Ready, Set, Enroll

April 2015 Update

Evolving Enrollment Support Models at California Community Health Centers

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Introduction

Since coverage expansion was implemented under the Affordable Care Act in January 2014, California has experienced significant growth in Medi-Cal (California Medicaid program) and new enrollment into Covered California (state health benefit exchange). Community Health Centers (CHCs) have played an essential role across California by engaging existing patients, leading community outreach and education efforts, and playing a central role in providing in-person enrollment, renewal and post-enrollment support to many of California's most vulnerable residents.

In addition to briefly reviewing statewide enrollment trends, this enrollment brief highlights CHC second year enrollment experiences, evolving enrollment and client engagement strategies, and important changes in the service and staffing models that CHCs are using to provide enrollment support services. This enrollment brief also reviews in detail the President's 2014 executive action on immigration, its potential impact on Medi-Cal eligibility and emerging CHC strategies to support coverage enrollment by undocumented clients. Key findings include the following:

- Most CHCs reported meaningful decreases in the number of Covered California and Medi-Cal applications they supported during the 2014-15 Open Enrollment period compared to 2013-14;
- Statewide, more than 6 out of every 10 completed enrollments during the second Open Enrollment period were for Medi-Cal, highlighting a continued trend in high Medi-Cal enrollment and capping a 41% annual growth in statewide Medi-Cal enrollment;
- Though coverage renewal and churn experiences have varied widely, CHCs highlighted common concerns, such as poor/incomplete member communication about the Medi-Cal renewal process, and lack of continuity of care and coverage gaps for enrollees moving between programs, among others;
- More complex client service needs, seasonal changes in enrollment volume, the need for highly trained staff, and uncertain future funding to support enrollment staffing, among other issues, are prompting CHCs to re-evaluate enrollment support service models and staffing levels;
- If allowed to move forward, the President's executive action could make up to 1.2 million California residents, or half of the undocumented population, newly eligible for DACA or DAPA deferred actions status. Provided they meet other Medi-Cal requirements, many of these residents could also be eligible to enroll in state-funded full scope Medi-Cal, suggesting a potentially significant coverage expansion opportunity.

In addition to synthesizing publicly available data and research, interviews were conducted with five Community Health Centers (CHCs) in California and one regional consortia, including: Alameda Health Consortium (Alameda County); AltaMed Health Services (Los Angeles County); Clinica Sierra Vista (Kern and Fresno Counties); Community Health Alliance of Pasadena (Los Angeles County); Marin Community Clinics (Marin County), and; San Ysidro Health Center (San Diego County).

Funded by Blue Shield of California Foundation, this enrollment brief is the last of four quarterly updates describing statewide Medi-Cal and Covered California enrollment trends, community health center (CHC) enrollment experiences and best practices, and key enrollment policy and implementation issues affecting enrollment entities in California. All of the "Ready, Set, Enroll" reports can be found at **pachealth.org**.

Covered California and Medi-Cal Enrollment Trends

Covered California

An estimated 495,073 Californians have enrolled and selected a Covered California Qualified Health Plan during the 2014-15 Open Enrollment Period (thru February 2015), representing 35% of the prior Open Enrollment period volume. Although data is not yet available on how many enrollees have also paid their first premium, during the first Open Enrollment period 80% of enrollees paid their premium. Other notable trends during the second Open Enrollment period include the following:

- *Proportional Increase in Latino and Young Adult Enrollment* – Latinos accounted for 37% of enrollments compared to 31% percent in the first year. In contrast, Asians made up 23% of first year enrollments and only 18% of second year enrollments. Young adults aged 18-34 represented 34% of second year enrollments compared to 29% in the first year.[1]

- *Minor Changes in the Enrollment Channel* – Reliance on Certified Insurance Agents and Service Center Representatives both increased in the second year, whereas self-enrollment decreased from 41% of enrollments in the first year to 30% in the second year. [2]

- *High Rate of Renewal* – An estimated 92% of continuing enrollees successfully renewed coverage.[3]

- *Service Channel* – Reliance on Certified Insurance Agents and Service Center Representatives both increased in the second year, whereas self-enrollment decreased from 41% in 2013-14 to 30% of enrollments in 2014-15.[4]

Medi-Cal

Eligible Californians can enroll into Medi-Cal at any time and are not limited to enrollment during the Covered California Open Enrollment period. Between December 2013 and January 2015 Medi-Cal enrollment increased by 3,568,638 individuals, or 41%. As of January 2015, an estimated 12,170,138 Californians were enrolled into Medi-Cal.[5]

- *High Medi-Cal Enrollment During Open Enrollment Periods* – Medi-Cal enrollment has far outpaced Covered California enrollment in the first two years. In total, more than 2.71 million Californians completed Medi-Cal applications during the 2013-14 and 2014-15 Covered California Open Enrollment periods compared to 1.89 million individuals that enrolled and selected a Covered California Qualified Health Plan.

- *Uncertain Renewal Rates* – The Department of Health Care Services (DHCS) estimates that up to 1 million Medi-Cal enrollees per month will be up for renewal. Historically, about 80% of Medi-Cal enrollees have renewed coverage on time, but up-to-date data on Medi-Cal terminations and renewal is not yet available.[6] Several factors may impact renewals in 2015, including the introduction of a longer and more complicated renewal form, sunset of a temporary one-year renewal postponement for Low Income Health Program (LIHP) and other enrollee categories, and high caseload demands at county eligibility offices, among other factors.

[1] "Covered California's Second Open Enrollment Yields Strong Numbers: Nearly 500,000 New Consumers Sign up for Health Plans". Covered California News Release, March 5, 2015.

[2] Ibid.

[3] Ibid.

[4] Ibid.

[5] Medi-Cal Monthly Eligibles Trend Report for January 2015, Department of Health Care Services http://www.dhcs.ca.gov/dataandstats/statistics/Pages/Medi-Cal-Certified-EligiblesRecentTrends.aspx

[6] "Possible Explanation Offered for Delayed Medi-Cal Termination Data". California Healthline, March 16, 2015. http://www.californiahealthline.org/capitol-desk/2015/3/possible-explanation-for-slow-medical-data

- *High Volume of Coverage Transitions* – Due to changes in income, employment and household circumstances, as many as 1 in 6 enrollees are annually expected to have their eligibility shift between Covered California and Medi-Cal.[7] Through January 2015, an estimated 100,000 individuals transitioned from Covered California to Medi-Cal. To date, no information is available on the number of individuals transitioning from Medi-Cal to Covered California.

2014-15 Open Enrollment Experiences at Community Health Centers

Select community health centers (CHCs) were asked to describe overall enrollment support experiences during the 2014-15 Open Enrollment period, key differences from the 2013-14 Open Enrollment period, Covered California and Medi-Cal renewal support experiences and strategies, and initial thinking about how to structure enrollment support services at their organizations for the long-term. The following section highlights key themes and findings from these conversations.

Demand for Enrollment Support

Big Decreases in New Enrollment Demand. Most CHC interviewees reported a 20% or greater decrease in the number of combined new Medi-Cal and Covered California enrollments processed by their agency. Several respondents also indicated that unlike the first year where there was strong early demand, enrollment activity was relatively slow until a rush during January and February. With an understanding that much of the demand in the prior year was driven by enrollment of existing patients and others highly motivated to gain coverage, CHCs reported testing new strategies, such as targeted advertising and community outreach, to generate demand. None of the respondents, however, reported a lot of success from these efforts.

Multiple Factors Contributed to Low Demand. In addition to the understanding that many of the remaining uninsured represented hard to reach populations (e.g. non-patients, mixed immigration families with fears about the process, those skeptical about the program), participating CHCs shared their perspectives about other contributing factors, including: short and ill-timed open enrollment period that straddled the winter holidays and preceded the tax season when most individuals became aware about the tax implications; decreased visibility due to reduced marketing and media coverage, and; more aggressive advertising and presence by Certified Insurance Agents seeking to provide application assistance services.

Renewal and Churn

Varied Demand for Renewal Support. CHCs reported varied levels of client demand for support with the renewal process. Not surprisingly, those CHCs that experienced more demand for renewal support in both Medi-Cal and Covered California tended to have more aggressive renewal strategies in place, such as mailings, automated calls, text message reminders and use of outbound call centers.

- *Medi-Cal Renewal Challenges* – Most CHCs shared concerns about the timeliness of communication to Medi-Cal members about the renewal process. Often pointing to overwhelmed county eligibility offices, CHCs commonly reported that many individuals and families failed to renew because they did not receive renewal packages. Others highlighted client confusion related to receiving renewal notices that were difficult to understand and complicated.

- *Covered California Needs* – Most CHCs reported minimal demand for Covered California renewal support. Those that did experience higher demand highlighted a few common client needs, such as help interpreting multiple and confusing letters, selecting new plans or understanding their options for renewing with their current plan.

[7] "The Ongoing Importance of Enrollment: Churn in Covered California and Medi-Cal". UC Berkeley Center for Labor Research and Education, April 2014.

Wide Variation in Degree of Program Churn. Overall, CHCs reported a wide variation in the degree to which clients moved between Medi-Cal and Covered California. Some interviewees reported seeing more movement from Medi-Cal to Covered California, whereas others reported just the opposite. Despite the different experiences, they highlighted some important challenges:

- *Continuity of Care* – Since Covered California and Medi-Cal provider networks are not the same, some clients found that their medical provider was not contracted with their new plan. CHCs highlighted this as a big barrier in retaining continuity of care for clients.
- *Transition Challenges* – Some clients moving from Covered California to Medi-Cal were pushed into the Medi-Cal backlog resulting in a gap in coverage. On the other side, some Medi-Cal enrollees determined eligible for Covered California were unable to complete the enrollment because they still had "active" Medi-Cal cases. Due to heavy caseloads among county eligibility workers, Medi-Cal terminations were not always timely.
- *Client Concerns* – Some clients did not want to change programs. For Medi-Cal enrollees moving into Covered California, the common concern was premium cost. Some Covered California enrollees who became eligible for Medi-Cal expressed concern about moving into a government program, limited provider networks and access issues.

Evolving the Enrollment Support Model

More Client Needs. Beyond direct application assistance, clients are now seeking broader guidance on navigating health plan choices, understanding how health insurance works, paying the premium, and selecting a provider, among other needs. Stated one CHC, "enrollment support requires time-intensive education and support to obtain and maintain coverage, utilize benefits and keep their medical home". Another CHC shared that over 30% of CEC time is now dedicated to post-enrollment support for their clients.

Enrollment as a Service Entry Point. Similarly, some CHCs reported that enrollment support services are emerging as a potentially important point of contact for either providing or linking clients to other complimentary services, such as immigration guidance, social services, case management or patient education services. According to several CHC interviewees, clients come to them not just because of the enrollment services they offer but because of the relationships and trust they have built in the community. Reflected one interviewee, "the question is how can we leverage these relationships?"

More Complex Staff Responsibilities and Training Requirements. As a result of an expanded scope of work, CHCs reported they are now identifying a broader skill set required to effectively provide enrollment support services. This includes knowledge of Medi-Cal and Covered California rules and options, client case management through the application process, ability to coach and educate on insurance choices, post-enrollment support, renewal support, community outreach and effective data tracking. Remarked one CHC, "the job is different now. It's a lot more complex then it used to be."

Boom and Bust Seasonality. Most CHCs increased staffing to accommodate high enrollment demand but are now challenged to provide adequate levels of service during open enrollment while also ensuring efficient and optimized staffing during down seasons. Anticipated shorter open enrollment periods, fewer new enrollments compared to renewals and unreliability of one-time funding further exacerbate this challenge.

Re-Thinking Staffing and Service Models. The issues discussed above, such as more complex service requirements, the need for highly trained staff, seasonal demand, and uncertain future funding, among other factors, are prompting CHCs to re-evaluate staffing and service models. While some are looking to modify or expand staff roles, others are looking at alternative staffing models/levels to balance changing demands:

- *Reduced CEC Staffing* – Due to reduced new enrollment demand and concern about external enrollment funding, several CHCs reported examining potential reductions in CEC positions.
- *Temporary Staffing* – Use of temporary CEC positions during open enrollment periods can allow CHCs to meet client demand without unnecessary full time staff increases. But, it also poses challenges related to sufficient training and onboarding for a complex service.
- *Cross-Training* – Most CHCs reported cross-training CECs in other areas, such as referral coordination and Medi-Cal retention, where they dedicate additional time when open enrollment periods are over.
- *Specialization* – Given the increased complexity and scope of client needs, developing staff teams to specialize in new enrollment, Covered California vs. Medi-Cal, retention, case management and post-enrollment support ensures that the organization has clearly committed resources to meet its most critical needs and highly effective staff.

Evolving the Enrollment Workforce
Clinic Spotlight – Community Health Alliance of Pasadena

Community Health Alliance of Pasadena (ChapCare) serves more than 15,000 low-income patients at six health centers in the San Gabriel Valley region of Los Angeles. In addition to enrolling existing patients, ChapCare invested heavily in education and enrollment of the broader community through outreach/education events, education via local newspapers and radio, and the opening of stand-alone enrollment centers, among other strategies. As part of this strategy, ChapCare expanded outreach and enrollment staffing to accommodate increased enrollment volume and new activities. Looking ahead, ChapCare is evaluating the required skill sets and appropriate staffing model to provide an effective and efficient enrollment support service.

Stated the Director of Development and Marketing, “Prior to the ACA, [enrollment assisters] had the county program, full scope Medi-Cal and limited scope programs. It was a more basic job – you had to be able to communicate the basics and be trusted”. Since coverage expansion, the required skill sets and scope of responsibilities for enrollment staff has expanded significantly. Aside from understanding additional coverage programs and enrollment systems, CECs also have more responsibilities related to customer service, outreach, case management, post-enrollment support and data tracking, among others. Stated the Director of Development and Marketing, “now with health insurance being a lot more complex and our choice of external enrollment centers, there really is a higher level of need for customer service and ability to retain information…. It’s a lot more complex of a job.” ChapCare has also found a need to adjust compensation in order to attract qualified individuals.

Covered California enrollments supported by ChapCare dropped by about 20% during the 2014-15 Open Enrollment period. With most patients already insured, lower community demand for Covered California enrollment and shorter open enrollment periods in future years, ChapCare is evaluating potential changes to its staffing levels and service approach. This may include reducing traditional outreach activities in favor of a more consistent presence through traditional media and strengthening the role and visibility of their enrollment centers. They may also pilot the use of temporary CEC staffing during open enrollment, but highlight potential challenges around timely hiring, appropriate training, certification and onboarding among other issues.

Adapting the Enrollment Support Model
Clinic Spotlight – AltaMed Health Services

AltaMed Health Services cares for over 180,000 patients in Los Angeles and Orange Counties. AltaMed was the first CHC to establish free-standing enrollment resource centers, along with a robust call center, aggressive patient in-reach campaigns, community outreach and advertising that resulted in more Covered California applications than any other Certified Enrollment Entity in California in both the 2013-14 and 2014-15 Open Enrollment periods.

During the 2014-15 Open Enrollment period, AltaMed experienced important changes in the level and type of client demand. The number of new Medi-Cal and Covered California applications processed by the agency was 28% lower than the first year. However, client support needs remained high. In addition to supporting a high volume of renewals, they reported that more than 30% of CEC appointment time was committed to post-enrollment support. Stated the Vice President, Sales and Marketing, "We saw a lot of people coming in for post enrollment support – help following up with the plans, paying the premium, finding a Spanish speaking health plan representative, a provider in the network". In large part, they see this as a result of the long-standing relationships and trust they have developed with community members.

Looking forward, AltaMed sees the need to ensure that new enrollment and retention is not crowded out by other needs. This may include developing dedicated new enrollment and retention teams. However, they also see an opportunity to leverage existing patient relationships it has developed to better address community needs and take advantage of new opportunities. This could include enhancing partnerships to support residents affected by the President's executive action or attaching other support services to the resource centers. Lastly, their second year experience highlights an intensifying need for health plans to develop more robust new member onboarding systems. Stated the Vice President, Sales and Marketing, "I feel very strongly that health plans need to develop new tools, materials and strategies to orient new members. They need to strengthen their new member onboarding."

Policy Updates

The following sections examines four policy topics, including:

- The impact of the President's 2014 immigration executive action on Medi-Cal eligibility;
- The status of California legislation to extend health insurance coverage to undocumented residents (Lara Bill);
- Status of the benefit and affordability "wrap" programs for pregnant women and newly qualified immigrants (NQIs), and;
- Expansion of full scope Medi-Cal benefits for pregnant women.

Impact of President's Immigration Executive Action on Medi-Cal Eligibility

Although undocumented residents in California are not eligible to purchase coverage through Covered California, those undocumented residents with PRUCOL status (People Residing Under Color of Law) are eligible under California law for full-scope Medi-Cal provided they meet the income, residency and other requirements.

Undocumented residents with PRUCOL status (including DACA and very likely DAPA), are eligible under California law for full scope Medi-Cal provided they meet other eligibility requirements.

Included in the PRUCOL category are those children and young adults who are eligible for the 2012 Deferred Action for Childhood Arrivals (DACA) program, or "Dreamers". If allowed to move forward, it would also include additional undocumented residents included in the DACA expansion and, according to immigration rights advocates, Deferred Action for Parents of Americans and Lawful Permanent Residents (DAPA) articulated in President Obama's November 2014 Executive Action on Immigration.

Currently, up to 358,000 undocumented children and young adults in California are eligible for DACA under the 2012 program. Up to 1,215,000 additional undocumented residents could be potentially eligible under President Obama's 2014 Executive Action for DACA/DAPA status. This suggests that up to 1,572,000, or about half of all undocumented Californians could become DACA/DAPA eligible.[8] These residents could be eligible to enroll in state-funded full scope Medi-Cal provided they meet Medi-Cal income, residency and other requirements. A recent policy brief by the UC Berkeley Labor Center estimated that up to 57% of Californians eligible for DACA/DAPA had income below the Medi-Cal eligibility threshold and lacked private insurance.[9]

A more detailed description of the DACA and DAPA categories is included below:

- *2012 Deferred Action for Childhood Arrivals (DACA) Program* – Implemented in 2012, DACA provides temporary relief from deportation for young undocumented residents that meet specific age, length of stay and schooling requirements, among others. In order to receive DACA status, eligible residents must complete an application process. The UC Berkeley Labor Center estimated that 58% of DACA eligibles in California submitted applications as of December 2013.[10] Other studies have shed some light on the reasons why remaining DACA eligibles do not complete the application process. Common barriers articulated included economic limitations (e.g. application cost), missing paperwork, legal concerns and fear of sending personal information to the government.[11] If eligible residents are able to complete the application process and receive deferred action status, it is very likely that they could become eligible for Medi-Cal.

If allowed to move forward, the President's executive action on immigration could make up to 1.5 million residents, or half of California's undocumented population, eligible for DACA or DAPA deferred actions status.

[8] "National and State Estimates of Populations Eligible for DAPA and DACA Programs". Migration Policy Institute, January 2015. http://www.migrationpolicy.org/programs/us-immigration-policy-program-data-hub/unauthorized-immigrant-population-profiles

[9] "Health Insurance Demographics of California Immigrants Eligible for Deferred Action". UC Berkeley Harbor Center, March 2015.

[10] "Realizing the Dream for Californians Eligible for Deferred Action for Childhood Arrivals (DACA): Demographics and Health Coverage". UC Berkeley Labor Center, February 2014.

[11] "Two Years and Counting: Assessing the Growing Power of DACA". Roberto G. Gonzales and Angie M. Bautista-Chavez, American Immigration Council, Special Report, June 2014

- *Expansion of the Deferred Action for Childhood Arrivals (DACA) Program* – Included in the President's immigration executive action was an expansion of the DACA program to cover young persons who entered the U.S. before their 16th birthday and have lived continuously in the US since January 1, 2010. The expansion also makes eligible to apply those who, in the existing DACA program, had "aged out" by being older than 31 on June 15, 2012. In the expanded DACA program, deferrals and work permits would be issued for three-year renewable periods. The Migration Policy Institute estimates that about 99,000 Californians will become newly eligible under the DACA expansion.[12]

- *Creation of the Deferred Action for Parents of Americans and Lawful Permanent Residents (DAPA) Program* – When implemented, the DAPA program would allow undocumented persons, who have a legal permanent resident or U.S. citizen child, apply for work authorization and protection from deportation. Persons would have to demonstrate that they have been in the country since January 1, 2010. The Migration Policy Institute estimates that about 1,116,000 California parents will become eligible under the proposed DAPA program.[13]

The President's executive actions for the expanded DACA and new DAPA programs have been met with considerable political resistance. On February 16, 2015 a federal district court temporarily blocked implementation of both actions and the federal government has appealed the decision. However, if the executive actions are permitted to move forward, more than 1.2 million additional Californians could become eligible for deferred action status and thus potentially eligible for Medi-Cal.

Interviewed CHCs were asked to describe their experiences providing enrollment support to patients eligible for PRUCOL status (e.g. DACA), as well as key strategies that they think will drive success in the future. Key themes included the following:

- Community members are subject to varied and inaccurate information about PRUCOL from immigration attorneys, the media and other avenues. Confusion and mis-information in the community highlight the importance of effective education/awareness campaigns;

- Immigration enforcement fears remain potent in immigrant communities and are stoked by both the national and local environments and events. The need for trusted community agencies to lead client engagement efforts remains critical;

- Community health centers are uniquely positioned to engage clients given their role as trusted, longstanding community resources and established patient and service relationships with a large number of eligible residents;

- Intensive CEC training on immigration rules and PRUCOL-related enrollment is important given the complexity of application requirements;

- Partnerships with legal aid agencies (and other trusted agencies) can facilitate CEC training, on-site legal aid resources and collaborative community education/awareness campaigns;

- Many county eligibility workers require additional training, knowledge and awareness about PRUCOL eligibility. Strong relationships with county eligibility offices are essential to ensuring that clients receive accurate information and effective enrollment assistance.

[12] "National and State Estimates of Populations Eligible for DAPA and DACA Programs". Migration Policy Institute, January 2015. http://www.migrationpolicy.org/programs/us-immigration-policy-program-data-hub/unauthorized-immigrant-population-profiles

[13] Ibid.

Engaging the Immigrant Community
Clinic Spotlight – San Ysidro Health Center

San Ysidro Health Center serves (SYHC) 90,000 patients through its network of 11 clinic sites and 23 program locations throughout the Southern and Central region of San Diego. SYHC's patient population is primarily low-income Latinos (75%). According to the Director of Outreach, "we have over 45 years as a highly trusted organization among immigrant populations. In addition to conducting outreach in areas with high percentage of immigrants, our patients and community members know that they can come to any one of our clinics and get information and assistance without fear or stigma".

In the last year, SYCH implemented several new efforts to increase engagement of the immigrant community, including:

- Bilingual Hotline – The hotline provides an accessible resource for clients to receive guidance from bilingual CECs, as well as complete screening and complete appointments. It has proven very popular and successful with immigrant populations. On average, the hotline handles up to 500 calls per week during the peak of the Open Enrollment period.
- Targeted Outreach Materials – An internally developed "Immigrant Options" flyer includes detailed relevant information for immigrant clients, such as mixed-status families, individuals with sponsors, and DACA eligible. Additional materials addressing immigration enforcement fears, the Medi-Cal Recovery Program, and other topics are also distributed.
- DACA Campaign – SYHC has hired staff who have received DACA deferrals. These staff conduct outreach to young people and students attending regional community colleges to provide education and support.
- Targeted Media – SYHC runs periodic Spanish-language newspaper ads and TV/radio commercials as well as 3-5 minute interviews on popular new stations that highlight immigrant options and seek to dispel common or pervasive myths.

SYHC has also implemented overall service changes to better respond to client needs. This includes implementing a new staffing model where one caseworker is assigned to support multiple CECs by conducting follow-up calls on incomplete applications, checking Medi-Cal eligibility, tracking new Covered California applications for effectuation, and renewal reminder calls, among other tasks. In addition, SYHC's CEC's also serve as a new patient intake and resource specialist, linking patients to a medical home for the first time as well as other needed support services. Stated the Director of Outreach, "[The CECs] have become a catch-all. Once [the client] develops trust, that CEC is theirs". Looking forward, SYHC plans to develop more comprehensive patient support services including care coordination and case management.

Despite these efforts, SYHC remains concerned about high levels of misinformation by Spanish-language media and lingering immigration enforcement fears in the community. Shared the Director of Outreach, "There is still fear about repercussions of enrolling a family member in a mixed-status household. In San Diego, there continues to be anti-immigrant sentiments in addition to deportation fears due to the proximity to the border.

Partnerships to Improve Immigrant Enrollment Support
Clinic Spotlight – Clinica Sierra Vista

Clinica Sierra Vista serves over 160,000 patients in the Central Valley counties of Kern and Fresno. Seventy-four percent of Clinica patients are Latino, many of whom are immigrants and/or farmworkers. Clinica has evolved as a leader of PRUCOL-related education and enrollment services. These efforts began in 2009 when new PRUCOL application requirements were rolled out and intensified in December 2014 when Fresno's indigent program was eliminated.

Clinica has developed an important partnership with the California Rural Legal Assistance Program (CRLA) to ensure that their staff understand PRUCOL rules and clients have other resources available to them. In addition to training Clinica CECs on immigration issues, CRLA places staff at Clinica sites on a regular basis to provide support for patients. The agencies also maintain regular communication about immigration issues.

Similarly, Clinica has invested in strengthening relationships and mutual training with county eligibility agencies. Stated Clinica staff, "A lot of eligibility workers have no idea what PRUCOL is and how to identify eligibles. They need more education…. This is concerning because many individuals go directly to the counties". In one county where Clinica is present, county eligibility workers and Clinica CECs have participated in shared PRUCOL trainings. Clinica also persuaded the County eligibility office to set up a distinct group in the eligibility department to handle all of the PRUCOL applications. This ensures appropriate expertise at the county and better communication throughout the application process.

Recognizing the sensitivity of the topic, the contradictory and confusing information presented to residents by immigration attorneys and others, and their unique role as a trusted community resource, Clinica has also invested in community education. This included a large DACA / PRUCOL education campaign following the launch of the 2012 DACA program. In regards to the President's recent executive action, staff shared, "we are a trusted resource in this community and we will be ready once we have more concrete information to move forward on".

Connecting the Dots in a Changing Coverage Environment
Clinic Spotlight – Marin Community Clinics

Marin Community Clinics (MCC) provides care to over 32,000 low-income patients at several facilities throughout Marin County. An estimated 78% of patients are Latino, many of whom are monolingual Spanish speakers. Since coverage expansion, MCC has increased enrollment staffing, added dedicated enrollment hotlines and email addresses, and invested heavily in community education and collaboration with other agencies. Prompted by an impending termination of the local Healthy Kids program (with transition to the Kaiser Child Health Plan), MCC has more recently begun to develop its PRUCOL-related education and enrollment support.

- *Patient Outreach* – MCC sent letters and made calls to patient families affected by the upcoming Healthy Kids program termination to invite them in for screening and guidance around coverage options. Families are being screened for DACA eligibility, referred to other services as needed, and provided enrollment support if appropriate. In the first couple of months, more than 70 families have been assisted with PRUCOL-related coverage enrollment.

- *Community Collaboration* – MCC learned that many of the agencies that provide DACA application support or other immigration-related guidance are not aware of potential Medi-Cal eligibility for their clients. For example, one community agency assisted 900 individuals with DACA applications but did not provide any education or guidance around Medi-Cal enrollment. MCC is seeking to both increase education and information-sharing between agencies, as well as, build more coordinated approaches to client support. Stated the Outreach and Enrollment Director, "I think one of the biggest challenges is that the organizations are not working together".

- *Staff Training* – MCC is also developing training materials and resources for its staff to ensure that they are providing accurate and appropriate guidance to clients. MCC has reached out to other CHCs, consortia and counties to begin assembling training materials and is pursuing both clinic-specific and collaborative trainings with regional CHCs and other enrollment entities in the county. Additionally, MCC is exploring ways to engage the county eligibility office to ensure that all CECs and eligibility workers receive appropriate training and provide consistent guidance to applicants.

The Lara Bill

Legislation to expand health insurance coverage and other protections to undocumented residents is also under consideration by the California State Legislature. At the center of a 10-bill package focused on undocumented residents is SB 4, introduced by Senator Ricardo Lara. Known as the "Lara Bill", it proposes extending eligibility for full scope Medi-Cal to undocumented individuals who are otherwise eligible for Medi-Cal. The Lara Bill would also enable undocumented residents that exceed Medi-Cal income eligibility thresholds to purchase health insurance from qualified health plans with their own money through the California Health Benefit Exchange (Covered California) and "to make available premium subsidies and cost-sharing reductions to the extent funding is available". [14]

On April 15, 2015 the California Senate Health Committee voted to advance the Lara Bill to the Senate Appropriations Committee for consideration. However, the legislation does not address how the estimated $1.3 billion in annual costs will be funded. [15]

[14] SB 4, April 6, 2015 version as forwarded by the Senate Committee on Health. http://leginfo.legislature.ca.gov/faces/billHistoryClient.xhtml

[15] California Senate Committee Oks Bill for Undocumented Health Coverage", California Healthline, April 16, 2015. http://www.californiahealthline.org/articles/2015/4/16/calif-senate-committee-oks-bill-for-undocumented-health-coverage.

Benefit and Affordability "Wrap" Programs for Pregnant Women and Newly Qualified Immigrants (NQIs)

As part of ACA implementation, California created "wrap" programs to provide expanded benefits and premium and cost-sharing assistance for two specific groups that are eligible for both Medi-Cal and tax subsidies in Covered California. The wrap programs will support two populations enrolled in Covered California qualified health plans: 1) pregnant women with income from 138% to 213% FPL; and 2) newly qualified immigrant (NQI) adults – those legally present less than five years -- without dependent children up to 138% FPL. For both populations, California Senate Bill 857, signed by Governor Brown in June 2014, limits the premium and cost-sharing payments DHCS would pay as part of the "affordability" wrap to the amount necessary to pay for the second lowest cost silver plan in Covered California. Qualified health plans would be prohibited from charging or requiring an NQI or pregnant enrollee to make any payments for any services subject to these payments.

In addition, SB857 clarifies that Covered California applicants or current enrollees who are eligible for Medi-Cal based on pregnancy can remain in or enroll in Covered California coverage and receive Medi-Cal coverage for pregnancy-related and postpartum services not covered by the qualified health plan (for example, dental benefits). These enrollees will also receive payment assistance for their premiums and cost-sharing. Pregnant women may also opt to remain in or enroll in Medi-Cal and not enroll in a Covered California plan. The process and all options will be made available to women at the time of applying to the Medi-Cal program or the Exchange and during their enrollment in Medi-Cal or Exchange coverage, as applicable.

DHCS has submitted required approvals to the federal government. The functional modifications to the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) are also scheduled but will not be implemented until after required eligibility changes for full-scope pregnancy coverage.

Expansion of Full Scope Medi-Cal Benefits for Pregnant Women

Senate Bill 857 also expands the income eligibility level for full-scope Medi-Cal benefits for pregnant women (with satisfactory immigration status) up to 138% of the federal poverty level (for a family of two, this is an annual income of $22,056). Prior to ACA implementation, the income eligibility cut-off for full-scope benefits in California was 60% of the federal poverty level (FPL) and pregnant women above would receive only pregnancy-related services. This change in the law was necessary to align pregnant women's income eligibility and scope of benefits with other groups' as implemented in the ACA. Eligible pregnant women will select a Medi-Cal managed care plan from which to receive services.

The Department of Health Care Services (DHCS) has submitted required State Plan and 1115 Waiver Amendments to the federal government and expects approvals by April 2015. For this eligibility change to take effect, the law requires functional modifications to CalHEERS. The numerous required modifications are underway and scheduled to roll out throughout 2015.

Conclusion

As trusted organizations that serve (and understand) low-income and vulnerable California communities, community health centers (CHCs) have played a leading role in identifying opportunities to strengthen patient enrollment/renewal experience and systems, as well as testing new strategies and approaches to educate and enroll eligible residents into coverage.

As highlighted in this brief, CHCs continue to explore options to better support the full range of client needs, including providing post-enrollment support services, facilitating medical home connections, considering options to more effectively link clients to other needed services and piloting new strategies targeting immigrant residents. CHCs are also spearheading efforts to develop highly successful enrollment services in ways that are also cost-effective. As California moves forward, CHCs will continue to play a critical role not only in enrolling and retaining individuals into health insurance, but in defining best-practices and cost-effective approaches to enrollment support.