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Understanding and Preserving California's Network of Community-Based Outreach, Enrollment, Utilization and Retention (OEUR) Services

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Introduction

The purpose of this brief is to provide a snapshot of the status of community-based outreach, enrollment, utilization and retention (OEUR) services in California. This analysis aims to provide health coverage stakeholders, policy makers and implementation partners a closer view of the important role community-based enrollers play in supporting those who still remain uninsured and those who are insured but still face challenges. Although the Patient Protection and Affordable Care Act (ACA) was signed into law in 2010, implementation did not begin until 2014. In this brief, we offer findings from various data sources including local, statewide, and specific data such as the Children's Health Outreach Initiative (CHOI), California Coverage & Health Initiative (CCHI), and findings from the Covering Kids and Family Regional Meetings in order to:

- Provide a summary of the current landscape and trends for OEUR services; and
- Use the analysis to inform recommendations for further research, investment, and sustainability.

Background

The value of a strong network of community-based OEUR services cannot be understated. While the ACA has successfully reduced the uninsured rates in California, challenges still exist. The Los Angeles County Health Survey conducted in 2015 revealed that almost 25% of adults reported difficulty in obtaining medical care when needed.[1]

25% of adults reported difficulty in obtaining medical care when needed in Los Angeles County.

This does not take into account the difficulty in accessing care when enrollment applications are delayed due to processing. Additionally, given the current political landscape after the 2016 election, the future of the ACA is unclear and it has been forecasted that many of the achieved advancements could be derailed by the new administration's legislation to repeal the Affordable Care Act.[2] These advancements have positively impacted vulnerable populations and began to have an effect, albeit slight, on health outcomes as new individuals have started using care.

Whatever happens to the ACA, ensuring that consumers are successfully enrolled, their coverage remains continuous, annual redeterminations are processed correctly, and other troubleshooting needs are addressed, remain a priority. Therefore, it is important to understand the value of and identify ways to sustain a comprehensive set of OEUR services that address healthcare access barriers and provide a vital resource to thousands of struggling Californians. The California Coverage & Health Initiative (CCHI) polled their network of 35 local CHI's, which

215,956

Individuals assisted by CHI's in 2016

includes well over 35 leads of community based enrollment entities, and they reported that in 2016 the number of individuals assisted was estimated at 215,956.

Now more than ever it is critical to ensure that families have the security and protection that comes with continuous access to healthcare coverage and to address the ongoing challenges for those communities that remain uninsured. Access to care is the first step to improving health outcomes among vulnerable communities.

Over the years, Community Health Councils (CHC), in conjunction with two of its coalitions, *California Covering Kids and Families* (CKF) and *LA Access to Health Coverage*, has aimed to elevate the importance of California's network of community based enrollers. For nearly two decades, this network has supported low-income populations, mixed status families, and communities of color to access, use, and maintain their coverage. Inherent in the delivery of this work are multiple OEUR efforts that go under-reported, including many barriers underexplored and when known, require extraordinary efforts to mitigate. For example, a client's intention to enroll for coverage may actually be the entry point for additional needs and services (i.e., food, housing, mental health) for which extended counseling may be necessary.

CKF is a statewide coalition aiming to expand coverage and reduce barriers to enrollment in public health coverage programs so that all Californians have timely access to affordable, quality healthcare. More locally based, *LA Access* brings together and builds the capacity of organizations conducting outreach and providing consumers with enrollment and troubleshooting assistance for public-sponsored health coverage in Los Angeles County. Both of these coalitions serve as vehicles to identify, vet, and inform policies that impact the health coverage landscape. In addition to advocating for and being a convener of community-based enrollers, CHC has been an enrollment entity in South Los Angeles since 1998.

CHC, along with various partners has developed a series of policy reports and comment letters to provide federal and state decision makers with recommendations on how to design a Navigator program; the importance of utilizing community - based enrollers beyond enrollment, and the ways these enrollers have overcome multiple implementation glitches in order to ensure consumers receive healthcare. A list of key reports can be found in Appendix A.

Table 1: Enroller Demographics

Gender	
Male	14.0%
Female	86.0%
Age	
18-24 years	6.9%
25-35 years	38.1%
36-49 years	32.9%
50+ years	22.1%
Ethnic/Racial Group	
African American/Black	6.0%
Asian/American Pacific Islander	10.6%
Native American	0.0%
Caucasian	5.1%
Latino (a)	75.3%
Other	3.0%
Highest Education Level Completed	
Less than a High School Diploma	3.1%
High School Diploma	16.2%
Some College	33.3%
Associates Degree	9.2%
Bachelor's Degree	38.2%

Source: 2015 CPHA Conference Participant Survey

Community-Based Enrollers

A participant survey disseminated at the 2015 California Partnership of Healthcare Advocates (CPHA) Conference revealed characteristics of participating enrollers and although the data is not representative of the statewide networks, it offers findings from a cross-section of the participants. The following Tables illustrate resulting observations.

Who are the enrollers?

This report provides a snapshot of community-based enrollers and their invaluable role in the health system. It is informed by CHC's vast expertise and partnerships through CKF, *LA Access* and other collaborations. As noted in Table 1 and in this cross-sectional data, approximately 80% of enrollers report having "some college" or higher education, and in fact, 1 in 3 report having a Bachelor's Degree. Specifically, this finding points to an educated and highly skilled work force with the added asset of being culturally competent and relatable because they come from the community. They tend to be predominantly female and Latino and although enrollers largely fall within the age range of 25-49 years (71%), many of them are also over the age of 50 (22.1%).

The primary languages used to assist clients are English and Spanish, as only 10.6% of enrollers identify as Asian/Asian Pacific Islander. The demographics of the enrollers surveyed at the 2015 CPHA Conference reflect the demographics of those who are enrolled in health coverage. According to Covered CA, at the end of the 2016 Open Enrollment Period, Latinos constituted the 2nd highest percentage of enrollees (34%) behind whites (35.9%). Asian enrollees represented 19% of the Covered CA population. Furthermore, the Department of Healthcare Services (DHCS) notes that Latinos represent 48% of the Certified Eligible population in Medi-Cal, with whites at 20% and Asians at 13%. Based on the demographics of enrollers surveyed, it is evident that enrollers represent and can linguistically support the communities they serve. Additionally, Covered CA shows that 63% of Navigators and 59% of Certified Application Counselors speak Spanish, with just over 10% speaking one or more Asian languages.

CHC also conducted a review of relevant literature, utilized survey data collected from enrollers participating in the 2015 CPHA[i] bi-annual meeting, and information collected across six regional enrollment network meetings across California.

Where do they work?

As previously stated, enrollers come from the communities they serve, navigating and connecting clients with a variety of services to fulfill their healthcare needs. Overtime, this important role has been designated different names. They have officially been called Certified Application Assistants (CAAs), Certified Enrollment Counselors (CECs), Navigators and Certified Application Counselors (CACs). In the work setting they can have a myriad of titles such as Promotoras, Enrollment Specialist, Outreach Workers, Benefits Counselors, or Community Health Workers.

As seen in Table 2, enrollers can work in many settings: 43.3% indicated being employed at a community-based organization and 37.5% indicated

Table 2: Enroller Work Site

Place of Employment	
Community-Based Organizations	43.3%
Health Plan	4.0%
Clinic/Hospital	37.5%
School-based	3.6%
Faith-based	0.0%
Other	11.6%
Length of Time Providing Outreach and Assistance	
Less than 6 months	10.3%
6 months to one year	7.3%
1 to 3 years	33.0%
3 to 5 years	15.0%
More than 5 years	34.3%
Average Monthly Earnings	
$0-$1000	5.0%
$1000-$1500	11.5%
$1500-$2000	15.5%
$2000-$3000	39.5%
More than $3000	28.5%

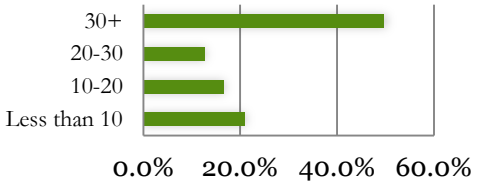
Source: 2015 CPHA Conference Participant Survey

[i] The CPHA conference is a bi-annual statewide conference for California's health coverage enrollment network including Certified Enrollment Counselors, Navigators, Community Health Workers, Promotoras, and other healthcare advocates. This is an initiative of the California Partnership of Healthcare Advocates (CPHA), a diverse network of healthcare advocacy organizations, clinics, health plans, non-profit organizations and public agencies.

being employed at a clinic or hospital. The majority have been helping the community for over 3 years; with over 30% at 5 years or more. Despite the fact that enrollers are educated, possessing at least some college, if not a Bachelor's degree (Table 1) over 70% make less than $3000 a month (36,000 annually). This is an indication of commitment to this work, despite the low wages.

What do enrollers do?

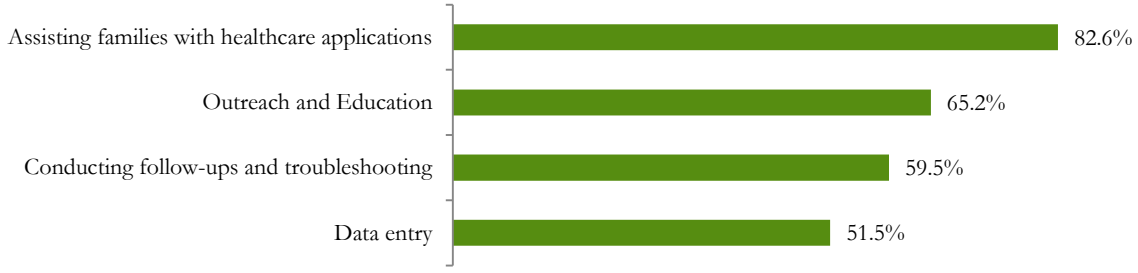
Figure 1: Hours per Week Spent on OEUR Activities



Source: 2015 CPHA Conference Participant Survey

The majority of enrollers (49.7%) spend more than 30 hours per week on OEUR activities (Figure 1) and often wear many hats, as can be seen in their various responsibilities as shown in Figure 2. The majority of their time, however, is spent participating in health fairs and community events (74%), outreach (78.3%), and above all assisting families with healthcare applications (82.6%). They facilitate health education sessions centered on topics such as prevention and wellness, public programs, and health reform. Approximately 50% reported participating in advocacy activities and often also engage their clients in advocacy (data not shown). Overall, the title of "enroller" may not be as inclusive nor truly reflect the varied roles carried on by this workforce.

Figure 2: Main Responsibilities of Enrollers



Source: 2015 CPHA Conference Participant Survey

How are enrollers trained?

According to the CPHA survey, enrollers receive health coverage training on a monthly or yearly basis (45.2% monthly, 45.7% annually). Most enrollers receive program updates/changes on a weekly (35.5%) or monthly basis (51.7%). Enrollers understand the importance of always receiving the most up-to-date information. However, the frequency of trainings for OEUR workers to match the ongoing updates across the state is inconsistent, posing challenges in ensuring that enrollers are prepared to support their clients with the most up-to-date information and training in the ever-changing field of health coverage policy.

Funding for Enrollers and OEUR Services

Over the years, a number of federal, state and private dollars have supported California's network of community based enrollers. Funding has ranged from grant-based funding to per

application reimbursement. The two main sources of funding (outside of private foundations such as The California Endowment and California Wellness Foundation) have been Healthy Families and Covered CA. Additional sources are provided in Appendix B.

Healthy Families & the Certified Application Assisters Program

While a number of pilot projects existed in California, it wasn't until 1997 through the State Children's Health Insurance Program (SCHIP) that a formalized state program began.[3] The Certified Application Assistant (CAA)[4] program certified agencies to become Enrollment Entities and their staff (called CAAs) were trained to assist with enrollment. These entities were reimbursed per successful enrollment (Healthy Families and Medi-Cal for Children) and Healthy Families renewal. By the end of the program Entities received $60 for those submitted online via Health-e-App system, $50 via paper, and $50 for cases sent to Medi-Cal during the Healthy Families Annual Eligibility Renewal.

However, reimbursements were trumped by several State Budget Cuts causing the funding to be eliminated several times until it finally closed in 2012. The program ran from 1998 to 2012 under the Managed Risk Medical Insurance Board (MRMIB) but was transitioned to the Department of Health Care Services (DHCS) during the Healthy Families to Medi-Cal transition.[5] At that point, DHCS encouraged all Enrollment Entities to enroll in the Covered California Enrollment Assistance Program.[6]

Covered California

Subsequent to Healthy Families, the federal government provided states with funds to establish and promote their marketplaces.[7] Covered California used funds to finance its Outreach and Education Grant Program. The program started in the fall of 2013 and was phased out in June 2015. States have implemented enrollment assistance under several categories from which Covered California benefited:[8]

- *Non-navigator Assistance Personnel- Certified Enrollment Counselors (CEC)*: This program ran from July 2013 – June 2015 and functioned much like the Healthy Families CAA program with a $58 reimbursement for every successful enrollment into a Qualified Health Plan and $25 for each renewal. Eventually, funding from the California Endowment (TCE to DHCS was used in part to provide reimbursements for Medi-Cal enrollment (through the Cal-HEERS portal only).
- *Navigators*: This grant based program began in September 2014 and has run through three cycles thus far. The role is similar to the CEC.
- *Certified Application Counselors*: This program is simply what the Non-Navigators transitioned to beginning July 2015. No reimbursement is received.

While there has been consistent funding for OUER services for nearly two decades, full funding for the comprehensive nature of these activities has been limited. Furthermore, detailing the actual costs of these services has not always been easy. Most available data is framed from the perspective of the state agency overseeing the coverage program (i.e. Medicaid). California, for example, had the highest CHIP enrollment rate in the country at 19.3 percent, covering children whose family income is up to 321 percent of the federal poverty level. Partnerships with schools, community-based organizations, and electronic outreach entities were among the strategies. CHIP spending is tied to program enrollment. In 2013, national CHIP spending per child enrolled at any point during the year was $1,419. Most states

spent between $1,000 and $3,000 per child. In California the range is $750-$999. Clearly, there is diversity of CHIP programs—both with respect to eligibility and benefits, which is why the costs vary.[9] In states where enrollees must prove constantly that they are eligible, very easily the cost is associated with the administration activities.[10] However, the cost of delivering enrollment in health insurance services is less known due to the inherent complexity of the time spent by enroller per enrollee, as stated previously. In 2005, researchers estimated that First 5 California matched local CCHI efforts by $1 per every $4 on premiums for children 0-5 years of age. In 2005 there were 9 CCHIs in operation that had raised $330 M to fund their programs (84% to subsidize premiums and the remainder for administration, outreach, and enrollment).[11]

To further add to the difficulty of determining the actual costs of enrollment is the complexity of situations presented by those who have been enrolling in coverage since the launch of the ACA. These include those with pre-existing conditions, homeless, and the recently incarcerated. All of whom require additional time to address their coverage eligibility and inherent complex needs. In fact, during these last few years, enrollers have had to engage with potential eligible enrollees in locations they may not have accessed before such as homeless shelters, work source centers or re-entry agencies. These complexities will continue to grow as our nation's social and economic supports are further eroded by the current decisions at the federal level.

Making the Case for OEUR Services

OEUR services are comprehensive and have been defined[12] as:

Outreach – The dissemination of basic information regarding program eligibility and benefits and/or any activity leading to direct contact and identification of potentially eligible children and families. This includes the use of educational materials, presentations, in-reach to an organization's existing client/member base or the out-stationing of County Eligibility Workers or Assistors/CAAs at points of service within the community and schools.

Enrollment – Step-by-step assistance provided to families in completing one or more applications for health coverage. This includes assessing eligibility; reviewing and gathering required documentation; troubleshooting after submission of an application on behalf of the family' following-up to ensure successful enrollment/approval; and providing post-enrollment assistance with selecting health plan/provider.

> The actual enrollment of the applicant into the program and activities associated with the verification of enrollment including follow-up with the applicant and program to ensure receipt of all required documentation.

Utilization Assistance – Follow-up activities multiple times from pre-application through acceptance to assist the family members with selecting health plan / provider, as well as trouble-shooting utilization issues, and conducting advocacy on behalf of client to maintain their health coverage over time, including assistance with annual redetermination.

Redetermination/Renewal Assistance – Activities employed to encourage families to use healthcare services once enrolled. This includes assistance accessing services, setting appointments, changing health plans/providers and encouraging appropriate use of preventive services. **Redetermination and renewal assistance aid in the retention of enrollees.**

As already mentioned, OEUR services function to ensure that children and adults can access and utilize healthcare coverage, as well as retain coverage even through eligibility status changes. Over the years, enrollers have proven their ability to successfully provide OEUR services. A 2011 report by the California Children's Health Initiative (CCHI) found that review of

community-based outreach and enrollment research "demonstrates that well-trained people who understand the local community context and can walk applicants through complex enrollment processes are extremely effective in increasing enrollment and retention in health insurance programs."[13]

OEUR entities have always been extremely important in providing assistance for enrollment.

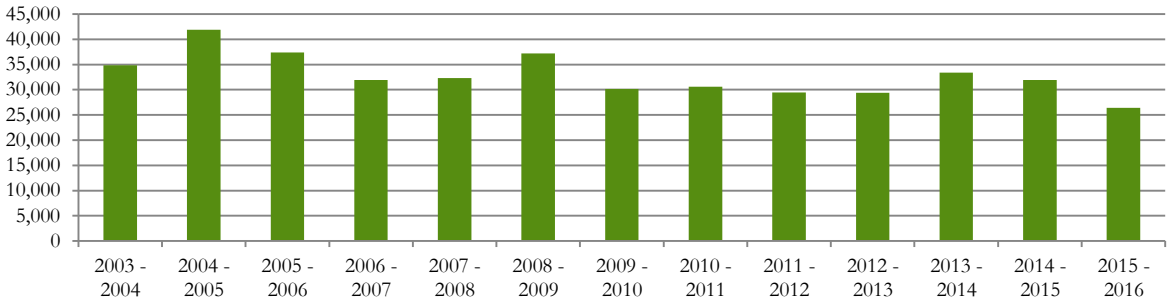
- In 2011, of the 212,102 joint applications processed for Medi-Cal and the Healthy Families Program, 75,684 (36%) were processed with the assistance of a Certified Application Assistant (CAA) of the 102,855 applications submitted using the online Health-e-App system, almost half (45,283) were submitted by a CAA.[14]
- In 2014, Covered California certified more than 6,000 Certified Enrollment Counselors (CECs),[15] who in turn enrolled 339,000 individuals during the first ACA open enrollment period, of which 68% were enrolled in Medi-Cal and 32% were enrolled in Covered California.[16]

A local example of the vital role played by OEUR entities can be found through the Los Angeles County Department of Public Health Children's Health Outreach Initiative (CHOI). From July 2003 to December 2016 CHOI enrollers assisted a total of 432,287 children ages 0-18 and pregnant women with an application for healthcare coverage.[17] A year-by-year breakdown of children enrolled with the support of CHOI enrollers can be found in Figure 3. Coverage programs for children have changed and evolved during the last 13 years (i.e. Healthy Kids 6-18 open, then closed; Healthy Families transition to Medi-Cal; Healthy Kids 6-18 closing and My Health LA for kids opening; Kaiser CHP ever-changing open enrollment periods; Covered CA and Medi-Cal expansion for family members; SB 75 Medi-Cal Expansion; Healthy Kids closing enrollment; and MHLA closing enrollment). The need for application assistance has been consistent, and CHOI OEUR workers have been there, assuring families through all these changes and helping them apply, enroll and retain coverage.

Figure 3 depicts the trends in new applications among consumers. While the vast majority of new applications are for new clients, some of these are also *new applications* for existing clients. For example, if an old client came in, for whom CHC submitted an application some years ago, but that health insurance had lapsed or the client became ineligible, and CHC assisted the client with a new application and submitted that application, then that would be considered a new application. Thus, Figure 3 is *new applications*, *not new unique clients*. Renewals of applications whether for existing clients or assistance with renewal applications for Non-Agency clients, are not included in this Table.

* Through 12/5/2016

Figure 3: New Enrollment Applications, CHOI 2003-2016*



Source: Los Angeles County Department of Public Health (2016) Children's Health Outreach Initiatives Database, December 2016.

Annually, on average 82.4% are successfully confirmed enrolled and during this same period CHOI enrollers assisted with over 300,000 issues, including:

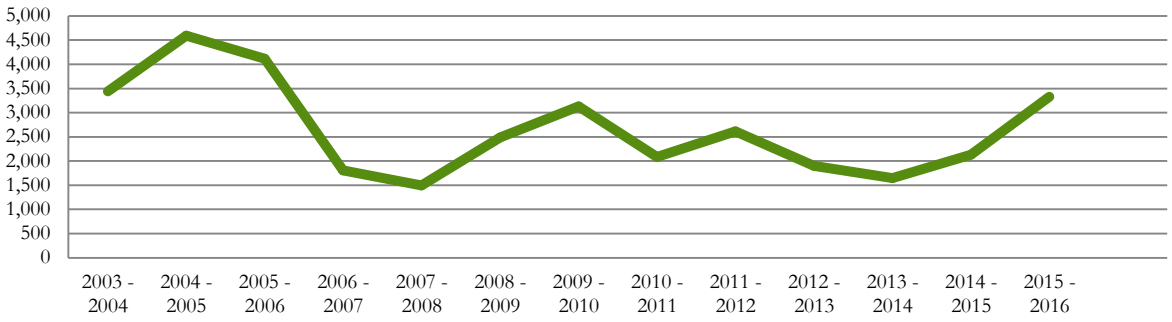
- Post application - i.e. applications were not received by the state or county, documentation problems, not knowing application status;
- Utilization barriers - i.e. access/provider problems, inability to pay, incorrectly billed, treatment denied; and
- The redetermination/renewal process - i.e. help completing renewal forms, resolving renewal issues with the program.

Although most enrollers can complete an application within 30 minutes, a significant amount of time is spent troubleshooting system errors, or post-application follow-up. The demand for additional assistance after enrolling in coverage is not just a California phenomenon. A July 2014 Kaiser Family Foundation survey revealed that 90% of navigators had been contacted by consumers for troubleshooting issues related to enrollment, utilization, and access. Anecdotally, CHC has found that with the multiple system updates and changes in policies, filling out applications can be problematic, especially when sites are experiencing technical difficulties on a regular basis. This is despite enrollers staying current with information, as mentioned previously.

Aside from the challenges to enroll in healthcare coverage, accessing healthcare is still a barrier. In 2015, an estimated 24% of Los Angeles County adults reported that obtaining medical care when needed is "somewhat or very difficult."[18] CHOI data collected by Los Angeles County Department of Public Health show that from 2003 until December 2016, over 36,000 applications had issues related to utilizing their benefits.[19] And, approximately 130 applications had problems with hours, location, language, transportation, or not having a provider available.[20] Overall, utilization-based issues represented 7% of application issues.[21] Figure 4 depicts the trends in application issues related to utilization of benefits. Although the data (Figure 4) indicates that utilization issues are least prominent when compared to post-application, post-enrollment and redetermination issues, it is important to understand and address utilization related application problems. Then, we can begin to connect the dots that enrollment into health coverage does not equate access to healthcare services.

The utilizing benefits trend has had an upward climb since the implementation of the ACA with Medi-Cal expansion and enrollment into Covered CA. This shows that as more people have coverage, *maybe for the first time*, and have difficulties navigating the complex healthcare system, utilization and access issues are also on the rise; higher than they've been at any point in the last 10 years. In part, this knowledge is available now because for the first time enrollers are able to record and document the issues and barriers. For example, statewide, The Commonwealth

Figure 4: Utilizing Benefits* (UB Code Issues)



Source: Los Angeles County Department of Public Health (2016) Children's Health Outreach Initiatives Database, December 2016.

Fund Biennial Health Insurance Survey of 2014 found that 31% of adults were unable to access care due to costs.[22] Given the many changes to the landscape of our healthcare system, community-based enrollers are more important than ever to ensure that healthcare is accessible.

Prior to the 2016 presidential election, there were already a number of policy changes that impacted health coverage in California, especially for immigrant communities.[23] Enrollers were called upon to support families with new options such as the expansion of Medi-Cal for all children regardless of immigration status (Senate Bill 75 in 2015). There are a host of new or updated policies that may or may not to be implemented in 2017, such as the Newly Qualified Immigrant Medi-Cal wraparound program and the 1332 Waiver under Covered CA.

OEUR services have been as crucial as ever with vast efforts aiming to narrow the gap among the uninsured. With the changing leadership at the federal level, advances in healthcare are now at greater risk for being lost and thus, populations slated to be served because of those measures will be lost; and consequently confused as to how to navigate the system.

Community-Based Enroller Issues and Concerns

In 2015 and 2016, CHC convened three Regional Enrollment Network Meetings across California through the CKF coalition in order to:

- Provide local enrollment counselors with key policy and program updates and connect them with state and healthcare representatives and advocates;
- Identify barriers and develop strategies to overcome those barriers; and
- Build the capacity of enrollers to act as change agents and engage with decisions makers.

The meetings took place in Kern County, Mendocino County, Sacramento County, the Inland Empire, Fresno County, and Yolo County and were coordinated by a group of CKF members representing clinics, health plans, community-based organizations, and statewide advocacy groups. A total of 181 participants from over 10 counties attended the enrollment meetings, of which, 161 responded to a survey regarding the successes and barriers to their work of enrolling consumers into Covered California or Medi-Cal. The outcome of these convening was, 1) agreement on methods to appropriately document the challenges faced by enrollers as they attempt to support their clients; and 2) to document that, despite the challenges, enrollers are able to have extraordinary success in enrolling people into healthcare. With that said, CHC continues to work with partners to determine the best ways to address the ongoing issues and challenges with either Covered California or the Department of Healthcare Services which oversees Medi-Cal.

The set of meetings in 2015 centered on Covered CA and Medi-Cal in general while the 2016 meetings focused primarily on the implementation of SB75 (which made all children under the age of 19 eligible for Medi-Cal regardless of immigration status). A brief was produced highlighting the results of the 2015 meetings.[24] The results from these convenings are organized into two Tables: Table 3 is a compilation of barriers and Table 4 highlights resources needed & other possible solutions to mitigate some of these barriers.

Table 3: Overarching Barriers

Overarching Theme	*Specific Barrier*
Challenges with State/County Departments	**Medi-Cal** • Clients continue to receive confusing notices and packets • Encountering County Eligibility Workers not knowledgeable about immigration issues • Consumer issues not resolved in a timely manner **Covered CA** • Information provided by service representatives not always accurate • There is often a disconnect between the messages provided by Covered California and those provided by Qualified Health Plans
Health Plan Related/ Network Adequacy	• Not enough providers, especially in rural counties • Travel issues not taken into consideration by the Health Plans in determining networks
Misinformation	• Mixed messages from different information outlets • Fear of immigration repercussions (This has increased dramatically in 2017) • Different messages across different counties • Lack of language-specific literature beyond the threshold languages in California

Technology issues	• Multiple enrollment and eligibility systems that do not appear to be in sync
	• Ongoing internet issues that make it hard to complete online applications (both with system glitches and internet connectivity)
	• **Covered CA**
	  ○ Phone system can be slow, takes long to get to a live person
	  ○ Appropriate language assistance not always available
	  ○ Payment system not efficient
	  ○ CEC helpline not always useful

Table 4: Overarching Resources Needed & Other Possible Solutions	
Overarching Theme	***Description***
Resources Needed	• Develop a reference manual similar to the Healthy Families manual with key information about Medi-Cal and Covered California that can be used as a CEC desk reference • Health Plans should create a separate help line exclusively for CECs and a Health Plan Authorization form allowing plan representatives to discuss consumer concerns with CECs
Trainings Needed	• Standardized health literacy training • Permanent Resident Under Color of Law (PRUCOL) training
Other	• Work with stakeholders to review training guidelines and determine new strategies to ensure that all Eligibility Workers are well-versed and kept up to date as policy/program changes occur

Recommendations

It is a great success that almost five million people have enrolled in Medi-Cal and in Covered California Qualified Health Plans.[25, 26] It is also just as important to understand that with this success several challenges have surfaced, including technology glitches, misinformation and ongoing barriers that limit access to care. Given the often high needs of those seeking care due to life circumstances, troubleshooting assistance has increased, yet funding for these type of services has rapidly diminished. A great investment has already been made for OEUR services, with a staff of culturally competent healthcare experts who can help vulnerable communities navigate a complicated healthcare system and work to ensure that families retain health coverage. Losing these services due to expired funding will be a detriment for not only vulnerable communities, but the entire State of California. In CHC's 2015 publication, *Knocking on Medi-Cal's Door: The First Year of Medicaid Expansion in California*[27] two recommendations were provided that are relevant to this brief:

1) Invest in comprehensive in-person assistance performed by community agencies, clinics and schools; and
2) Invest in improving and standardizing training for all service channels.

CHC provides these additional recommendations to ensure the sustainability of OEUR programs throughout the state:

1. **Conduct research to quantify actual OEUR costs:** In the third cycle of Navigator funding, Covered CA attempted to provide a more realistic per enrollment rate (approximately $250)[ii] that would take into consideration the costs of supporting activities beyond application assistance. However, no research has been conducted on the actual costs of providing such comprehensive activities or what variances may exist when working with harder to reach populations or supporting clients with complex health conditions. Having such information will allow the state and other potential funders to strategize on the most effective methods to fund OEUR programs. Given limitations on government funds, foundations are the ideal entities to financially support this research in coordination with community researchers and advocates.

2. **Conduct research on the benefits of OEUR services beyond health coverage enrollment*:*** Studies have noted the importance of OEUR services when it comes to

[ii] This is based on the enrollment/renewal goals per funding category (Covered CA Navigator Program Request for Application 3.0 2015)

increasing health coverage enrollment and retention and improved access to a usual source of care. However there are few studies that show the benefits that OEUR services have on utilization of preventative care and consequent savings achieved from minimizing delayed care and emergency room usage; or its effect on population health outcomes. As we enter into a new healthcare landscape with limited overall funding, the state must actively lift up strategies that can advance the Triple Aim (better health, better care, and lower costs),[28] while lowering long-term costs. To support this research Health Plans could be instrumental in providing data and supporting initial pilot studies to assess such research.

3. **Capture savings by streamlining technology systems to reduce enrollment/renewal barriers and reduce administrative burdens:** Administrative burdens are not only a cost to the state and county but to the enrollment entity. It is highly recommended that the states understand the associated costs when the systems are not working or are creating extra and undue burdens on the user. While this will be a long term fix, unless these technology systems are streamlined to support OEUR services, administrative burden and costs will persist**.** As more individuals are using the online pathway to submitting applications (either on their own or with assistance),[29] it is critical that the system work efficiently; but even when improvements are made, glitches in the systems persist. Although issues with technology are not only isolated to the online applications systems, enrollers spend a significant amount of time helping consumers navigate glitches between two technology systems (Covered CA and local county systems). Recently DHCS announced improvements to its ombudsman line which, if necessary, connects beneficiaries to the local county customer service lines. However, the system isn't set up to connect them directly to a local representative but instead has them wait online up to an hour to talk to a customer service center representative (both Covered CA and the local county office).

4. **Work with Health Plans to develop and fund an OEUR funding pool:** Health Plans have a history of providing funding directly to enrollers; however, in most cases it has been a reimbursement arrangement contingent on enrollment into the specific health plan. This of course can be in conflict with the requirement that certified enrollment entities must offer unbiased information. As a solution Health Plans could provide a specified amount of funding annually into a pool that would be used to support OEUR programming. Whether this pool could be managed by DHCS, supplement the Navigator program or be administered by a community-based entity would need to be explored. However, the March 2016 approved Managed Care Organization Tax could be used as a template from which to begin contemplating how to collect and manage these funds. It could be a volunteer agreement between health plans, although it would still require that an agency, that is not a health plan, manage and develop funding criteria for such a pool. A pilot in one or more counties would provide a better assessment of how this can be designed and scaled to a statewide initiative.

5. **Capture savings by using technology to increase health literacy and improve access** assessment of how this can be designed and scaled to a statewide initiative. Much like enrollment and eligibility technology systems, improved technology that supports health literacy efforts (i.e. mobile applications, social media) and access/utilizations to care (telehealth) would create costs savings that could be redistributed to OEUR services. Furthermore, if the healthcare system was simpler to navigate and access, the cost of

OEUR services could be drastically reduced. Enrollers could potentially spend less time helping clients resolve enrollment and access barriers but more time on education (prevention and changes to policies/procedures) and supporting consumers experiencing complex situations and conditions.

6. **Institutionalize public and private partnerships to continue to support OEUR services and research:** Foundation dollars have played a significant role in supporting OEUR efforts as well as expanding health coverage programs for those children ineligible for public programs. With few exceptions, often this funding has lacked coordination between funders and, given the expected increased demand to these funders now is the time for state and foundation leaders to determine a joint approach to fund OEUR services and research. It is already evident that given the ongoing threats from the current administration, there will be a plethora of requests to support programs in jeopardy of losing government funds or being eliminated.

Conclusion

In order to sustain all progress made to-date with regard to enrollment and retention, collaboration and coordination are needed among all organizations and government entities. Our recommendations are based on existing data and years of experience as an enrollment entity and a convener of enrollment entities with the purpose of increasing efficiencies and access to healthcare. Nonetheless, we are also cognizant that other priorities may come to the forefront given the current political landscape. The findings laid out in this report are provided as a reminder of the comprehensive role that community based enrollers have played in the safety-net and the benefits they have provided. We offer this information as a testament of their continued relevance and importance now more than ever. As such we must lift up this information to advocate for sustainability of OUER services and avoid pitfalls that could easily regress communities to a state of no access and limited utilization of health coverage, which will consequently worsen health outcomes. We look forward to working with the state, health advocates, consumers, and other stakeholders to advancing these recommendations and further lifting up the importance of community-based outreach, enrollment, utilization and retention (OEUR) services in California!

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APPENDIX A – CHC reports

These reports can be found at www.chc-inc.org

Knocking on Medi-Cal's Door: The First Year of Medicaid Expansion in California: This report assesses California's efforts to widen the doorway to Medicaid coverage by reaching out to, enrolling and retaining low-income people of color and Limited English Proficient communities in the Medi-Cal program. Through the use of key informant interviews and secondary sources the authors were able to identify policy decisions, implementation strategies and outcomes that were notable successes or barriers in the Medi-Cal expansion and offer recommendations to improve the efficiency and reach of the program. The recommendations focus on areas where DHCS can make improvements in the Medi-Cal infrastructure and are designed to address multiple barriers. This report was published with the support of The California Endowment.

On the Path to Enrollment: Millions of Californians will be newly eligible for health insurance coverage under the Affordable Care Act starting January 1, 2014. Many will need help understanding, accessing, and using these benefits. This report provides information about the outreach, enrollment, and assistance programs required under the ACA, and about efforts to implement this continuum of consumer support in California. Published with the California HealthCare Foundation. (October 2013) **Report Addendum**: On the Path to Enrollment: Getting Californians Covered Under the ACA, Changes for the Second Open Enrollment Period, 2014-15. Published with the California HealthCare Foundation. (November 2014)

Bridging the Health Divide: Designing the Navigator System in California: This report details over a dozen recommendations for building a robust and consumer-friendly Navigator program in California. It provides an overview of the enrollment demands the state will face in 2014 and explores effective strategies for ensuring that as many individuals and businesses as possible can successfully enroll into coverage.

Policy Framework for Outreach, Enrollment, Retention & Utilization for Healthcare Coverage in California: This report describes the experiences and successes of local programs, such as Children's Health Initiatives, in providing health coverage to all children and families throughout California. (May 2006)

Bridging the Health Divide: LA Access Case Study: The LA Access to Health Coverage Coalition was established in 2002 to increase access to quality, affordable health insurance programs for low-income individuals in Los Angeles County. This report examines how Coalition agencies have adopted Outreach, Enrollment, Retention and Utilization strategies to enroll children into public insurance programs. It focuses on the unique approaches Coalition members have adopted to reach uninsured, eligible children and families.

Bridging the Health Divide: California's Certified Application Assistants: More than 20,000 individuals in California are trained as "Certified Application Assistants" to help families enroll in and maintain their public healthcare coverage. While the profession has grown and evolved through the years, very little is known about this dynamic workforce that bridges children and families to healthcare coverage and services. To assess the potential to advance the CAA profession, Community Health Councils conducted a survey of CAAs in Los Angeles County. Read the resulting report, *Bridging the Health Divide: California's Certified Application Assistants.*

Path to Accessing Health Coverage: Outreach, Enrollment, Retention & Utilization: California still faces the reality of more than 800,000 uninsured children. This policy brief identifies future challenges and opportunities and puts forward principles to strengthen outreach, enrollment, retention and utilization in California.

APPENDIX B – Additional Historical Funding Sources

Medical Outreach/Medicaid 1931 (b): In 1996 the Personal Responsibility and Work Opportunity Reconciliation Act was enacted and the automatic linkage that had been in place between cash aid and Medicaid was severed and 1931(b) Medicaid category was established. With the 1998 implementation of California's program, counties were provided financial support to conduct outreach to individuals who may no longer be eligible for welfare benefits under the reform but can continue to remain eligible under the 1931(b) Medi-Cal program. Each county was to be provided a basic grant of $90,000 and additional funds were to be allocated based on the counties beneficiaries.[i]

SCHIP Outreach: In 2001 the California received short-term 2-year fund to support community-based and school-based outreach and enrollment activities associated with Medi-Cal and the Healthy Families Program from July 2001 through June 2003. However because of other reductions the program was cut in the 2002-2003 State Budget.

County Outreach Enrollment Utilization Retention Grant: The 2006-2007 California State Budget approved $72.2 million to increase enrollment of eligible children into the Medi-Cal and the Healthy Families Program. The funding included $20.8 million to support county outreach and enrollment efforts.[ii] However on August 24, 2007 upon signing the 2008-2009 California State Budget the Governor eliminated the remaining COEUR funding to address the State's budget shortfall.

Connecting Kids to Coverage Outreach and Enrollment Grants: This funding which is overseen by the Department of Health and Human Services (HHS) provides local grant across the country for outreach and enrollment activities as well as supports a national campaign.[iii] The funding began as part of the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 and was continued through the ACA for a combine four cycles. Approximately, 14 California entities have received nearly 11.5 Million over the first three cycles.

Partnerships to Increase Coverage in Communities: The HHS Office of Minority Health oversees this funding which is designed to support minority populations with health coverage education and enrollment. [iv] The first cycle (2014-2016) provided $3,203,913 in funding to 13 entities across the country. One organization in California was awarded $249,898. The 2nd cycle was released in 2015 which would award 17 grants will be awarded nationally at a maximum of $250,000 for each.[v]

Health Center Outreach & Enrollment Assistance: The federal Health Resources and Services Administration made $150 million in outreach and enrollment grants available for health centers to assist patients "in establishing eligibility for and gaining access to Federal, State, and local programs that provide or financially support the provision of medical, social, housing, educational, or other related services."[vi] In the summer of 2013, 129 California health centers were awarded $3,125,000 for FY 2014 to perform this task.[vii]

Medi-Cal Outreach and Enrollment Grants: TCE provided DHCS with 26.5 Million which was matched, along with matching federal dollars to create a total of $53 million. As a result, $25 million were distributed to the state's 58 counties to cover outreach and enrollment activities conducted between February 2014 and June 2016.[viii]

Medi-Cal Renewal Funding: This was an additional $6,000 from TCE to DHCS in the which was matched with federal dollars and were added to the existing county Medi-Cal Outreach and Enrollment Grant Funding for renewal activities

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Private Foundations: From 1998-2004 Private Foundations such as the California Endowment, The California HealthCare Foundation, The California Wellness Foundation, and The David and Lucile Packard Foundation had collectively contributed over $96.8 million towards areas for policy change, technical assistance, technology solutions and evaluation, with approximately $12 million towards OEUR activities throughout the state.[ix] These foundations have continued to support OEUR activities in a variety of ways especially during the initial years of ACA implementation.

First 5 Commissions: While funding was provided locally, the development of Children's Health Initiatives across the state was the first coordinated effort to create comprehensive set of OEUR practices across the state. The local CHIs pushed for the creation of local health coverage programs for children left out of Medi-Cal and Healthy Families and funded local organizations to offer OEUR services. Even with funding cuts many still continue to provide this much needed service in the community and coordinate regional fundraising efforts.[x]

Medi-Cal Administrative Activities (MAA): The MAA program is administered at the federal level through the Center for Medicare and Medicaid Services (CMS), at the state level through the DHCS and at the local level through a local government agency (LGA), which is often the local department of health services. For LGAs, costs associated with MAA claimable activities are matched at the federal financial participation rate (FFP), which is roughly 50%. In order to be reimbursed for MAA activities, organizations must have "Certified Public Expenditure" funding as sources of matching funds which cannot originate from the federal government. A variety of activities performed by counties and community-based organizations are reimbursable for specific roles and activities under the Medi-Cal Administrative Activities program including providing Medi-Cal outreach, assistance with an application and program planning and policy development.[xi] Many counties have utilized MAA funding to supplement many of the grant programs listed above.

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