-net providers. These partnerships translate into greater quality of care for hard to reach populations because the plans and providers are located in the community, speak multiple languages, and understand diverse cultures and values.

With the goals of ensuring safety-net provider participation and bringing critical populations into coverage, LCHC suggests the following metrics be used when certifying health plans.

Recommendations:[14]

- *In each geographic area, the Board should designate a Community Provider Plan that is the participating health plan with the highest percentage of traditional public and private safety-net providers in its network. Subscribers selecting such a health plan should be given a premium discount in an amount determined by the Board.*

- *The Board should ensure that the range of choices of health providers available to each applicant include traditional public and private safety-net providers, such as free and community clinics, beyond those identified as essential community providers in the ACA.*

- *The Board should require that in order to have an effective provider network and service delivery system, a QHP shall maintain a system to assign enrollees to network medical home providers based on patient choice, provider capacity, the provider's demonstrated ability to tailor care to patients needs and other applicable factors.*

- *The Board should require default provisions to operate in a manner that advantages safety-net providers and takes into consideration maintaining relationships with providers that have traditionally served these hard to reach populations.*

- *Premium payments and cost sharing requirements should be structured in a neutral manner so as to not result in a disincentive for enrollees to select safety-net providers as their medical home.*

- *The Board should require QHPs to comply with existing federal and state laws, such as the Civil Rights Act of 1964, that seek to ensure access and availability to individuals from diverse backgrounds and life situations.*

- *The Board should ensure that health insurers provide information to potential enrollees on the languages spoken by network providers as a condition of certification of QHPs by the Exchange. Further, QHPs must be required to meet multicultural health network adequacy standards including availability of language services and a practitioner network capable of serving a diverse membership. The National Committee for*

[14] Id. at footnote 13 supra

Quality Assurance's 2010 publication: "Standards and Guidelines for Distinction in Multicultural Health Care (MHC)" provides a helpful model for how networks can meet these important standards.[15]

IV. THE EXCHANGE SHOULD ESTABLISH POLICES THAT ENSURE A NO WRONG DOOR AND NO DETERRENTS APPROACH TO ENROLLMENT.[16]

Background:

An essential component of ensuring the success of the Exchange is maximizing enrollment to the fullest extent possible. LCHC supports the "no wrong door" approach to enrollment. We believe that consumers should be required to use only one universal application that is available online, by phone, mail, or in person and that there is assistance available to a consumer at each of these enrollment interfaces. The application should include specific and clear instructions on how to accurately determine household size and income in order to ensure that any discrepancies are not erroneously penalized in consideration of complex family structures that have varying levels of individual eligibility. There should be no deterrents to enrollment that discourage or create undue barriers for applicants such as warnings, investigations, home visits, proofs of identity, or other measures that are not required by law. Currently, individuals applying for Medi-Cal and Healthy Families can do so through a Single Point of Entry (SPE) where determinations are made as to a child's eligibility for either program. This however does not yet reach the level of streamlining as contemplated by the Patient Protection and Affordable Care Act (ACA) nor provisions of recently passed legislation, AB 1296 (Bonilla). The Exchange now has the opportunity to develop an eligibility and enrollment system that facilitates inter- agency communication. The simplification of the enrollment process is dependent on the ability of the various administrators of public programs to share information. Without this, the realization of a single access point and a single streamlined application will not be possible.

Recommendations:

- *The Board should actively partner with the Department of Health Care Services, the Managed Risk Medical Insurance Board, Department of Social Services and others to develop a streamlined universal application that is available online, by phone, mail, or in person.*
- *The Board should actively partner with the Department of Health Care Services, the Managed Risk Medical Insurance Board, Department of Social Services and others to develop policies and enforce existing policies that ensure that there is assistance available to a consumer at each of these enrollment interfaces.*
- *The Board should actively partner with the Department of Health Care Services, the Managed Risk Medical Insurance Board, Department of Social Services and others to develop clear application instructions on how to accurately determine household size and income in order to ensure that any discrepancies are not erroneously penalized in consideration of complex family structures that have varying levels of individual eligibility.*

[15] California Pan-Ethnic Health Network: *Comments on the Federal Notice of Proposed Rule Making on Health Insurance Exchanges*. September, 2011

[16] CGC §100502. The board shall, at a minimum, do all of the following to implement Section 1311 of the federal act: (f) Inform individuals of eligibility requirements for the Medi-Cal program, the Healthy Families Program, or any applicable state or local public program and, if, through screening of the application by the Exchange, the Exchange determines that an individual is eligible for any such program, enroll that individual in the program.
100503. In addition to meeting the minimum requirements of Section 1311 of the federal act, the board shall do all of the following:
(k) Undertake activities necessary to market and publicize the availability of health care coverage and federal subsidies through the Exchange. The board shall also undertake outreach and enrollment activities that seek to assist enrollees and potential enrollees with enrolling and reenrolling in the Exchange in the least burdensome manner, including populations that may experience barriers to enrollment, such as the disabled and those with limited English language proficiency

- *The Board should establish enrollment goals based on eligible population, and investigate jurisdictions where proportionate goals are not being met for potential bias or insufficient access.*

- *The Board should encourage a streamlined universal application and enrollment process that includes food stamps, school meals, and other programs that are designed to support health and well-being.*

V. THE BOARD SHOULD SUPPORT COMMUNITY LEVEL PREVENTION AND HEALTH PROMOTION MEASURES AIMED AT IMPROVING HEALTH OUTCOMES.

Background:

The Affordable Care Act recognizes the great burden of preventable chronic diseases and conditions on the health care delivery system and on health care spending. Resources are made available to states and localities to support population-level programs aimed at improving conditions for improved health outcomes. California entities have received over $23.5 M for Community Transformation Grant programs to prevent chronic diseases through evidence-based community-level interventions. Public polling reveals that Latino voters highly favor such programs. Low-income Latino communities are in great need of improved social and physical environmental conditions that reduce risk for diabetes, obesity and other chronic conditions and that are addressed by community-based programs.

Recommendations:

- *The Board should support community level prevention and health promotion measures such as Community Transformation Grants and other programs aimed at improving health outcomes.*

- *The Board should develop models and incentives for health homes and other providers to advocate for and link to community level prevention / health promotion measures.*

- *The Board should call for Congress to sustain funding for the ACA Prevention and Public Health Trust.*