Open Enrollment: Lessons from the Field

Statewide Enrollment Data

Medi-Cal enrollment increased significantly from about 7.8 million in 2013 to about 12.2 million in 2015 – nearly 4.5 million new enrollees[1] of whom close to a million were children moving into Medi-Cal from the Healthy Families programs and about 650,000 were adults moving from county indigent programs into Medi-Cal managed care[2].

- ACA expansions (3.5 million) and hospital presumptive eligibility (31,000) were the biggest drivers of increased enrollment of the newly insured[3]
- Coverage in the traditional categories of families, aged and disabled increased very little to not at all during this time frame.
- Managed care enrollment in Medi-Cal increased by 58% between December 2013 and June 2015.[4]

The expansion of Medi-Cal managed care seeks to provide better outcomes at reduced cost, in part through improved prevention and better access to primary care, and there is evidence this is working in California. The state's performance dashboard indicates the emergency room visits per 1000 member months have declined since January 2014, the start date of the Affordable Care Act. Also declining over the same time period are emergency room visits with an inpatient admission and inpatient admissions per 1,000 member months.[5] There is very wide variation among the plans on their HEDIS quality scores; some of the variation appears to be linked to regional differences, and others to the plan administrators.[6]

Covered California enrollment increased from nothing to 1.4 million over the same 18-month time frame.[7] 90% of Covered California enrollees are in subsidized coverage (i.e. their incomes are below 400% of the federal poverty level. 92% of those in subsidized coverage are enrolled in either silver or bronze coverage, and the percent of individuals enrolling in bronze increased significantly in year two.[8] Youth enrollment went up compared to middle aged enrollment in year two. Lati-

[1] Acosta M, Kho J. 2015. Healthcare Financing Report. Insure the Uninsured Project. Available at: *http://itup.org/uncategorized/2015/07/23/2015-health-*

[2] Ibid.

[3] Ibid, p. 9, Table 3.

[4] California Department of Health Care Services Medi-Cal Managed Care Enrollment Reports December 2013 and May 2015 at *http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Enrollment_Reports/MMCDEnrollRptSep2013.pdf* and *http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Enrollment_Reports/MMCEnrollRptMay2015.pdf*

[5] California Department of Health Care Services, Medi-Cal Managed Care Performance Dashboard (September 17, 2015) at *http://www.dhcs.ca.gov/services/Pages/MngdCarePerformDashboard.aspx*

[6] Ibid. Bay Area, County Organized Health Systems and Orange plans had particularly high HEDIS rankings while a number of Central Valley plans had much lower performance rankings; plan scores ranked from close to 100% to less than 40%. Central Valley region has higher patient risk profiles and fewer local physicians available. Member satisfaction with their plans showed less extreme variability with rankings varying from a high of over 90% to a low of just under 70%.

[7] Covered California, First Open Enrollment Period 2013-2014, Lessons Learned p. 69 at *https://www.coveredca.com*

[8] Covered California, Executive Director's Report Open Enrollment Year 2 Update (March 5, 2015), Active Member Profiles (June 2015) at *http://hbex.coveredca.com/data-research/* Eight percent of Covered California subscribers with incomes between 138 and 150% of FPL are selecting bronze rather than enhanced silver; 17% of subscribers with incomes between 150 and 200% of FPL are choosing bronze rather than enhanced silver and 33% of subscribers with incomes between 200 and 250% of FPL are choosing bronze rather than enhanced silver. Covered California Active Member Profile as of June 2015.

no/African American enrollment went up to CalSim projected levels in the second year of open enrollment. 33,000 entered the program during special enrollment period of the tax season.

Covered California completed its third set of rate negotiations with health plans. The most affordable premiums were in Los Angeles, Southern California and the Central Valley.[9] The most affordable plan in Region 16 (Los Angeles) was $150 per month for the lowest cost bronze plan for a twenty-five year old; the cost of coverage through the lowest cost bronze plans in the most costly regions (8 and 9) was 50% higher. The weighted average of premium increases was 4% while the savviest shoppers could save 4.5% on average.[10] This also varied widely by region; in Region 16 (Los Angeles), savviest shoppers saved 15.5%.

The composition of non-profit community clinic visits changed quite dramatically between 2013 and 2014 as clinics responded to the coverage expansions. Medi-Cal managed care patient visits increased by 55%; Medi-Cal fee for service visits increased 21%; clinics' privately insured visits (includes Covered California) increased by 19%. Clinics' uninsured visits fell by 28%; many counties eliminated their payments to clinics for their care to the uninsured in light of the ACA expansions. Clinics' bottom lines improved from 21¢ per visit to $3.50 per visit.[11]

California has been one of the nation's leaders in implementing the ACA. This paper looks at the enrollment successes and delivery systems performance reported in our regional workgroups in the San Diego (page 2), Orange (page 3), North Central (page 5), Bay Area (page 6), Central Coast (page 9), Central Valley (page 10), Northern Rural (page 13), Inland Empire (page 16), and Los Angeles (page 20) counties. It identifies both the successes and the next step challenges identified by those on the ground implementing the Affordable Care Act. It will be updated as the OSHPD hospital data for 2014 is released. We hope it will be useful to all our workgroup participants as we enter year three of Open Enrollment.

San Diego's Enrollment Success

San Diego's Medi-Cal Managed Care enrollment grew by 38% between December 2013 and June 2015.[12] One of the local Medi-Cal managed care plans had a very high ranking on the Medi-Cal managed care HEDIS scores.[13]

San Diego exceeded Covered California's expected enrollment levels by nearly 300% in year one and had one of the largest percentage growth rates in the state during year two Open Enrollment.[14]

The composition of community clinic visits in Southern California changed dramatically between 2013 and 2014. The number of Medi-Cal managed care patient visits increased by 46%; Medi-Cal fee for service visits increased 28%; their privately insured visits (includes Covered Califor-

[9] See, Wulsin, Summary of Covered California premiums 2016 (ITUP, July 28, 2015 at *http://itup.org/blog/2015/07/28/summary-of-covered-california-premiums-for-2016/* and Covered California, 2016 Plan Rates (July 27, 2015) at *www.coveredca.com%2Fpdfs%2F7-27-coveredca-2016planrates-prelim.pdf*

[10] Ibid.

[11] Acosta M. 2015. Regional Primary Care Clinic Stats from Final OSHPD Data. Insure the Uninsured Project. Available at: *http://itup.org/blog/2015/10/05/preview-of-regional-primary-care-clinic-stats-from-preliminary-oshpd-data/*

[12] Wulsin L. 2015. Care, Coverage and Financing for Southern California's Remaining Uninsured. Insure the Uninsured Project. p. 2. Available at: *http://itup.org/special-features/2015/06/15/care-coverage-and-financing-for-southern-californias-remaining-uninsured/* California Department of Health Care Services Medi-Cal Managed Care Enrollment Reports December 2013 and May 2015 at *http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Enrollment_Reports/MMCDEnrollRptSep2013.pdf* and *http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Enrollment_Reports/MMCEnrollRptMay2015.pdf*

[13] California Department of Health Care Services, Medi-Cal Managed Care Performance Dashboard at *http://www.dhcs.ca.gov/services/Pages/MngdCarePerformDashboard.aspx*

[14] Care, Coverage and Financing for Southern California's Remaining Uninsured. Insure the Uninsured Project, p. 21; Covered California Regional Open Enrollment Data (2015) at *http://hbex.coveredca.com/data-research/*

nia) increased by 10%, and their uninsured visits fell by 21%. Clinics' bottom lines were $1.89 per visit, a decline from 2013.[15]

Workgroup participants pointed to several factors supporting San Diego's successful enrollment:

- Aggressive outreach and collaboration: Certified Enrollment Counselors and Navigators were responsible for 25% of all enrollments. San Diego was an early adopter of the CEC approach, and helped with pilot training and certification. Stakeholders were quick to start outreaching as soon as possible, giving them a head start over other counties. Local brokers helped support outreach efforts.
- Clinics had a coordinated strategy to collaboratively reach minority communities with special locally developed materials. They developed their own explanatory materials on coverage of mixed-status families and affordability. Outreach was careful to emphasize that enrollment will not endanger mixed-status families with immigration enforcement actions.
- They used local television networks and newspapers to reach the Latino community.
- They created materials that directed interested people to trusted local community agencies. Tapping into community trust aided enrollment efforts.
- San Diego collaborative helped develop affordability messaging that was successful in explaining why getting coverage was a smart option. The materials emphasized that the penalty for not getting care isn't just the tax penalty, but rather the costs of uncovered care. They walked potential applicants through the financial breakdowns; many who initially refused to enroll had never looked at the actual financial numbers and then decided to enroll.
- Second year enrollment may have been high because of success in reaching out to and following up with those who declined to enroll during the first year. The first year captured low-hanging fruit, while the second year capitalized on relationships built during the first year that didn't initially yield enrollments.

San Diego experienced an emergency room usage surge despite the presence of a wide and well-developed clinic network Stakeholders suggested that not all clinics were ready for the increase in primary care utilization, and enrollees also may have been confused by different models of care between plans and systems.

- Two main issues leading to inappropriate ER usage: lack of appointment availability at the clinics and lack of subscribers' experience with a medical home and primary care.
- Lack of clinic capacity underscores the need and opportunity to shift to team-based care.
- Confusion about how to use healthcare underscores the need for consumer education.
- Lack of post-enrollment education (poor engagement with existing resources such as group information sessions) and overly complex consumer resources (e.g. statement of benefits is confusing for low-literacy beneficiaries; online websites are challenging to navigate).
- Enrollment process needs to culminate with a linkage to primary care, not just coverage.
- Possible approaches to improve the linkage process:
    - Creation of plan-specific quick reference guides to aid clinics and enrollers in guiding new enrollees on the first steps after getting coverage and inclusion of simple introductory materials in mailing materials;
    - Plan collaboration with clinics to locate and follow-up with patients post-enrollment;
    - Plans should incentivize providers to promptly link patients to primary care providers (Kaiser approach).

Orange County's Success

Orange County performed very well during the first two years of open enrollment. The county had a 60% growth in Medi-Cal managed care enroll-

[15] Regional Primary Care Clinic Stats from Final OSHPD Data.

ment over an 18-month period.[16] CalOptima is back up near the top of the Medi-Cal managed care HEDIS rankings.[17] Orange enrolled close to 300% of anticipated enrollment for the first year's open enrollment in Covered California, and maintained and sustained its market share in year two of Open Enrollment.[18]

The composition of community clinic visits in Southern California changed dramatically between 2013 and 2014. The number of Medi-Cal managed care patient increased by 46%; Medi-Cal fee for service visits increased 28%; their privately insured visits (includes Covered California) increased by 10%, and their uninsured visits fell by 21%. Clinics' bottom lines were $1.89 per visit, a decline from 2013.[19]

Best practices that helped Orange County stakeholders succeed during open enrollment:

- Covered OC Collaborative applied for outreach and enrollment funding from Covered California, which helped them pool information, coordinate ongoing and future outreach efforts and ensure effective collaboration between different community groups.
- On-site health navigators at community clinics helped patients navigate the enrollment system. Local hospitals played equally important roles in enrolling their patients.
- The Clinic Coalition and four individual health centers formed a health enrollment collaborative. They found that a focus on education first was key to enrollment success. The first task was to allay confusion about the importance of enrollment, especially for individuals with limited-English proficiency.
- Due to the difficulties in transmitting information electronically between Medi-Cal and Covered California, Medi-Cal enrollments were directed to the county instead of CalHEERS to avoid serious delays in determining eligibility and receiving coverage.
- OC's private-sector led safety net had great flexibility to rapidly redirect enrollment efforts and change strategies as they learned which ones worked best and with what groups.

Covered California in Orange County:

- Confusing messaging from Covered California on tax penalties left many consumers unsure about what penalties they might owe.
- Poor access to Covered California's enrollment data made it difficult for the OC Collaborative to identify areas of the county needing additional application assistance.
- The electronic interfaces between Covered California and the county social services office created difficulties enrolling Medi-Cal eligibles following a determination by CalHEERS that they were Medi-Cal eligible, rather than Covered CA eligible. Local hospitals frequently had to resort to presumptive eligibility.

Other Covered California issues:

- Many patients were surprised by the high deductibles and co-pays for bronze plans they had selected. Some patients have purchased coverage but are paying cash for services at a negotiated rate because they cannot afford the plans' copays and deductibles. Subscriber education on choices of metal tiers needs to improve.
- Future enrollments will be more challenging because the remaining uninsured are likely to have looked at the costs and benefits of coverage and have chosen not to enroll in coverage; it's no longer lack of familiarity, so the next challenges are improving affordability.[20] The

[16] California Department of Health Care Services Medi-Cal Managed Care Enrollment Reports December 2013 and May 2015

[17] California Department of Health Care Services, Medi-Cal Managed Care Performance Dashboard (September 2015)

[18] Care, Coverage and Financing for Southern California's Remaining Uninsured. Insure the Uninsured Project; Covered California, Regional Open Enrollment Data (2015)

[19] Regional Primary Care Clinic Stats from Final OSHPD Data

[20] In their references to affordability, the participants are referring to the subscriber share of premiums, rather than the premiums themselves. The subsidized subscriber shares depend on the second lowest cost silver plan (the reference plan), the subscriber's income, and

safety net will need to learn the selling skills of commercial brokers. There is interest in local premium assistance to help make coverage more affordable once the federal and state governments clarify the rules under which this is permissible.

- The family glitch, where people are offered workplace coverage that is unaffordable for their family but are federally barred from receiving subsidies for affordable coverage on the Exchange due to the rules on individual and family affordability, needs to be fixed.[21]

North Central Successes

North Central performed exceedingly well during the first two open enrollments. 85% growth in Medi-Cal managed care enrollment over the period from December 2013 to June 2015.[22] Two of the local health plans ranked close to the top of the state's Medi-Cal managed care HEDIS ratings.[23]

Sacramento region counties reached 242% of anticipated enrollment for the first year's open enrollment in Covered California and North Bay counties reached 323% of projected enrollment in year one.[24] North Bay counties lost market share (from 3.7% to 3.5% of state enrollment) in year two of Open Enrollment – i.e. other counties are catching up, while Sacramento Valley counties increased market share (from 5.0% to 5.1%) in year two of Open Enrollment.[25]

The composition of community clinic visits in North Central changed dramatically between 2013 and 2014 in response to the ACA expansion. Medi-Cal managed care patient visits increased by 71%; Medi-Cal fee for service visits increased 15%; their privately insured visits (includes Covered California) increased by 24%, and their uninsured visits fell by 32%. Non-profit clinics' bottom lines were $10.98 per visit.[26]

Workgroup participants reported several strategies (bulleted below) that improved outreach, education, access and beneficiary utilization:

- There has been extensive and effective outreach. Participants suggested the first enrollment round caught the majority of local program eligibles, with the second enrollment round catching only those who missed enrollment deadlines.
- Now the work needs to shift to making sure people are using their coverage effectively. Enrollment isn't enough – how do we improve outcomes after enrollment? A lot of work needs to be done to make sure that individuals are linked to a local primary care doctor and understand how to use their coverage and to ensure that they utilize it appropriately.
- A major concern from stakeholders is whether there are enough providers to ensure access to all the newly enrolled individuals, in particular access to Medi-Cal providers. We need to develop new solutions, including telemedicine and incentives to keep primary care networks open later and on weekends to ensure existing resources are better utilized.
- Transportation and its costs can be a huge issue, especially for specialty care (e.g., you live in Redding but the closest specialty care is in San Francisco).

the subscriber's choice of plan and tier of coverage. Subscribers can minimize their premiums by selecting the lowest priced bronze, but that exposes them to large out of pocket when they need care and of course they may lose the tax credits to reduce their out of pocket that are only available if they select enhanced silver. ITUP has suggested that California might use a §1332 waiver to develop an enhanced bronze. See Connolly, Opportunities for California Under §1332 of the Affordable Care Act. *http://itup.org/blog/2015/09/14/opportunities-for-california-under-%C2%A71332-of-the-affordable-care-act/* and Wulsin, Care, Coverage and Financing for Southern California's Remaining Uninsured.

[21] Coleman, Children's Health Coverage Under the Affordable Care Act (ITUP, April 2014) at *www.itup.org/health-financing/2014/02/07.childrenshealthcoverage-aca/*

[22] Medi-Cal Managed Care Enrollment Reports December 2013 and May 2015

[23] Medi-Cal Managed Care Performance Dashboard

[24] First Open Enrollment Period 2013-2014, Lessons Learned p. 69

[25] Regional Open Enrollment Data (2015), Enrollment by Pricing Region, Enrollment by County

[26] Regional Primary Care Clinic Stats from Final OSHPD Data

- Other important tasks: addressing retention and churn and continuity of treatments between programs as income level shifts.
- Many individuals came in with little previous healthcare for their substance abuse or behavioral health disorders, so plans and providers need to adapt to provide care to meet these needs. Increased focus needs to be on delivery of effective behavioral health. Currently health plans and counties are figuring out the most effective SUD networks and services.

Covered California in North Central

- Some individuals have incomes at the margins, so they don't fit consistently in either program and churn back and forth.
- Some confusion over plan choice as well, leading to customer frustration with the plan benefits they selected.
- Tech issues between CalHEERS and county social services are compounding frustration.
- In addition, local community clinics are overworked due to lack of adequate private physician participation in Medi-Cal, which could impact the quality of care in the future if not alleviated.
- A lot of case-by-case overrides and workarounds are being used currently to get around enrollment snafus and to handle difficult cases.
- Should the counties handle all issues related to Medi-Cal MAGI determination since coordination between the two programs is proving so difficult? Can the two computer programs be interfaced?

What changed in the second round? What new lessons have been identified?

- Covered California's biggest issue – lack of affordability of health plan premiums for subscribers with tight household budgets makes it more likely these subscribers will choose the lowest-cost bronze plans with high deductibles.[27]
- Are there new innovative outreach approaches that have been working? People need to hear from trusted community members, especially in more insular and isolated communities.
- What plans are now available in North Central California, and to what degree have they included the safety net providers? There has been a lot of difficulty identifying in-network providers with some plans, especially Blue Shield and Anthem. FQHCs in Sacramento have been left behind by the Covered California plans. More FQHCs need to be included in the networks, but they need hospital partnerships. Some hospitals and medical groups have already teamed up with plans and don't want to craft new hospital arrangements with any new providers, preventing new plans from entering the market and preventing the existing plans from extending their networks to the FQHCs. This severely hinders the ability to bring the safety net into Covered California plans in Sacramento.
- Plans will need to work with community health educators so that people with coverage know how to get care; they need to be much more proactive.

Bay Area Successes

The Bay Area's broad implementation of the Bridge to Reform waiver gave these counties a strong platform to launch ACA enrollment. Medi-Cal managed care enrollment in San Francisco increased by 73% in the 18-month time frame from December 2013 to June 2015; Contra Costa increased by 72%, Alameda by 60%, Santa Clara by 54%, and San Mateo by 42%.[28] San Francisco Health Plan, Health Plan of San Mateo and Santa Clara Family Health Plan all ranked close to the top of the state's HEDIS Medi-Cal Managed Care rankings.[29]

Covered California enrollment in the Bay Area out-performed Covered California projections

[27] See n. 20.

[28] Medi-Cal Managed Care Enrollment Reports December 2013 and May 2015

[29] Medi-Cal Managed Care Performance Dashboard

during the first year by 323%, and the Bay Area out-performed every other region.[30] During the second year Bay Area counties' market share of the new Covered California enrollment fell compared to Southern California, where counties such as Inland Empire, San Diego had large enrollment growth spurts. Santa Clara and Alameda each declined from 4.7% to 4.4% of state enrollment in year two. San Francisco declined from 2.9 to 2.3%; Contra Costa from 2.8 to 2.2% and San Mateo from 1.9 to 1.7%.[31]

The composition of community clinic visits in the Bay Area changed substantially between 2013 and 2014 in response to the ACA expansion. Medi-Cal managed care patient visits increased by 35%; Medi-Cal fee for service visits increased 29%; their privately insured visits (includes Covered California) increased by 28%, and their uninsured visits fell by 18% (a much smaller decline than clinics in other regions). Alameda County increased community clinic funding for their care to the remaining uninsured by 28%, in sharp contrast to most other California counties. Non-profit clinics' bottom lines were $11.17 per visit.[32]

Participants' experiences are reported below:

- Healthy San Francisco played a key role in jump-starting Medi-Cal enrollment for San Francisco's uninsured. Human Services Agency reports that their Medi-Cal caseload has doubled to over 100,000 with 56,000 cases being MAGI Medi-Cal. Handoff between Healthy San Francisco and Medi-Cal can be confusing for people to navigate; Healthy San Francisco has a much simpler application process compared to Medi-Cal.
- Major renewal issues persist, e.g. 5,000 people are on enrollment hold for the San Francisco Health Plan (a very big number for a small county).
    - The renewal process is complex. New renewal packets are tied to individuals by barcodes – you can't use a generic form, so if you lose your form HSA has to fax the unique form to the renewal applicant. Errors cannot be amended without HSA intervention.
- People still cannot pick their Medi-Cal managed care plan on CalHEERS, so they may end up with a default primary care provider rather than their preferred network, leading them to underutilize care because they aren't familiar with the default provider. This disrupts care continuity for patients who already had a primary care provider and find the extra step to choose a new provider off-putting. This happens when people don't choose a provider to begin with, as well as when renewals get mixed up, or timelines missed.
- Application backlog is largely eliminated, but there is now a renewal backlog. Capacity issues at social services offices remain. Some people are now on hold for up to 90 days when they miss their renewal dates. We still have backlog issues, and need workforce to handle outreach and retention and for the department to effectively process caseload within the 45 day turnaround.
- Many people who have enrolled would have been eligible pre-expansion, which suggests an ongoing need for outreach and education.

Covered California in the Bay Area

- CalHEERS seems to be far far more usable than it was during the initial launch. Many of the bugs seem to have been ironed out. No show-stopping errors blocking applications.
- Covered California needs to improve its technical support in terms of answering complex questions -- inconsistent answers depending on whom you talk with; it has manifested primarily in some complicated tax issues.
- An unexpected side effect of minimum wage increases is loss of Medi-Cal coverage due to income bump. Some cannot afford their Covered California premiums for enhanced silver

[30] First Open Enrollment Period 2013-2014, Lessons Learned p. 69

[31] Regional Open Enrollment Data (2015), Enrollment by Pricing Region, Enrollment by County

[32] Regional Primary Care Clinic Stats from Final OSHPD Data

at the steep 138% cliff.[33] This could blossom into a much bigger problem given the number of municipalities that are considering a raise in the minimum wage. San Francisco has a safety net for these cases (HSF will cover people during the transition).

- Is provider access an issue? Since San Francisco already had Healthy San Francisco, many uninsured already had doctors, which helped alleviate potential shocks from people transitioning into Medi-Cal. Healthy San Francisco has seen a decline in complaints about access issues recently (down to 1 or less a month).

- Has there been a spike in ER visits due to poor access to doctors (e.g. overloaded community clinics)? While it doesn't seem to be an issue, still we need to investigate.

- Is there a need to educate new enrollees on how to utilize their healthcare? Individuals need a lot of education about the Healthy San Francisco to Covered California transitions. Many people are not used to how Covered California plans work, and don't know how to use them. Others end up back at the clinics after using up their 3 free primary care visits in the bronze plans.
- In Marin County, readmissions are up; issue in Marin is weak follow-up access to care after discharge. Marin has a lot of specialists, and they have contracts for Medi-Cal, but they won't see enough Medi-Cal patients; we need to find ways to incentivize their performance.
- Bronze vs. Silver: many people are now choosing bronze plans over silver because:
  - Financial hardship makes lower premiums of the bronze plans attractive for low-income people.
  - People don't understand the benefits of enhanced silver. We need to study if the people selecting bronze are those who would have been eligible for enhanced silver.
  - Could be a combination of sticker shock and misunderstanding how insurance works.
  - Covered California website doesn't make it glaringly obvious that the enhanced silver plan is a better choice.
- San Francisco has seen a lot of people sign up for catastrophic plans.
  - Possibly because there are a lot of youth, but it may also point to misunderstanding how insurance works under the ACA. For example, Chinese Community Health Plan's bronze plan is only a dollar more than catastrophic, but people still selected catastrophic.
- There may be a huge misunderstanding of what deductible means, and how it impacts access to care. There are enough families in bronze that this is important. People still don't understand the concepts and differences between copays/coinsurance/deductibles.
- No data available to see if the use of assisters impacts choices between bronze and silver, or if assisters aren't helping.
- Anecdotally, the spike in youth enrollment may also play a role. People who are newly insured and have never had health insurance don't really get how to use it and don't see how this matters, and just check the cheapest box not understanding what they're doing.
- Healthy San Francisco will be providing medical reimbursement accounts to provide additional premium assistance to eligible residents to help with premium affordability and out of pocket costs. Individuals are only eligible if their employer has contributed to their Healthy San Francisco coverage for them.
    - Cost-sharing subsidy will ensure an individual's out of pocket is no more than 5% of income.
    - Overall, it should cover 60% of the employee's premiums remaining after the Federal subsidy (i.e. if the individual's share is $100 per month, Healthy San Francisco will

[33] See n. 20.

pay $60 and the individual will pay $40)
- Individuals with incomes up to 500% of FPL can be eligible.
- Projected to begin mid-2016; it will cover approximately 3,000 individuals.

Central Coast Successes

Central Coast performed very well during the first two open enrollments. Growth in Medi-Cal managed care enrollment over the period from December 2013 to June 2015 ranged from 47% to 59%.[34] Enrollment in Santa Cruz and San Luis Obispo grew by 59%, Ventura by 58%, Monterrey by 54% and Santa Barbara by 47%. The two local health plans, CenCal and the Central California Alliance ranked close to the top of the State's Medi-Cal managed care HEDIS ratings.[35]

Central Coast region reached 293% of anticipated enrollment for the first year's open enrollment in Covered California.[36] Northern Central Coast counties markedly lost market share (from 2.4% to 2.0% of state enrollment) in year two of Open Enrollment, while Southern Central Coast counties also lost market share (from 4.4% to 4.2%) in year two of Open Enrollment as the enrollment surged in Southern California counties like San Diego and the Inland Empire. Ventura kept its market share of new enrollments in year two at 2.2%; Santa Barbara fell from 1.2% to 1.1% and San Luis Obispo declined from 0.9 to 0.7% market shares. Santa Cruz fell from 1.1 to 0.8% and Monterrey declined from 1.2 to 1.1% market shares.[37]

The composition of community clinic visits in the Central Coast region changed substantially between 2013 and 2014 in response to the ACA expansion. Medi-Cal managed care patient visits increased by 41%; Medi-Cal fee for service visits increased 25%; their privately insured visits (includes Covered California) increased by 52%, and their uninsured visits fell by 23%. Non-profit clinics' bottom lines were -$3.83 per visit in 2014, but improving substantially from -$7.27 per visit the year before.[38]

What factors helped drive enrollment?

- ACA has raised awareness of the importance of health insurance. Many Medi-Cal eligible realized they could enroll. People are now more aware of benefits to which they are entitled.
- CBO partnerships played an important role. In Monterey, CBOs were essential to outreach and helped the county exceed enrollment expectations. San Luis Obispo CBOs drove the majority of new enrollments and did a good job at diverting applicants directly to their Department of Social Services in cases of Medi-Cal eligibility rather than using CalHEERS.
- Santa Barbara Department of Public Health did a lot of community outreach and quickly enrolled staff to serve as CECs, and did a lot of in-reach to clinics' uninsured population, with attempts to enroll patients when they came to the clinic for service. Many of the uninsured were already receiving services from Public Health operated clinics.
- How many Medi-Cal eligibles are left? Anecdotal experience suggests enrollment is still growing, even though projections suggest enrollment will plateau. We need more data to get a clear and accurate picture on the remaining uninsured; the CalSIM data is outdated.
- Surging private insurance premiums for employers in San Luis Obispo could trigger churn of children and youth from private employer plans into Medi-Cal.

Medi-Cal Managed Care on the Central Coast

- What is the working relationship between community clinics and county clinics like? Col-

[34] Medi-Cal Managed Care Enrollment Reports December 2013 and May 2015

[35] Medi-Cal Managed Care Performance Dashboard

[36] First Open Enrollment Period 2013-2014, Lessons Learned p. 69

[37] Regional Open Enrollment Data (2015), Enrollment by Pricing Region, Enrollment by County

[38] Regional Primary Care Clinic Stats from Final OSHPD Data

laboration is strong in areas with provider shortages. FQHC leadership is vital to improving collaboration.

- Specialty Care Shortages? Some specialists are willing to provide services at an FQHC site. Doctors are willing to provide community service but aren't interested in bringing these patients into their office practices. In Santa Barbara, this is how a lot of specialty care is delivered. Many providers don't want to take patients with Medi-Cal FFS, but have fewer issues with Medi-Cal managed care plans. One-month wait time for transitioning into Medi-Cal managed care is problematic. County clinics are stepping up to fill some of these specialty care voids.
- Price is one problem, but access is another. In some cases, specialty care is available but expensive; in others, no price will bring in providers. They just aren't there.
- Children's oral healthcare can be hard to access. Six month wait times for urgent dental care. An increasing number of Santa Barbara dentists unfortunately will not accept Denti-Cal for children.
- Behavioral health specialists are scarce. FQHCs are struggling to find behavioral health providers who will accept referrals. Telemedicine could help meet some of the demand.

Covered California on the Central Coast

- Why might the Central Coast's percentages of statewide enrollment have decreased in the second year of enrollment?
    - Possibly due to the region's fast start in year one and/or the increased Medi-Cal enrollments.
- Metal Tiers: 45% of Monterey Covered California subscribers are in bronze-level plans. Why would people pick bronze over enhanced silver? Possible explanations include:
    - Poor education on affordability advantages of enhanced silver?
    - Serious affordability issues, such that they can only afford the monthly premiums for the lowest priced bronze?[39]
- Covered California is experiencing some access issues for specialty care, especially critical for certain special needs groups, like AIDS patients. For example, State ADAP pays premiums for platinum coverage for this group, but the patients can't find any providers in San Luis Obispo who will accept their plans. Shifting plan formularies are also making life difficult for AIDS patients.
- Technical Issues Needing Improvement: Covered California operators do not give consistent answers about complex enrollment issues – e.g. some of the tax issues. CalHEERS enrollment is still challenging for some applicants – arcane workarounds are needed to register certain people.
- Medi-Cal Churn: Covered California coverage is terminated as soon as an individual's income level drops below a certain level but not vice versa with Medi-Cal.

Central Valley Successes

Central Valley performed well during the first two open enrollments.[40] Growth in Medi-Cal managed care enrollment over the period from September 2013 to May 2015 ranged from 33% to 185%.[41] Enrollment in Stanislaus grew by 185%, Merced by 45%, Fresno by 38% and Tulare by 33%.

Central Valley region reached 186% of anticipated enrollment for the first year's open enrollment in Covered California.[42] Half the Central Valley counties increased market shares in year two of

[39] See n. 20.

[40] See Acosta, Perkins and Wulsin, Delivery Systems and Financing Care for the Remaining Uninsured in Fresno, Imperial, Merced, Stanislaus and Tulare Counties (ITUP, September 2015) at http://itup.org/the-uninsured/2015/09/11/delivery-systems-and-financing-care-for-the-remaining-uninsured-in-fresno-imperial-merced-stanislaus-and-tulare-counties/

[41] Medi-Cal Managed Care Enrollment Reports December 2013 and May 2015

[42] First Open Enrollment Period 2013-2014, Lessons Learned p. 69

Open Enrollment while most others were stable. Fresno kept its market share of new enrollments in year two at 1.7%; Stanislaus fell from 1.3% to 1.2%; Kern increased from 1.3% to 1.6%, and Tulare increased from 0.7 to 0.8% market shares. Merced was stable at 0.6%, and Imperial increased from 0.3 to 0.5% market shares.[43]

Central Valley relies heavily on an extensive network of community clinics. The composition of community clinic visits in the Central Valley region changed substantially between 2013 and 2014 in response to the ACA expansion. Medi-Cal managed care patient visits increased by 26%; Medi-Cal fee for service visits increased 15%; their privately insured visits (includes Covered California) increased by 19%, and their uninsured visits fell by 28%. Non-profit clinics' bottom lines were $0.27 per visit in 2014, improving substantially from -$11.53 per visit the year before.[44]

Some of the keys to local enrollment success were:

- Local collaboratives of community clinics, counties, hospitals, health plans and CBOs supported by foundation grants, Covered California and DHCS.
- Bridge to Reform pre-enrollment in Tulare, Merced and Imperial; in-reach by community and county clinics.
- Trusted relationships with local communities. Developing trust with undocumented individuals about enrolling eligible family members.

Some of the difficulties that must be addressed are:

- Need for better information exchanges between Covered California and the local enrollers so they can understand who has in fact been enrolled and who is not. Local enrollment entities have to maintain their separate databases, rather than coordinate with their Covered California partners.
- Poor understanding of what the 4 different metal tiers of coverage under Covered California offer, and too much focus on a plan's monthly upfront costs. Lots of focus on enrollment, but not necessarily selecting an appropriate level of coverage in the right plan for the individual.
- Need for post-enrollment education on how to use subscribers' covered services and new plans effectively. Lack of education and support for the newly insured. People who have new coverage don't yet know and understand that they should go to local clinics rather than the emergency room. This will likely require a whole-system approach, with work from consumer advocates, plans, community providers, etc.
- Need for better collaboration between the clinics and the local hospital emergency departments. Creating a community health network to ensure warm handoffs among providers.

The rural areas of the Central Valley are plagued by lack of an adequate health care workforce and the financial resources to address these shortages. Recommendations from the workgroup participants included support for pipeline programs, for recruitment and retention, for team based care, for telemedicine and an updating of FQHC rules to remove regulatory obstacles to telemedicine and team based care. Some of the biggest issues that need to be addressed are:

- Lack of adequate numbers of local specialists.
- Lack of a sufficient supply of behavioral health services, particularly lack of Board Certified psychiatrists.
- Patients required to travel to LA, Bay Area and Sacramento for scarce specialty care not available locally. Travel costs are prohibitive for low-income families.
- Expanded access to care – many access points are closed in the evenings and on weekends when workers get off work. Tulare and Imperial community clinics and Merced's Mercy Hospital emergency department have made big strides to address this.

Tulare

- Collaboration started with the Bridge to Reform waiver, which allowed for significant col-

[43] Regional Open Enrollment Data (2015), Enrollment by Pricing Region, Enrollment by County

[44] Regional Primary Care Clinic Stats from Final OSHPD Data

laboration and integration among the local safety net.
- As opposed to competing, safety net providers are moving towards collaborating and combining their efforts while avoiding duplication of work
- Working to extend public health into the community clinic system, incorporating group needs assessments, and focusing on community public health needs.
- New leadership and the ACA made it possible to shift towards collaboration and have candid discussion to set up a framework on which to move forward.
- Trying to figure why people don't participate in the Exchange, and how to incorporate them.
- Developing ways to share specialists through collaboration. Trying to get RHCs (Rural Health Clinics) and FQHCs to work together so that the hospital linked and based RHCs offer specialty care and the FQHCs offer primary care.
- ER discharge planning and coordination needs some work to improve coordination of follow up care and better hand-offs.

Fresno

- Biggest collective challenge and opportunity is enrolling people in Medi-Cal. Not everyone is aware that the old county programs (MISP) have sunset, and some are resistant to going into Medi-Cal (where the application and enrollment process is significantly more complicated).
- Biggest pleasant surprise was the numbers of long time uninsured area residents eligible for Medi-Cal as Permanently Residing Under Color of Law.
- Hospital/Clinic collaboration is very fractured at the current moment. Working to bring local stakeholders back towards collaboration.
    - Hospitals are competing over residency programs and specialty staff.
    - FQHCs are competing over funding for new access points and teaching residency programs and positions, but there are not enough to go around.
- Bringing more teaching residency slots into the local FQHCs has the potential to improve the quality of care of the system as a whole, and increase the supply of medical care in the community.

Stanislaus

- County operates both primary care clinics and a specialty care clinic, open to all low-income patients. County specialty clinic offers specialty services where possible, and takes referrals from the private community clinics. Many patients have remained with their existing primary care clinics after moving from the county indigent program into Medi-Cal managed care.
- Very hard to find an adequate supply of specialists in the county, other than the county specialty care clinic; many specialty care referrals require travel to UCSF or UC Davis. There are many more patients than there is specialty care capacity. Working with both health plans to expand support for out of county travel for patients needing specialty treatments.
- Working on expanding behavioral health capacity in community clinics.

Merced

- Pre-ACA, the county's capacity for direct services was very limited; episodic care model was very inefficient. Post-ACA, majority of county indigent patients were moved successfully into Medi-Cal. Moving county indigent into Medi-Cal has made a very significant improvement in the effectiveness of care. Broad local collaboration with strong county leadership has helped shift care from episodic to whole person.
- Merced's community is highly collaborative. The local Collaborative is working to improve behavioral health care utilization. Foundation grants have helped support their efforts.
- Clinics are working on providing health services to high school students and their families, especially behavioral health. Students had a strong need for behavioral health, especially crisis care. Parents also needed help with care for their children facing these issues. Working

on deploying additional school-based sites to provide screenings and care and hoping to roll out services across the school district.

- Mercy Hospital has been working closely with local efforts to provide care to the newly insured. Both Mercy and the Alliance noted the large increases in ER utilization and the need for better education of subscribers and collaboration and training for all safety net providers. Hospital has expanded its weekend and evening hours and staff to meet the gap in available care at those times. Struggle to control uptick in emergency department usage is a common theme in all three Alliance counties. Alliance is investing $116 million into capacity building for primary care and behavioral health care to improve alternatives to the hospitals' emergency room.

North Rural Enrollment Successes

North Rural performed well during the first two open enrollments. Growth in Medi-Cal managed care enrollment over the period from December 2013 to July 2015 ranged from 55% to 79%.[45] Enrollment in Mendocino grew by 59%, Modoc by 55%, Humboldt by 79%, Shasta by 56% and Siskiyou by 64%. The local Medi-Cal managed care plan had a very high ranking on the Medi-Cal managed care HEDIS scores.[46]

North Rural region reached 229% of anticipated enrollment for the first year's open enrollment in Covered California.[47] The North Rural counties lost market share in year two of Open Enrollment. Humboldt kept its market share of new enrollments in year two at 0.4%; Mendocino fell from 0.3% to 0.2%; Shasta increased from 0.4% to 0.5%, and Siskiyou was stable at 0.1 market shares. Modoc and Del Norte increased from 0.0%, to 0.1% market shares.[48]

North Rural relies heavily on an extensive network of community clinics. The composition of community clinic visits in the North Rural region changed substantially between 2013 and 2014 in response to the ACA expansion. Medi-Cal visits increased by 40%; Medi-Cal managed care patient visits increased by 363%; Medi-Cal fee for service visits decreased 26%; their privately insured visits (includes Covered California) increased by 16%, and their uninsured visits fell by 50%. Non-profit clinics' bottom lines were $6.01 per visit in 2014, improving from $5.34 per visit the year before.[49]

Mendocino

- Factors driving enrollment success
  - Low provider density means once all the clinics get involved; most of the population is being reached.
  - Strong pre-existing relationships among social services, clinics, family resource centers were the foundation for outreach and enrollment.
- Enrollment Challenges

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[45] California Department of Health Care Services, Medi-Cal Managed Care Enrollment Reports December 2013 and July 2015 at *http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Enrollment_Reports/MMCDEnrollRptSep2013.pdf* and *http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Enrollment_Reports/MMCEnrollRptMay2015.pdf*

[46] California Department of Health Care Services, Medi-Cal Managed Care Performance Dashboard at *http://www.dhcs.ca.gov/services/Pages/MngdCarePerformDashboard.aspx*

[47] Covered California, First Open Enrollment Period 2013-2014, Lessons Learned p. 69 at *https://www.coveredca.com*; Covered California, Executive Director's Report Open Enrollment Year 2 Update (March 5, 2015), Active Member Profiles (June 2015) at *http://hbex.coveredca.com/data-research/* Eight percent of Covered California subscribers with incomes between 138 and 150% of FPL are selecting bronze rather than enhanced silver; 17% of subscribers with incomes between 150 and 200% of FPL are choosing bronze rather than enhanced silver and 33% of subscribers with incomes between 200 and 250% of FPL are choosing bronze rather than enhanced silver. Covered California Active Member Profile as of June 2015.

[48] Regional Open Enrollment Data (2015), Enrollment by Pricing Region, Enrollment by County

[49] Acosta M. 2015. Regional Primary Care Clinic Stats from Final OSHPD Data. Insure the Uninsured Project. Available at: *http://itup.org/blog/2015/10/05/preview-of-regional-primary-care-clinic-stats-from-preliminary-oshpd-data/*

  - Poor interface between the CalHEERS and county social services computer systems hindered Medi-Cal enrollments through Covered California
  - Covered California enrollment experience is greatly improved, but there are still issues: e.g. inaccurate 1095A forms.
  - Enrollment counselors don't get enough financial support for their work. No grants were given to enrollers working in Mendocino. There is a lot of focus on under-reached minority groups, but not enough on under-reached geographic areas
- Enrollment Improvements
  - Shop and Compare is a useful tool for consumers
  - Medi-Cal determinations are now done in a timely fashion
  - Most Mendocino county physicians are participating as Covered California and Medi-Cal providers, somewhat easing challenges accessing primary care, but there is still a shortage of primary care physicians in the county.
  - Specialty care access is difficult because of Mendocino's rural nature, and many clinicians are retiring or choosing to work for Adventist clinics instead of local community clinics.
- Emergency Department utilization
  - High ER use is due both to a lack of sufficient access to and a poor understanding of how primary care works. Education is needed, but there are no leaders championing it. High ER usage will likely continue in Mendocino until there enough primary care physicians to provide adequate care.
- Remaining Uninsured
  - Restricted scope Medi-Cal private nonprofit primary care clinics are the primary source of care to the undocumented.
  - Dental is the biggest unmet need among uninsured youth. The uninsured undocumented do not access specialty care until their condition is life-threatening, qualifying for emergency Medi-Cal

Humboldt

- Factors driving enrollment success
  - Open Door clinics worked closely with Humboldt Health and Human Services, easing a lot of potential enrollment pain; they helped provide people on the ground to process enrollments and operate a local call center. Community members are willing to partner up and work transparently; good, collaborative, multi-agency efforts helped improve enrollment and then access to care. HRSA and Navigator grants helped fund on-the-ground efforts.
- Improvements over past enrollments
  - The adjustments made to the Navigator program were reasonable, even though total allocation was only about 1/4th of what was needed. Stakeholders built deeper relationships with Covered California's Navigator support staff who have been very helpful
- Persisting enrollment issues
  - Covered California's CalHEERS system is still failing to meet expectations, despite improvements. Response times are still too slow. While the web site is much improved, it requires a lot of arcane workarounds and overrides to enroll people.
  - Family glitch is becoming an urgent problem. Some individuals will likely owe premium assistance back to the Federal Government. Some people are taking employer coverage despite its unaffordability, pushing their families into near-poverty conditions. It may be better for local small employers to stop offering coverage for spouses.
- Issues with Covered California coverage
  - Many patients with bronze or catastrophic plans are better off being uninsured due to poor coverage of needed

  - care. The large number of individuals on these low-tier plans is artificially deflating the number of uninsured.
  - Narrow networks are still a major problem. No one wants to be a provider due to low reimbursements; moreover, plan websites still do not provide accurate provider information
- ACA §1332 Waiver allows States to waive and modify aspects of the ACA. It could be used to create more affordable subsidized plans, e.g. "enhanced bronze". It could be used to address the family glitch and allow employers to provide financial assistance to purchase exchange plans
- ED utilization has increased following the expansion.
  - Anecdotally, this is partially because of poor specialty care access, which is also problematic for those with employer-sponsored insurance.
  - Open Door has several-months wait time for routine primary care appointments, but has timely access to visits for patients with urgent or acute needs.
- Delivery system capacity issues
  - Fewer MDs today: local MD-to-resident ratio is decreasing. The ratio of MDs to other providers has shifted; there are now more NPs and PAs who are helping offset shortages. Delivery system is stressed.
  - Referrals don't work well; currently piloting a system based on referral templates that outline responsibilities for primary and specialty care.
  - E-Consults could improve the effectiveness of referrals, but there are a lack of participating specialists and many technical issues hindering rollout. We need to consider using more out-of-area specialists, but this seems unnecessary when there are in-area specialists. Open Door projects spending $1 million to transport their patients to specialty care; telemedicine might help address these costs.
- Remaining Uninsured
  - SB4 will likely be implemented in May.
  - Youth on Restricted-Scope Medi-Cal will automatically be upgraded to full scope. All other youth will have to apply, so now is the time to enroll uninsured youth into Restricted-scope.
  - Outreach will largely be word of mouth, though some events will play a role in increasing penetration. There may be people unwilling to register due to their distrust of registering for a government program
  - Failure to pass an MCO Tax means the implementation might be put on hold.

Shasta

- Update on Coverage Expansions
  - Northern Rural successes in exceeding enrollment projections may reflect successes in the southern portions of the North Rural region; Northern frontier area has had a less successful experience, as people seem to prefer staying on a sliding-fee schedule with their local clinics.
  - Clinics' uninsured visits have decreased from 30-40% of caseload to 6-8% of caseload.
- What factors aided enrollment?
  - Shasta Health and Human Services coordinated enrollment, made sure handoffs between enrollers and county went smoothly, helped with outreach and obtained a Blue Shield grant for Covered Shasta to train community partners on Medi-Cal enrollment
  - Partnership worked closely with members, providers and the county on enrollment.
  - Managed Care transition brought in a systems discipline that helped enrollers and partners think in whole-systems.
  - Medi-Cal is less perceived as welfare and more as a well-respected health plan, helping overcome stigma

- Clinics in-reached to get their patients covered.
- Conversion of CMSP to Medi-Cal Managed Care helped enrollment.
- There are fewer undocumented individuals in this region compared to other parts of California.

- Enrollment Challenges
  - Some individuals claimed religious exemptions; later they ended up needing coverage but had no options.
  - There is still some political opposition – some people want nothing to do with Obamacare.
  - Off-the-grid individuals would rather pay on a sliding fee scale rather than sign up for insurance
- Emergency Department utilization has increased
  - Many patients treat the ER like a clinic, as do many providers. Partnership is trying to educate providers on when it is appropriate to send patients to the ER.
  - Alternative perspective: if the ER doesn't see enough patients, it can't sustain itself financially. Beware of adverse impacts to payer mix in the ER by reducing ER visits; 40% of the county's population is Medi-Cal
  - Not all ERs are able to triage patients back to primary care. Until lack of clinicians is addressed, ED utilization will remain high
  - How can more clinicians be recruited?
    - Heavy debt discourages them from working in areas like Shasta. Many clinicians leave as soon as their loans are forgiven.
    - Need to rely on more PAs and NPs, but they need more clinical experience to be effective.
- Remaining Uninsured
  - SB4 will extend care to undocumented children as long as an MCO tax replacement is passed
  - CMSP is considering extending its scope of care to the remaining uninsured to provide more than primary care. Funding could also go to specialty care and/or to workforce development.

Inland Empire

Inland Empire performed well during the first two open enrollments. Growth in Medi-Cal managed care enrollment over the period from December 2013 to July 2015 ranged from 64% to 104%.[50] Enrollment in Riverside grew by 104%, and in San Bernardino by 64%. The local Medi-Cal managed care plan for the two counties had an above average ranking on the Medi-Cal managed care HEDIS scores.[51]

Riverside reached 172% of anticipated enrollment for the first year's open enrollment in Covered California and San Bernardino reached 150% -- far lower than neighboring Orange and San Diego counties.[52] The Inland Empire gained market share from 8.8% to 9.5% between year one and year two of Open Enrollment – one of the highest gains in market share of any region. Riverside

[50] California Department of Health Care Services, Medi-Cal Managed Care Enrollment Reports December 2013 and July 2015 at *http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Enrollment_Reports/MMCDEnrollRptSep2013.pdf* and *http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Enrollment_Reports/MMCEnrollRptMay2015.pdf*

[51] California Department of Health Care Services, Medi-Cal Managed Care Performance Dashboard at *http://www.dhcs.ca.gov/services/Pages/MngdCarePerformDashboard.aspx*

[52] Covered California, First Open Enrollment Period 2013-2014, Lessons Learned p. 69 at *https://www.coveredca.com*; Covered California, Executive Director's Report Open Enrollment Year 2 Update (March 5, 2015), Active Member Profiles (June 2015) at *http://hbex.coveredca.com/data-research/* Eight percent of Covered California subscribers with incomes between 138 and 150% of FPL are selecting bronze rather than enhanced silver; 17% of subscribers with incomes between 150 and 200% of FPL are choosing bronze rather than enhanced silver and 33% of subscribers with incomes between 200 and 250% of FPL are choosing bronze rather than enhanced silver. Covered California Active Member Profile as of June 2015.

grew its market share of new enrollments in year two from 5.0% to 5.2%; and San Bernardino grew from 3.8% to a 4.3% market share.[53]

Inland Empire relies heavily on an extensive network of county and community clinics. The composition of community clinic visits in the Southern California region changed substantially between 2013 and 2014 in response to the ACA expansion. Medi-Cal managed care patient visits increased by 59%; Medi-Cal fee for service patient visits increased by 16%; their privately insured visits (includes Covered California) increased by 11%, and their uninsured patient visits fell by 28%. Nonprofit clinics' bottom lines were $1.89 per visit in 2014.[54]

What drove enrollment success in the Inland Empire?

- Large eligible population as well as an aggressive approach to identifying and helping eligibles enroll
    - Uninsured patients at Arrowhead have decreased (to 6–8% vs. 40% before)
    - Over the last two years, we saw that projections of eligibles were way off, vastly underestimating the number of eligibles.
    - Inland Empire Health Plan (IEHP) did a lot of outreach to let newly-eligibles know about the benefits they were entitled to
    - Per-application compensation helped bring a lot of partners into the outreach efforts, including groups that traditionally don't play a role (e.g. churches)
    - From an outcomes perspective, prior to the ACA most people had to travel very far to get to a public hospital or clinic for care. People now have access to healthcare at neighborhood clinics or nearby hospitals. This is really key in a very large county with few hospitals.
    - Brokers were not educated on Medi-Cal before – the recent enrollment push did a lot to educate brokers on how Medi-Cal worked and help them get eligibles into the programs they were eligible for. CBO's worked closely with counties, carriers
    - There's better coordination in the Inland Empire, preventing application logjams and allowing partners to quickly get issues addressed
    - Also did a lot of work to dispel myths about Medi-Cal ("e.g. it's only for indigents, it's a bad program, it's welfare").
    - We used partnerships with IEHP and Covered California to get issues addressed quickly
- San Diego and the Inland Empire had the largest enrollment growth in Year 2. How did IE maintain and accelerate enrollment growth in year 2?
    - Anecdotally, Inland Empire had very good enrollment execution, reducing barriers to entry and making sure application and enrollment flows were smooth. There are some under-reached populations nonetheless.
    - Community clinics felt that there was good coordination and preparation for open enrollment, with careful ties among all the partners. Also made use of patient service representatives who were already tied in with families to handle enrollment for programs like Medi-Cal. Open enrollment went very smoothly, especially compared to other counties
    - IEHP played a good role in coordinating
    - A year ago, there was more frustration about enrollment (e.g. backlogs, Covered California seemed to not give enough resources and attention to the IE), what happened? Covered California's outreach to minority groups im-

[53] Regional Open Enrollment Data (2015), Enrollment by Pricing Region, Enrollment by County

[54] Acosta M. 2015. Regional Primary Care Clinic Stats from Final OSHPD Data. Insure the Uninsured Project. Available at: *http://itup.org/blog/2015/10/05/preview-of-regional-primary-care-clinic-stats-from-preliminary-oshpd-data/*

  - proved; systematic and structural changes were made.
  - IE health underwriters did excellent work training enrollment counselors. In 2014, agents enrolled the majority of people; CAHU ended up providing a lot of enrollment support.
  - The new challenge is continuing these efforts – a lot of barriers have been removed. It will be much harder to convince the remaining uninsured to get coverage. We will need to engage with these people and emphasize moving from a culture of coping to a culture of coverage. There is an opportunity, but the remaining uninsured are less interested in moving into coverage than the recently insured. Very careful messaging and coordination will be required
  - We want to have CEC reimbursements extended so stakeholders could continue efforts financially. However, Covered California cut these reimbursements, taking out significant portions of the outreach and enrollment infrastructure; these enrollers have been key to getting the hard-to-enroll people.
- Who is the remaining uninsured population?
  - Some include criminal justice populations being released (many eligibles who are healthy who don't come forward to apply). County is trying to pre-enroll these individuals prior to their release. Behavioral health is particularly important for some of them.
  - Student enrollment is hit-and-miss. More effort is needed because of the "young invincible" effect. Eligibility is tricky for out-of-State students. At the very least, we can get them on catastrophic.
  - There are a few cases of people choosing not to get coverage, then they have an episodic incident
- There is heavy price sensitivity, with many more enrollees electing bronze. Many have moved from silver to bronze, giving up enhanced silver benefits. At the lowest level of income, where people have 94% coverage of their copays and deductibles, there's good enhanced silver penetration. As income rises, people start moving back to bronze as they lose cost-sharing subsidies. Likely because bronze-level let's them have 3 visits without deductible. If you're a young invincible, that seems to make sense.
- Other issues:
  - More pro-active education is needed about intake packets and renewal packets. Otherwise people don't do the necessary intake work, and forget to renew.
  - It is proposed to have Medi-Cal plan choice done at the same time of enrollment, rather than waiting several days. Then the intake, enrollment, plan and provider choice and patient/subscriber education work can be done right away at the same time.

Payment & Delivery System Transformation

- In the Inland Empire, a lot of capacity building was done in the past 2 years. Community Health Inc. was able to bring on 14 providers to meet the increased demand; wait times are down to 2–3 days, 3 to 8 providers on call in any clinic. The hope is UC Riverside Medical School will help pipeline more providers into the IE.
- IEHP has had an increase in private providers as well, no major capacity issues except in remote communities where it's hard in general to find any doctors, Medi-Cal coverage or not. There are private sector providers that struggle to work with health plans; more work can be done to make better use of these providers.
- Good behavioral health access; network is now 7 years into development, with nearly 800 contracted providers. Also IEHP contracts with County Mental Health for care to the dual-eligibles. Looking to use e-consult to provide same-day BH consults in PCP settings.
- Access to specialty care is challenging; how do we develop that access? Plans provided sti-

pends to outside specialists to do part-time work in the IE. IEHP Board approved $10 million dollar fund for existing practices to hire more doctors and bring them into the area, helps fuel reasons for doctors to relocate to the IE, strengthen existing practices to recruit. We have managed to recruit 50 new doctors so far. It is very hard to retain doctors, even if they trained in the area. Working with Loma Linda to find ways to retain hard-to-get specialty doctors.

- How can we educate consumers about community clinics to ensure newly enrolled individuals make use of them? They are usually a one-stop shop for all key services. There's a false perception that there are fewer services at community clinics, instead there are more and they also provide many prevention services. When you need access to higher-level services, they have affiliations with other facilities to better coordinate care for their clients. Many IPAs do similar case management work.

Remaining Uninsured

- RU population significantly declined in IE's clinics and hospitals; however the Borrego clinics reported an increase in uninsured patient visits.
- Concerns about people who will decline to renew their insurance due to premium increases during third open enrollment.
- Price: Some people are dropping their coverage because their jobs started paying better, leading to a loss of subsidy; they feel like they are spending an unfair share of their new financial freedom on the costs of health care. The enrollee base in Covered California is largely on the low-end of the income spectrum; the high end will leave unless their affordability is improved.
- Immigration Barriers: mixed status families are often reluctant to take actions that their perceive could impact their residency status.
- Public hospitals: Emergency Medi-Cal is the main way to fund care for the undocumented. The waiver renewal will now offer a coverage system and funding for the uninsured through public hospitals. The waiver will put more responsibility on public hospitals to provide coordinated care, as opposed to reactionary care. The waiver's PRIME program offers a merit based payment system for care to the remaining uninsured, where money is rewarded on ability to prevent unnecessary use; points are awarded for preventative care and coordination that avoids heavy use; it places the emphasis on "value".
- Changing behavior: People who are newly covered are frequently still in a "reactive" care-seeking mode; they need to shift to a "proactive" approach that makes use of primary care.
- Coverage for the undocumented
    - Passage of SB4 calls for the coverage of undocumented youth under Medi-Cal. Currently enrollers should get children into emergency Medi-Cal since they'll automatically be shifted to full scope. A lot of education and outreach needs to be done to ensure families are aware that they can enroll, and that there is no danger of deportation associated with the enrollment.
    - SB10 will try to expand care to adults as well, but we need to work on developing a robust cost effective program to cover the rest of the uninsured undocumented (e.g. MyHealthLA).

Other Updates from IE Participants

- For brokers, the last quarter has been very challenging – many big enrollment programs coming up at the same time: Covered California open enrollment and renewals, small group renewals and Medicare open enrollment. These are all tough; having all these enrollments overlap makes no sense.
- The administration of these programs isn't efficient. There needs to be more dedication to program simplification. Community clinic and broker alliances could be a great way to improve local outreach and enrollment efforts

- Lack of education on how health insurance works keeps people from understanding and maximizing the value of their coverage.
- People transitioning from Medi-Cal to Covered California are suffering several month transition lags; Medi-Cal termination notices don't let people know they can promptly get on Covered California.

Los Angeles

Los Angeles County performed well during the first two open enrollments. Growth in Medi-Cal managed care enrollment over the period from December 2013 to July 2015 grew by 56.5%.[55] Enrollment in LA Care grew by 52%, and in Health Net by 66%. Both Medi-Cal managed care plans for Los Angeles County had average rankings on the Medi-Cal managed care HEDIS scores.[56]

Los Angeles reached 226% of anticipated enrollment for the first year's open enrollment in Covered California -- far lower than neighboring Orange and San Diego counties.[57] Los Angeles gained market share from 28.7% to 29.1% between year one and year two of Open Enrollment. The northern part declined in market share of new enrollments in year two from 12.7% to 12.1%; and the southern part grew from 16.0% to a 17.0% market share.[58] Premiums in Covered California for Los Angeles County residents were among the most affordable in the state.[59] Rate increases in Los Angeles were substantially less than the statewide weighted average of 4.0% -- 0.2% in Region 15 and +2.5% in Region 16.[60]

Los Angeles relies heavily on an extensive network of county and community clinics. The composition of community clinic visits in the Los Angeles region changed substantially between 2013 and 2014 in response to the ACA expansion. Medi-Cal managed care patient visits increased by 57.6%; Medi-Cal fee for service patient visits increased by 6%; their privately insured visits (includes Covered California) increased by 3.8%, and their uninsured patient visits fell by 28%. Non-profit clinics' bottom lines were $-1.35 per visit

How has the enrollment succeeded and what are the barriers to enrollment that need fixing?

- Administrative complexity is getting in the way of delivering care. Why is Medi-Cal so unbelievably complex for people who are already struggling in poverty? Simplification of the application process is really important.
- Simplify the administration of all the programs. Many clinics have patients who are still trying to get all the documents needed to complete their enrollment in Medi-Cal. If it was hard

[55] California Department of Health Care Services. Medi-Cal Managed Care Enrollment Reports (December, 2013 and July 2015) at *http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Enrollment_Reports/MMCDEnrollRptSep2013.pdf* and *http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Enrollment_Reports/MMCEnrollRptJuly2015.pdf*

[56] California Department of Health Care Services, Medi-Cal Managed Care Performance Dashboard at *http://www.dhcs.ca.gov/services/Pages/MngdCarePerformDashboard.aspx*

[57] Covered California, First Open Enrollment Period 2013-2014, Lessons Learned p. 69 at *https://www.coveredca.com*; Covered California, Executive Director's Report Open Enrollment Year 2 Update (March 5, 2015), Active Member Profiles (June 2015) at *http://hbex.coveredca.com/data-research/* Eight percent of Covered California subscribers with incomes between 138 and 150% of FPL are selecting bronze rather than enhanced silver; 17% of subscribers with incomes between 150 and 200% of FPL are choosing bronze rather than enhanced silver, and 33% of subscribers with incomes between 200 and 250% of FPL are choosing bronze rather than enhanced silver. Covered California Active Member Profile as of June 2015.

[58] Covered California Regional Open Enrollment Data (2015), Enrollment by Pricing Region, Enrollment by County

[59] Covered California Plans and Rates (July, 2015) at *www.CoveredCa.com*. In Region 15, the lowest priced bronze HSA plan is $153 a month for a 25 year old, $161 for the lowest priced bronze HMO, and $165 for the lowest priced bronze PPO. In Region 16, the lowest priced bronze HSA plan is $180 a month for a 25 year old, $150 for the lowest priced bronze HMO, and $179 for the lowest priced bronze EPO.

[60] Ibid. The lowest bronze fell by -2.9% and the lowest silver increased by 5.4% in Region 15 while the lowest bronze fell by -9.9% and the lowest silver by -4.5% in Region 16.

enough with citizen adults, imagine trying to get undocumented children with monolingual parents into Medi-Cal under SB 4.

- Coordination is key to making everything work; organizations need to move away from operating in silos. There is a much greater need to internally and externally coordinate enrollment efforts and the delivery of care.
- Molina, LA Care and Health Net have not seen ER spikes among their Los Angeles Medi-Cal membership.
- The ACA has had a major impact on the Department of Health Care Services' Medi-Cal managed care insured population. Originally, there were less than 100,000, now there are over 350,000. This has forced DHS to make sure there is timely access to care and make sure they work with patients to change their health seeking behaviors (staying in network, doing health assessments, not relying on the emergency room). DHS has focused on patient retention, making sure that patients are getting quality service. Patients overall seem to like their doctors, but their wait times are still very long. Patient retention is key to making sure that DHS can be a vibrant provider for its population.
- The payer mix at White Memorial is now up to 40% Medi-Cal, and down from 10% to 5% uninsured. Their Covered California patients are for the most part new to this model of insurance and need to be educated how to use it.
- Hospitals' bad debt and charity care is down 40% in Los Angeles based on the recent OSHPD data. Hospitals' Medi-Cal managed care volume is going up 42%, but newly insured patients are still accessing care through the ED, leading to an increase in ED volume. A lot of non-traditional Medi-Cal hospitals are seeing an increase in their Medi-Cal patients; some of these hospitals never had much Medi-Cal volume before.
- Lessons learned from Covered California. The newly enrolled population is very price sensitive: they are choosing the plans with the lowest monthly premiums, and many people have signed onto bronze products.
- We must work on better educating potential enrollees about their options so they understand the value of plan tiers and the important opportunities offered by enhanced silver.
- There was massive growth in the numbers of community clinic patients and the volume of services between 2011–2013, but the clinics' growth in patients and visits slowed between 2013 and 2014. However, many clinic patients experienced payer transitions into Medi-Cal managed care. LA community clinics went from 53% uninsured to 40% uninsured. Many are newly enrolled in Medi-Cal managed care; clinics went from a third of clinic patients with Medi-Cal to 51% of clinic patients with Medi-Cal. Two thirds of clinics' patient enrollments through CalHEERS ended up in the Medi-Cal program.
- Unlike the Bay Area, Los Angeles has a very large proportion of its population below the poverty level and therefore enrolled in Medi-Cal. Unlike the rural North, Los Angeles has a very high percent of county residents who are undocumented.
- Health Net participates in Medi-Cal managed care and Covered California, with many of its enrolled members residing in Los Angeles. We have seen a lot of back and forth movement (churning) between Medi-Cal and Covered California; we are working with the state to ease that transition.
- The expansion has greatly increased the Medi-Cal volume to 85% of total Department of Mental Health patients, with the majority of the remainder uninsured. The newly enrolled Medi-Cal population is different in its needs, compared to the severely mentally ill that DMH was previously responsible for. We need to develop infrastructure, need to improve capacity to make sure patients get access to care in a timely fashion, need to maintain safety net functions (emergency services, involuntary services, disaster response), and need to figure out how to better exchange data in the face of confidential barriers. We also have to learn to manage the interfaces with a large number of entities and payers in Los Angeles. ■