Covered California

Addressing Health Equity and Health Disparities

Background Brief Prepared for:
California Health Benefit Exchange Board Meeting

Revised for

Quality, Network Management and

Delivery System Reform Forum

January 21, 2014

COVERED CALIFORNIA

Health Equity and Health Disparities

SUMMARY

The purpose of this background brief is to outline Covered California's principles related to addressing health equity and health disparities, summarize consultation provided in March 2013 to Covered California by prominent thinkers on the topic, and offer an overview of activities that align with Covered California's commitment to addressing this topic. The brief is intended to foster reflection, discussion, and action toward promoting health equity and reducing health disparities within the span of Covered California's mission and values. Its last section poses questions to encourage a thoughtful approach to potential next steps.

ISSUE

Defining Disparity

The National Institute on Minority Health notes that "Despite improvements in the overall health of the American people, racial/ethnic minorities and other populations suffer disproportionately in the burden of illness and death. These populations are referred to as health disparity populations."* The National Institutes of Medicine, in a frequently-cited 2003 study, defines *disparities* in healthcare as racial or ethnic differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention.

> Evidence of racial and ethnic disparities in healthcare is, with few exceptions, remarkably consistent across a range of illnesses and healthcare services.
>
> *National Institutes of Health, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," 2003*

Principles

The Covered California Board has identified addressing health equity as core to the organization's mission and values. Vision, mission, and values consistently and strongly reflect this commitment:

"The California exchange's vision is to improve the health of all Californians by assuring their access to affordable, high quality care.

Our mission is to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that

* NIH Health Disparities Strategic Plan and Budget Fiscal Years 2009-2013, p. 13

empowers consumers to choose the health plan and providers that give them the best value." (see https://www.coveredca.com/hbex/about.html)

The California Health Benefit Exchange is guided by six primary values, all of which touch on health equity, and three of which speak directly to addressing equity and disparities (see italics for direct references):

- **Consumer-focused:** At the center of the Exchange's efforts are the people it serves, including patients and their families, and small business owners and their employees. The Exchange will offer a consumer-friendly experience that is accessible to all Californians, *recognizing the diverse cultural, language, economic, educational and health status needs of those we serve*.
- **Affordability:** The Exchange will provide affordable health insurance while assuring quality and access.
- **Catalyst:** The Exchange will be a catalyst for change in California's health care system, using its market role to stimulate new strategies for providing high-quality, affordable health care, *promoting prevention and wellness, and reducing health disparities.*
- **Integrity:** The Exchange will earn the public's trust through its commitment to accountability, responsiveness, transparency, speed, agility, reliability, and cooperation.
- **Partnership:** The Exchange welcomes partnerships, and its efforts will be guided by working with consumers, providers, health plans, employers and other purchasers, government partners, and other stakeholders.
- **Results:** The impact of the Exchange will be measured by its contributions to expanding coverage and access*, improving health care quality, promoting better health and health equity,* and lowering costs for all Californians.

Our mission is to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value.

Covered California Mission Statement

March 2013 Consultation on Health Equity and Health Disparities

In March 2013, the Covered California Board convened a panel to focus on the impact of health disparities in California. This provided an opportunity for the Board to consider stakeholder thoughts regarding Covered California activities to date, and recommendations for best practice from key experts in the field.

Ellen Wu, Executive Director of the California Pan-Ethnic Health Network, facilitated the panel. Panelists included Gilbert Ojeda, Latino Coalition for a Healthy California; Darcel Lee, Black Health Network; Sandra Naylor Goodwin, California Institute for Mental Health; Silvia Yee, Disability Rights and Education Fund; and Poshi Mikalson, LGBTQ Reducing Disparities Project .

Panelists emphasized that implementation of the Affordable Care Act in California presented some historic opportunities to assist vulnerable populations. Each panelist outlined specific needs and key issues facing particular populations of disparity, and pointed out potential priorities for action and attention by Covered California. The text of panelists' remarks is included as Appendix 1.

Covered California – Current Activities

- Marketing, Outreach & Enrollment

In these areas of Covered California operations, activities have been guided by these precepts:

  - Consider where eligible populations live, work and play. Select strategies and channels that are based on research and evidence of how different populations can best be reached and encouraged to enroll and, once enrolled, retain coverage.
  - Marketing and outreach strategies will reflect and target the mix and diversity of those eligible for coverage.
  - Establish a trusted statewide enrollment assistance program that reflects the cultural and linguistic diversity of the target audiences and results in successful relationships and partnerships among assisters serving state affordable health insurance programs.

Marketing and enrollment activities have been guided by research, including projections of potential enrollment populations and their demographic characteristics. Covered California has invested extensively in research, in particular commissioning CalSIM and the National Opinion Research Center at the University of Chicago to understand market segments, locations, languages, and other demographic characteristics and the best ways to communicate with potential enrollees and encourage enrollment.

The University of California's California Simulation of Insurance Markets (CalSIM), a California-centric, micro-simulation model that estimates the effects of the Affordable Care Act on the enrollment of individuals in insurance coverage, has provided Covered California with eligibility

and enrollment estimates by race and ethnicity, income, age, gender, region, English proficiency and current insurance status. These data are used throughout the organization to inform marketing, outreach and plan contracting strategies to ensure that resources are targeted to the areas of highest need.[†]

The work of the National Opinion Research Center (NORC) for Covered California has been to test marketing approaches and strategies by market segment in order to most effectively reach potential enrollees. NORC has conducted extensive field surveying and polling in languages other than English to support Covered California's marketing.

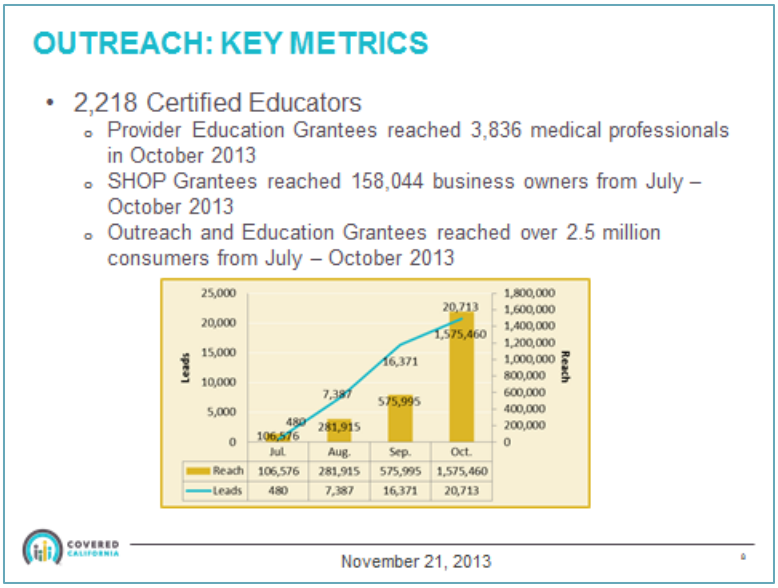
- Outreach and Education Grants

In 2013, forty-eight organizations were selected by Covered California for grants totaling $37 million in order to reach an estimated 9 million consumers and more than 200,000 small businesses through outreach and education activities in all 58 counties in California. The selected organizations will reach consumers in the following 13 languages: Arabic, Armenian, Chinese, English, Farsi, Hmong, Khmer, Korean, Laotian, Russian, Spanish, Tagalog and Vietnamese.

An additional set of grants under the Provider Education Grant Program were awarded in order reach an estimated 200,000 health care professionals across the state. Organizations selected for funding are: the California Medical Association Foundation, $1.5 million; the California Academy of Family Physicians, $865,000; the California Society of Health-System Pharmacists, $535,000; and the National Council of Asian Pacific Islander Physicians, $200,000. Engaging diverse providers as well as consumers is an important element of connecting with communities of disparity throughout the state.

The following graphic from a November 2013 Board meeting illustrates the impact of outreach in the state:

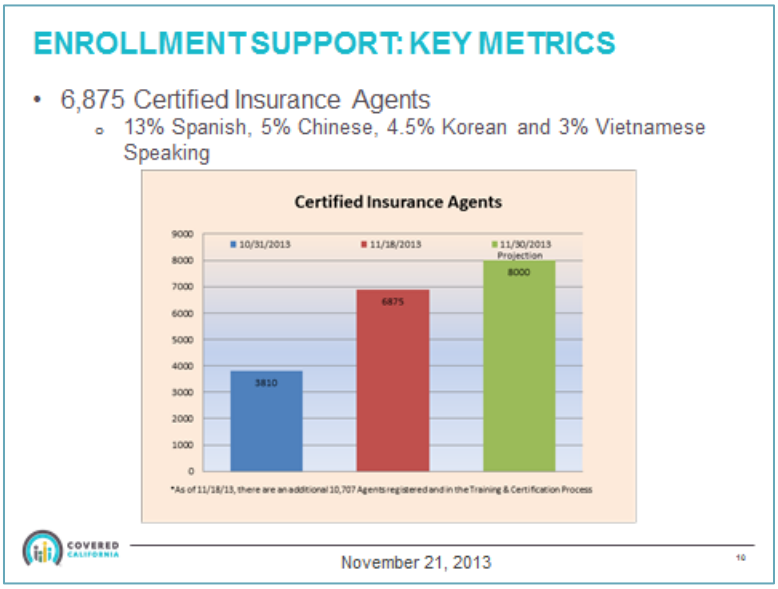
[†] See http://www.healthexchange.ca.gov/StakeHolders/Pages/CalSIM18Data.aspx

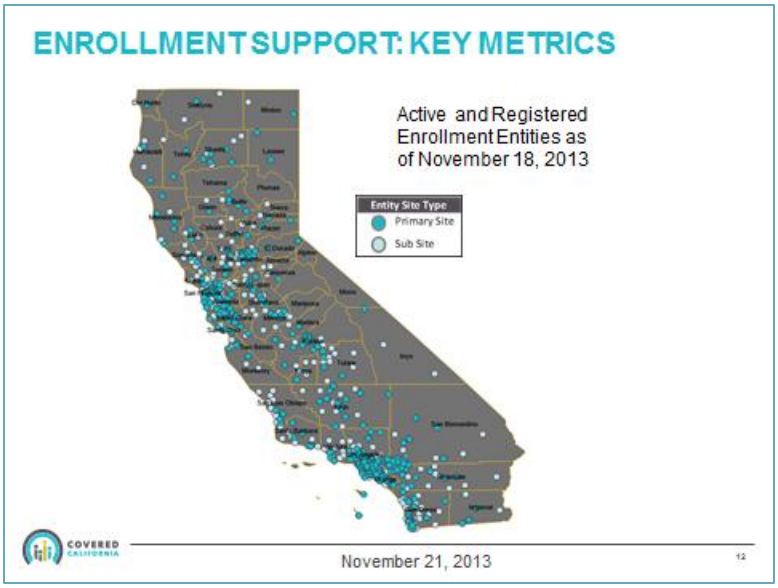


- Enrollment Assistance

Enrollment assistance is provided through organizations and individuals that have established relationships with local communities and resources and that are likely to have access to eligible Covered California enrollees. Assisters through these programs have received training to offer culturally and linguistically appropriate assistance to potential enrollees.

The following graphics from a November 2013 Board meeting illustrate the involvement of enrollment assisters statewide:

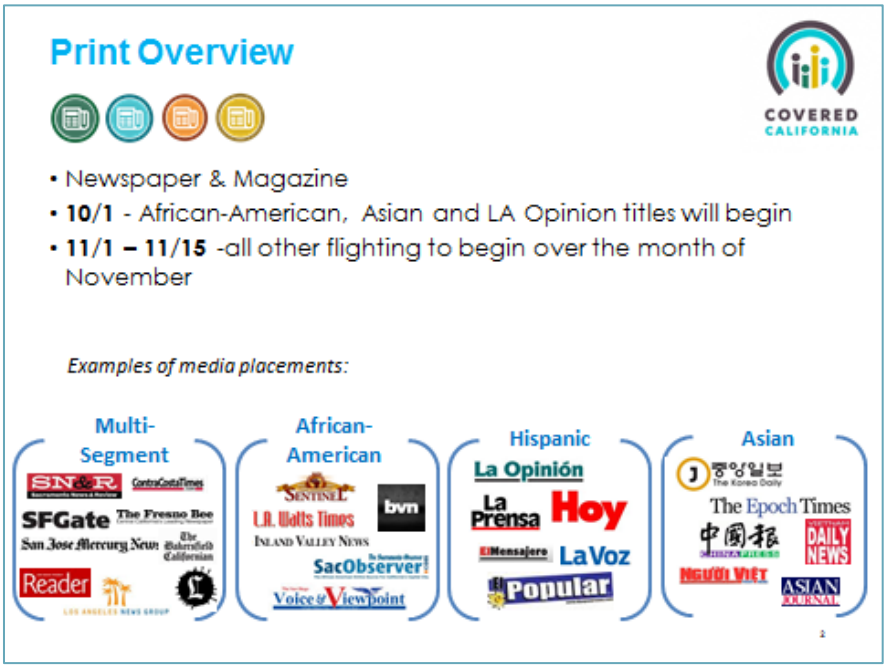




- Media and Promotional Efforts

Covered California has purchased California-based media, including multi-ethnic and multilanguage television, radio, print, billboard and social media through a media campaign that began in September 2013. Covered California's marketing efforts are guided by an advisory committee (one of four advisory committees commissioned by the Board) .

Below is a slide summarizing the print outreach element for fall 2013.



The consumer-facing website, CoveredCA.com, offers fact sheets on Covered California and how to enroll, as well as application materials, in 13 languages in addition to English: Spanish, Arabic, Armenian, Chinese, Farsi, Hmong, Khmer, Korean, Lao, Russian, Tagalog, and Vietnamese.

Below is a sample of additional materials available to consumers on the website:

Covered California's Service Centers, with branches in Sacramento, Fresno, and Contra Costa County, can support calls in these 13 languages, and provide interpreter services for additional languages as needed. It is the goal of Service Center representatives to provide a clear, accurate, first-class consumer experience in a culturally and linguistically appropriate manner. The consumer and enrollment interface, CalHEERS (the California Healthcare Eligibility, Enrollment and Retention System), a joint project with the California Department of Health Care Services, supports the efforts of highly trained customer service representatives in conducting enrollment (over 450,000 enrolled as of January 2013).

- Plan Management

Covered California's 2012 solicitation for Qualified Health Plans on the individual exchange required the inclusion of Essential Community Providers, that is, providers with a history of serving low income and traditionally underserved communities, in networks proposed by issuer health plans.

The model contract and its attachments focused on the goals of addressing health disparities and health equity, and required the submission of information using the eValu8 tool for standard information collection on plan performance; including the module on Racial, Cultural and Language Competency, and a review of demographic and service data collected by plans. Qualified health plans have collaborated with Covered California in developing and planning for data submission on demographics and key service metrics under the contract..

> *Covered California and the Contractor recognize that promoting better health requires a focus on addressing health disparities and health equity. Because of this, Contractor agrees to work with the Exchange to identify strategies that will address health disparities in meaningful and measurable ways.*
>
> *Covered Californa Model Contract, 2013*

- Quality

Plan engagement on innovative data and quality monitoring has been led by the Quality Network and Delivery System Reform team. This team has convened regular forums on topics related to quality as a way of building consensus and carefully defining the measures and data elements most needed by Covered California. Staff are planning for a new infrastructure for collection and analysis of information related to populations served and methods of service delivery; a request for proposal will be posted soon seeking a contractor to provide this service. The successful vendor will provide a host of analytic platforms to support Covered California in understanding plan performance and the care provided to enrollees.

> *The partnerships established will be the key to meeting the goal of a completely health care covered California.*
>
> *See Covered California website: https://www.coveredca.com/hbex/partners.htm*

- Stakeholder Engagement

In September 2012, the Covered California Board adopted a stakeholder engagement plan that described a variety of engagement opportunities designed to encourage broad participation by Covered California's diverse stakeholders. Opportunities i**ncl**ude public Board meetings held around California and the availability of translation services for public comment; webinar and phone participation options for Board and stakeholder meetings to provide for participation by individuals around the state; and topic-specific meetings that are held around the state with a diverse array of

participants. The stakeholder engagement plan also included the establishment in 2013 of topic-specific stakeholder advisory groups. These groups have been established; they operate under Board-approved charters and provide a voice to key communities and constituencies. They are convened throughout the year (usually quarterly, though tribal consultations are held annually. Those stakeholder groups are:

- Marketing, Outreach, and Enrollment Assistance
- Plan Management
- SHOP
- Tribal Consultation

A portion of the Covered California Board policy establishing formal tribal consultation is found below.

> *The Exchange is committed to strengthening and sustaining an effective government-to-government relationship between the Exchange and the Tribes by cultivating reciprocal trust and respect through a meaningful consultation process…Consultation will occur through formal annual meetings with Tribes, as well as through meetings specially-requested by Tribal leaders. In addition to consultation, a Tribal Advisory Workgroup will help guide the Exchange in development of policies impacting Tribes, Tribal health programs, and urban Indian health programs.*[‡]

Covered California's first formal consultation with tribes occurred on November 7, 2013, in Sacramento, California.

Next Steps and Questions

- Many publications focusing on health disparity and health equity emphasize the importance of data collection as a first step in understanding opportunities for promoting health equity. Covered California has pursued data relating to health disparity populations to plan and implement the Exchange. What other opportunities for data collection are there for Covered California?
- Covered California plans to bring consumers (enrollees) brought into its plan management stakeholder process in near future. What is the best way to involve a consumer in a way to support promotion of health equity?
- How can Covered California balance the need for data with the need to protect the privacy of enrollees and the need to assure security of health related data?

[‡] See Covered California website: https://www.coveredca.com/hbex/tribal-consultation/

- What other ways can the Exchange encourage promotion of health equity and reduction of health disparities through its marketplace activities?

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APPENDIX 1

WRITTEN REMARKS PROVIDED TO PANELISTS CONVENED ON THE TOPIC OF HEALTH EQUITY AND HEALTH DISPARITIES AT COVERED CALIFORNIA BOARD IN MARCH 2013

The Latino Coalition for a Healthy California

A Framework for Implementing the Patient Protection & Affordable Care Act to Improve Health in Latino Communities

Preamble

*Twenty years ago, the Latino Coalition for a Healthy California (LCHC) adopted a set of principles to guide policy advocacy and organizational activities. We boldly addressed underlying values, key issues, and challenges to improve Latino health and inform the debate about health reform. Over the years, LCHC continued to call for systemic health reform, keeping the principles at the core of its policy advocacy and communications efforts. Finally, in 2010, President Obama signed the landmark Patient Protection and Affordable Care Act (ACA) that provides a national vision and framework for comprehensive health reform. In 2011, California became the first state to pursue implementation of the ACA; later that year, LCHC convened a Blue Ribbon Task Force of experts on Latino health and the ACA to help inform a fresh perspective. It is within this context that we now present "**A Framework for Implementing the ACA to Improve Health in Latino Communities**" to system leaders and advocates for Latino health.*

The ACA provides the resources and the reach to improve health in Latino communities. The ACA aims to make health care coverage available to more than 30 million previously uninsured Americans. In California, Latinos comprise the single largest group of persons newly eligible for coverage under the ACA: Unfortunately undocumented immigrants remain ineligible. Significantly, beyond the notion of expanding health care coverage, a primary goal of the ACA is achieving health equity -- the elimination of potentially avoidable differences or disparities between socially advantaged and disadvantaged groups.[1]The ACA not only includes provisions related broadly to health insurance coverage, health insurance reform, and access to care, but also provisions related to reduction of racial and ethnic disparities, data collection and reporting, quality improvement and prevention in clinical and community settings.[2] The ACA provides opportunities for states to make lasting and comprehensive system and local community changes aimed at achieving health equity and health improvement for the most vulnerable populations. ACA provisions across the spectrum -- coverage and access, prevention, care coordination, population health, and quality and efficiency -- offer public officials, providers, and advocates for healthier communities a broad range of levers for improving health care and the health status of all residents.

Implementation of the ACA is an imperative, but it is highly vulnerable. Health and health care are at a critical juncture. State implementation policies must be comprehensive, strategic, inclusive and innovative if there is any hope of delivering the full promise of the ACA. State and national policies must extend beyond ACA health care coverage expansions and health care system changes. In order to achieve the health improvements and savings needed to sustain health reform, the ACA supports community and social investment efforts and policies that promote community-wide prevention, and wellness, and address the broader social and economic determinants of health. Unfortunately, the ACA is under relentless attack for political reasons, and the budget to implement many of the measures of particular importance to improve Latino community health is highly vulnerable.

LCHC aims to support implementation of the ACA as long as it is improving health and equity in Latino communities. LCHC will be a leading voice urging policymakers and stakeholders to make meaningful and sustained progress in addressing the access, affordability, quality and equity gaps, and environmental conditions affecting the health of the Latino community through full implementation of the ACA. The Framework outlined here represents LCHC's agenda and commitment to working for coverage and access to care, health equity, and health-supportive community conditions to the benefit of Latinos, and all Californians.

Priorities

1. Health Care Access Must be Equitable and Available to All

ACA coverage expansions, subsidies for low- and moderate-income families and health insurance underwriting reforms will significantly improve access to health care coverage and reduce the ranks of the uninsured among all Californians. The ACA will expand coverage through public programs such as Medi-Cal and through subsidized coverage in the state Health Benefit Exchange (Exchange) to an estimated 3.9 million Californians, including more than 2 million Latinos. At the same time, the ACA left behind millions of undocumented immigrants who will remain uninsured and challenged to secure access to health care. The ACA retains citizenship and documentation requirements for Healthy Families and Medi-Cal and excludes undocumented immigrants from Exchange coverage, making them ineligible for federal subsidies and prohibiting them from buying Exchange coverage even if they pay the full cost. These limitations of the ACA compel investment and protection of a robust health care safety net as outlined below, through community clinics and other safety net providers, to serve children and adults who are left out of the coverage expansions. In addition, the state can and should develop policies and programs to ensure access to care for undocumented persons including but not limited to state-only programs, reimbursement for emergency services, and multi-national coordination with immigrant countries of origin. Finally, state policies must incorporate the principle of shared responsibility among public, nonprofit and private providers, including penalties and incentives for broad-based outreach and access to care for all Californians.

2. Outreach and Enrollment Systems Must Be Barrier-free and Culturally Responsive

Fulfilling the promise of the ACA coverage expansions will depend on active engagement and outreach to newly eligible individuals and responsive enrollment strategies and systems. Application and enrollment systems for public programs and the Exchange must be accessible, culturally and linguistically appropriate, streamlined and seamless to ensure maximum enrollment of individuals and families who are eligible. California has the opportunity and the responsibility to fully realize the ACA promise of "no wrong door" by developing and coordinating multiple entry points for eligibility and enrollment, beyond web-based enrollment options, and by making connections with and supporting available local assets, such as community clinics, schools, faith-based groups, ethnic media and other community-based organizations to inform and assist individuals and families in gaining coverage. Eligibility and enrollment systems must also be sensitive and responsive to the needs of families with mixed immigration status to avoid indirect negative consequences from ACA implementation, such as citizen children of immigrant parents being left out of coverage for which they are eligible. State and local programs should invest in vigorous outreach strategies involving trusted sources and tailor marketing messages to diverse cultural and language groups.

3. The Health Care Safety Net Must Be Strengthened

California will continue to need a viable and strong safety net delivery system and must be intentional and strategic in ensuring its preservation and expansion. The ACA presents both risks and opportunities for safety net providers: new funding for health centers, support for patient-centered care and expansions of the primary care workforce, tempered by declining payments to safety net hospitals, existing financial challenges and marketplace changes that may intensify competition for newly insured individuals, further endangering the financial viability of these essential providers. State implementation should embrace reimbursement models that support safety net providers and enhance their ability to

retain insured patients. California must build on existing innovative programs aimed at safety net preservation, such as the Low-income Health Plan, and ensure that new coverage offered through the Exchange incorporates safety net preservation policies. The Exchange should consider rewarding health plans with networks inclusive of safety net providers and adopting health plan payment strategies to guarantee adequate safety net provider payments, including payments to county and community clinics. Linkage and integration between health care and public health, including data sharing, should be strengthened for continuity of care, enhanced resilience of the most vulnerable, and to leverage health-supportive community resources.

4. Reforms Must Support and Promote Delivery System Improvements

Expansion of coverage to previously uninsured persons, as well as the prevention and quality imperatives of the ACA, present tremendous opportunities for state-level reform of the delivery system, including an enhanced emphasis on primary and preventive care, chronic disease management and improved care coordination. Delivery system change should be a fundamental goal of all state implementation activities, policies and financing arrangements. Health reform implementation should include existing successful models and develop new access points for further refinement and testing of desirable system improvements such as primary care health homes, team-based approaches to care and supportive services beyond medical care that enable individuals to effectively access care. Community-based and safety net providers have and are developing innovative programs to address these challenges, often focused on the diverse populations who will be the focus of coverage expansions. Safety net and community providers should be one of the foundations of the new delivery system and should not be excluded or disadvantaged in their participation in new models such as Accountable Care Organizations. The "health home" model for continuous, team-based, and patient-centered care should be promoted widely, and a dynamic bridge should be established between medical care and community-based programs that aim to improve health outcomes.

5. Delivery System Must Embody Quality, Continuity, and a Priority for Prevention

Comprehensive health reform must fundamentally be built on a culture of quality, continuity, and prevention, inclusive of clinical and community-based prevention. State policies should seek and maximize ACA opportunities to invest in and model effective prevention policies and programs. Continuous quality improvement, evidence-based clinical and community prevention practices, health education, and health promotion throughout the life-course should be integrated into all coverage models, supported through adequate reimbursement, and be monitored for impact. Prevention and health promotion should be directed to the individual patient as well as to the community; be inclusive of advocacy skill-building towards personal resilience, health-supportive community conditions, and system improvement; be accessible to diverse languages and cultures. Recognizing that individual care outcomes as well as population health status are heavily influenced by social and environmental conditions, efforts and policies that aim to improve health must involve communities and sectors that are instrumental in shaping those social and environmental conditions. Consequently, prevention as an element of health reform requires a "health equity in all policies" approach, aiming for health-supportive practices and conditions where people live, play, work, and go to school. This may look like health-supportive policies and investments, for example, in education, violence prevention, youth development, and local environmental planning.

6. Services and Coverage Must Be Comprehensive and Affordable

The ACA for the first time establishes a minimum benefit level to ensure that all covered persons have access to comprehensive services, including parity in mental health and substance use treatment services, and oral health services. Reform implementation should ensure meaningful access to services through adequate reimbursement of providers, reasonable benefit cost-sharing and competitive premium pricing.

The education, employment and economic conditions of Latinos are generally much lower than other populations. What is affordable for many Californians may not be affordable to the majority of Latino uninsured. This means that the availability of truly affordable coverage will be a key factor in reducing the number of uninsured Latinos. Policies and services,

including coverage and subsides through the Health Benefit Exchange, should balance comprehensive coverage and affordability. State policies and federal communications should explore and monitor the impact of the federal definition of affordable coverage based solely on the premiums for individual employees and seek a more realistic measure of affordability, such as the cost of family coverage, in determining a family's eligibility for subsidies through the exchange. In developing coverage options through the Exchange, policymakers should specifically evaluate and work with stakeholders, including Latino organizations, to develop and ensure coverage options that have the lowest cost, highest quality and most accessible services tailored to meet the needs of low-income Latinos and other low-income communities. The state and local governments must continue to explore innovative means to assure health care coverage, affordability, and access to health care for all California residents, regardless of immigration status.

7. Expand and Cultivate a Well-Trained Multicultural Workforce

ACA coverage expansions will dramatically increase the demand for health care workers at all levels -- including physicians, nurses, pharmacists, mental health professionals and direct-care workers. These increased demands come at a time of persistent health care professional shortages and other factors impacting demand such as the aging of the population. The ACA recognizes the workforce challenges the health care system faces and includes provisions to invest in and help to address the demand. State implementation must include proactive policies to develop a well-trained, multicultural workforce and to ensure that all health care professionals and workers are competent to provide services to the diverse cultures, languages and communities represented in California, including Latinos. The state should maximize available state and federal funds in support of the educational resources and programs for health care worker training and education. To maximize limited resources, the state should adopt innovative strategies to efficiently employ existing health professionals and direct care workers though team-based care, featuring community health workers (*promotoras*) and appropriate scope of practice standards. Specific policies must be designed and adopted to ensure an adequate workforce in underserved rural and inner-city communities.

8. Support Full Funding for Prevention and Public Health

Preventing illness before it happens is the surest way to contain costs while improving health. Disparaged by detractors as a "slush fund" and raided to balance the budget, the Prevention and Public Health Fund is actually the ACA's most promising feature toward changing health conditions in Latino communities. Fueling community-wide projects specifically designed to prevent the most common causes of premature death and hospitalization, including heart disease, diabetes, and tobacco-related cancer, and doing so by remedying underlying inequities, the Prevention Fund is one feature of the ACA that truly benefits everyone -- no exclusions. A broad diverse base of support is needed to advocate for funding prevention as a first order priority, and with the message that without prevention everyone loses.

9. ACA Implementation Merits Research, Evaluation, and Accountability

A cost-effective health care delivery system must be evidence-based and fully accountable. The ACA incorporates and advances the goals of improving the quality and delivery of health care through enhanced data collection, quality measurement and best practices research. The ACA increased emphasis on data, measurement and research is an opportunity to conduct and expand meaningful, ongoing analysis of the unique health needs and challenges faced by ethnic and minority communities, differences in how they access and approach health care, strategies aimed at rural and inner city communities, and consistent measurement of progress in reducing disparities. Research and evaluation should aim to accelerate improvements in morbidity, mortality, quality of life, prevention services, and health-supportive community conditions. Research must lead to increased understanding of what Latino patients need and want as patients and as individuals empowered to impact their own health and the health of their families and communities. Research should include non-medical, community-based participatory studies, community resource assessment, and demographic mapping to assist in the design and development of services and programs.

10. Latino Communities Are Essential Partners for ACA Implementation and for Improving Health

No California population is more affected by the ACA than Latinos. Latinos constitute the largest number of uninsured; the majority of enrollees in government assisted health coverage programs such as Medi-Cal and Healthy Families, and will become the largest single group of newly covered enrollees when the ACA is implemented in 2014. Consequently, Latinos should be proportionately represented in all decision-making and advisory bodies relating to ACA implementation. State and local government, including the Health Benefits Exchange, the Department of Health Care Services, the Department of Public Health, and the Managed Risk Medical Insurance Board, as well as health plans and provider organizations, should be recruiting and grooming capable Latinos for leadership positions to work on ACA implementation.

ACA implementation must include multiple strategies to reach out to and engage Latino consumers and providers to develop system improvements as well as health-supportive improvements in community conditions. Innovations in education and outreach in Latino communities should involve culture and language competent adult education, ESL classes, parenting classes, workplace learning opportunities, neighborhood promotoras, distance learning and social media. Not only should Latinos be empowered as consumers to manage their own health care, but also as civic advocates for health consideration in all policy decisions, as monitors for equity in health care, and as stewards for healthy communities.

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[1]Dennis P. Andrullis and Nadia J. Siddiqui, "Health Reform Holds Both Risks and Rewards for Safety-Net Providers and Racially And Ethnically Diverse Patients," *Health Affairs,* vol 30:10, (October 2010): 1830.
[2]U.S. Department of Health and Human Services, "Action Plan to Reduce Racial and Ethnic Disparities," (2011), http://minorityhealth.hhs.gov/.

Panel Presentation to Covered California – March 21, 2013

I am Darcel Lee, Executive Director of California Black Health Network. I want to first thank the Board of Covered California for this opportunity to speak directly to you. CBHN is comprised of a small staff, but we are engaged with Covered California as often and as best we can be considering our small staff and limited resources. Our work has also included listening to feedback from our constituents across the state with respect to their reactions to the work of Covered California.

While the majority of the work of Covered California has been extraordinary, purposeful and well received by our community, there are concerns that I have gathered as I have traversed this state from San Diego to Sacramento. I am couching our concerns within the mission of Covered California and some of the six primary values that guide your work:

1) As it relates to your mission of reducing health disparities: let me discuss "Hot Spotting." Hot Spotting was started in the criminal justice system. They began to look at crime and target their resources geographically – where there is the highest incidence of crime, based on geographic area, zip code and ethnicity, resources are marshaled and deployed. For example: you have $100 and 3 groups that each need $100. Instead of equally dividing the $100 among those three groups, hot spotting is used as a measure and the group with the highest incidence of crime gets 50 or 60% of the resources and the other two groups get the balance. I think you get the picture.

   African Americans may be the smallest percentage of the overall population in California, but we carry the greatest burden of disease and negative health outcomes. While CBHN is addressing this issue from a prevention and wellness perspective, in the context of Covered California and what you are here to do, **we recommend that Covered California employ a best practice that focuses on where the greatest burden of disease exists and that "*health disparities math*" then be employed to assess how resources will be used to effectively eliminate these disparities.** In other words, if disparities exist between populations but, resources are deployed evenly across the board, you may actually increase disparities because those resources are not getting to the areas where the burden of disease is the greatest. This is particularly applicable to physician reimbursement issues.

2) Next I will speak to the guiding value of Integrity and Partnership including a commitment to responsiveness, speed, reliability and working with providers and health plans.
   - **a.** CBHN has already been receiving feedback and stories of less than satisfactory consumer experiences within the current Low Income Health Programs and related to the PICP. Because we have time constraints here, I will not go into those stories now. **However, the recommendation of CBHN is that a best practice will be established that provides for analysis and review of these two programs so that some of these infrastructure issues will be addressed prior to the full implementation of the ACA in January of 2014.**

b. As assisters and navigators are considered, and interpretive services provided, **CBHN recommends that languages of lesser persuasions not be forgotten.** For Example, in San Diego there are neighborhoods with high populations of African, West African, Ethiopian, and Afro Cubans. These are people who speak languages and embrace cultures that are often excluded when we think of the provisions of culturally competent services.

c) We all know there has been uproar about enough providers to handle the increase of patients entering the system in 2014. Essentially our physicians are feeling that they are being expedited away from their practices because the reimbursement rates under Covered California for medical expansion will either be too low or kept the same as they are today. Our physicians, who are usually in small practices with limited staff and resources will be required to purchase HER systems, subjected to additional paperwork and data tracking and more than likely expected to treat a greater number of patients with higher risk conditions because they have heretofore had no coverage and therefore no prior treatment or limited treatment.

California is already the second lowest state in the nation for Medicaid reimbursement – only Mississippi is lower. And yet, the cost to physicians to conduct business here is the highest in the nation. There are no African American primary care physicians in private practice in Sacramento – they are either retired or they have left. There are only two (2) pediatricians and only (1) who accepts Medical. Today it is already too costly for physicians coming out of medical school to start independent practices so they go into managed care. This example can be mirrored in both urban and rural areas around the state.

d. That brings us to the managed care scenario which holds yet another issue for our providers. The California Medical Association is currently studying the issue of cultural competency. Many of the plans being considered by Covered California are contracting with IPAs that do not hire physicians of color. This makes it very difficult for patients to maintain a trusting, culturally competent, working relationship with their current physicians, not to mention the difficulty of navigating these systems. **We recommend that Covered California employ a best practice of engaging a group of African American physicians in an advisory capacity as you design the health plan marketplace and consider reimbursement thresholds.** These are compassionate, willing providers of care but under the new system, they simply want to ensure their viability and sustainability.

On that note, it should be noted that CBHN is already working with the California State Legislature and Dr. Pan and others on the Medical Expansion issue, provider reimbursement and the Bridge issue. However, we are very much interested in being "at the table" as Covered California seeks to integrate these issues into the overall structure of the Exchange.

3) Lastly, your background paper discusses the marketing, outreach, and enrollment assistance work of Covered California. CBHN has submitted our application for an outreach and education grant for $1Million. We pulled together 14 organizations that cover geographic areas from San Diego to Sacramento. Our collaborative is experienced with this type of work and includes a variety of innovative and strategic outreach and education initiatives including a specific culturally competent model that is time tested and proven to be effective. Our collaborative is made up of a diverse group of professionals who both understand the special nuances of reaching our own population and what motivates them to act. **Recommendation for a best practice? Strongly consider the strength of our collaborative in the context of your guiding principles and allow us to do the work that will generate the most success for a group of people that are in the most need. If we are not selected, then glean from our ideas and use them to ensure African Americans are reached in the most culturally competent manner possible.**

Thank you.