

Ready, Set, Enroll

Community Health Center Strategies to Facilitate Enrollment of Uninsured Patients into Coverage Under the Affordable Care Act

Prepared by Rafael A. Gomez, MPP and Bobbie Wunsch, MBA of Pacific Health Consulting Group in collaboration with Leonard Finocchio, Dr. P.H.

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Introduction

The Patient Protection and Affordable Care Act (ACA) of 2010 will expand coverage to millions of Californians. Under the ACA, as many as 880,000 Californians will be newly eligible for Medi-Cal and 1.6 million eligible for subsidies through the health insurance exchange. An additional 880,000 residents are already eligible for Medi-Cal but not enrolledⁱ.

Insurance enrollment under the ACA is envisioned as a “no-wrong door” approach offering applicants a number of avenues into coverage including an online portal, telephone assisted application and in-person support from certified enrollment counselors (CECs) and county eligibility workers, among others.

Despite these important steps to make insurance enrollment easier and faster, California faces a daunting task of enrolling millions of eligible residents with limited knowledge about the changes in coverage options or resources available to help them with enrollment. Over 75% of Californians have little or no knowledge of the exchange (“Covered California”) and more than 50% of those eligible for free coverage under the expanded Medi-Cal program do not know they are eligibleⁱⁱ.

Community health centers have an instrumental role to play in educating patients about the major changes in health care coverage options, explaining their eligibility requirements, and assisting with their application, enrollment and health plan choices. Additionally, the ACA transition provides a window of opportunity for health centers to strengthen their financial viability by significantly increasing the proportion of patients with insurance coverage and reinforcing patient loyalty to their health center provider.

The intent of this paper is to provide practical guidance to community health centers as they embark on the critical task of supporting their patients and communities in enrolling in Medi-Cal and subsidized Covered California insurance programs.

The first section, **Eligibility Requirements and Special Populations**, provides an overview of Medi-Cal and Covered California subsidy eligibility by income and population characteristics. Additionally, it highlights key changes in eligibility for special populations served by health centers, such as mixed eligibility families, legal immigrants and pregnant women.

The **Health Center Role in Enrollment Assistance** section provides practical guidance on how health centers can facilitate enrollment into insurance for uninsured patients. It starts by outlining steps to identify, segment and target education and enrollment strategies, including:

- Internal patient report specifications to identify the number of uninsured patients that fall into different coverage eligibility categories;
- Methodologies to segment the uninsured patient populations that are *most likely* to be eligible for Medi-Cal and Covered California subsidies, and;
- In-reach strategy and timing considerations for different coverage populations.

Additionally, this section investigates promising practices in enrollment assistance among health centers and spotlights several California health centers. Topics addressed include:

- Engaging and educating staff in a “culture of coverage”;
- Promoting patient awareness/understanding of new coverage options *and* health center resources;
- Targeted in-reach strategies to those uninsured patients that are most likely to be eligible for Medi-Cal (high-yield populations);
- Understanding how health center policies and practices incentivize or dis-incentivize patients to apply for coverage;
- Establishing enrollment assistance as a core health center function, and;
- Re-imagining enrollment assistance in a post-reform environment.

Lastly, the **“No Wrong Door” Enrollment Options** section describes the multiple enrollment pathways that will become available to patients under the ACA: online, phone-based, in-person and mail/paper-based enrollment. In addition to reviewing the key features and design of these pathways, it also highlights some of the practical challenges and limitations that health centers should be aware of when enrollment begins on October 1. This includes discussion of:

- Electronic verification functionality and initial limitations;
- Timing for interfaces between the CalHEERS online portal and county SAWS eligibility systems;
- Interim enrollment pathways for new versus currently Medi-Cal eligible patients, and;
- Certified Enrollment Entity application requirements, certification process and tools to support patients.

Eligibility Requirements and Special Populations

Essentially, all legal California residents with incomes up to 400% FPL will be eligible for free or subsidized coverage under the ACA. Income eligibility will be determined using a new standard based on federal income tax returns called Modified Adjusted Gross Income (MAGI). Other required eligibility elements include citizenship or satisfactory immigration status and California residency. Table 1 describes eligibility for different populations based on income.

Table 1: Eligibility for Free or Subsidized Coverage by Federal Poverty Level (FPL)

Eligible Population	0 – 100%	100 – 138%	139 – 200%	138% - 250%	250 – 400%
Children 0 - 19			Medi-Cal – full scope		Covered California
Adults 20 - 64		Medi-Cal – full scope			
Adult legal immigrants residing in US <5 years – <u>with</u> children in, or eligible for, Medi-Cal		Medi-Cal – full scope		Covered California	
Adult legal immigrants residing in US <5 years – <u>without</u> children in, or eligible for, Medi-Cal		Covered California <i>with affordability and benefit “wraps”</i>		Covered California	

Special Populations

As the service provider of diverse communities, health centers should be keenly aware of eligibility requirements for special populations, including mixed eligibility families, legal immigrants and pregnant women. The below section briefly describes changes in eligibility for these populations.

Mixed eligibility families. An estimated 1 in 12 children who enroll in Medi-Cal in 2014 will have adults in the household who are eligible for subsidies in Covered Californiaⁱⁱⁱ. The CalHEERS enrollment system is designed to automatically determine eligibility and enroll household members into the appropriate program. These families and households will need extra education and guidance during the application process to fully explain their respective programs.

Legal immigrants residing in the US <5 Years. Currently, Medi-Cal provides full-scope coverage in existing categories for legal immigrants present in the US less than five years who otherwise meet eligibility criteria. The ACA creates tax credit eligibility for this group from 0 – 400% FPL to purchase subsidized coverage through insurance marketplaces. A new California law also modifies Medi-Cal eligibility for some in this group^{iv}.

Specifically, the following eligibility applies to legal immigrants present less than five years, who are over 21 years old, and have income 0 - 138% FPL:

- Those ***without dependent children*** will be eligible for Covered California. To assure parity with what would have been received in Medi-Cal, this group will receive an affordability “wrap” whereby the state will pay their premium and cost-sharing obligations. Moreover, this group will also be entitled to a benefits “wrap” whereby they receive benefits and services offered by Medi-Cal that are not provided by their Covered California Qualified Health Plan (e.g. dental care). Starting in 2014, or when the DHCS and Covered California have the operational capability, this group will enroll into Covered California during open enrollment periods but remain eligible for Medi-Cal until such enrollment opportunities arise.
- Those ***with dependent children*** who are eligible for or enrolled in Medi-Cal will be eligible for Medi-Cal or remain in Medi-Cal if currently enrolled. The purpose is to keep families together in Medi-Cal.

Pregnant women. Under current law, pregnant women with incomes between 59 and 100% FPL are eligible for Medi-Cal benefits limited to pregnancy-related services for the first two trimesters then full-scope benefits in the third trimester.

As of January 1, 2014, however, pregnant women with incomes up to 100% FPL will be eligible for full-scope Medi-Cal benefits in all trimesters. As available under current law, pregnant women 101 – 200% FPL will be eligible for Medi-Cal benefits limited to pregnancy-related services during the first two trimesters and then full-scope Medi-Cal during the third trimester. Women 138 – 200% FPL who are enrolled in a Covered California qualified health plan and become pregnant will have the option to disenroll from Covered California and enroll in limited-scope, pregnancy-related Medi-Cal services if they so chose.

The Health Center Role in Enrollment Assistance

Community health centers in California stand to play a significant role in educating patients about the ACA, supporting enrollment and retention, and assisting patients in making choices that are right for them and their families. The ACA provides a unique opportunity to not only engage patients and other uninsured community residents that are newly eligible for coverage but also re-evaluate the effectiveness of enrollment assistance services at health centers. Further, facilitating patient enrollment into Medi-Cal and Covered California can significantly strengthen health center financial viability.

The following sections highlight steps each health center can take to assess patient needs and target enrollment assistance strategies, as well as highlight promising practices among health centers.

Identifying Target Populations and Selecting Coverage Transition Strategies

A critical first activity in developing patient in-reach strategies and workflow improvements is to evaluate the best available data to describe the size and characteristics of the uninsured population. An effective review of the data provides health centers with the information needed to determine the number of patients requiring assistance, understand the potential impact on workflow and staffing, and prioritize where and how to most effectively target enrollment assistance activities. The analysis can be approached in three basic steps:

- **Step 1:** Develop reports on potential coverage eligibility
- **Step 2:** Segment the data to identify high-yield populations
- **Step 3:** Use data findings to inform strategy

Step 1: Develop Reports on Potential Coverage Eligibility

Data on the number of patients that are potentially eligible for Medi-Cal and Covered California (with and without subsidies), as well as those that are likely to remain ineligible, enable health centers to determine size and characteristics of the demand for coverage transitions and evaluate key questions related to staff training, patient education, targeted in-reach strategies and enrollment assistance workflow. A preliminary patient eligibility analysis might be structured in the following manner:

	Report Specifications	Potential Eligibility
Adult Uninsured	<p>Population:</p> <ul style="list-style-type: none"> • Aged 20 – 64 • Uninsured • Excluding Family PACT and restricted Medi-Cal • Select timeframe (e.g. visit w/in 6, 12 months) <p>Crosstab By:</p> <ul style="list-style-type: none"> • FPL (0 – 138%, 139 – 200%, 201 – 400%, 400%+) • Primary language spoken at home <p>Other Analysis:</p> <ul style="list-style-type: none"> • Previously enrolled in Medi-Cal or LIHP • Household member currently enrolled in Medi-Cal 	<p>Current/ Expanded Medi-Cal:</p> <ul style="list-style-type: none"> • Medi-Cal previously enrolled • LIHP previously enrolled • Household members in Medi-Cal • 0 – 138% FPL and English • 0 – 138% FPL and non-English <p>Covered California:</p> <ul style="list-style-type: none"> • 139 – 400% FPL (w/ subsidy) • 401%+ (w/out subsidy) • Can segment by language

	Report Specifications	Potential Eligibility
Family PACT	<p>Population:</p> <ul style="list-style-type: none"> Family PACT enrolled Select timeframe (e.g. visit w/in 6, 12 months) <p>Crosstab By:</p> <ul style="list-style-type: none"> FPL (0 – 138%, 139%+) Age (19 and younger, 20+) Primary language spoken at home 	<p>Expanded Medi-Cal:</p> <ul style="list-style-type: none"> Aged 20+ with income below 138% FPL and English primary language very likely <p>Covered California with Subsidy:</p> <ul style="list-style-type: none"> Aged 20+ with income above 139% FPL and English primary language very likely
Low Income Health Program (LIHP)	<p>Population:</p> <ul style="list-style-type: none"> Currently Enrolled in LIHP <p>Crosstab By:</p> <ul style="list-style-type: none"> FPL (0 – 133%, 134 – 200%) 	<p>Expanded Medi-Cal:</p> <ul style="list-style-type: none"> 0 – 133% FPL <p>Covered California with Subsidy:</p> <ul style="list-style-type: none"> 134 – 200% FPL
Children Uninsured	<p>Population:</p> <ul style="list-style-type: none"> Aged 0 – 19 Uninsured Select timeframe (e.g. visit w/in 6, 12 months) <p>Crosstab By:</p> <ul style="list-style-type: none"> FPL (0 –250%, 251 – 400%, 400%+) Primary language spoken at home Exclude CHDP Gateway and Family PACT <p>Other Analysis:</p> <ul style="list-style-type: none"> Previously enrolled in Medi-Cal/Healthy Families (and other local programs) 	<p>Current Medi-Cal or Other Local:</p> <ul style="list-style-type: none"> Previously enrolled in Medi-Cal/Healthy Families 0 – 250% FPL and English

With the above analysis, health centers can identify which transition populations their patients fall into and begin to craft patient education, in-reach and workflow strategies based on the size and needs of these populations.

Transition Population	Proxy Measures of Eligibility
Expanded Medi-Cal Eligible	<ul style="list-style-type: none"> LIHP previously enrolled LIHP currently enrolled Household members in Medi-Cal Adults Aged 20 – 64, 0 – 138% FPL Family PACT enrolled, Aged 20+
Covered California Eligible	<ul style="list-style-type: none"> 139 – 400% FPL and 401%+
Current Medi-Cal Eligible	<ul style="list-style-type: none"> Previously enrolled in Medi-Cal or Healthy Families Children 0 – 250% FPL and English as primary language

Step 2: Segment Data to Identify High-Yield Populations

Segmenting patient data by key characteristics enables health centers to more precisely target and/or phase in relevant in-reach efforts beginning with those patients that are most likely to enroll in coverage. It also allows the development of unique in-reach activities that are targeted to individual populations. Health centers can also consider which patients are likely to remain ineligible, due to documentation status or other factors, and craft communication and patient engagement strategies that are sensitive to and supportive of this patient population.

Navigating Documentation Status

Many health centers struggle with how to determine patients' documentation status and how to approach transition activities in a way that is both sensitive and realistic. Internal reports only provide estimates of the undocumented population and will require health centers to apply local assumptions about their population. Regardless, the exercise is an important step in developing a thoughtful patient support strategy that reflects health center values.

Sample Methodology for Estimating Remaining Ineligibles

Calculate the upper limit by identifying the number of uninsured adults with FPL 0-138% (Medi-Cal) and 139 – 400% (Covered California subsidy), and with a primary language other than English (*note: primary language is typically a better proxy than SSN, which is often left blank during registration*).

Segment those non-English speakers with previous Medi-Cal or LIHP/indigent program enrollment, or with household members currently enrolled in Medi-Cal. These patients have a higher likelihood of eligibility.

Apply reasonable assumptions about the percentage of remaining non-English speakers that will be eligible for coverage. Determine a range (*note: many communities under-estimate the number of non-English speakers that are actually eligible for coverage*)

Equipped with patient demographic data and contact information, health centers can target high-yield populations with personalized and proactive education and application support. Two criteria that can be used to develop targeted and/or phased in-reach activities include: 1) the likelihood of Medi-Cal eligibility as indicated by previous enrollment, household member enrollments and demographic characteristics, and 2) patient identification with the health center as indicated by most recent visit, number of visits and/or PCP assignment.

For example, a health center with limited resources may start by testing direct patient calls only with previously Medi-Cal enrolled patients and those with household members currently enrolled in Medi-Cal. Or, they may elect to cast a wide net by sending targeted mailers to all potentially Medi-Cal eligible patients who visited within the last six months.

The graphic below illustrates how a health center may choose to identify high-yield populations and prioritize in-reach activities to different transition populations.

1. Identify Potential High-Yield Populations

Extremely Likely Medi-Cal Eligible

- Previously enrolled in full scope Medi-Cal
- Previously enrolled in LIHP (or other indigent programs in non-LIHP counties)

Likely Medi-Cal Eligible

- Uninsured adults aged 20 – 64, 0 – 138% FPL, with household members enrolled in Medi-Cal
- Uninsured adults aged 20 – 64, 0 – 138% FPL, English as the primary language
- Enrolled in Family PACT, aged 20 – 24, 0 – 138% FPL, English as primary language

Potentially Medi-Cal Eligible

- Uninsured adults aged 20 – 64, 0 – 138% FPL, non-English as primary language (*see documentation status discussion*)

2. Filter by Additional Criteria

- Date of most recent visit (6, 12, 18, 24 months)
- Number of visits within the last year (1, 2+)
- Assigned to a PCP (Y, N)
- Active patient (Y, N)

3. Prioritize Populations for Targeted In-Reach

Priority Population (EXAMPLE)

Priority 1

- Medi-Cal and LIHP previously enrolled with PCP assignment and visit in last 6 months
- Family PACT aged 20+, 0 – 138% FPL with visit in last 6 months

Priority 2

- Adults 20 – 64, 0 – 138% FPL with PCP assignment and visit in last 6 months

In-Reach Activities (EXAMPLE)

- Direct patient calls
- Individualized mailers
- “Combing” of clinical schedules to schedule application assistance visits

- General mailer
- Direct registration and provider referrals based on SFS levels

Step 3: Use Data to Inform Patient Education, Targeted In-Reach Strategies and Enrollment Workflow Improvements

Health centers have essentially three major strategies available to support patient transitions into coverage under the ACA:

- Patient awareness and education
- Targeted in-reach to priority populations, and
- Ongoing enrollment assistance services

The next section reviews options and promising practices for health centers to consider when utilizing the above patient support tools. An analysis of health center data describing the size and characteristics of ACA transition populations can clarify: the level of patient demand; patient education and staff training requirements; strategy options to most efficiently move patients into coverage; and the strength or weakness of current application assistance services.

Transition Population	Considerations for Application Assistance Strategy
Expanded Medi-Cal Eligible	<ul style="list-style-type: none"> • Depending on size of population, may lack capacity to proactively in-reach to entire population • Need to determine how to prioritize populations and in-reach activities • Develop clinical visit workflow changes to identify and direct refer priority populations (e.g. direct provider referral at time of visit) • Consider timeline to begin in-reach activities given unique enrollment pathways for new vs. existing Medi-Cal eligible prior to January 2014 • Articulate key messages to encourage patient action (i.e. cost, access)
Covered California Eligible	<ul style="list-style-type: none"> • Need to determine whether the health center will actively support applications or direct patients to other resources first • If large population, additional staff and patient education likely required on individual mandate, subsidies and enrollment resources • Consider in-reach timeline, given limited open enrollment period to enroll in Covered California (Oct 2013 to March 2014 in first year)
Current Medi-Cal Eligible	<ul style="list-style-type: none"> • High numbers of currently eligible may indicate a breakdown in current enrollment assistance workflow and a need to revise practices • Consider timeline to begin in-reach activities given unique enrollment pathways for new vs. existing Medi-Cal eligible prior to January 2014
Low Income Health Program (LIHP)	<ul style="list-style-type: none"> • LIHP enrollees will transition into Medi-Cal but may require support/education regarding transition process, redetermination, health plan and medical home selection, and/or explanation of benefits • Consider how in-reach can address likely patient questions or confusion and reinforce patient loyalty to health center
Remaining Ineligible	<ul style="list-style-type: none"> • If large population, identify staff training requirements related to legal immigrants, mixed eligibility families and restricted Medi-Cal • Articulate how materials and messaging will address documentation status and reinforce commitment to the population • Clarify extent to which potentially ineligible/undocumented patients will be included in education and in-reach activities

Staff and Patient Education

Most uninsured patients are unaware of how the ACA will work and how it will affect them. They are also unaware of the new coverage options that are available. Similarly, most health center staff have only a basic understanding of ACA coverage options, mechanisms for enrollment or how health centers support patients. Investing in staff and patient education is an essential activity and the foundation for effective enrollment assistance services over the long-term.

Build a culture of coverage among staff. Simply stated, the “culture of coverage” recognizes that every staff member, including receptionists, medical assistants, billers and providers, plays an essential role in educating patients about coverage options and directing them to enrollment assistance services.

The ACA transition provides an important opportunity to educate staff about coverage options available to patients and articulate *their role* in helping patients get coverage. It also affords an opportunity for the organization to highlight coverage transitions as an organizational priority and embed shared responsibility into everyday operations. Establishing a shared commitment to coverage among all staff is perhaps the most fundamental step in developing effective enrollment assistance services.

Promising Practices: Building a Culture of Coverage

Conduct trainings for all staff (including providers) on coverage programs and health center resources. Consider holding periodic refresher trainings throughout the year and incorporating coverage sessions into new staff orientation.

Articulate the role that different staff positions play in supporting coverage and reinforce those roles. For example, receptionists can ensure that patients complete screening forms and understand the value of coverage, providers can share materials and urge patients to meet with enrollment assistance staff/CEC, and billers can use the billing process to redirect patients to get screened for coverage. Consider these roles when designing workflows, developing dashboard measures and training staff on their roles.

Set organizational goals and track progress visibly. Like quality, productivity and clinical access, helping patients attain health insurance is an organizational priority to which everyone contributes. Highlight its importance by setting goals, visibly tracking and communicating about progress, and recognizing performance.

Spotlight: Petaluma Health Center

When Healthy Families eliminated Certified Application Assistor reimbursements in 2004, Petaluma Health Center made a conscious decision to maintain its patient outreach and enrollment assistance department due to its impact on patient access and health center financial viability. Over the years, application assistance has evolved into a central patient service and is firmly integrated into organizational operations.

New staff and providers participate in orientation trainings describing coverage programs and on-site services, and providers lean on enrollment assistance staff on a daily basis. Assistors receive direct referrals for follow up, participate in warm hand-offs and are even called on by providers to provide in-visit patient consultations. The partnership between clinical and support services has fostered a culture of coverage in the organization.

Spotlight: North East Medical Services

North East Medical Services (NEMS) serves nearly 60,000 patients in San Francisco's Chinatown and across the Bay Area. Thirty bilingual member services staff trained as Certified Application Assistors (and soon to be Certified Enrollment Counselors) support new patient registration/orientation and work closely with existing patients to facilitate program renewal and changes. As one of the first pilot sites for the Healthy San Francisco program, NEMS has meaningful experience communicating with and guiding patients through major program changes.

Relying on staff scripts and basic flyers written in English, Chinese and other languages, NEMS' first phase of patient communication sought to provide basic information on the ACA with an opportunity for patients to schedule one-on-one sessions with member services staff. They also plan to provide daily group education sessions, which patients can sign up for, at different clinic sites, as well as link ACA education to ongoing health education services.

Internally, NEMS views providers as key patient educators, and they are developing basic scripts that providers can use to educate patients, along with simple guidance for identifying those patients that are likely eligible and should speak with a member services staff person.

Invest in a patient awareness and education campaign. As recently as August 2013, 75% of California voters under age 65 said they had little or no knowledge of Covered California. Half of those eligible for free coverage under the expanded Medi-Cal program said they did not know they are eligible^v.

Health centers should make thoughtful efforts to raise patient awareness about the ACA, peak interest in how it might affect them, and provide clear guidance on how the health center can support them getting coverage.

Promising Practices: Patient Awareness and Education

Market with reckless abandon. Think about where patients have downtime and place messages there. This could be posters in the waiting rooms, flyers in exam rooms, educational videos in the waiting room and even recorded messages on the phone system for those on hold.

Incorporate basic patient education into the clinical visit and other direct patient interactions. Develop simple scripts, protocols and flyers for staff at every level, including the call center, registration, medical assistants, billers and providers – everybody plays a role. Utilize basic but clear messaging that emphasizes potential eligibility and how to connect with on-site resources.

Give providers a small but essential role. Patients trust and listen to their providers. Engage providers to quickly highlight ACA coverage expansion and refer patients to on-site resources. Think about simple tools that providers can use, such as flyers, easy referrals via the EHR or the website, as well as any easy guidance to help them target patients with a high likelihood of eligibility (i.e. all patients with specific SFS level).

Place educators in the waiting room. Many health centers are placing outreach workers, promotoras or even volunteers in waiting rooms to provide personal education and link patients to enrollment assistance resources. Those health centers that are not participating in the outreach grants can still access an abbreviated version of the certified educator training online at www.coveredca.com.

Tailor messages to your patient population. Consider your population when crafting messages. Do you anticipate most newly eligible will move into Medi-Cal only or do you have a number of patients becoming eligible for Covered California? Do you serve a large number of mixed eligibility or non-English speaking patients? Messaging should consider their perspectives and questions.

Hold group education sessions. Group sessions at health center facilities (and in the community) provide a forum for interested patients to learn more about major ACA components, such as the individual mandate or the new exchange marketplace, as well as connect with enrollment assistance sessions. Brief regular sessions at health center facilities are likely to be more successful than one or two major presentations because patients will have more flexibility on when to attend.

Three Simple Patient Messages

- 1) You might be eligible for free or reduced cost insurance.
- 2) We can help you enroll.
- 3) Here is where to go for individual assistance.

Targeted In-Reach to High-Yield Populations

Given limited capacity, it is appropriate for health centers to concentrate enrollment assistance efforts on those populations that are most likely to transition into health coverage. This includes identified high-yield populations, patients with a meaningful connection to the health center and those patients that express great interest in gaining coverage. Over time these activities can be extended to additional uninsured patients.

High-Yield Populations

- Previously enrolled in full-scope Medi-Cal
- Previously enrolled in LIHP
- Family PACT enrolled, 20 – 24, 0 – 138% FPL, English as primary language
- Uninsured adult, 20 – 64, 0 – 138% FPL
 - Household members enrolled in Medi-Cal
 - English as primary language

Prioritize limited resources. Linking uninsured patients to coverage is a task that health centers will be tackling for the foreseeable future. In many health centers, 30% or more of patients will require some sort of education or linkage to coverage options – that is one out of every three visits. Given the enormity of this task, it is reasonable to phase in targeted in-reach activities, beginning with those patients that are most likely to be eligible and responsive to engagement.

Be deliberate in identifying high-yield population lists. Methods for developing lists of patients who are very likely Medi-Cal or subsidy eligible are

discussed at length earlier in the paper. Since targeted in-reach is staff and resource intensive, health centers should think carefully about other filtering criteria that can narrow initial in-reach efforts to those patients who will be the most responsive. Common criteria include date of most recent visit, those with multiple visits in a year or those with a PCP assignment. A full discussion of segmenting methods can be found in the *Identifying Target Populations and Selecting Coverage Transition Strategies* section.

Spotlight: LifeLong Medical Care

Serving low income and senior residents in Berkeley, Oakland, San Pablo and Richmond for more than 35 years, LifeLong Medical Care has developed deep relationships in the community.

Close to a year ago, LifeLong launched an intensive community outreach effort hosting education sessions at local barbershops, laundromats, youth groups, community churches, and local libraries, among other locations. Beginning in October, LifeLong anticipates providing remote enrollment assistance using laptops at these community venues.

Learn from other patient engagement efforts. Lessons from previous patient engagement efforts can provide important lessons about which in-reach strategies will work with the patient population. For example, the Quality Improvement Department has likely experimented with direct mailings, targeted calls, case management and provider messaging. The Billing Department may have tested different types of mailings, reviewing patient bills at the time of appointments, front desk messaging and collection calls. Consult with various health center departments to learn about successes/failures and generate new ideas for in-reach.

Promising Practices: Targeted In-Reach Activities

Conduct proactive outreach to high-yield patient populations

- Send mailers from the health center or assigned provider that are tailored to individual populations, such as those previously enrolled, those with family members in Medi-Cal or Covered California eligibles.
- Conduct direct patient calls to schedule an enrollment assistance appointment or initiate an online application over the phone.

Develop mechanisms to engage high-yield patient populations at the time of a clinical visit

- Flag patient records or categories for direct referral by registration and/or the provider at the time of a clinical visit (e.g. targeting specific Sliding Fee Scale levels).
- “Comb” clinical schedules for high-yield populations (e.g. previously enrolled, extremely likely Medi-Cal eligible) and either schedule an appointment or introduce the patient to enrollment staff at time of clinical appointment.

Develop hot lists for direct follow up

- Create a single referral tool (e.g. EHR, website) that staff, such as outreach workers, receptionists, medical assistants and providers, can use to direct refer patients for follow up.
- Give patients a single resource, such as the website, to express interest in learning more and provide contact information for direct follow up.

Low Income Health Program (LIHP) Transition

Although health center patients that are LIHP enrollees will automatically transition into Medi-Cal or Covered California on January 1, 2014, these patients may still require support with and education about the transition. Health centers should be educated about the LIHP transition and consider what communication and/or in-reach is necessary to support patients.

LIHP Eligibility and Communication

- *Enrollees with income 0 – 133% FPL* will transition into Medi-Cal without having to undergo an eligibility determination. They will receive a general notice in September, a health plan notice in late October, and welcome packets with BIC cards in late November.
- *Enrollees with income 134 – 200% FPL* will be eligible for subsidized Covered California coverage. They will receive a notice from Covered California in September and will be contacted by Covered California customer service representatives beginning in October.

LIHP Redetermination for Medi-Cal Eligibles

- LIHP enrollees who transition to Medi-Cal with a redetermination date between January 1 and March 1, 2014 will have their redetermination deferred to April 1, 2014.
- LIHP enrollees who transition to Medi-Cal with a redetermination date between October 1 and December 31, 2013 may have their redetermination deferred for a full year. *Note: Counties must choose this option, so health centers should check with their respective counties.*

Medi-Cal Health Plan and Medical Home Selections

- Enrollees will be moved into managed care plans with a priority placed on keeping current primary care providers (PCP).
- Notifications will identify which plans have enrollees' PCP and instruct beneficiaries that they can change their managed care plan.
- If no action is taken they will be assigned to a plan that includes their PCP.

Enrollment Assistance as a Core Health Center Function

Health centers should evaluate the efficiency, productivity and customer service performance of current services and identify improvement opportunities. Some key questions to ask when assessing workflow include:

- How do current policies and practices encourage or discourage patients to complete coverage applications?
- How efficiently are enrollment assistance resources being used and how effective are we at getting patients into coverage?
- How is application assistance workflow likely to change following health reform?

Re-think patient incentives. A valuable step in developing enrollment assistance services is to examine how organizational policies and practices may encourage or discourage patients from seeking coverage. For example, are patients educated about the enrollment assistance resources available in the health center? Do they understand how coverage can reduce their costs? On the other hand, are there any consequences for patients who fail to pay their bills or forget to bring back their pay stubs, and how does this incentivize or dis-incentivize patient follow-up on applications?

Health centers may want to consider implementing explicit policies requiring patients who are identified as potentially eligible to apply for Medi-Cal or Covered California, in order to maintain their eligibility for the sliding scale.

Promising Practices: Patient Incentives

- Market enrollment assistance as a patient service, not a hoop to jump through.
- Make enrollment assistance services convenient by including drop-in appointments, linking appointments to clinical appointment times or making support available after hours.
- Require potentially eligible patients under 200% FPL to apply for Medi-Cal and Covered California in order to maintain Sliding Fee Scale eligibility.
- Enforce patient billing/collection practices and strictly adhere to sliding fee scale policies articulating grace periods and documentation to strengthen incentives to pursue coverage.

Indicators of Breakdown in Application Assistance Workflow

- **“Unknown” income** – If there are a lot of uninsured patients with “unknown” income, many are likely not completing the sliding scale application. This can be caused by inconsistent distribution and explanation of applications, inconsistent follow up, and/or lax billing practices.
- **Uninsured children** – Since many communities have near-universal coverage for children, a meaningful percentage of uninsured children can indicate shortcomings in enrollment assistance services.
- **Previously enrolled** – A high number of patients previously enrolled in Medi-Cal or Healthy Families suggests a need for improved renewal support and perhaps a breakdown in the screening and referral process to get patients to enrollment assistance.
- **High self-pay accounts receivable** – It may seem unrelated, but if patients consistently fail to pay bills or nominal fees they probably do not see any negative consequences for non-payment or view the clinic as a “free” clinic. These patients may not see as much incentive to apply for coverage as patients in clinics where billing and collection is strictly enforced.

Optimize operational efficiency, productivity and patient experience. As with clinical operations, enrollment assistance services must be actively managed in order to deliver efficient, effective and consumer-oriented services. Common challenges include under-utilization of enrollment assistance appointments, low patient awareness about services, and ineffective targeting of services to high-yield populations.

Promising Practices: Operational Efficiency, Productivity and Patient Experience

Make services convenient to the patient

- Place computers in the waiting room (or adjacent space) so patients can apply for coverage online. Make staff or volunteers available to answer questions and assist patients as needed.
- Link in-person screenings with clinical appointments so the patient only has to show up once.
- Provide drop-in appointments for patients there for clinical appointments.
- Offer after-hours and weekend enrollment assistance.

Keep it personal

- Encourage providers to make personal referrals.
- Have patient letters/mailers come from their provider.
- Allow for warm hand-offs or short appointments where enrollment assistors can make personal connections with patients even if no appointments are available.
- Assign enrollment assistors to clinical teams and include them in morning huddles to review patient needs for the day.
- Utilize volunteers or promotoras to educate patients and link them to enrollment assistors.

Prioritize limited on-site resources

- Automatically schedule enrollment assistance appointments for new patients without insurance or those with expiring insurance/SFS eligibility.
- Target in-reach to high-yield populations (see earlier section).
- “Comb” clinical schedules for high-yield populations (e.g. previously enrolled) and either schedule an appointment or make personal contact with enrollment assistor at the time of clinical appointment.

Spotlight: AltaMed Health Services Corp.

AltaMed, in Los Angeles and Orange County, is one of the largest community health centers in the country, serving close to 150,000 patients. In anticipation of a transition of nearly 25,000 patients into Medi-Cal and Covered California, AltaMed has plans to launch a major patient in-reach and enrollment assistance campaign. In addition to identifying patients that are likely eligible for coverage through its internal patient database, AltaMed has created a simple referral tool on its website that allows staff and providers to refer patients interested in learning more about health coverage options. Patients can also self-refer. Both web-referrals and patient lists of likely eligibles will be fed directly into a centralized client relations management (CRM) system that will queue up targeted patient telephonic outreach focused on patient education and engagement in the enrollment process. The CRM allows AltaMed to track patient contacts and case status from start to closure.

Given that demand for enrollment support will far outpace on-site resources at their facilities, AltaMed is also piloting free-standing service centers located at malls and other community settings. There, CECs will provide direct education and enrollment assistance to community members interested in coverage.

Operational Performance Measures

- **Percent of appointment slots utilized, no show rates** – Indicates degree to which current capacity is utilized. Low utilization suggests breakdown in scheduling process or mismatch between how/when services are offered compared to patient needs.
- **Number of completed full and renewal applications by line of business and by enrollment assistor/CEC** – Indicates organizational and individual productivity, service demands (e.g. new vs. renewal) and training needs (high-volume programs).
- **Percent of submitted applications resulting in enrollment** – Generally indicates knowledge and skill level of enrollment assistor.
- **Wait time for appointment** – Reflects patient experience, capacity and/or breakdown in scheduling process.

Re-Imagining Enrollment Assistance in a Post-Reform Environment

In the current environment, health center staff guide patients through an often complex and cumbersome public coverage application process by ensuring accurate submission of detailed applications, assembling documentation and advocating for patient cases under consideration. In light of significant coverage expansion under health reform, simplified eligibility requirements and new tools, such as the online portal and phone-based customer service centers, health centers should consider how their role in helping patients obtain and keep health insurance coverage will change.

From advocate and assistor to coverage facilitator. With most patients now eligible for some form of subsidized coverage, and additional tools available to support enrollment, health centers may be increasingly called upon by patients to help them understand coverage choices and navigate the process, rather than drive the application process.

Emphasis on retention and transitions. Although it is likely to take several years to achieve full enrollment, health center workloads will gradually shift from enrollment to retention and transition between coverage programs. In this environment, patients will require less intensive support for individual applications but more ongoing communication about coverage periods, information on different coverage programs, and guidance on transitions between them.

Reduced demand for in-person appointments. Reliance on in-person appointments makes sense when application processes are extremely complex, require significant documentation and are paper-based. In-person appointments also allow the development of trust with clients who are sharing personal

Information about income, family situations and legal status. With more online options available (for both the individual and CEC) and federal/state interfaces that limit documentation requirements, patients may assert stronger preferences for other types of support that do not require them coming into the health center.

Looking Forward: Ideas on the Changing Health Center Role in Enrollment Assistance

- **Invest in retention.** Develop standard practices to ensure on-time renewal of patients in coverage programs, such as reminder mailings or phone calls, telephonic renewal support and/or active coordination with your local Medi-Cal health plan or county social services office.
- **Develop a proactive communication schedule with patients.** In addition to referrals when patients come in for care, consider developing a regular communication schedule to remind patients of renewal dates, coverage program changes/updates, helpful enrollment hints, etc. Make patients aware of the importance of coverage and establish your health center as an important resource to help.
- **Develop your role as a real-time resource.** Patients are likely to need less intensive support for applications and more real-time answers to questions about coverage programs, application processes and transitions between programs. Consider ways that the health center can provide more flexible and low-intensity services, such as a resource telephone hotline, staff resources in the waiting room or more drop-in availability for quick questions. Additionally, consider distributing collateral to patients that answers common questions.
- **Pilot changes in how enrollment assistance is provided.** Begin testing alternative support models with patients, such as remote enrollment support, self-service kiosks in the waiting room and patient self-enrollment guides, among others. Begin testing models that respond to changing patient needs and are provided in a more convenient and patient-driven way.
- **Think about patient empowerment.** Following coverage transition, more patients will need health center support but will also have more tools at their disposal. Over time, patients will gain experience with the enrollment/renewal process and familiarity with the tools. Invest in efforts to build patient self-efficacy and confidence for managing their own coverage, while keeping health center staff available to answer questions.

“No Wrong Door” Enrollment Options

As health centers begin enrollment support activities, it is useful to understand both the design and function of these enrollment options, as well as some of the practical challenges and limitations at the time enrollment begins on October 1.

Californians will have four principal options to enroll in individual coverage under the Affordable Care Act:

- **Online** enrollment using the CalHEERS portal
- **Phone-based** enrollment via the Covered California customer service centers
- **In-person** enrollment support from Certified Enrollment Counselors (CECs) and county Medi-Cal eligibility workers
- **Mail-in** enrollment using a paper-based uniform application that mirrors the CalHEERS online application

Option 1: Online Enrollment

The online application portal, or California Healthcare Eligibility, Enrollment & Retention System (CalHEERS), is designed as a single streamlined application that allows Californians to apply for Covered California (subsidized and un-subsidized) and Medi-Cal, either on their own, with the help of a Certified Enrollment Counselor (CEC), or with support from the Covered California service center. CalHEERS is scheduled to go-live on October 1, 2013 and can be accessed at www.coveredca.com.

Major CalHEERS functionality will include the ability to create, manage, submit/track status of applications, select health plans, and upload required documents/files directly into the system. Consumer applicants using CalHEERS will also be able to request help via online chat or by calling the toll-free Covered California customer service center. Consumers may also work with CECs who can help with all aspects of the online application in CalHEERS even after a consumer has begun their application.

Table 2 – Key Functionality Milestones for CalHEERS

Functionality	Launch Date
CEC registration	Active
“Shop and compare” tool for QHP plan option and cost comparisons	Active
Enrollment begins for Covered California and new Medi-Cal eligible	October 1, 2013
CalHEERS – Federal data services hub interface	October 1, 2013
Coverage begins for Covered California and new Medi-Cal eligible	January 1, 2014
CalHEERS – SAWS interfaces	January 1, 2014
Medi-Cal managed care health plan selection	April 1, 2014
CalHEERS – state data interfaces	TBD 2014

Electronic Verification

The CalHEERS “business rules engine” is designed to automatically determine eligibility for Modified Adjusted Gross Income (MAGI) Medi-Cal and Covered California subsidies once an application has been completed, by electronically verifying (where information is available) applicants’ income, citizenship/immigration status, and California residency (for Medi-Cal only) using interfaces to federal and state data sources.

Table 3 - Eligibility and Electronic Verification

Eligibility Requirement	Federal Data Services Hub	State Data Sources
Income	Internal Revenue Service	Franchise Tax Board Employment Development Dept.
Citizenship	Dept. of Homeland Security	N/A
Immigration status		
California residency	N/A	Department of Motor Vehicles Franchise Tax Board County SAWS Systems

Electronic verification will not be fully functional on October 1, 2013. Different functionality will be phased-in over time. Key phase-in considerations include the following:

- Applicants for Medi-Cal will have to upload documents that prove California residency to CalHEERS or provide such information (in-person or via mail) to a county eligibility worker, since electronic verification of California residency will not be available until sometime in 2014. County eligibility workers will also have the ability to use their local county eligibility systems to verify residency of individuals enrolled in other public benefit programs (CalWORKS, CalFRESH) without requiring additional paper documents.
- Federal data interfaces are expected to be operational on October 1, 2013 but the proportion of applicants that will encounter some level of challenges with electronic verification is unknown. If CalHEERS is unable to verify citizenship/legal status or income electronically, applicants will need to manually upload documents to CalHEERS, which will then be verified by a Covered California customer service representative or a county eligibility worker.
- All documents uploaded into CalHEERS or submitted to the county eligibility office require review and verification by an eligibility worker prior to completion of the eligibility determination on the application.

Patient Support Considerations: Electronic Verification

At least initially, nearly all applicants eligible for Medi-Cal or Covered California subsidies will need to provide additional documentation either by uploading documents directly into CalHEERS or submitting them to county eligibility offices for review. Health centers should be knowledgeable about required documentation and prepared to actively assist patients in identifying and uploading appropriate documentation to facilitate their application and enrollment.

Documentation Applicants May Need to Apply

When applicants' required eligibility information cannot be verified electronically, items from the following documentation list may need to be included with the paper application, scanned and uploaded (if applying online), or shown in person to an eligibility worker.

Requirement	Covered California	Medi-Cal
Citizenship or legal immigration status	Passport, Social Security card, immigration documents	
Income	No paper documentation requirement	<i>One of the following:</i> <ul style="list-style-type: none"> • Most recent tax return • Paystubs • If <i>projecting</i> annual income, evidence of predicted changes in income, including signed contract with terms, or history of predictable income fluctuations.
California residency		<i>One of the following:</i> <ul style="list-style-type: none"> • Rent or mortgage receipt • Utility bill • California driver's license or DMV identification • California motor vehicle registration • Proof of California employment or registration with employment service • Children's school registration • Enrolled in public assistance • Registered to vote in California

CalHEERS Interfaces with Medi-Cal Eligibility and Enrollment Systems

Effective January 1, 2014, the CalHEERS system will interface with the three existing county eligibility systems, known collectively as the Statewide Automated Welfare Systems (SAWS). The interfaces will allow the exchange of application data and real-time use of the eligibility business rules engine by the county SAWS systems. Some specific components of the new design will include:

- Online applications with completed electronic verifications that have been determined eligible for Medi-Cal will be transferred to the county SAWS system and county eligibility workers to accept the Medi-Cal eligibility determination and manage the case on an on-going basis.
- Incomplete Medi-Cal applications (including those requiring additional verifications) will be transferred to county eligibility workers for follow-up in the applicants' county of residence.
- Although they expect faster processing, counties will be held to the same legal requirement to determine Medi-Cal eligibility within 45 days for individuals who are not applying on the basis of a disability.

- Similar to current practice, applicants needing an eligibility determination for aged, blind or disabled status will be referred to counties, which will follow-up to obtain additional information supporting eligibility. The eligibility rules for these individuals reside in the SAWS systems. CalHEERS is not designed to support the full application process for these non-MAGI populations.

Statewide Automated Welfare Systems (SAWS)

The three county eligibility and enrollment systems are collectively known as the SAWS. LEADER serves Los Angeles County, CaWIN serves 18 counties, and C-IV serves the remaining 39 counties. These systems perform eligibility determination, enrollment, redetermination and case management for the state's main health and human services programs, including Medi-Cal, CalWORKs, CalFresh and numerous counties' General Assistance programs.

Each of the SAWS systems also includes an online application portal that allows for applications for multiple human service programs, including Medi-Cal. These online portals will be modified as of January 1, 2014 to include all of the eligibility elements necessary for a MAGI determination either for Medi-Cal or tax subsidies with Covered California.

Facilitating Medi-Cal Applications Between October 1 and December 31, 2013

Supporting patient applications for Medi-Cal during the period between October 1 and December 31, 2013 will be challenging for a number of reasons. Most importantly, enrollment assistors will be presented with unique considerations for **currently** vs. **newly** eligible Medi-Cal applicants.

Between October 1 and December 31, 2013:

- The electronic interface between CalHEERS and SAWS will not be operational until January 1, 2014.
- The CalHEERS system will only evaluate applicant eligibility for Medi-Cal according to the new MAGI Medi-Cal eligibility requirements that become effective on January 1, 2014. If found eligible, coverage will not begin for newly eligible applicants until January 2014 so any applicants with current eligibility would be without coverage until that date.
- The SAWS systems, on the other hand, will continue to evaluate eligibility according to existing Medi-Cal eligibility requirements and will not have the capability to evaluate eligibility for coverage under the new requirements until January 1, 2014.
- Though the interface will not be operational, if an individual presents at a local county social services office, eligibility workers will assist the individual to apply for the coverage based on their needs. There may be instances of duplicate application entry into both eligibility systems, especially if an individual started an application in CalHEERS but also wants an evaluation for coverage using existing Medi-Cal rules, in order to access care immediately.

Patient Support Considerations: Medi-Cal Applications Between October 1 and December 31, 2013

Health centers may want to consider the following options when supporting patient Medi-Cal applications between October 1 and December 31, 2013:

- Delay targeted in-person outreach to Medi-Cal eligible populations until either late in 2013 or early in 2014 to avoid multiple changes in enrollment assistance workflow.
- Facilitate applications for **newly** Medi-Cal eligible patients through the CalHEERS system beginning on October 1, for coverage that will begin in January.
- Facilitate applications for **currently** Medi-Cal eligible patients using the SAWS systems or local county social services (consistent with current practice) until December 31 so those applications may be considered immediately, according to current eligibility criteria.
- Consider referring preliminarily eligible patients to the Covered California toll free number for Medi-Cal eligibility assessment, referral to their county of residence (when appropriate), or eligibility determination for tax credits in Covered California.
- Coordinate closely with county social services to understand the county strategy for supporting enrollment. Counties are expected to utilize different strategies to accommodate the influx of applications and may face different challenges related to timely and accurate application processing.

Option 2: Phone-Based Enrollment

Patients will also have the option to enroll in coverage over the phone. Covered California customer service representatives have been deployed at three call centers in California: Sacramento, Fresno and Concord. The call centers will include both evening and weekend hours. Customer service representatives will conduct assessments, eligibility reviews and proceed with enrollment for most customers.

After a short series of preliminary questions known as “Quick Sort,” callers who are likely Medi-Cal eligible will be transferred immediately by phone to a county eligibility worker. This “warm hand-off” will follow clear protocols and will be administered through agreements between Covered California, DHCS and counties.

Option 3: In-Person Enrollment

Certified Enrollment Counselors (Community-Based)

In addition to online or phone-based enrollment options, Californians can look to Certified Enrollment Entities (CEEs) and associated Certified Enrollment Counselors (CECs) for support with their insurance application for Medi-Cal or Covered California. Covered California in collaboration with DHCS, through its In-Person Assistance Program, will manage both the CEE and CEC application, training and certification programs. Covered California’s In-Person

Assistance Program description, applications and other materials can be found online at: www.healthexchange.ca.gov/Pages/EnrollmentAssistanceProgram.aspx

In order to utilize the online portal to support applications into Medi-Cal or Covered California, and be paid for successful Covered California enrollments, entities must first apply and complete training to become a Certified Enrollment Entity (CEE). Certification as a CEE then enables entities to recruit and manage the CEC application and agreement processes for their staff. CEEs may add new CECs who have completed training, certification and background checks at any time.

Certified Enrollment Counselors (CEC) will provide one-on-one assistance with applications, health plan selection and annual renewals. Eligible persons must undergo a criminal background check and fingerprinting, complete a three-day training, and pass an online certification exam. CECs will support applications through CalHEERS as the system will have specific functionality for CECs including profile creation, application queue management, application status tracking, and annual renewal reminders.

Patient Support Considerations: In-Person Assistance

Most health centers are expected to pursue certification as a CEE and to employ CECs in order to better assist patients. However, the ability to provide patient assistance is not limited only to CECs.

- CEE/CEC certification enables entities to utilize the CalHEERS portal to start, manage and support patient applications. It also allows health centers to claim reimbursement for successful enrollments from Covered California or Medi-Cal.
- Non-CEC staff and volunteers can also provide in-person education, guidance on the application process or eligibility requirements, or even real-time support for patients completing applications themselves. For example, a health center could choose to establish a computer lab so patients can complete the on-line application and have staff and volunteers on-site to answer questions and provide computer support.

County Eligibility Workers (County Social Services Offices)

County eligibility workers have also been trained to support and process enrollments for both Medi-Cal and subsidized coverage at Covered California, as well as address mixed eligibility families. As they currently do, eligibility workers will continue to case manage Medi-Cal enrollees and support them with any eligibility questions and annual renewal needs. New customer service workflows developed by the Department of Health Care Services (DHCS) and California counties can be reviewed online at: www.cwda.org/tools/healthcare.php

Option 4: Mail / Paper-Based Enrollment

Californians may also apply using a paper application. The single streamlined application is the same online as it is on paper. Paper applications sent to the Covered California service center will be optically scanned into CalHEERS, assessed for completeness, and receive follow-up by Covered California customer service representatives if the applicant is likely tax subsidy eligible. Applications that are likely Medi-Cal eligible will be transferred to county eligibility workers in the appropriate county for any needed follow-up and/or ongoing case maintenance.



Conclusion

The Affordable Care Act is an unprecedented opportunity to provide health insurance coverage to millions of Californians that otherwise could not afford it. As trusted resources and health care providers for the state's most vulnerable residents, health centers will play a central role in educating and enrolling our patient communities. Health centers are also tasked with monitoring the effectiveness of major changes in eligibility pathways and advocating for patients to ensure that the goals of health reform become reality.

The dramatic coverage expansions under ACA can also serve as a reflection point for health centers to examine the effectiveness of current enrollment assistance services and commit to these services as an essential, efficient and patient-focused health center function. As with all clinical and patient support services provided by community health centers, the extent to which enrollment assistance can be firmly established as a core health center service will play an instrumental role in determining the health and well-being of California's low-income residents.

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For more information or inquiries please contact Rafael Gomez (rgomez@pachealth.org) or Bobbie Wunsch (bwunsch@pachealth.org) of the Pacific Health Consulting Group (www.pachealth.org).

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^{iv} (ABx 1 1, §25, Section 14102)

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