Lessons from the Medi-Cal Expansion Frontlines:

Supporting County Eligibility Workers and Certified Enrollment Counselors to Achieve "No Wrong Door"

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Executive Summary

Enrollment in California's health insurance program for low-income individuals, Medi-Cal, grew by 35% between 2013 and 2014 under the Affordable Care Act (ACA). This historic enrollment growth was bolstered by factors such as the implementation of early and strategic statewide efforts to maximize enrollment, collaboration between government agencies at the state and county level, the provision of foundation and federal funding to support enrollment efforts, and the commitment of frontline workers who assist with enrollment. However, barriers in the enrollment process remain.

This report is based on research conducted by a team of University of California researchers between November 2014 and May 2015 involving eight focus groups with county Eligibility Workers (EWs) and Certified Enrollment Counselors (CECs) in four California regions. Additionally, key informants from 26 organizations were interviewed. The purpose of this study is to assist counties, health centers, community-based organizations, the California Department of Health Care Services (DHCS), and Covered California in developing strategies to make the Medi-Cal enrollment process smooth, efficient, and timely for applicants as well as the workers that assist them.

EWs, CECs, and key informants who participated in this study reported that CalHEERS challenges have been the biggest barrier to smooth and timely enrollment. EWs reported that workload was too high to achieve the level of customer service and thoroughness that they desired. EWs and CECs also reported that some eligible applicants decided not to apply for Medi-Cal due to immigration-related fears, concerns about the state's estate recovery policy, and stigma associated with Medi-Cal enrollment. EWs and CECs reported not having sufficient information and support to efficiently and smoothly assist applicants with enrollment.

While all of these Medi-Cal enrollment barriers are crucial to address, this report focuses on the communication and training challenges because our study focused on the direct experience of EWs and CECs who comprise a substantial channel for enrollment. While challenges with CalHEERS continue to be a significant barrier for workers and applicants, this study was not designed to do a root-cause analysis of the technical challenges associated with enrollment.

Workers who participated in this study reported an ongoing desire for training and communication that is up-to-date, engaging, and reflective of real world examples—even after CalHEERS is stabilized. In brief:

- EWs and CECs identified a need for more training, delivered in regular, engaging, case-based instruction to improve their effectiveness and insure consistent implementation of eligibility policy. They especially desire modes of communication, beyond email, that allow them to keep up with the changing policy and IT environment, such as weekly capacity building sessions with supervisors or local experts, and centralized, up-to-date repositories of information, such as a frequently-updated FAQ or Wiki.

- They focused on a need for improved communication within and between DHCS and Covered California, and between counties and enrollment entities at the local level. They advocated for additional Medi-Cal training for CECs, increased communication between CECs and EWs, and phone lines and online resources to promote the timely and accurate dissemination of new policy changes and CalHEERS updates. They also asked for support from local "experts" in the form of supervisors or content experts who can attend centralized trainings and update workers at their office about changing policy or CalHEERS issues at weekly meetings, and function as resources to address questions between meetings.

- EWs and CECs need assistance in defining the limits of their responsibilities and identifying appropriate resources for applicants who have questions about ACA tax policy, immigration issues, and the Medi-Cal Estate Recovery Program.

- The combined Medi-Cal and Covered California application should be simplified to the extent allowable under the ACA.

- Eligibility determination should be clearly and consistently communicated to applicants.

- Written communication to applicants should be at an appropriate reading level and accurately translated.

- Enrollment of populations with Limited English Proficiency can be improved with increased community partnerships and more bilingual staff.

Efforts are already underway at the state and local level to implement some of these recommendations, and a number of modifications were already made to improve the post-ACA Medi-Cal enrollment system prior to this study. As the Medi-Cal enrollment system continues to evolve, the effectiveness of the strategies adopted should be evaluated. Involving frontline workers such as EWs and CECs in the implementation and continuing evaluation of the recommendations presented in this report will be critical to ensuring a strong Medi-Cal enrollment system.

Introduction

Enrollment in California's health insurance program for low-income individuals, Medi-Cal, has grown significantly since eligibility was expanded on January 1, 2014, under the Affordable Care Act (ACA). However, barriers in the enrollment process remain. Many of the barriers reflect the large size of the state and the significant numbers of newly eligible individuals, the variety of required modifications and changes within the Medi-Cal IT enrollment system, and the ongoing release of new policy guidance.

The purpose of this study is to assist counties, health centers, community-based organizations, and the California Department of Health Care Services (DHCS) in developing strategies to maximize Medi-Cal enrollment by making the enrollment process smooth and efficient for applicants as well as the workers that assist them. Another important audience is Covered California, the state's Health Benefit Exchange, given its involvement in Medi-Cal enrollment and its commitment to enrolling eligible populations in health insurance.

This report is based on research conducted by a team of University of California researchers between November 2014 and May 2015 involving eight focus groups with 62 county Eligibility Workers (EWs) and 39 Certified Enrollment Counselors (CECs) in four California regions: Bay Area, Central Valley, Los Angeles, and the Inland Empire (see Appendix A for details on study methods.) Additionally, key informants from 26 organizations were interviewed, including policy experts, advocates, health care providers, funders, government officials, and representatives from community-based organizations serving the immigrant community in California (see Appendix B). An advisory committee of stakeholders and health policy experts guided the design of this study and provided valuable input in the interpretation of results (see Appendix C).

In this report, we describe California's Medi-Cal enrollment growth under the ACA and the factors that supported that growth. We also outline the Medi-Cal enrollment system challenges and potential solutions from the perspective of EWs and CECs, who are on the frontlines of Medi-Cal enrollment. In particular, this report focuses on the need to support EWs and CECs with the real-time information and support they need in a changing IT and policy environment.

While EWs' and CECs' roles, scope of responsibilities, training, and experiences differ, participants in this study faced some common barriers in helping applicants enroll in Medi-Cal and they often had similar recommendations on how to make the enrollment process smoother and more efficient.

EWs and CECs are collectively referred to as "frontline workers" throughout this report in contexts in which their reported experiences were similar. EWs and CECs are referred to separately in contexts in which they expressed different barriers or recommended different solutions.

California has been a Leader in Medicaid Enrollment under the ACA

High enrollment numbers

A combination of early actions and proactive enrollment strategies has made California a leader in expanding Medicaid enrollment under the ACA. As of September 2014, approximately 2.2 million Californians who were newly eligible for Medi-Cal enrolled under the ACA.[1] These were primarily childless adults with income at or below 138% of the Federal Poverty Level (FPL), or $16,240 for a single adult in 2015, but also parents at certain income levels (between 109% and 138% FPL) who were not previously eligible. Approximately 810,000 California parents and children, who were previously eligible for Medi-Cal, were newly enrolled by September 2014.[2] It is likely that some of this growth would have occurred regardless of the ACA due to regular churning in and out of the Medi-Cal program. In total, over 3 million people enrolled in Medi-Cal between October 2013 and September 2014. This level of enrollment growth is historic. Between 1966 and 2012, Medi-Cal enrollment grew by 4% annually, on average. Between 2013 and 2014, Medi-Cal enrollment grew by 35%.[3]

Early and strategic efforts to maximize enrollment

An essential part of California's success was early implementation of the Medi-Cal Expansion through county-based Low Income Health Programs (LIHPs), which gave the state a head start on Medi-Cal enrollment under the ACA. Through a Section 1115 Waiver approved by the federal government, California received federal funds that matched county spending on coordinated systems of care for eligible low-income adults who enrolled in LIHPs starting in 2011. In California, 53 out of 58 counties participated in LIHP.[4] Approximately 650,000 Californians were transitioned from the LIHPs to full Medi-Cal coverage on January 1, 2014, under this "Bridge to Reform" program.[5]

Other new programs and initiatives have also contributed to increased Medi-Cal enrollment:

- **Hospital Presumptive Eligibility:** Under the ACA, California implemented a Hospital Presumptive Eligibility (HPE) program, through which more than 260,000 Californians have received temporary Medi-Cal benefits lasting up to two months since the program began on January 1, 2014. In the HPE program, individuals can immediately access health care services paid for by Medi-Cal after submitting a simplified application at one of 279 authorized hospitals.[6]

- **Express Lane Enrollment:** As of April 2015, approximately 200,000 Californians were enrolled in Medi-Cal as a result of the Express Lane Enrollment program, in which most individuals who are eligible for California's food stamp program CalFresh are enrolled in Medi-Cal without a separate eligibility evaluation.[7] The state was granted federal approval to implement this ACA option to simplify the Medi-Cal enrollment process.

- **Criminal Justice Enrollment:** At least three-quarters of California counties have adopted efforts to provide health coverage enrollment assistance to individuals being released from county jails or on probation, with the authority granted to counties under state law (Assembly Bill 720 [2013]). Many counties have used funds from Assembly Bill 109 (2011) to support their efforts.[8]

Streamlining of enrollment and renewal processes

California's efforts to implement the new enrollment and renewal policies and processes required under the ACA have also likely contributed to increased enrollment, though the findings of this study highlight that further work is needed to fully realize the goal of streamlined processes.

- More Californians are eligible for Medi-Cal under the ACA because asset tests are no longer used to determine eligibility for non-elderly individuals applying for Medi-Cal on the basis of income.

- The state developed a single combined application for Medi-Cal and Covered California, which is now available in 13 spoken languages and 12 written languages. Having a single application for both programs may be helping to direct applicants to the program for which they are eligible, but the length and the complexity of the application was identified by study participants as a barrier to enrollment, as discussed later in the report.

- California is using federal electronic data sources to confirm applicants' information, such as income and immigration status, when available, in order to determine eligibility for Medi-Cal at the time of initial application and renewal.

- Medi-Cal coverage is automatically renewed without the need to fill out any paperwork if an enrollee's continued eligibility can be confirmed using up-to-date information in the possession of the county human services department and available data sources, such as taxable income and household size.

Collaboration between government agencies, with stakeholder input

This historic health coverage expansion was bolstered by significant collaboration between government entities including the California Department of Health Care Services, Covered California, and the county offices responsible for determining Medi-Cal eligibility. DHCS and Covered California both have ongoing processes to solicit stakeholder feedback on the implementation of the ACA.

Human services departments in California's 58 counties are responsible for determining eligibility for and enrolling applicants in public assistance programs including Medi-Cal, CalWORKs (California's cash aid and services program), CalFresh (California's Supplemental Nutrition Assistance Program), and a variety of other programs. This county-based system, in existence since the Medi-Cal program began in 1966, allows each county to accommodate the demographic and geographic differences that exist across California. For example, county human services departments' structures, procedures, and capacities may vary based on the size of the population; whether the county is urban, rural, or suburban; or the languages spoken by applicants. This system also allows for horizontal integration between programs. When an applicant applies for Medi-Cal, they can also have their eligibility for other public programs determined.

Foundation and federal funding of outreach and enrollment efforts

Significant funding from California foundations in support of Medi-Cal outreach and enrollment contributed to high enrollment levels. The California Endowment (TCE) provided $26.5 million in funding for Medi-Cal outreach and enrollment efforts, which were matched by the federal government to total $53 million. This allowed for $25 million in grants to 36 counties to increase Medi-Cal outreach and enrollment efforts.[9] The other $28 million was used to temporarily pay Certified Enrollment Entities and agents a $58 fee per approved Medi-Cal application. TCE also funded $6 million in support for Medi-Cal renewals assistance activities, which were federally matched.[10] Blue Shield of California Founda-

tion (BSCF) provided nearly $2.5 million to help counties maximize enrollment in the LIHPs and to help the state and counties successfully transition LIHP enrollees to Medi-Cal. BSCF also provided more than $3 million in funding to support local and statewide ACA efforts to enhance outreach and enrollment. These foundations also provided additional funding for policy research that helped to facilitate and evaluate key elements of ACA implementation.

Committed frontline workers critical to high sign-up rate

The high level of Medi-Cal enrollment achieved is also a reflection of the dedicated efforts of frontline workers who assist Californians in understanding their coverage options and submitting their applications. Medi-Cal applicants rely heavily on enrollment assistance, especially in-person assistance. Six in ten new Medi-Cal enrollees who were previously uninsured had assistance in the enrollment process, according to a survey by Kaiser Family Foundation in the spring of 2014, after the first ACA open enrollment period. Of these, 31% relied on a county worker or an enrollment counselor in the community, 9% had help from a family member or friend, 8% were assisted by a Covered California representative, 4% had assistance from a health insurance broker or an agent, and 6% had help from someone else.[11] Among Californians who newly enrolled during the second ACA open enrollment period, approximately 40% who were newly insured in Medi-Cal enrolled in-person. The other most common enrollment channels were phone (22%), Internet (13%), and by mail (11%).[12] A recent survey of Medi-Cal eligible Latinos found that 51% would most prefer to enroll in-person.[13]

More inclusive eligibility policy

California has adopted more inclusive eligibility criteria for Medicaid than other states. Comprehensive Medi-Cal coverage is available to certain low-income Californians who are not eligible under the ACA or federal policy.

- **Deferred Action:** Under state policy, immigrants granted relief from deportation and work authorization through the federal Deferred Action for Childhood Arrivals (DACA) program are eligible for Medi-Cal if they are low income. If this federal program is implemented, parents granted Deferred Action for Parents of U.S. Citizens and Lawful Permanent Residents (DAPA) will be eligible for Medi-Cal.

Workers Involved in the Medi-Cal Enrollment Process

County Eligibility Workers: Approximately 22,000 county Eligibility Workers (EWs) employed by county human services departments assist Californians with their Medi-Cal applications, perform eligibility determinations, and conduct ongoing case management activities including annual renewals and processing changes if there is a change in life circumstances of the beneficiary (for example, changes in marital or employment status). Under state law, EWs have the sole authority to enroll applicants in Medi-Cal and other social services programs and assign applicants to one of more than 200 Medi-Cal aid codes, each with differing rules for eligibility. Determining eligibility and assigning aid codes is a complex process, requiring skill and extensive knowledge of the intricacies of California's Medi-Cal program. Of the EWs participating in this study, the majority (63%) had at least three years of experience with Medi-Cal enrollment. One out of five had more than ten years of experience.

The roles and structure of the EWs' work varies somewhat by county. EWs are generally based in county offices. In certain counties, some EWs are out-stationed in provider settings or in the community, where they play a unique role in being able to complete the enrollment process from start to finish and serving as a direct link between coverage and care. EWs may assist applicants in-person or by phone, process mail-in applications, process online applications, and/or serve more specialized roles. Some EWs focus on the Medi-Cal program, while others are cross-trained to enroll applicants in multiple programs, such as CalWORKs and CalFresh, as well as Medi-Cal. County EWs also assist in enrolling eligible individuals into insurance through Covered California; in some counties, a subset of EWs are assigned this role. As of May 2014, more than 8,000 county staff had been certified to utilize the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS), the IT system developed specifically for ACA-based Medi-Cal or Covered California enrollment.[14]

Certified Enrollment Counselors: As of June 2015, more than 5,000 Certified Enrollment Counselors (CECs) helped Californians understand the health coverage programs available and assist with their initial Medi-Cal and Covered California applications and annual renewals.[15] CECs were employed by Certified Enrollment Entities (CEEs), which include health centers, schools, community-based organizations, labor unions, tax preparers, and other organizations. In this report, we focus on CECs employed by health centers because they played a vital role in Medi-Cal enrollment. CECs have been an especially important resource for Spanish-speaking applicants, as 59% of CECs statewide speak Spanish.[16] To be certified through Covered California, CECs must complete a training program, submit to fingerprinting and background checks, and annually pass an exam to maintain certification.[17] Of the CECs participating in this study, the majority (64%) had assisted with Medi-Cal applications for two years or less, while 13% had more than ten years of experience.

Covered California's outreach and enrollment infrastructure has undergone significant changes recently. Beginning in July 2015, approximately 1,755 workers who are certified by Covered California to assist with applications became known as **Certified Application Counselors** (CACs). These CACs are affiliated with an organization that received one of 69 of Covered California's Navigator Grants, which will collectively award $10.3 million in funding between August 1, 2015, and June 30, 2016.[18] In the 2016 plan year, approximately 2,627 CECs are projected to continue to assist with enrollment through 446 Certified Application Entities (CAEs), although those entities will not be compensated by Covered California for their enrollment assistance activities. Covered California will continue to certify and train CECs and CACs. While participants in this study were CECs, the challenges they described and the recommendations they made also extend to workers with the new CAC title.

Certified Insurance Agents: More than 13,000 Certified Insurance Agents (also sometimes called brokers) help Californians understand their eligibility for health coverage and assist with purchase of private coverage or completing Medi-Cal applications.[19] While agents have historically focused on enrolling individuals in private coverage, agents are required to facilitate enrollment in Medi-Cal under their licensing agreement with Covered California. In order to become certified with Covered California, agents must have a valid license with the California Department of Insurance, complete a one-time Covered California training and online exam, and submit to fingerprinting and background checks.

Payment data suggests that agents have played a sizable role in Medi-Cal enrollment, with agents receiving $5.9 million in commissions through May 2015, compared to CEEs receiving $7.1 million.[20] Per-application payment for Medi-Cal applications ended June 30, 2015.

Covered California Call Center employees: Additionally, nearly 1,000 state employees working for Covered California Service Centers assist consumers with enrollment in Covered California, refer Medi-Cal eligible applicants to counties, and provide support for CECs, agents, and health plans.[21]

Hospital frontline workers: Thousands of frontline workers at hospitals help applicants enroll in temporary Medi-Cal benefits through the Hospital Presumptive Eligibility program.

- **Recent Legal Permanent Residents:** Even prior to the ACA, Legal Permanent Residents in California have been eligible for full Medi-Cal benefits regardless of how long they have held that immigration status, whereas under federal policy Legal Permanent Residents are only eligible for Medicaid after five years.

- **Undocumented children:** As soon as May 2016, low-income undocumented children will be eligible for full-scope Medi-Cal under state policy (Senate Bill 75 [2015]). Under federal rules, these children are only eligible for limited-scope benefits.

- **Pregnant women:** California enacted legislation (Senate Bill 857 [2014]) that goes beyond the minimum federal requirements by expanding eligibility for full-scope Medi-Cal coverage to citizen and lawfully present pregnant women with incomes at or below 138% FPL. This became effective August 1, 2015.

Some Medi-Cal Eligible Californians Still Face Enrollment Challenges

While California has been a leader in Medicaid enrollment under the ACA, focus groups with frontline workers revealed that a number of Medi-Cal enrollment challenges remain.

The ACA undertook a vision of "no wrong door," a system in which applicants can apply for health insurance through any enrollment channel or agency and seamlessly enroll in the program for which they are eligible. But that vision is not yet a full reality in California. Surveys of newly insured and uninsured Californians by the Kaiser Family Foundation indicate that the Medi-Cal enrollment process is difficult for some applicants. Among Californians who were newly insured through Medi-Cal in spring of 2014, 26% reported having difficulty with the enrollment process, 28% said it was somewhat easy, while 46% said it was very easy.[22] Approximately one third (37%) of Californians who remained uninsured in the spring of 2015 had tried to get coverage in the prior six months but failed to enroll. Of those, 20% tried to get coverage through Medi-Cal.[23]

Medi-Cal enrollment rates under the ACA have been high, but California's enrollment work will never be complete because individuals frequently move between sources of coverage including Medi-Cal, Covered California, and job-based coverage when their life circumstances change. For example, 21% of individuals enrolled in Covered California are projected to move to Medi-Cal or other public coverage within any 12-month

period due to a change in their eligibility.[24] California will continue to face an ongoing operational challenge in ensuring that individuals can enroll in the appropriate Medi-Cal program in a timely and smooth way, whether initially when they are reviewed for their eligibility or as a result of "churning," when they change coverage sources.

The enrollment challenges discussed in this report have varied consequences for applicants, depending on the specific challenges faced, the persistence of the applicant, and the level of assistance the applicant receives in pursuing enrollment. Some eligible applicants may remain uninsured after encountering difficulties in the enrollment process or having their application inappropriately denied. Others may ultimately be enrolled in Medi-Cal after delays. Others may enroll in Medi-Cal, but receive a lower level of benefits than they are eligible for, such as restricted-scope Medi-Cal or share of cost Medi-Cal, when they are actually eligible for full-scope benefits without a share of cost. Barriers to Medi-Cal enrollment could also affect Covered California enrollment levels and ease of enrollment because both programs rely on the same single application, California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS), and the same frontline workforce, and many applicants do not know whether they are eligible for Medi-Cal or Covered California when they apply.

CalHEERS challenges are the biggest barrier to smooth and timely enrollment

Under the ACA, a new statewide California Healthcare Enrollment, Eligibility and Retention System (CalHEERS) was launched in October 2013 as the system for real-time eligibility determination for Covered California. The system also preliminarily determines eligibility for ACA-based Medi-Cal coverage, at which point the case information is sent to the appropriate county to finalize. Counties use one of three Statewide Automated Welfare Systems (SAWS) to enroll applicants in Medi-Cal, CalWORKs, CalFresh, and other social services programs.[25] In addition, the Medi-Cal Eligibility Data System (MEDS) stores Medi-Cal enrollee information on a statewide basis. Interfaces have been developed between CalHEERS, SAWS, and MEDS.

Frontline workers reported that CalHEERS problems and gaps created significant barriers to enrollment. Due to the tight 15-month development timeline for CalHEERS, some functionalities were delayed beyond the start of the ACA in order to focus on implementation of more urgent functions. According to key informants, CalHEERS updates are still occurring in 2015 to address issues that were identified prior to program launch, and other needed fixes have been identified through use of the system. In nearly all focus groups, frontline workers reported that when a CalHEERS problem is fixed, other new problems are often unintentionally introduced.

A CalHEERS 24-Month Roadmap for IT changes has been developed and is being managed by Covered California and DHCS, in collaboration with the CalHEERS Project, the County Welfare Directors Association of California (CWDA), and SAWS.[26] The plan uses a rolling 24-month timeframe, and key informants estimated it could take at least three to four more years until all necessary updates are complete.

CalHEERS-related barriers have necessitated great effort and follow-up from some applicants in order to effectively enroll, and, in some cases, have resulted in eligible applicants remaining uninsured. Problems with CalHEERS and the frequent changes associated with fixing the system have caused significant frustration and increased workload for frontline workers and their supervisors.

The challenges with CalHEERS were identified by study participants and key informants as the single largest barrier to realizing smooth and timely enrollment processes. However, these problems are only discussed in this report to the extent they relate to communication and training. CalHEERS problems and recommended solutions are continuously shifting, making it difficult to include specifics about the status of the system given that our study findings reflect a single point in time. Comprehensively discussing CalHEERS problems is also outside the scope of this study because the study methods were not designed to capture detailed and accurate information about the IT changes under the ACA. Furthermore, it is difficult to disentangle which CalHEERS problems raised by frontline workers were a reflection of underlying issues with the system, and which were a reflection of the pervasive confusion and insufficient information that resulted from a system in flux.

High workloads were also a significant barrier for eligibility workers

EWs reported that workload was too high to achieve the level of customer service and thoroughness that they desired. While DHCS, counties, and researchers anticipated increased enrollment under the ACA, the 35% increase in Medi-Cal enrollment between 2013 and 2014[27] was

significantly higher than projected. Key informants reported that funding for county human services departments has been and continues to be insufficient to meet the high enrollment demands. Workload challenges due to higher than expected enrollment are compounded by CalHEERS challenges and the high number of applicants submitting duplicate applications.

Frontline workers want improved communication and training

Frontline workers reported not having sufficient information and support to efficiently and smoothly assist applicants with enrollment. The most widely reported and strongly expressed needs related to having real-time information and support to effectively enroll or assist with enrollment in a system that is still in flux, both in terms of policy guidance and IT systems changes. Frontline workers also want increased communication between EWs and CECs, greater clarity about what they can and cannot say to applicants (e.g., tax advice or immigration-related legal questions), and a desire for clearer written communications to applicants to reinforce frontline workers' counseling.

Applicants' fears and concerns sometimes hindered enrollment

Frontline workers reported that some eligible applicants decided not to apply for Medi-Cal due to immigration-related fears, concerns about the state's estate recovery policy, and stigma associated with Medi-Cal enrollment. We are unable to address these barriers in this report because the information gathered in this study was from the perspective of frontline workers who shared their impressions regarding the experiences of applicants; a study of applicants would be a more appropriate way to explore these issues.

Addressing all types of barriers will be essential to ensuring that Medi-Cal enrollment processes are smooth for workers and applicants on an ongoing basis. This report primarily focuses on the study findings related to communication and training, but also discusses other barriers identified to the extent that they relate to communication and training. Many of the barriers identified were interrelated. For example, the CalHEERS challenges increased EWs' workload. The high workload resulted in limited time for frontline workers to participate in training and review information about policy or system changes. Insufficient training and lack of clarity about their roles and responsibilities made some frontline

workers hesitant to directly address applicants' fears and concerns.

While the focus of this report is on Medi-Cal enrollment, the successes and barriers identified in this study may also be relevant to Covered California enrollment practices and policies, given the interweaving of the two programs under the ACA. Furthermore, applicants may be served by both programs over time, as their life and economic circumstances change. Too, some families are enrolled in both programs simultaneously since the income level for children to be eligible for Medi-Cal is higher than it is for adults. The ease with which applicants can enroll in either program can affect how ACA coverage programs are perceived in communities and how likely enrollees are to encourage other family and friends to enroll.

Systemic challenges underlie many of the barriers identified

Many of the barriers identified in the study reflect two underlying challenges. First, some of the complications result from the fragmented nature of the health coverage system established under the ACA. The ACA re-shaped and expanded Medi-Cal for most individuals under age 65 but generally maintained the existing rules and systems for Medi-Cal seniors and individuals with disabilities who are enrolled in Medi-Cal. The ACA created a new program of tax subsidies administered through Covered California and changed insurance market rules particularly for those with individually purchased coverage. Employer-based coverage continues to remain another pillar of the health system.

Under the ACA, an Exchange (Covered California in this state) is responsible for administering individual and small group coverage options, while a state Medicaid agency (DHCS in this state) administers the Medicaid program. DHCS and Covered California were responsible for jointly developing CalHEERS and creating a single application for coverage programs. Covered California plays an important role in Medi-Cal by referring applicants who apply through the Service Centers to counties for enrollment and by training CECs and agents who assist with Medi-Cal applications. However, funding sources for Medi-Cal and Covered California are separate. While the state agencies' missions overlap, they have different responsibilities and goals.

Secondly, some initial glitches and inefficiencies would reasonably be expected given the large scale of the

changes undertaken under the ACA, the number of people affected in a large state like California, and the short window for implementation. After a short 15-month development period for CalHEERS, the new IT system was implemented early in its development while known glitches were present in order to begin the ACA in California on time. Even as California had fewer computer problems than other states or the federal exchange, glitches in CalHEERS were much greater than anticipated. The complexity and short implementation timeframe also resulted in workers lacking sufficient training on changing eligibility policies and CalHEERS changes, and consumers not being fully aware of the new programs and enrollment processes in spite of a state-wide media education effort.

DHCS, Covered California, county human services departments, and enrollment entities have already begun addressing many of the barriers identified by this study. Remarkable progress has been made, but much work remains. Throughout this report, we outline solutions suggested by frontline workers and key informants, some of which may already be in the process of being implemented.

Training: The Challenges of Learning in a Changing Environment

County Eligibility Workers (EWs) and Covered California Certified Enrollment Counselors (CECs) in this study reported that high quality and up-to-date training and information resources are the foundation to successful enrollment of eligible Californians in Medi-Cal. Appropriate training and resources allow workers to apply policy changes quickly and ensure that the enrollment process for newly eligible populations is smooth and timely.

All study participants, including frontline workers and their supervisors, reported that EWs and CECs receive training prior to assisting with applications or enrollment. However, initial training varied widely between programs, locations, and regions.

- CECs reported that they are required to complete an initial web-based training of two days with annual web-based recertification. CECs described this training as insufficient to allow them to meet the enrollment needs of their local populations. As a result, CEC supervisors at some enrollment sites and community-based organizations designed supplementary trainings on topics relevant to the populations they served (e.g., immigrants, the elderly, etc.).

- County EWs generally receive about 12 weeks of initial training with a mixture of formal teaching, observing experienced EWs, and processing applications with on-the-job training support. The content and breakdown of this training varies based on the programs an EW will be working on (Medi-Cal, CalFresh, etc.) and the county in which they are working. At times, workers within the same county reported varying levels of initial training, but this may partly reflect changes in training practices that have occurred over time, since many of the EWs in the focus groups had been in their jobs for years.

Significant numbers of the frontline workers and key informants in this study reported that the training they received around the time of ACA implementation was of limited utility, as it became quickly outdated due to the frequent technical updates required to address the many problems with the statewide California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS), the Medi-Cal enrollment system that was launched at the beginning of the first ACA open enrollment period. The ongoing problems in the CalHEERS system continue to detract from the time workers can spend focusing on evolving Medi-Cal eligibility policy as well. In the absence of accessible, up-to-date, and relevant training, a lack of knowledge about or misinterpretation of federal

and local policy can lead to inappropriate Medi-Cal denials, loss of coverage, or enrollment in incorrect programs, such as restricted-scope or share of cost Medi-Cal when individuals are eligible for full-scope benefits.

It is important to note that DHCS, Covered California, the County Welfare Directors Association of California (CWDA), county human services departments, enrollment entities, and community-based organizations have all developed trainings and resources and made a number of efforts to support frontline workers with the information they need to assist with Medi-Cal enrollment under the ACA. However, our study findings suggest that frontline workers are not consistently receiving and/or absorbing that information due to the rapidly changing environment and competing demands for their time during the early implementation of the ACA.

Frontline workers emphasized that access to IT and policy information through training and other information sharing strategies can build their capacity to assist Californians in Medi-Cal enrollment. They also voiced that additional follow up training and updates about policy and IT are equally important to enrollment success given recent changes in Medi-Cal eligibility and enrollment with implementation of the ACA and the ongoing changes to CalHEERS.

Updating Training on an Ongoing Basis

Frontline workers identified the need for well-developed and up-to-date training on changing Medi-Cal policies and CalHEERS. The many technical problems with CalHEERS and the frequent updates to address those difficulties have made it particularly challenging for counties to ensure accurate and relevant training during the ramp up period. Compounding this problem, key informants report that at times counties have been asked to implement policy or IT changes quickly, leaving little opportunity for adequate training. One EW expressed her frustration with CalHEERS training given these limitations: "Part of the problem is the training that we received originally was in September and October of 2013 prior to everything going into effect. We have not been re-educated on all of the changes that have occurred." Similar challenges have arisen for CECs, with some noting significant, but not unexpected, changes in CalHEERS since the first open enrollment period. Given the evolving nature of these systems, all frontline workers advocated for a shift from annual or occasional training to weekly capacity building.

Using a Variety of Modes for Communicating Changes to Workers

Given the rapid changes in CalHEERs and shifting policy environment with the implementation of the ACA, it is necessary to develop strategies for disseminating important IT and policy updates to frontline workers. Across all focus groups, EWs and CECs reported that email was a particularly common strategy used for disseminating messages about IT and policy changes, but that email was ineffective due to the high volume that they receive daily and the competing demands for their time. Both types of frontline workers also reported that training and policy-related emails can be long and sometimes largely unrelated to the programs or populations with which they work. One frontline worker summarized how the volume of email can be overwhelming to the point of becoming paralyzing: "I feel like they send so many emails. And each email is urgent or important. So it becomes kind of not important." While email will likely remain a necessary channel of communication with frontline workers, given the frequency of CalHEERS changes and policy clarifications, workers reported that relying primarily upon email is not an effective method for disseminating training information and requested that it not be used as the sole channel for sharing rapidly evolving updates. Participants requested a wider variety of information dissemination strategies to fortify communication about important policy and IT updates.

> **"The trainings are usually coming very late or right before [a change] happens. So most of us are going into uncharted territories, every time a change happens." – CEC**

To support a wider variety of communication strategies with frontline workers and implement more frequent capacity building locally, CECs and EWs proposed that a local supervisor in each office could be responsible for processing information about updates and distilling the most relevant content for each site's frontline workers at weekly staff meetings. This supervisor could also act as a resource for workers with questions between weekly meetings. A few counties and enrollment sites reported piloting similar models successfully. Some suggested using this weekly meeting time to review challenging cases

that frontline workers encounter each week in order to focus training on the most relevant topics for each site.

These findings are consistent with a California Health-Care Foundation study involving focus groups with county Eligibility Workers in California in 2011 which found that "some workers said they find it hard to read written communications from the county on Medi-Cal rule changes. These workers preferred face-to-face and in-person communications." They also reported appreciating supervisors' efforts to distill information.[28]

Creating Consistent Policy Interpretation

Frontline workers report challenges with inconsistent interpretation and implementation of policies related to Medi-Cal enrollment. Workers cited examples ranging from how to count disability income to how to categorize populations permanently residing in the U.S. under color of law (PRUCOL). When asked how to improve the Medi-Cal enrollment process, one EW stated, "I think just for us to all have the same type of training and the same information all across the board because … [if] you don't know what to tell them, it's prolonging the process or the application for them." Workers reported that more timely and effective dissemination of changing policy information would better support their work. Workers report that it is often difficult to resolve differences in policy interpretation: "It's just we get different answers from everybody, depending on who you ask," one EW explained. Another frontline worker explained that misinterpretation of policies may be further complicated by limited written resources: "There is nothing in writing to really say, 'This is how it's supposed to be done.' It's kind of three months down the line, five months down the line, something comes up. It's a bulletin, emergency communication: 'Hey, go back in all those cases that you denied three months ago. Look at it again.'"

Achieving complete consistency of policy interpretation may be unattainable in such a large and dispersed system, but workers proposed a number of solutions that would help move the state closer to that goal. Workers proposed addressing this challenge by having content experts from each office or enrollment entity attend regular centralized trainings and disseminate information about policy changes to the other frontline workers at each site, which is already happening in some units and counties. Content experts could disseminate this information in combination with the weekly staff meetings that workers requested with their supervisors to remain abreast of IT and policy changes.

EWs and CECs requested centralized phone help lines staffed by content experts to further assist in providing consistent policy interpretation for frontline workers. Covered California established a Help Desk to address questions from CECs, but CECs reported being unable to reach content experts through this channel and instead are having their calls forwarded to general customer service representatives who could not answer their questions. Other CECs reported calling county Medi-Cal offices directly with questions and being frustrated by long hold times.

Frontline workers also proposed that DHCS develop a centralized, frequently-updated website that workers can reference when policy or IT-related questions arise; this might be structured as a Frequently Asked Questions (FAQ) page or a Wiki. For IT-related challenges, stakeholders interviewed for this study noted that it would be necessary to have answers organized by each of the three types of county IT systems (SAWS) in order to make it a relevant and useful resource for all counties. Covered California and DHCS have developed some tools for frontline workers including Job Aids, which provide detailed instructions on topics like filling in income in CalHEERS and uploading applicants' verification documents.[29] While these tools are currently available, they were not mentioned by focus group participants.

Key informants also expressed concern that these tools become outdated quickly due to the instability and continuous fixes in the CalHEERS system. Another existing resource is a DHCS-provided searchable database of All County Welfare Directors' Letters, which EWs can search to find past DHCS guidance on new or changed policies and procedures.[30] While improving the consistency of policy interpretation is important, achieving perfect consistency will be difficult given that tens of thousands of workers assist with enrollment across hundreds of enrollment sites, often facing a wide variety of applicant situations.

Creating Applicable and Engaging Training

EWs and CECs universally requested case-based training that addresses complex cases that will not yield automatic approvals. One frontline worker explained, "They're going to teach you the perfect stuff. And you come out in the real world, and there are no perfect cases in the real world." In particular, frontline workers requested that training include PRUCOL applications, applications with complex household structures, and applications with mixed immigration status households. Workers

advocated for a fully functional test environment where they can complete data entry for these applications from start to finish rather than watching a trainer present the application process. Most frontline workers expressed a preference for in-person training over online modules or webinars that are less engaging. "The training that's going on even now, it's all modules. It was better when you had a face-to-face, because you could ask questions," one worker explained. However, key informants in rural regions reported a preference for online training or webinars due to the considerable time and expense required for staff to travel to centralized training sites.

Closing Gaps in Knowledge

EWs and CECs reported that all frontline workers need additional training on several key topic areas. Some of these areas are new under the ACA, while others reflect existing policies that gained new importance under the ACA.

PRUCOL populations: Frontline workers reported a great deal of confusion about how to process applications for immigrants who are permanently residing in the U.S. under color of law (PRUCOL). Certain low-income immigrants, such as immigrants granted deferred action, those with asylum, or refugees admitted to the U.S. before a certain date, are eligible for full Medi-Cal benefits under a long-standing California state policy. The number of Californians who are PRUCOL greatly increased in recent years due to President Obama's executive action establishing the Deferred Action for Childhood Arrivals (DACA) program in 2012. The number of PRUCOL-eligible Californians increased further due to the Medi-Cal Expansion under the ACA which, under state policy, also applied to low-income individuals who are PRUCOL, beginning on January 1, 2014.

Many CECs and EWs reported misconceptions about immigrants with DACA not being a PRUCOL population, as well as the mistaken belief that PRUCOL applicants are only eligible for emergency Medi-Cal. One CEC reported incorrectly that, "I was told that they have to have a condition. A critical condition in order to be qualified." In some focus groups, EWs disagreed amongst themselves on the eligibility policy for PRUCOL. CECs and EWs also had variable knowledge about the immigration-related legal implications of Medi-Cal enrollment for PRUCOL populations. They reported being uncertain about how to report income for applicants that were previously filing taxes under a false social security

number or not filing taxes at all. One CEC reported, "We don't really explain about PRUCOL, because to be perfectly honest, I could not do a presentation about it, really. I just give it to the supervisor." The County Welfare Directors Association of California (CWDA) offers recorded webinars on DACA and Coverage for Immigrants on their website, which may be helpful in increasing CECs' and EWs' understanding about Medi-Cal eligibility policies for immigrants.

> "If I was Covered California, I would make sure that first my counselors are well-trained to begin with ... that we know our information, that we know how the system works, that we're not just barely doing the minimum to deliver our training.... And then make those trainings engaging, right? Person-to-person, have them practice hands-on, going through an actual application during the training session. I think that will be a great benefit." – CEC

Household determination for MAGI Medi-Cal: Under the ACA, eligibility for income-based Medi-Cal and subsidized coverage through Covered California is determined based on an applicant's Modified Adjusted Gross Income (MAGI).[31] MAGI, which is a measure of annual household income defined in tax law, is a new concept under the ACA. Another factor in determining eligibility, household size, is now also tied to tax law under the ACA. While federal regulations establish relatively similar definitions of MAGI and household size for Medicaid and Exchange coverage, there are some differences between the two programs in how those eligibility inputs are defined, which makes determining household size more challenging. Frontline workers reported struggling with how to correctly enter household size for applicants who have households that are not traditionally structured or not accurately represented by the number of household members on their income taxes. There was also confusion about whether or not adult children should be counted in the household. One EW explained,

"We were never really told how to figure out, like with [counting the members of] tax households…. We're kind of learning as we're going." Key informants noted that this aspect of the ACA is complex and that even professional tax preparers in the community struggle with it.

Tax implications of the ACA: Frontline workers reported frequently being asked about tax penalties for being uninsured under the ACA. They reported lacking clarity about who might be fined and if they, as workers, are allowed to counsel applicants about possible tax penalties for not enrolling in health insurance.

Medi-Cal Estate Recovery Program: Under state law, California recovers costs from the estates of certain deceased Medi-Cal beneficiaries. Costs are recovered from enrollees who were enrolled in Medi-Cal when they were age 55 or older, or were institutionalized at any age. Frontline workers reported that misconceptions and concerns about the Estate Recovery Program have led some Californians not to apply for Medi-Cal. Some workers reported limited knowledge about which populations are impacted by the Estate Recovery Policy and when the policy might be invoked. The state policy existed prior to the ACA, but it has received more attention under the ACA. This is likely due in part to the significant increase in the number of Californians who are eligible for Medi-Cal and subject to the Estate Recovery Program.[32]

Information on Medi-Cal Programs for CECs: In addition, CECs reported wanting more information about different Medi-Cal programs (such as full-scope versus emergency Medi-Cal, or share of cost Medi-Cal) and a greater understanding of how to determine eligibility for Medi-Cal based on MAGI. Some efforts are already underway to address this knowledge gap. The County Welfare Directors Association of California (CWDA) facilitated a training process whereby county employees in some regions partnered with local Covered California enrollment entities to create trainings in which EWs drew from their years of expertise in enrolling Californians in Medi-Cal to provide additional training for CECs. CECs described this approach as highly effective: "We actually have supervisors that will give a presentation for us. They will come for like two hours … and they're just such an excellent resource." Covered California and DHCS incorporated more information about Medi-Cal into their training programs for CECs and agents in the second year of ACA implementation.

Information on Covered California plans for EWs: Similarly, some EWs lacked knowledge about Covered California's plans and how to assist applicants who are not eligible for Medi-Cal, but who could be helped in enrolling in Covered California. This is particularly important as EWs frequently assist families in which the children are eligible for Medi-Cal and the parents are eligible for Covered California. This mixed program eligibility occurs in families with income between 139% and 266% of the Federal Poverty Level because the Medi-Cal eligibility threshold for children is higher than for adults. While some workers reported being uncertain of how to enroll an applicant in Covered California, several counties had specialized units that focus on Covered California applications, supporting health insurance enrollment for members of mixed status families.

Reducing Workload to Allow Additional Time for Engagement in Training

EWs and CECs both reported that high workloads made it difficult to complete follow-up trainings and read email updates. Key informants and focus group participants noted that investment in an expanded workforce will be needed to allow frontline workers the time for ongoing training while maintaining high-quality client services. The workload for frontline workers has been higher under the ACA due to the significant growth in enrollment and the CalHEERS challenges that can make many individual cases more time consuming.

EWs and their supervisors report that workload burden is further exacerbated because a separate application is generated in CalHEERS *each time* an individual applicant attempts to apply through the Covered California website—and many applicants make multiple attempts. Prior to the ACA, applications were completed through the county SAWS where duplicate applications were not possible. CalHEERS does not have any built-in checks to prevent duplicate applications from being generated. EWs advocated for implementation of a system to make it impossible to have the same social security number entered on multiple CalHEERS applications.

Until recently, the challenge of multiple applications was further compounded by county workers' inability to take "negative action" in CalHEERS to deny or discontinue Medi-Cal for any of several reasons, one of which was the presence of duplicate applications. At the end of July

2015 EWs' ability to take negative action was implemented (including for duplicate applications), however, EWs still cannot use negative action for certain types of discontinuances (such as failure to complete determination when an applicant fails to provide documents) until other systems changes are made.[33]

SUMMARY RECOMMENDATIONS

- Transition training from annual or periodic events to weekly capacity building sessions.

- Supervisors or local content experts lead weekly capacity building sessions and act as topical resources for frontline workers including reviewing actual challenging cases.

- Supervisors and content experts attend regular centralized training to improve consistency of policy implementation.

- Minimize the primary reliance on email for dissemination of policy or IT updates and establish alternative centralized communication channels, organized by SAWS, such as FAQ or Wiki pages which can be updated in real time with relevant policy and IT changes.

- Establish dedicated centralized phone lines for frontline workers from across the state to call with policy and IT-related questions, staffed by content experts, with IT assistance specific to each SAWS.

- Increase EW staffing to allow additional time to engage in training.

- Incorporate changes within CalHEERS that prevents the submission of applications for individuals with same social security numbers.

Supporting Workers: Assistance in Trouble-Shooting Challenging Applications

Medi-Cal Eligibility Workers (EWs) and Certified Enrollment Counselors (CECs) both reported needing additional support for problem-solving challenging Medi-Cal applications, which could be the result of CalHEERS problems, workers' lack of familiarity with an application type, or unusual circumstances in a particular application. Frontline workers proposed several strategies that would provide them with additional tools and assistance to process such applications. The strategies suggested in this section would complement the enhanced training frontline workers desire, which is described in the section on training.

EWs and CECs reported frequently encountering instances in which they were certain that an applicant was eligible for Medi-Cal based on the information submitted, but were unable to process the application or receive an eligibility determination through CalHEERS. In many cases, the barrier to approval was a result of problems in CalHEERS itself. Sometimes workers faced difficulties in submitting or being forced to restart ap-

plications as a result of a minor detail in an application that differed from the norm, such as an applicant having "1/2" in their home address. Other challenges included data being incorrectly entered into CalHEERS online by applicants or CECs, and outdated applicant information in CalHEERS. Workers' lack of knowledge or experience with different categories of applications also contributed to complications This was most commonly the case with PRUCOL applications, though workers provided several other specific examples of applications that were challenging because of the applicants' unique circumstances. Regardless of the specific problem with any one application, the strategies below can support frontline workers in handling new challenges as they encounter them.

Sharing Creative Solutions

Frontline workers reported spending a large amount of time identifying ad hoc "workarounds" to ensure that Medi-Cal applications were processed while CalHEERS problems are being fixed. The workers explained that

IT issues are addressed through formal systems such as "tickets" submitted to the CalHEERS Help Desk, but emphasized that these systems are overloaded and often slow. The applicants that frontline workers are seeing often have active medical issues or require ongoing medication which cannot be delayed while these tickets are being processed, leading frontline workers to create unofficial workarounds to get Californians the health care they require and for which they likely qualify. These ad hoc workarounds, distinct from the official workarounds that have been designed and sanctioned by CalHEERS or SAWS, are time consuming to develop and are typically informally shared and implemented. EWs in particular reported being torn between denying or delaying health care access for an applicant whom they identify as Medi-Cal eligible, or using an "unapproved solution" to move applications through the system. As workers develop these fixes, they reported feeling powerless to disseminate these strategies to EWs at other sites. One EW explained:

> "I think one issue is we're just workers, so we can only voice so much. And I have voiced it to the higher-ups, and they'll say, 'oh, yeah, we should do something about it,' but they never do. Because I can't email the whole county and go, hey, this is a fix for it, and they're going to be like, 'why do you email everybody?' So when I figure something out, I'll tell [my supervisor]. He'll tell me, 'we'll tell our unit.' But then that's only among us."

CECs and EWs expressed a desire for the ad hoc workarounds to be approved at a local or statewide level; this would allow them to assist applicants more quickly by using accepted processes. Key informants reported that more than 100 workarounds have already been approved. Some have been identified by CalHEERS and involve direct entries in CalHEERS by any approved user of its system (whether an EW, CEC, or other authorized user), while other workarounds are Medi-Cal specific and are thus approved for EWs only, and can be entered into the SAWS systems to be transmitted to CalHEERS. The workarounds are sent out by CalHEERS as part of release notes or by SAWS directly to counties. The existence or use of approved workarounds was not mentioned by focus group participants, indicating that not all workers are aware of the workarounds or where to find them. The frequently expressed desire for approved workarounds may reflect that the list is not as comprehensive or as available as workers would like.

CECs and EWs both proposed the creation of a centralized repository of frequently asked questions (including IT and policy issues), as well as a list of active IT "tickets." This repository could be added to and updated by DHCS and Covered California support staff. Frontline workers envisioned this as a reference where they could find "approved solutions" and see what problems DHCS and Covered California are in the process of solving.

> "Every week [at our site we] look at Covered California for updates, trouble-shootings, things on Medi-Cal, and then at our weekly meetings, we talk about our cases. We bounce off each other for help in how to advocate for patients, and look for ways to go around their loops and hoops that they have for us." – CEC

This repository could also be structured as a Wiki. On a smaller scale, some sites reported developing reference documents of the system workarounds and clarifications about eligibility policy that frontline workers had discovered through their work. These system and policy updates were also shared in weekly staff meetings to augment ongoing training at some sites. Additional information about strategies to optimize training for frontline workers can be found in the previous section.

Like EWs, CECs repeatedly expressed their desire to share new solutions and best practices with peers. Frontline workers reported that solution sharing is important as limited dissemination of information leads to different solutions being implemented at different sites, as well as duplication of time and effort in developing workable solutions. One EW explained that although her supervisor shared new solutions with their unit, "it's not consistent within the offices. It needs to be [shared] with the rest of the offices so we all know the process or what to do or what the problem is and how to fix it."

As discussed in the training section of this report, frontline workers want to have the option to contact a centralized call center with experts who specialize in CalHEERS and each SAWS. CECs also requested designated contacts at the county level that can be available to

answer Medi-Cal related questions. EWs and CECs also proposed having a "live chat" feature within CalHEERS to allow them to ask for assistance from DHCS or Covered California support staff. All of these channels of communication could be used to disseminate consistent solutions on a larger scale, through ongoing updates to phone support staff and on websites for each program.

Another troubleshooting strategy, which was implemented in some counties, was to develop a team of experts or problem-solvers who could take over challenging cases or become content experts in certain domains such as PRUCOL applications or changes in Medi-Cal determination related to the Affordable Care Act (ACA). One such team member explained, "We have freedom to do what we need to do to try to get these cases passed and exploring options…. A lot of times we've got to develop the steps. And that's my favorite part." These teams were often given license to create and implement IT or data entry solutions that were not permitted for use by other frontline workers. The County Welfare Directors Association of California recently established and published a list of liaisons available to troubleshoot immigrant applications at each County Medi-Cal office.[34] As an alternative to having specialized teams take over challenging applications, frontline workers proposed having experts available on site to assist EWs. Out-stationing EWs in the community was suggested as a way of assisting CECs. These resources might assist with managing challenges in CalHEERS, as well as filling knowledge gaps of frontline workers. Key informants were supportive of this strategy and cite the need to invest in these positions through state dollars, which can be federally matched up to a rate of 75% if the program meets certain criteria.[35]

Facilitating a Culture of Support

EWs and CECs identified opportunities to strengthen the institutional culture in such a way that frontline workers would feel enabled to get help with difficult applications. For example, some EWs reported feeling discouraged from seeking support from their supervisors. One EW reported that there is "something very important [in] how you get treated and get talked to by a supervisor." The EW went on to recall feeling challenged by his supervisor about his work efficiency when asking for assistance. EWs and CECs both reported that, due to the large amount of problem solving required in their jobs, they appreciated supervisors who partnered with them to identify solutions rather than those who see workers with questions as deficient.

SUMMARY RECOMMENDATIONS

- DHCS and Covered California expand approved IT "workarounds" for workers to use while IT problems are being fixed.

- Share approved IT "workarounds" and answers to questions about policy and eligibility with frontline workers through a variety of channels including:

  o centralized SAWS-specific call centers staffed with experts equipped to problem-solve in real time with EWs and CECs on questions related to CalHEERS, SAWS, Medi-Cal, and Covered California policy;

  o county contacts designated to respond to questions from CECs and CACs;

  o a live chat feature within CalHEERS also staffed with experts equipped to problem-solve in real time with frontline workers;

  o in weekly staff meetings throughout the state to assure greater consistency and scaling of solutions [see also the training section of this report]; and

  o a Frequently Asked Question website which is updated regularly by DHCS and Covered California.

- Assign a team of experts to handle or assist with challenging cases.

- Develop and maintain an up-to-date centralized repository to serve as a reference for CalHEERS-related questions and answers and provide a list of CalHEERS issues that have been identified and are in the process of being addressed.

- Foster a culture of support for problem-solving with frontline workers and their supervisors to facilitate identification and reporting of remaining CalHEERS issues and promote enrollment of eligible Californians in Medi-Cal.

Building Understanding: Increasing Communication between Frontline Workers

Both Covered California Certified Enrollment Counselors (CECs) and County Eligibility Workers (EWs) in this study expressed that they share the common goal of enrolling Californians in Medi-Cal and expressed a desire to build professional alliances, increase communication between workers, and increase transparency in the application process to promote the successful enrollment of Californians in Medi-Cal. Frontline workers' experiences with fragmented communication within and between systems and their proposed solutions are described below.

Building Alliances

While CECs and EWs are both working towards the common goal of getting Californians enrolled in health insurance, at times members of each group expressed frustration with perceived deficiencies in the level of efficacy, knowledge, and customer services skills of their counterparts, including CECs, EWs, insurance agents, and Covered California Service Center staff. At the same time, CECs and EWs were also frequently able to identify challenges the other groups faced that may have contributed to the problems. For example, one CEC reflected that the stress expressed by many EWs was likely due to their heavy workloads. EWs expressed frustration at receiving CEC-assisted applications that were incomplete or contained errors, but in some cases acknowledged that these problems might have been due to insufficient training or limited experience.

While some level of frustration was present in every focus group, overall CECs and EWs were committed to working together with all types of workers who assist with applications. An EW said, "Ninety-eight percent of the Covered California [CECs] I speak to are awesome. They're like, 'Help me. What do I look for? What do I do?' They're great. We all agree. It's a team. We're all on the same team. We've got to stop splitting it out." Increased education and contact can help to decrease frustration and build professional alliances. One CEC explained, "If we had more of a concept of what the steps are that the [EWs] are taking to get these cases approved maybe we'd be a bit more sympathetic for them." Training that includes information about the roles of different frontline enrollment workers and increases contact between EWs and CECs can increase collegial understanding and facilitate working together to enroll Californians in Medi-Cal, a point discussed further below.

Promoting Communication between EWs and CECs

EWs and CECs reported wanting a better understanding of other frontline workers' roles in facilitating the enrollment process. One EW explained that she would like to learn more about the ways that applicants are educated and referred through the Covered California Service Center: "I would like to find out how Covered California does more of their processing. I'd like to know more about what they do before they transition or refer a new client over to us. Maybe that would help us to get the person the care that they need because I think that there isn't enough communication between us right now."

Frontline workers also reported that it would be helpful to have direct contact with each other when transitioning cases from CECs to EWs or tracking cases after submission. While some CECs try to reach local EWs by phone, this is often challenging due to insufficient staffing and time constraints. CECs suggested having a dedicated contact person at each county's Medi-Cal office to answer general questions and facilitate communication between EWs and CECs, which is a system that is already in place in some counties. In one county, CECs were encouraged to use email to contact certain EWs. That county designated a specific list of topics which were acceptable for email questions to prevent EWs from being overburdened with email inquiries.

As an alternative to using phone calls or email, one EW noted the utility of a case comments field when transitioning cases between workers: "We have case comments [in SAWS], where we enter—we make any changes to a certain case, or we went in there. And I noticed that [CECs] don't have that." All participants agreed that a case comments field in CalHEERS that was available to and used by CECs, agents, and Service Center staff would allow them to explain unique aspects of challenging cases as they are transitioned to county EWs.

Reciprocally, EWs could note when cases are accessed and where they are in the approval process, allowing CECs to keep applicants informed about their application progress and help applicants gather additional required documentation. As an alternative, the case comments entered by EWs in SAWS could be duplicated in CalHEERS or made accessible to CECs, agents, and Service Center staff.

Increasing In-Person Contact between CECs and EWs

Direct in-person contact was also regarded among frontline workers as a strategy for improving the rate of successful completion of applications and for rapidly addressing delays in application processing. In some Federally Qualified Health Centers, county EWs and CECs work side by side in the enrollment process. "We have a county worker on our site. I don't know if you do. Because we're Federally Qualified. We have him there for the community. I can do an application on Monday for, say, somebody who just got out of prison. He's going to have Medi-Cal on Friday…. That's how fast it's going for us," one CEC explained. CECs reported that these out-stationed EWs, who might be at a site as little as once a week, were a reliable source of support to CECs in troubleshooting challenging cases and educating CECs about Medi-Cal enrollment.

Both EWs and CECs advocated for increased in-person contact in the form of Medi-Cal supervisors providing training to CECs about Medi-Cal enrollment. Such communication would likely benefit agents who are also involved in enrolling eligible populations. One EW, discussing application delays related to incorrectly entered data, explained, "We need to have more eligibility education with the Covered California [CECs]. I think it would streamline and make the process a lot easier for these customers who are getting so frustrated and just want to give up." In regions where EWs were providing training to CECs, this training was regarded as highly effective: "We actually have supervisors that will give a presentation for us. They will come for two hours … and they're just such an excellent resource."

Increasing Transparency in Application Processing

CECs in this study reported that applicants often return to them asking for updates on their application status.

To assist applicants with this request, CECs asked for increased transparency during the Medi-Cal application processing. In particular, some CECs expressed frustration with long phone wait times and discourteous answers to their questions when inquiring about Medi-Cal applications. CECs expressed a particular desire to have access to the cause of denials when applicants did not receive Medi-Cal. This would allow them to answer applicants' questions about denials, ensure that the denial was based on current and accurate information, and assist applicants in finding alternative sources of health insurance or health care. Key informants added that EWs often do not have access to application status information as a result of glitches in CalHEERS. In addition, respondents noted that the eligibility results can change when the same application is run through CalHEERS at different times.

> "If we had the capability to see the Medi-Cal system, and what's going on with the applications that haven't been called, that would be great. To have maybe even limited access, 'Okay, I see that you had a case that was denied. This is the reason why it was denied.' Now, we're not going to go and change things, but we can at least see what's going on." – CEC

Some suggested that the use of a case comments field in CalHEERS would allow EWs to communicate application status updates. Others proposed a "read only" access to the county system to allow CECs to track the application progress without the ability to edit the application, which would need to be developed within the constraints of privacy guidelines. This strategy has been piloted in Los Angeles County, where CECs had a special "dashboard" in the county's applicant enrollment website. Applicants in this county could grant CECs permission to view their applications, thus allowing CECs to track application progress, identify the EW assigned to each case, and review what additional documentation might be required. One CEC explained, "You do the application and it tells you where in the process they are. It will say

that it's docked in, it's already there, but it doesn't have a case worker. Then it will go up to pending, and then it will either go from pending to approved or denied."

Key informants noted that prior to the ACA, all three SAWS were equipped with a limited access feature allowing application assisters, similar to CECs, to track applications and document their interactions with Medi-Cal applicants. It is possible that these systems are still available and could be more widely utilized.

In addition, through the paper and online application process, applicants already have the option to choose an authorized representative who is allowed to see their application and talk with Covered California Service Center representatives or county Eligibility Workers about the application on an ongoing basis. Not all EWs and CECs may be aware of this option and the opportunities it allows.

Transparency in the Medi-Cal application process not only allows CECs to provide good customer service, it also has the potential to diminish the burden of applicant calls to county offices as CECs are able to field more questions and provide applicant reassurance. In addition, CECs reported that some applicants who become impatient with long delays in their application processing initiate multiple applications with other CECs or through the Covered California website, causing increased workload for EWs. In the case of the county that provides read-only electronic access, this system allowed CECs to see if an applicant had a Medi-Cal application pending or active Medi-Cal, likely reducing duplicate applications and providing rapid access to health care for those who were already enrolled, but who were unaware of their coverage status. All efforts at increasing transparency will be limited by instability or inconsistencies in CalHEERS which may cause delays or incorrect eligibility determinations.

SUMMARY RECOMMENDATIONS

- Counties and enrollment entities promote communication between frontline workers in the following ways:

    o Increase in-person contact through county-led trainings on Medi-Cal and Covered California for CECs and CACs;

    o Increase in-person contact via EWs out-stationed at community enrollment sites to process applications and help troubleshoot difficult cases;

    o Establish dedicated phone lines to allow CECs andCACs to reach EWs with their questions; and

    o Increase electronic contact through a case comments field in CalHEERS allowing CECs and CACs and EWs to communicate about applications.

- DHCS, Covered California, and counties increase transparency in the application processing steps and in disclosure of reasons that applications are denied by:

    o Encouraging and allowing all frontline workers to utilize a case comments field in CalHEERS;

    o Allowing CECs and CACs to have limited read-only access to county SAWS to monitor application progress, find out if an applicant has a pending case or active Medi-Cal application, assisting with uploading additional information, and reviewing the reasons for denial with an applicant, to the extent allowed under privacy guidelines; and

    o Promoting the county-wide use of the release of information waiver built into the Medi-Cal/Covered California application, thus allowing EWs and CECs/CACs to discuss cases with each other.

Clarifying Roles: CECs and EWs are Often Unsure about the Limits of their Roles and Responsibilties

All frontline workers in this study expressed a commitment to assisting eligible Californians in enrolling in Medi-Cal, but many reported wariness about the limits of their jobs. Some CECs reported struggling to help applicants understand their roles and the scope of their responsibilities overall. One CEC explained, "I don't like to be called social worker. I am not a social worker. This is what I tell them, like, 'I am not a social worker. I am just a connection between you and the Medi-Cal services or Covered California.… I am only the connection between the services and you as a member of the community. I don't work for Covered California.'" There are also some specific topics related to Medi-Cal enrollment that frontline workers reported they were reluctant to address with applicants due to perceived professional limitations, legal implications, and lack of resources to which they might refer applicants.

Both CECs and EWs reported reluctance to discuss the tax implications of the Affordable Care Act (ACA) though applicants frequently come in with tax-related questions and many key provisions of the ACA are based in tax law. One EW explained, "I saw an H&R Block commercial the other night where it was talking about what does the Affordable Care Act mean for your taxes, tax credits, tax rebates, all this kind of stuff. And [applicants are] asking us and we're supposed to have all the answers, but we're not tax professionals." Other frontline workers reported hearing about applicants who were misinformed by local tax professionals. For example, several frontline workers reported having applicants who were not eligible for health care plans under the ACA due to their immigration status, but who were incorrectly advised by tax preparers that they owed a fine because of their lack of health insurance. "Even tax preparers are making that mistake. I'm having a lot of people who are not documented coming in saying that they're being charged fines," one CEC said. Most frontline workers felt unable to advise applicants about these mistakes because they had been told by supervisors not to give tax-related advice. In guidance provided to counties, DHCS stated, "County EWs are not authorized to interpret tax rules or inform individuals about what constitutes taxable income, deductions or expenses. The Department of Health Care Services (DHCS) strongly urges counties

to remind their staff to refrain from providing tax information."[36]

Frontline workers also reported hesitance to talk with applicants about how they arrived at the Modified Adjusted Gross Income or household size on their income tax returns, despite the fact that these two numbers are critical to Medi-Cal eligibility. "All you can do is just take the number they say is their income, and you put it in. And you're not allowed to coach or ask questions or anything else. You just put the number in there because, if not, you're liable for it," one EW explained. While this is not the approach taken by all frontline workers, this sentiment was echoed by CECs and EWs at several sites.

Their perceived limits also constrained some frontline workers' willingness to address Medi-Cal eligibility and tax issues for PRUCOL populations, or those immigrants who are permanently residing in the U.S. under the color of law. One CEC reported concerns about assisting applicants who gained a social security number when they were granted DACA but had previously used false social security numbers to file taxes "because we don't want to get blamed." Workers should be trained to handle those applications like any other application for which income cannot be verified electronically, a situation that may occur for a variety of reasons. In general, when income or other eligibility information cannot be verified electronically, workers are instructed to request paper verification from applicants. Other frontline workers reported feeling that they are unable to help applicants identify whether they are eligible for Medi-Cal benefits through PRUCOL status. "It almost feels like, as a worker, you're providing a disservice to the applicant because you want to tell them, 'Look, this is what's in your best interest. If you check PRUCOL, you're going to get full-scope benefits.' But we can't tell them that. We can't coach them in any of that," one EW explained. One CEC summarized this sentiment as "You're their enroller, not their lawyer."

This hesitation extended to addressing questions from other immigrant applicants as well. Some EWs reported being told by their supervisors not to discuss immigration issues with applicants: "We're not supposed to give them legal advice." In addition, for applicants in mixed immigration status families, in which children are

eligible for Medi-Cal, but their undocumented parents are not, many frontline workers reported not referring Medi-Cal-ineligible parents to safety net health centers or county indigent health care plans. Some CECs, particularly those at Federally Qualified Health Centers, assisted applicants in connecting with these services, but some EWs in some counties reported that this fell outside of their scope of work.

Another area in which frontline workers reported frequently being asked to extend their services beyond their comfortable scope of responsibility was in discussions about the Medi-Cal Estate Recovery Program. While some CECs reported having a handout about the Estate Recovery Program, and some EWs reported having a hotline they could refer applicants to, others were unwilling to discuss the program beyond providing these resources to applicants. One CEC explained:

> "Everybody has a different perspective. So sometimes, I prefer to tell them, 'I prefer you to read it because it's your understanding.' I don't want them to come back to me and say, 'Oh, [she] said this and this and this.' It's very easy. They come back to you and they say, 'Well, [she] didn't want to do it,' or '[she] is the one who told me how to do it.' So I prefer to say, 'Listen, it's in Spanish. Just read it. Try to understand.' I just try to tell them I have to be neutral. I cannot advise you. I just don't advise. I have no problem with that."

In this case, the CEC reported referring applicants to a local legal aid clinic for additional advice, but most frontline workers reported lacking connections in the community for legal, tax, or immigration referrals. While there are natural limits of any role, frontline workers largely reported a lack of appropriate referral resources to help their applicants address the issues that they saw as outside of their role and responsibility.

SUMMARY RECOMMENDATIONS

Assist Medi-Cal applicants in obtaining the information they need while supporting workers in not exceeding the limits of their roles and responsibilities with the following strategies:

- DHCS and Covered California clarify workers' roles in advising applicants about immigration-related issues, and the Medi-Cal Estate Recovery Program;

- Counties and enrollment entities provide workers with information on community-based, legal services, or other organizations to which applicants can be referred when a topic is beyond the scope of workers' roles;

- Counties and enrollment entities work with community-based organizations to identify trusted resources for applicant referrals;

- Provide scripts for workers related to difficult questions or topics in order to help them understand what they can and cannot say;

- Establish a task force or committee to examine strategies for ensuring that applicants have the information they need to appropriately report their income for eligibility determination and understand the tax-related implications of enrolling in Medi-Cal;

- Develop and provide frontline workers with language and literacy-level-appropriate written resources to share with applicants who have tax-related questions; and

- Provide frontline workers with existing written and legal aid resources to share with immigrant applicants who have questions or concerns about the impact of applying for Medi-Cal on their immigration status, including the U.S. Immigration and Customs Enforcement memo on ACA applications and the fact sheet for immigrants jointly developed by Covered California and community partner.

Supporting Workers: Aligning Applicant Communications to Reinforce Frontline Workers' Counseling

County Eligibility Workers (EWs) and Covered California Certified Enrollment Counselors (CECs) both reported that communication barriers result in applicant confusion and frustration, and lead to increased workload for those assisting applicants.

Clarifying and Simplifying Applications

Under the ACA, states were required to develop a single application for Medicaid and subsidized coverage through the Exchanges to ensure "no wrong door" for applicants. DHCS and Covered California developed a single application process for Medi-Cal and Covered California which consumers can access through covered-ca.com or an alternative 36-page paper application.[37]

Frontline workers report that the new combined application is "very complicated" and "very intimidating" with "so many questions" that are laid out with small font, particularly on the paper application. This leads to many applicant questions and a high phone call burden for EWs. One explained, "The applications are very confusing. I agree. They need to make them not so lengthy and less confusing. I have so many customers calling me." One EW recalled that "The application we had before was ... very friendly. It was actually smaller [shorter in length], and it was for more people [in one household] than the application now. This one is like a book, and it's only for four people."

Some applicants were so confused by the new combined application that they were unaware which program they were actually applying for. This was particularly true for those applying through the Covered California website or Service Center, or using the single streamlined paper application. Frontline workers reported that some applicants believe "I have Covered California because my application is right there." Other applicants lack clarity about the required supporting documentation, such as tax household information or documentation required for income verification, increasing the casework for the EWs processing it.

To address these challenges EWs and CECs recommended streamlining the application. They also suggested overcoming applicant confusion by providing applicants with additional information about the differences between Covered California and Medi-Cal. CECs and EWs also acknowledged that some applicants might just require the direct assistance of caseworkers: "Many of them, their biggest challenge is right when they come into the office. They, some of them, don't know how to read and write. So it boils down to time, and taking the time to help them complete the Medi-Cal applications."

DHCS and Covered California have been soliciting stakeholder feedback on the joint application. This is an important process that should continue. However, the extent to which the joint program application can be simplified and shortened is limited by the information required to be collected by states and Exchanges under the ACA. The ACA requires different information for determining eligibility for Medi-Cal and premium tax credits, which contributes to the length of the application. For example, Covered California is required to ask whether an applicant for premium tax credits has an offer of affordable job-based coverage, but that information is not necessary for determining Medi-Cal eligibility. Efforts to clarify and simplify the application will also be bolstered by efforts to improve and stabilize the CalHEERS system.

Making Notification of Eligibility Determination Timely, Clear, and Consistent

Under federal law, Medicaid eligibility determinations are required to occur within 45 days of filing an application, except for applicants applying on the basis of disability for whom the required timeframe is 90 days.[38] Under the same law, the Medicaid agency must send the applicant a written Notice of Action (NOA) at the time that the application is processed, stating whether he or she is approved or denied Medi-Cal coverage and the reason for approval or denial.[39] Under a recent court order, DHCS is required to notify applicants for whom an eligibility determination has not been made within the 45-day timeframe of their right to appeal and request a hearing due to the delay.[40]

A typical NOA for Medi-Cal approval includes the first month of eligibility and the household size and income amount used to determine eligibility. When a Medi-Cal application is denied, the NOA includes the reason

for denial and information about an applicant's rights to appeal. However, the notices for new ACA coverage under Medi-Cal were programmed into CalHEERS, and the notices have been viewed in general as confusing to applicants and, at times, lacking sufficient information to explain to the applicant the reason for an action.

> "The correspondence they get. The way the notices of action are worded, the way the application is filled out, how to explain it. Just the information that is sent to them, that is something that I would change…. The language that's used. I mean, I'm [Spanish speaking] too. Sometimes I read the notices, and … I don't even understand." – EW

In addition, EWs and CECs reported that it is not always clear who is responsible for notifying applicants of eligibility determinations. In one county an EW explained, "The policy of the department right now is that CalHEERS sends out the notices.… But some notices go out and some notices don't go out. It's not consistent." In another county, a few EWs reported notifying applicants by phone about determination, while others in the same county did not think that they were responsible for notifying applicants.

Legislation passed in 2014 (Senate Bill 1341 [2014],) requires that all notices for Medi-Cal be generated in the SAWS, rather than in CalHEERS, to avoid these problems and streamline the process on the Medi-Cal side. SB 1341 is due to be implemented in early 2016. In addition to the changes planned under state law, DHCS solicited feedback from stakeholders on proposed changes to the wording of Notices of Action letters in April 2015.[41]

For some applicants, receipt of their Benefits Identification Card (BIC)—the Medi-Cal card—is the first notification of benefits that they get: "In reception, a client will come in and say they've received a card, but they don't know if they've got benefits or not because they got a card, but they didn't get any letter saying they got [Medi-Cal] or not. So it's the card that comes first." This likely resulted from a batch process in which some applicants

were provided Medi-Cal coverage using temporary aid codes in order to address a backlog of applications that occurred in 2014. Individuals assigned temporary aid codes received a BIC and a welcome packet, but not a NOA because their case had not yet been processed. These delays in notification about Medi-Cal enrollment can cause delays in care for applicants who have active medical issues; they are often eligible to receive services months before receipt of their BIC, but may not be aware of their eligibility.

In other cases, frontline workers reported that applicants are confused by multiple notification letters being generated by CalHEERS, a known issue that was partially fixed in July 2015: "Another thing that I see as a problem or confusion for the patients is they receive six or seven letters stating the same thing." Key informants reported that sometimes applicants receive notices with conflicting eligibility decisions. Covered California reported in June 2015 that "there is currently a technical issue that is creating more than one eligibility notice for individuals who qualify for Medi-Cal. Covered California, the Department of Health Care Services and county partners are working together to correct this technical issue."[42] The partial fix implemented in July 2015 reduced the prevalence of multiple notices, but did not fully eliminate this issue.[43] The implementation of SB 1341 in 2016 is likely to resolve the issue.

CECs and EWs reported that it is difficult for applicants to interpret their program eligibility from their notification letters. CECs reported that notification letters are particularly confusing for Californians who apply through the Covered California website. One CEC explained that these applicants

> "… come in super panicked because … whenever they send a letter to somebody saying that you're eligible for Medi-Cal, the letter says, 'Oh, you're not eligible for coverage.' But it says you're not eligible for Covered California health care…. People just shut down. They're like, 'You said I was eligible….' And I think it's the wording. Why can't the letter from Covered California say, 'Okay, congratulations. You're eligible for Medi-Cal'?"

In addition, EWs report that the type of Medi-Cal or health insurance an applicant is eligible for is not always clear:

"I've noticed that there's a wording issue between the Covered California letters that go out and the ones that CalWIN[44] sends out, because both of them refer to Medi-Cal and they're both talking about a completely different thing…. They're not eligible for MAGI [Modified Adjusted Gross Income], but they are [eligible] for non-MAGI. So you get a lot of calls where clients are confused as to whether or not they're actually approved."

For families with income between 139% and 266% of the Federal Poverty Level, in which children qualify for Medi-Cal while parents qualify for Covered California, the notification letters can be even more confusing as eligibility is listed or denied for each program and each family member, with some information in smaller font and less visually easy to identify or comprehend. Each of these situations then contributes to additional phone calls and in-person requests for clarification, placing a further burden on frontline workers.

EWs and CECs supported a plan for addressing technical problems that previously led to duplicate notification letters. They also advocated for a clear and consistent notification timeline in order toexpedite entry into care. Frontline workers suggested reformatting Covered California notifications: "I think they should just put what they're eligible for and not confuse them with everything." Others suggested beginning the notification letter by highlighting the programs for which the applicant is eligible. In addition, workers stressed the need to communicate at a literacy level that makes information accessible to applicants: "Everything we [SAWS] send out has to be at a fifth grade level … they [CalHEERS] are sending it out at college reading level."

Ensuring Materials and Application Support are Language-Appropriate

EWs and CECs reported that applicants with limited English proficiency (LEP) have particular challenges in communicating during the application process. While all of the sites in this study reported providing phone and at least some in-person, interpreting services, it remains challenging for applicants to get linguistically congruent information. For example, many of Medi-Cal and Covered California's written notifications are not appropriately translated according to frontline workers and key informants. "They are not written in the language for our clients to understand…. They are written in proper Spanish.… Clients do not speak proper Spanish" one EW reflected. Similarly, a CEC reported, "I saw Hindi and it's totally bizarre. I'm like, who translated that?"

Key informants also reported that Californians are not always receiving notifications in their preferred languages. In addition, the online application is only available in English and Spanish. A majority of EWs and CECs in this study report speaking Spanish with applicants, though CECs were more likely to report doing so. They also reported that it can be challenging to reach bilingual EWs: in one county, "the waiting time for a Spanish speaker is a lot longer than for Armenian or an English speaker." These barriers accumulate to create greater challenges for immigrant populations applying to Medi-Cal.

To ameliorate these challenges EWs and CECs suggested hiring more bilingual frontline workers, strengthening community partnerships to build trust with LEP populations, and improving the quality of translations in written documents and social media campaigns.

SUMMARY OF RECOMMENDATIONS

- Shorten and simplify the combined application for Medi-Cal and Covered California to the extent allowable under the ACA.

- Make it clearer to applicants that they are applying for both Medi-Cal and Covered California, for example by clearly labeling applications, websites, and notices as coming from both programs, and explain the differences between the programs.

- Ensure that all applicants receive a single written notification of their eligibility that clearly explains the program(s) for which members of the household have been determined eligible, written at an appropriate reading level. California is working towards this goal.

- Hire more Spanish bilingual frontline workers to ensure appropriate access for applicants with LEP.

- Strengthen community partnerships to build trust with LEP populations.

- Improve the quality of translations in written documents and social media campaigns in terms of literacy level, language translation, and health literacy.

Conclusion

Frontline Workers are Experts in Enrollment

The dedicated frontline workers for Medi-Cal and Covered California who participated in this study are all working hard to enroll eligible Californians in Medi-Cal, a task made more challenging given a surge of applications after the implementation of the Affordable Care Act (ACA) and the growing pains of an evolving CalHEERS system and changing eligibility policy.

This study focused on the expertise and experiences of frontline workers, including county Eligibility Workers (EWs) and Covered California Certified Enrollment Counselors (CECs), to identify successful enrollment practices and ways that DHCS, Covered California, and EWs' and CECs' supervisors can support frontline workers in being even more effective in Medi-Cal enrollment. Frontline workers are the foundation of the enrollment process. By drawing from their insights, we can improve the effectiveness of their work and promote the enrollment of Californians in Medi-Cal. Similarly, to ensure their continued success, frontline workers must remain involved in the implementation and continuing evaluation of all of the recommendations presented in this report.

EWs and CECs noted that CalHEERS problems are the single largest barrier to Medi-Cal enrollment. This issue has been widely recognized by other stakeholders as well. A number of efforts are underway to improve the system, but completing the necessary fixes and enhancements is at least several years away, according to key informants.

It is important that staffing levels adequately account for the extra time and resources needed to conduct enrollment activities while CalHEERS fixes are ongoing and while the number of duplicate applications remains high. Higher-than-expected Medi-Cal enrollment under the ACA also contributed to the need for greater staffing.

It is also important that training and communication strategies are designed in a way that allows workers to get the information they need in real-time while CalHEERS is in flux. Workers who participated in this study reported an ongoing desire for training and communica-tion that is up-to-date, engaging, and reflective of real world examples—even after CalHEERS is stabilized. Table 1, below, summarizes the recommendations of frontline workers in this study related to training and communication. In brief:

- Frontline workers identified a need for more training, delivered in regular, engaging, case-based instruction to improve their effectiveness and insure consistent implementation of eligibility policy. They especially desire modes of communication, beyond email, that allow them to keep up with the changing policy and IT environment, such as weekly capacity building sessions with supervisors or local experts, and centralized, up-to-date repositories of information, such as a frequently-updated FAQ or Wiki.

- They focused on a need for improved communication within and between DHCS and Covered California, and between counties and enrollment entities at the local level. They advocated for additional Medi-Cal training for CECs, increased communication between CECs and EWs, and phone lines and online resources to promote the timely and accurate dissemination of new policy changes and CalHEERS updates. They also asked for support from local "experts" in the form of supervisors or content experts who can attend centralized trainings and update workers at their office about changing policy or CalHEERS issues at weekly meetings, and function as resources to address questions between meetings.

- Frontline workers need assistance in defining the limits of their responsibilities and identifying appropriate resources for applicants who have questions about ACA tax policy, immigration issues, and the Medi-Cal Estate Recovery Program.

- The combined Medi-Cal and Covered California application should be simplified to the extent allowable under the ACA.

- Eligibility determination should be clearly and consistently communicated to applicants.

- Written communication to applicants should be at an appropriate reading level and accurately translated.

- Enrollment of populations with Limited English Proficiency can be improved with increased community partnerships and more bilingual staff.

Signs of Progress

As noted in the introduction to this report California has been a leader in Medicaid expansion under the ACA, with more than 3 million Californians newly enrolling in Medi-Cal in the first year of the ACA. This success was bolstered by early strategic efforts to maximize and streamline the enrollment process. DHCS and Covered California have continued to work hard to address many of the issues identified in this report including developing a 24-month road map for improving CalHEERS[45] and making adjustments to training programs in response to feedback.

Future Steps

The findings in this report shed light on additional opportunities for continued targeted strategies to promote enrollment of Californians in Medi-Cal. It will be critical to monitor which of these strategies are adopted and ensure ongoing evaluation of their impact, including soliciting regular feedback from frontline workers and their supervisors. One strategy could include creating and maintaining a repository of best practices, and comparing and contrasting counties that have adopted different strategies to identify those most likely to promote enrollment in light of the various issues faced in different parts of the state.

Since this study was conducted, Covered California's outreach and enrollment infrastructure has undergone significant change. CECs who are affiliated with Navigators, entities which receive grant awards from Covered California to provide enrollment assistance, will now be called Certified Applications Counselors (CACs). Workers who are affiliated with Certified Application Entities (CAEs), which will operate in an unfunded model, will continue to be called CECs. The temporary $58 fee provided to enrollment entities and insurance agents for each successful Medi-Cal application ended with applications dated June 30, 2015. Under this new model, it will be important to continue to gather CECs' and CACs'

input on the support they need to effectively assist with Medi-Cal applications.

In addition, it will be important to examine which Californians have newly enrolled in Medi-Cal and which remain eligible but unenrolled, and the reasons that those Californians continue to lack coverage. Data from the most recent California Health Interview Survey has become available to address this question quantitatively. In-depth interviews with eligible populations to further understand the barriers to enrollment would help provide a more comprehensive picture of those segments of the population most marginalized from the enrollment effort, even when they are clearly eligible.

Table 1 below summarizes the recommendations from frontline workers and identifies the agencies that might best assist in implementing these recommendations. In addition to DHCS, Covered California, and county Medi-Cal offices and community enrollment sites with CECs or CACs, community and state-wide partners can play an important support role in the implementation of these recommendations. Some of the recommended solutions may already be in place in some counties and enrollment sites, but have not been implemented consistently statewide. Other recommendations may be partially in place but frontline workers expressed a desire for further support or resources.

Organizations such as the County Welfare Directors Association of California (CWDA), Service Employees Union International (SEIU), and the California Primary Care Association (CPCA), along with regional clinic consortia and the health centers they represent, can provide ongoing guidance and feedback from local administrators and frontline workers on the effective implementation of these recommendations. Community-based organizations, such as immigrant advocacy groups and legal aid offices, can be referral resources for applicants and strengthen community partnerships to build trust among immigrant populations. These partners can also assist in education and outreach for applicants, promoting successful enrollment stories within each community.

One frontline worker summarized her experience helping Californians enroll in health care as follows: "Just being able to help someone … the emotion is sometimes so strong. At the end of the day, you know you helped this person. That's what I love doing. I made a difference in this person's life." California's EWs and CECs

are committed to helping the state maximize enrollment of eligible populations in Medi-Cal. Through their participation in this study they have offered guidance about how to best support them in their critical work. Their insights and reflections should be considered as instrumental in implementing the next set of system and process improvements, which should be evaluated and monitored carefully over time as Medi-Cal and Covered California continue to strengthen their efforts to increase the numbers of Californians with health insurance benefits and continue to improve the experience they have enrolling in coverage.

Table 1: Summary of recommendations organized by likely organizational level at which implementation would occur

Recommendation	Authority for Implementation
Statewide	
Increase EW staffing to allow for additional time for training and to accommodate increased workload	California policymakers via budget process
Create and staff a live chat feature within CalHEERS to assist frontline workers with real time problem-solving	DHCS, Covered California, and CalHEERS
Establish centralized call centers (SAWS-specific) for frontline workers to call with policy and IT-related questions and troubleshooting, staffed by content experts	DHCS and Covered California
Build web-based communications channels for CalHEERS and policy updates including FAQ pages or Wiki pages	DHCS and Covered California
Develop a SAWS-specific centralized repository to serve as a reference for IT-related questions and answers and provide a list of CalHEERS issues that are in the process of being addressed	DHCS and Covered California
Expand approved IT workarounds for workers to use while CalHEERS 24-Month Roadmap is being implemented	CalHEERS and SAWS
Encourage and allow all frontline workers to utilize a case comments field in CalHEERS	DHCS and Covered California
Allow CECs and CACs to have limited read-only access to county SAWS to monitor application progress, find out if a Medi-Cal application is pending or has been approved, assist with uploading additional information, and review the reasons for denial with an applicant to the extent allowable under privacy guidelines	DHCS, Covered California, and SAWS
Provide scripts for workers related to difficult questions or topics in order to help them understand what they can and cannot say	DHCS and Covered California
Establish a task force or committee to examine strategies for ensuring that applicants have the information they need to appropriately report their income for eligibility determination and understand the tax-related implications of enrolling in Medi-Cal	DHCS and Covered California
Develop and provide frontline workers with language and literacy-level-appropriate written resources to share with applicants who have tax-related questions	DHCS and Covered California
Simplify the application for Medi-Cal/Covered California to the extent allowable under the ACA	DHCS and Covered California
Revise written materials and media to appropriate literacy levels and with accurate translations	DHCS and Covered California

County or Local	
Implement weekly capacity building meetings between supervisors and frontline staff	County offices and community enrollment sites
Local content experts participate in weekly capacity building sessions and act as topical resources for frontline workers	County offices and community enrollment sites
Assign a team of experts to handle or assist with challenging cases	County offices
Identify and establish referral relationships with community-based resources for applicant referrals for tax information, legal aid, and immigration questions	County offices and community enrollment sites
Educate frontline workers about available written resources for applicants on tax information, legal aid, and immigration questions	County offices and community enrollment sites
Strengthen community partnerships to build trust with limited English proficiency populations	County offices and community enrollment sites
Expand EW-provided Medi-Cal training for CECs and CACs	County offices and community enrollment sites
Promote the use of the release of information waiver built into the application to allow EWs and CECs/ CACs to discuss cases with each other	County offices and community enrollment sites
Identify EWs or a dedicated phone line in each county office that can be a point of contact for local CECs and CACs with questions	County offices
State and County/Local	
Decrease reliance on email to communicate training updates to frontline workers, and replace with an alternative system for effective dissemination of information to improve standardization of policy implementation across the state	DHCS, Covered California, county offices, and community enrollment sites
Supervisors and content experts from each site attend regular centralized training to improve consistency of policy implementation	DHCS, Covered California, county offices, and community enrollment sites
More widely disseminate approved IT workarounds through a variety of channels	DHCS, Covered California, and county offices
Foster a culture of support for problem-solving between frontline workers and their supervisors to facilitate reporting of remaining CalHEERS issues and promote enrollment of eligible Californians in Medi-Cal	DHCS, Covered California, county offices, and community enrollment sites
Increase presence of out-stationed EWs at local community health centers or other enrollment sites with increased state investment	State policymakers and county offices
Educate frontline workers about their scope of responsibilities	DHCS, Covered California, county offices, and community enrollment sites
Ensure that determination notices are clearly worded and consistently sent to applicants	DHCS, Covered California, and county offices
Continue to increase the bilingual workforce to assist applicants and enroll them	DHCS, Covered California, county offices, and community enrollment sites

Appendix A: Methodology

Focus Groups

Focus groups were conducted between January and May 2015 across four regions of California: the Bay Area, the Central Valley, the Inland Empire and Los Angeles County. Participating counties were selected to represent urban and rural areas in different parts of the state and all three county Statewide Automated Welfare Systems (SAWS). Two focus groups were completed in each region, one with county Medi-Cal Enrollment Workers (EWs) and one with Covered California Certified Enrollment Counselors (CECs). EWs were recruited through county offices with union assistance in some regions. CECs were recruited via snowball sampling in regional clinic consortia. Eligibility criteria for participation included being a CEC or EW in one of the target regions, over 18 years of age, and being willing and able to participate in a focus group in English.

Focus groups lasted approximately 90 minutes and were conducted by experienced moderators who obtained verbal informed consent from each participant on the day of the study. Focus groups were held during work hours in local office conference rooms identified by the county or clinic consortiums as being convenient to the participants. A light meal was provided. When permitted by local management, participants were compensated for their time with a $30 Amazon gift card.

Participants completed a demographic questionnaire. Topics discussed in the focus group included: barriers to the Medi-Cal enrollment process, enrollment challenges for populations who are newly eligible for Medi-Cal or populations who historically have poor access to health care, and possible creative solutions to these barriers. Focus group recordings were professionally transcribed and thematic analysis was completed by two members of the research team.

Each focus group was preceded by a one-hour phone call with supervisors of frontline workers to hear supervisors' perspective on the questions asked during the focus group and to gather any region-specific background information that was helpful for the researchers to garner greater contextual knowledge prior to the focus group.

Eight focus groups were held with a total of 101 participants: 62 (61%) participants were EWs and 39 (39%) were CECs. Overall 74% of participants identified as Latino. As noted earlier in the report, based on statewide data CECs in this study are an important resource for Spanish-speaking applicants. A majority of EWs and CECs in this study report speaking Spanish directly with applicants, though CECs were more likely to report doing so. EWs were more likely to have been assisting Californians in enrollment for longer than CECs. While most participants were working in urban areas, CECs were much more likely to be working in rural regions than CECs in this study (26% vs 5%). The vast majority of CECs in this study were based in health centers, while the vast majority of EWs were stationed at county offices.

Key Informants

Key informants were interviewed by phone between October 2014 and April 2015 with individuals representing 26 organizations. Informants included policy experts, advocates, county administrators, health care providers, funders, government officials, and representatives from organizations serving the immigrant community in California (Appendix B). Interviews lasted approximately 30 to 60 minutes. Depending on the informant and the phase of the study in which the interview was conducted, questions were intended to: understand enrollment processes, enrollment channels, systems, and key barriers; validate and contextualize focus group results; describe existing resources; understand barriers for specific populations; understand how enrollment differed in rural regions in the state; and understand the role that hospital-based enrollment workers and Certified Insurance Agents played in Medi-Cal enrollment.

Validation of Findings

Following completion of these methods, the research team shared preliminary results with the study's Advisory Committee and other key stakeholders who provided feedback on the validity of the study's findings and overall consistency with their experiences with Medi-Cal enrollment. The study findings were also presented to the SEIU Eligibility Worker Industry Council, a statewide group of union members who perform eligibility work. EWs in attendance, representing at least seven counties around the state and a variety of job titles, provided feedback on the validity of the study's findings and added contextual details about some of the barriers and solutions identified through the focus groups.

Appendix B: Key Informants Interviewed

The following individuals participated in key informant interviews:

1. California Association of Public Hospitals: Jackie Bender

2. California Department of Health Care Services: Rene Mollow, John Zapata, Crystal Haswell

3. California Health Benefits Advisors: Phil Daigle

4. California HealthCare Foundation: Amy Adams and Catherine Teare

5. California Immigrant Policy Center: Betzabel Estudillo

6. California Partnership: Maribel Nunez

7. California Primary Care Association: Beth Malinowski

8. California State Association of Counties: Michelle Gibbons and Farrah McDaid

9. California Welfare Director's Association: Cathy Senderling-McDonald

10. Contra Costa County Health Services: Shannan Moulton

11. Covered California: Isaac Menashe and Jamie Yang

12. Educators for Fair Consideration: Jazmin Segura

13. Health Alliance of Northern California: David Lavine and Doreen Bradshaw

14. LA County Department of Health Services: Larry Gratton

15. Madera County: Dawn Fowler, Carolyn Spain, Jean Bounds, Alfredo Velarde

16. Maternal and Child Health Access: Donald Nollar and Celia Valdez

17. National Immigration Law Center: Gabrielle Lessard

18. North Coast Clinics: Tim Rine

19. Pacific Health Consulting Group: Bobbie Wunsch

20. PerryUndem Research/Communication: Michael Perry and Naomi Mulligan Kolb

21. San Bernardino County Human Services Department: Brian Pickering

22. San Bernardino County Medical Center: Ron Boatman

23. San Bernardino County Transitional Assistance Department: Elisa Miller

24. Service Employees International Union (SEIU) California State Council: Tia Orr

25. The California Endowment: Richard Figueroa

26. Western Center on Law and Poverty: Elizabeth Landsberg

Appendix C: Advisory Committee Members

The following individuals served on the Advisory Committee for this study, guiding the design of the study and providing valuable input in the interpretation of results:

1. Jackie Bender, Director of Policy, California Association of Public Hospitals

2. Crispin Delgado, Program Officer, Health Care and Coverage, Blue Shield of California Foundation

3. Betzabel Estudillo, Health Policy Coordinator, California Immigrant Policy Center

4. Richard Figueroa, Director of Health and Human Services, The California Endowment

5. Alvaro Fuentes, Executive Director, Community Clinic Consortium of Contra Costa and Solano Counties

6. Elizabeth Landsberg, Director of Legislative Advocacy, Western Center on Law and Poverty

7. Gabrielle Lessard, Health Policy Attorney, National Immigration Law Center

8. Beth Malinowski, Associate Director of Policy, California Primary Care Association

9. Tia Orr, Service Employees International Union, California State Council

10. Brian Pickering, Administrative Supervisor, San Bernardino County

11. Cary Sanders, Director of Policy Analysis, California Pan-Ethnic Health Network

12. Cathy Senderling-McDonald, Deputy Executive Director, County Welfare Directors Association of California

13. Anthony Wright, Executive Director, Health Access

Endnotes

[1] California Department of Health Care Services (DHCS), Research and Analytic Studies Division. Medi-Cal Statistical Brief: Medi-Cal's Historic Period of Growth, A 24-Month Examination of How the Program has Changed since December 2012. August 2015. This excludes the 5% of newly eligible individuals who are enrolled in restricted-scope Medi-Cal.

[2] These estimates reflect enrollment between October 2013 and September 2014. DHCS and Covered California. California Eligibility and Enrollment Report: Insurance Affordability Programs, for the Reporting Period October 2013 through September 2014.

[3] DHCS, Research and Analytic Studies Division, August 2015.

[4] All California counties participated in LIHP except Fresno, Merced, San Luis Obispo, Santa Barbara, and Stanislaus counties.

[5] DHCS. Medi-Cal Outreach and Enrollment Update. Presented at DHCS Stakeholder Advisory Committee. May 7, 2014.

[6] This reflects Hospital Presumptive Eligibility enrollment as of April 19, 2015. DHCS. Medi-Cal Enrollment Update. Presented at DHCS Stakeholder Advisory Committee. May 20, 2015.

[7] This reflects Express Lane Enrollments as of April 25, 2015. DHCS. Medi-Cal Enrollment Update. Presented at DHCS Stakeholder Advisory Committee. May 20, 2015.

[8] Californians for Safety and Justice. Health Coverage Enrollment of California's Local Criminal Justice Populations.

[9] The California Endowment. Press Release: The California Endowment and California Department of Health Care Services Announce Multi-Million Dollar Commitment for Medi-Cal Outreach and Enrollment. June 27, 2013.

[10] The California Endowment. "The California Endowment President and CEO Robert K. Ross, MD, Releases Statement on Key Legislation to Keep Children in School." October 2, 2014.

[11] Kaiser Family Foundation. Where are California's Uninsured Now? Wave 2 of the Kaiser Family Foundation California Longitudinal Panel Survey, July 30, 2014. Note: A third wave of the survey was conducted in Spring 2015 but survey results for this question were not reported in the more recent version of the survey.

[12] Kaiser Family Foundation. California's Previously Uninsured After the ACA's Second Open Enrollment Period. Wave 3 of the Kaiser Family Foundation California Longitudinal Panel Survey, July 2015.

[13] GfK for The California Endowment. Medi-Cal Expansion and Re-Enrollment Messaging Test Among Hispanics. June 2015.

[14] Covered California. Covered California Open Enrollment 2013-2014: Lessons Learned. October 2014.

[15] Covered California. Executive Director's Report. Presented at June 18, 2015 Board Meeting.

[16] Covered California. Executive Director's Report. Presented at June 18, 2015 Board Meeting.

[17] Covered California. Executive Director's Report. Presented at August 20, 2015 Board Meeting.

[18] Covered California. Executive Director's Report. Presented at August 20, 2015 Board Meeting.

[19] Covered California. Executive Director's Report. Presented at June 18, 2015 Board Meeting.

[20] Covered California. Executive Director's Report. Presented at June 18, 2015 Board Meeting.

[21] Covered California. Proposed Fiscal Year 2015-2016 Budget.

[22] Kaiser Family Foundation. Where are California's Uninsured Now? Wave 2 of the Kaiser Family Foundation California Longitudinal Panel Survey, July 30, 2014. Note: A third wave of the survey was conducted in Spring 2015 but survey results for this question were not reported in the more recent version of the survey.

[23] Kaiser Family Foundation. California's Previously Uninsured After the ACA's Second Open Enrollment Period. Wave 3 of the Kaiser Family Foundation California Longitudinal Panel Survey, July 2015.

[24] Dietz M, Graham-Squire D, and Jacobs K. The Ongoing Importance of Enrollment Churn in Covered California and Medi-Cal. UC Berkeley Center for Labor Research and Education Policy Brief. April 2014.

[25] The SAWS are Consortium IV (C-IV), California Work Opportunity and Responsibility to Kids Information Network (CalWIN), and Los Angeles Eligibility, Automated Determination, Evaluation and Reporting (LEADER).

[26] The 24-month roadmap is posted by DHCS under the meeting materials for the AB 1296 Stakeholder workgroups. See for example: http://www.dhcs.ca.gov/Pages/AB1296_Stakeholder_Meeting_4-17-15.aspx.

[27] DHCS, Research and Analytic Studies Division, August 2015.

[28] California HealthCare Foundation. Under Pressure: Front-Line Experiences of Medi-Cal Eligibility Workers. February 2012.

[29] Covered California. In-Person Administrative System. Accessed July 24, 2015.

[30] DHCS. E-PARC Search Center. Accessed September 20, 2015.

[31] Eligibility for individuals applying for Medi-Cal on the basis of categorical eligibility, such as being aged or disabled, continues to be determined using non-MAGI income definitions.

[32] By December 2014, approximately 560,000 Californians ages 55-64 enrolled in Medi-Cal under the ACA after becoming newly eligible. California Department of Health Care Services (DHCS), Research and Analytic Studies Division. Medi-Cal Statistical Brief: Medi-Cal's Historic Period of Growth, A 24-Month Examination of How the Program has Changed since December 2012. August 2015.

[33] DHCS. Medi-Cal Eligibility Division Information Letter No I 15-19, Overview of the California Healthcare Eligibility, Enrollment, and Retention System Release 15.7 Medi-Cal Program-Related Functionalities. August 3, 2015.

[34] CWDA and The California Endowment. County Contact List for Medi-Cal Assistance for Immigrant Californians. Accessed September 20, 2015.

[35] Centers for Medicare and Medicaid Services. Medicaid and CHIP FAQs: Enhanced Funding for Medicaid Eligibility Systems. August 2013.

[36] DHCS. All County Welfare Directors Letter 15-15. March 12, 2015.

[37] Covered California. Application for Health Insurance. Accessed June 15, 2015.

[38] These time frames can be extended under certain circumstances such as the when the county is working with an applicant to gather needed information.

[39] 42 CFR § 435.912(c)(3)(ii)

[40] Department of Health Care Services. Medi-Cal Eligiblity Division Information Letter No. I 15-11. Subject: New Noticing Requirements and Procedures under Rivera v. Douglas (2015). April 7, 2015.

[41] DHCS. NOA Changes in 15.7. Presented by DHCS at AB 1296 Stakeholder Meeting. April 17, 2015.

[42] Covered California. Covered California Notices to Consumers. Accessed June 15, 2015.

[43] Interview with County Welfare Directors Association, September 1, 2015.

[44] CalWIN is one of three Statewide Automated Welfare Systems used by counties to determine eligibility and enroll applicants in Medi-Cal and other programs like CalWORKs and CalFresh.

[45] The 24-month roadmap is posted by DHCS under the meeting materials for the AB 1296 Stakeholder workgroups. See for example: http://www.dhcs.ca.gov/Pages/AB1296_Stakeholder_Meeting_4-17-15.aspx.

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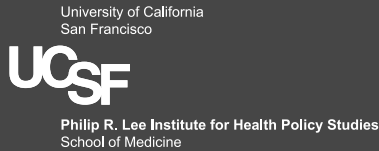
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