

**Affordable Care Act Year Two: Education,
Outreach and Enrollment
Oversight Hearing
State Capitol, Room 4203
10:00 a.m. – 1:00 p.m.
October 30, 2014
Background Paper**

To date, over 3 million previously uninsured Californians have enrolled into health coverage under the Patient Protection and Affordable Care Act (ACA). Approximately, 1.2 million Californians have enrolled in the California Health Benefit Exchange (Covered California) and Medi-Cal enrollment has increased from 8.6 million in December 2013 to 11.2 million. As a result of the coverage expansions under the ACA, between 90 and 92 percent of non-elderly Californians are predicted to have health coverage by 2019. Despite California's significant enrollment success in Covered California and in Medi-Cal, the enrollment process has been difficult for some consumers and fell far short of the oft-stated goal of a "first class customer experience."

PURPOSE

This hearing will serve to update legislators and the public about lessons learned from the first year of enrollment into Covered California and Medi-Cal coverage under the ACA. Covered California and the Department of Health Care Services (DHCS) representatives will explain program strategies that are being employed to garner the best possible enrollment outcomes for year two. The hearing will also focus on progress made towards a simplified and streamlined enrollment process and provide oversight of the following issues:

- Outreach and education approaches aimed at increasing enrollment among harder to reach target populations, including those with limited English proficiency.
- Overview of the demographic makeup of those enrolled and the populations targeted for enrollment.
- Operational challenges between multiple eligibility, data and enrollment systems.
- Covered California's processes and procedures with regard to payments, training, and communications with, and between, enrollment contractors and staff.
- Notifications to enrollees.
- Policy and administrative decisions made by Covered California and DHCS that affect the enrollment process.
- Performance standards for entities enrolling individuals in Medi-Cal and Covered California.

BACKGROUND

Enacted in 2010, the ACA greatly expands health insurance coverage in California and nationally. Since the enactment of the ACA, millions of low- and middle-income Californians have gained access to health insurance coverage under the expansion of Medi-Cal (California's Medicaid program), through easier enrollment and retention policies established for Medi-Cal,

through premium and cost-sharing subsidies offered through Covered California, and through reforms of private insurance market rules.

Under the ACA, starting in 2014, Americans are required to maintain health insurance or pay a penalty, with exceptions for financial hardship (if health insurance premiums exceed 8% of household adjusted gross income), religious beliefs, incarceration, or immigration status. Health insurers operating in the small business and individual insurance markets can no longer impose pre-existing health condition exclusions or discriminate based on health status. Health insurers must offer policies on a guaranteed issue and renewal basis; and can only charge premiums based on adjusted community rating, meaning rates can be based only upon age, family size, geographic location, or tobacco use (California does not permit rates based on tobacco use and required guaranteed renewal for all products and guaranteed issue for small employer products prior to the ACA).

The ACA also requires states to either establish a health insurance exchange to make individual and small business coverage available for residents to purchase, or rely on a new federal exchange. The exchanges not only serve to sign people up for insurance, but also administer federal health insurance premium tax subsidies and cost sharing reductions to help people pay for their health insurance policies. This financial assistance is only available to individuals purchasing health insurance through exchanges.

With the passage of SB 900 (Alquist), Chapter 659, Statutes of 2010, and AB 1602 (John A. Perez), Chapter 655, Statutes of 2010, California established Covered California, as a state-based exchange that is operating as an independent government entity with a five-member Board of Directors. California also granted Covered California authority to selectively contract with health insurance companies that offer policies on California's exchange. As a newly established entity, Covered California had to act quickly to bring on staff and expertise to develop policies and systems, select health plans and establish a brand identity necessary to begin enrolling Californians into coverage starting in October of 2013.

Outreach and Education

Covered California focused its marketing and outreach through two streams: 1) paid digital and traditional advertising and direct marketing, including supportive collateral materials, media relations, coordinated events and social media outreach; and 2) an outreach and education grant program, community outreach network of uncompensated partners, and insurance agents and other in-person assistance programs directly assisting consumers. Covered California spent \$57.5 million on media categorized as follows: 44% going to multi-segment general market, 39% Latino (in-language and Bilingual), 10% Asian (in-language and Bilingual), and 7% African American. This represents enhanced investment in all sectors after an assessment of early enrollment efforts at the end of 2013. More than \$4 million in collateral materials (brochures, fact sheets including a "Welcome" trifold in English, Spanish, Chinese and Vietnamese) were made available for outreach and education. A total of \$40 million in grant funding was awarded to 50 organizations with over 250 subcontractors for public awareness, education and outreach.

Enrollment by Ethnicity and Race

On October 1, 2013, Covered California released the goals and forecasts for the subsidy eligible population. Based on the California Simulation of Insurance Markets (CalSIM) Version 1.8, 2.6 million Californians were predicted to be eligible for federal subsidies, about half Latino and more than 25% primarily speaking Spanish. An additional 13% (350,000) subsidy-eligible Californians were identified as speaking other languages, including Chinese and Vietnamese. CalSIM projections were revised in May 2014. Base projections lagged in the first three months for the Latino and Black/African American populations but by the end of the enrollment period actual enrollment exceeded Covered California's base projections. After the first three months, Covered California increased its investment in Spanish language marketing efforts by \$4.5 million, with a focus on media vehicles that perform best with Spanish speaking target audience and key markets with high concentration of Latinos. In addition, Covered California partnered with Univision and the California Endowment. Dolores Huerta, co-founder of the United Farm Workers, was enlisted to produce radio spots and videos available on YouTube, in English and Spanish, calling on Latinos to sign up for insurance. A targeted on-the-ground strategy was developed in collaboration with Covered California's community partners to create face-to-face opportunities for enrollment, particularly in Latino communities in Los Angeles, the Inland Empire, and the Central and San Joaquin valleys. Covered California found that Black/African-Americans were most likely to enroll through a self-service channel (59%). Asians were most likely to enroll through an agent (54%) and Latinos were likely to seek-in person assistance, enrolling through agents (28%), Certified Enrollment Counselors (20%) and county or plan-based enrollers (2%).

Covered California Enrollment

Covered California's first open enrollment period began October 1, 2013 and closed on March 31, 2014. Early enrollment reports indicated 30,830 enrolled in October, 78,377 enrolled in November with a jump to 400,096 in December (about 12,096 enrollments per day). As of January 15, 2014, 625,564 individual health plans had been selected. Through the end of March 2014, enrollment was at 1,209,791.

Medi-Cal, which allows people to enroll throughout the year, enrolled 1.9 million people during this same period, including 1.1 million who enrolled through Covered California. Due to technical difficulties in the final month of open enrollment, Covered California allowed people who had started applications by March 31st to complete those applications until April 15th. As of April 15, 2014, a total of 1,395,929 Californians had enrolled in Covered California (which included selecting plans during the first open enrollment period) which was 241 percent of Covered California's base enrollment projections for March 31, 2014.

An October 16, 2014 press release issued by Covered California indicates that of the Californians who selected a plan during the initial open enrollment period, 1,140,000 (81%) paid premiums and had coverage take effect. Covered California's October 16, 2014 Individual Market Enrollment Report indicates that from June through September 2014, 200,000 people took advantage of special enrollment opportunities. This number is slightly lower than Covered California expected. Covered California believes this is because Medi-Cal redeterminations have not occurred as expected. This document also indicates that 150,000 people have disenrolled from coverage and Covered California expects an additional 15% will not renew

during the upcoming enrollment period which would bring the disenrollment rate to 30%. Covered California forecasts an annual disenrollment rate of 37%.

Covered California established multiple channels to facilitate enrollment, including employing nearly 600 full- and part-time workers at three call center locations (Rancho Cordova, Fresno, and Concord). Although Covered California contracted with Language Line Solutions for interpreter services, many non-English speakers received assistance from Covered California call center staff in their native language. By March 2014, service center representatives directly handled 57% of Spanish speakers, 96% of Russian, 72% of Hmong, 81% Tagalog, 67% Korean, 57% Cantonese, 47% Vietnamese, 92% Arabic, and 85% of Armenian callers.

In addition, Certified Insurance Agents, Certified Enrollment Entities (employers of Certified Enrollment Counselors), county eligibility workers, health plan based enrollers and community outreach organizations were tapped to assist with enrollments. Certified Enrollment Counselors are paid \$58 per application and Covered California paid out nearly \$3.6 million as of September 2014. Certified Enrollment Counselors enrolled 339,000 individuals, of which 32% were enrolled in Covered California and 68% in Medi-Cal. Forty-eight percent of individuals assisted by Certified Enrollment Counselors were Latino. As of May 2014, a total of 8,227 county staff across 58 counties completed training and passed the exam to be certified by Covered California. As of April 2014, there were more than 1,200 certified and active plan based enrollers employed by, or under contract with, a qualified health plan.

Overall the California launch was acclaimed a success but it was not without issues. As reported at a public board meeting by Covered California staff, 40 percent of those surveyed found the overall enrollment process difficult to complete. Covered California identified a number of challenges and opportunities based on the October-December period. In the six months from the beginning of open enrollment to the end of open enrollment the number of Certified Enrollment Counselors, 58 percent of whom are Spanish speaking, grew from 772 to 5,598. In addition, the number of Certified Insurance Agents grew from 3,810 to 12,236.

Website, CalHEERS and Application Issues

The ACA requires a single, accessible, standardized paper, electronic, and telephone application process for insurance affordability programs, which requires a joint application for Medi-Cal and Covered California. The joint application is required to be used by all entities authorized to make an eligibility determination for any of the insurance affordability programs. (Medi-Cal and coverage through Covered California with a premium or cost-sharing subsidy are “insurance affordability programs.”)

Development of a public website began in December of 2012 with the intent that it be the “engine that drove enrollment for Covered California and the expansion of Medi-Cal.” This engine is referred to as California Healthcare Eligibility, Enrollment and Retention System (CalHEERS). According to Covered California, the website would provide an easy, secure avenue to move a consumer from browsing to shopping. The enrollment and eligibility business rules were jointly developed by senior staff of Covered California and DHCS. The launch was phased in with three distinct releases: 1) the initial shop and compare functionality in July 2013, 2) eligibility and enrollment functions by September 2013, and 3) integration with county

welfare systems by January 2014. According to Covered California, the website met its ambitious timeline for functionality.

In its “Lessons Learned” report, Covered California admits that consumers were confused by website-generated notices, and that traffic to the website was substantially higher than anticipated. There were planned and unplanned outages of the website, including nearly five days in February. A technology team of experts from Oracle, Accenture, Level 3, CISCO, health plans, DHCS and county social service agencies was consulted. Course corrections were made, but Covered California continues to identify issues and implement improvements.

Another issue identified by Covered California is that final changes to the field tested paper application were not programmed into the online application, and that the paper application was not available in Spanish and Asian languages until December 2013. Additionally, 10% of the paper applications required follow-up due to missing information. Feedback from many sources demonstrated that multiple touch points were necessary before most applications could be submitted.

Covered California Service Center Issues

Covered California indicates the hiring of staff was challenged early on related to issues around legal authority for background checks but intensive recruitment continued through March 2014. Training time for staff was reduced as call volumes rose and staff were called upon to answer phone lines. For a variety of reasons initial call center service goals of answering 80% of calls within 30 seconds were not achieved. In December 2013 call center performance yielded less than one percent (.5%) of calls answered within 30 seconds and by February 2014 performance was 2.4% of calls answered within 30 seconds. According to Covered California, the tremendous interest in Covered California created high service center volume but also some unanticipated drivers of service center volume existed, such as slow ramp up of service channels (e.g. agents and enrollment counselors). Covered California has identified the need for updates of training and policies, user-friendly systems operations, consumer talking points, and other strategies to improve performance.

Certified Insurance Agent Issues

The demand by insurance agents on certification and training outpaced the resources available. This led Covered California to change its policy about mandatory training. Covered California also found that marketing material needed to include Certified Insurance Agents as a resource for free enrollment assistance. Pinnacle Claims Management was brought on to work with agents, and Pinnacle added a dedicated agent support line in February 2014. However, call center and website issues added to implementation challenges and the ability to handle the demand by agents needing assistance. Despite these challenges, Certified Insurance Agents played a significant role in enrolling Asian and Pacific Islander and Latino populations. They also requested more information and training about special enrollment and Medi-Cal enrollment. DHCS has begun contracting with Certified Insurance Agents to facilitate Medi-Cal enrollments based on the \$58 fee per completed application.

Certified Enrollment Counselors

As documented by the California Pan-Ethnic Health Network, Certified Enrollment Counselors identified the following barriers during the first enrollment period: several website glitches, particularly in the Spanish language website, long wait times and dropped calls, particularly during the transfer to multilingual call center representatives, inaccuracy of translated materials, including some translations that might be viewed as offensive, lack of provider directory which would allow consumers to determine which providers can address cultural and linguistic needs, lack of trainings in languages other than English, lack of real-life enrollment scenarios and hands-on training tools, and lack of reimbursement and training to handle calls from consumers about how to use their health coverage. Also confusion about Medi-Cal enrollment, special enrollment, misinformation about Deferred Action for Childhood Arrivals and delays in Certified Enrollment Counselor payments were documented.

Plan Based Enrollers

Health plan based enrollers also needed support from Covered California service center and staff. The type of inquiries and assistance was different than the assistance needed by Certified Enrollment Counselors and ultimately resulted in Covered California establishing separate communications and communication channels for health plan based enrollers.

Plan Selection and Network Issues

Covered California indicates that consumers who had coverage prior to 2014 faced confusing changes to both their coverage and networks of available providers. While Covered California required participating health plans to provide electronic versions of participating provider directories for publication and integration on the Covered California website, Covered California was disappointed to find the data and records representing tens of thousands of doctors, hospitals and medical centers contained many errors and omissions. Ultimately Covered California removed the online directory tool and instead linked to each company's online directory.

Citizenship and Immigration Verification

In the summer of 2014, Covered California began sending notices out to request documentation and notify enrollees that their coverage would be terminated if their status could not be verified. Notices were sent out to 98,900 households representing 148,667 people. Individuals with outstanding inconsistencies will have coverage terminated as of October 31st. Notices were to include a dedicated Helpline and process for appealing the termination, as well as a modified tagline page indicating important information in all Medi-Cal threshold languages. Covered California indicates they will continue to accept documents and resolve inconsistencies through the end of the calendar year, and will reinstate individuals who provide acceptable documents retroactive to November 1, 2014. By the end of September, approximately half of the households were cleared. The Fresno service center was taken off the phone process and all headquarter staff with appropriate clearance to handle the documents were dedicated to processing these verifications.

Notices and Issues

Covered California sent out letters to consumers receiving subsidies, such as premium assistance or cost-sharing reductions, requesting proof of income and reminding consumers to report changes in income to Covered California. If income is verified as eligible for premium

assistance, and subsequently a person becomes Medi-Cal eligible, the person does not have to repay the premium assistance as long as the change in income is reported within 30 days. Covered California encourages reporting so that people can switch programs. On Covered California's online application, there is a button that allows a person to 'Report a Change' to update income electronically, or a service center representative can be contacted for assistance. However, reporting changes in income has resulted in problems for some consumers when income changes initiate confusing notices or enrollment terminations create gaps in coverage. Because of these issues, the ability to report changes through the website was taken off-line for a period of time.

Covered California's website indicates that some consumers may have received duplicate eligibility notices or eligibility notices that have different information from the other. Normally, consumers should receive only one eligibility notice when they apply for coverage or make a change to their account that impacts their eligibility, such as updating their income. However, there is currently a technical issue that is creating more than one eligibility notice for individuals who qualify for Medi-Cal. According to the website, Covered California, DHCS and county partners are working together to correct this technical issue. Until the problem is fixed, consumers may be confused about which eligibility notice is valid and has the correct information about Medi-Cal eligibility. If a consumer received more than one eligibility notice for Medi-Cal with different dates, the consumer is approved for Medi-Cal in the earliest month listed on the notices. The Covered California website suggests that consumers who have questions about when their Medi-Cal eligibility started should contact their local county office at the phone number listed on the notice.

According to the Health Consumer Alliance, which has a contract with Covered California to assist consumers referred by Covered California, trends of individual cases analyzed in August 2014 found the following top issues raised by consumers: lack of understanding about Covered California, especially affordability and premium tax subsidies, confusion about special enrollment periods, navigation with incorrect referrals to Medi-Cal, delays obtaining insurance cards or policy information after enrollment, disenrollment for failure to pay, when payment was made, network adequacy complaints, and assistance with changes in income.

The Medi-Cal Expansion and Medi-Cal Specific Issues

Prior to the enactment of the ACA, adults were generally not eligible under federal law for Medi-Cal coverage unless they met categorical eligibility requirements, such as being low-income and having minor children living at home, having a disability, being over the age of 65, or being pregnant. In addition, prior to the enactment of the ACA, most low-income adults applying for Medi-Cal were required to meet an "asset test." The asset test put limits on the amount of cash, savings, stocks, bonds, mutual funds, property, and life insurance an eligible individual was allowed to own in order to be Medi-Cal eligible.

California was one of over 25 states that elected to implement the Medicaid coverage expansion under the ACA to low-income adults under age 65 without minor children who were not otherwise eligible. AB 1 X1 (John A. Perez), Chapter 3, Statutes of 2013-14 First Extraordinary Session implemented this ACA provision to extend Medi-Cal coverage to most adults who are at or below 138 percent of the Federal Poverty Level (for a single adult, 138 percent of the FPL is

\$1,342 per month or \$16,105 per year in 2014). DHCS, which administers the Medi-Cal program, refers to this coverage expansion as the “optional expansion.” New ACA requirements also apply to California’s Medi-Cal program and are intended to simplify and streamline eligibility, enrollment and renewal (DHCS refers to these provisions as the “mandatory expansion”). These include:

- Allowing individuals to apply for Medi-Cal in person, via phone, by mail, and through the internet or facsimile;
- Establishing a new hospital presumptive eligibility program that allows individuals to be determined Medi-Cal eligible at a hospital based on self-attestation of income;
- Eliminating the asset test for certain groups of applicants to Medi-Cal; and,
- Establishing a new methodology for counting income in Medi-Cal, known as modified adjusted gross income (MAGI) for individuals under age 65;

Medi-Cal Eligibility Determination Requirements

Unlike Covered California, Medi-Cal is open year-around for enrollment. Existing regulations designate county welfare departments in each county as the agencies responsible for local administration of the Medi-Cal program under the direction of DHCS. Existing regulations require county departments to complete the determination of Medi-Cal eligibility as quickly as possible, but not later than any of the following:

- 45 days following the date the application, reapplication or request for restoration is filed.
- 90 days following the date the application, reapplication or request for restoration is filed when eligibility depends on establishing disability or blindness.

The 45- and 90-day periods can be extended if the applicant has, for good cause, been unable to return specified eligibility-related documents or necessary verification in time for the county department to meet the promptness requirement, or if there has been a delay in the receipt of reports and information necessary to determine eligibility and the delay is beyond the control of either the applicant or the county department.

Applicants have a right to appeal a denial of eligibility or other negative action.

Existing law also sets forth an application process for people applying for coverage either electronically or with a written application submitted through CalHEERS for applicants who are Medi-Cal eligible based on MAGI. If Covered California and DHCS are able to electronically determine the applicant’s eligibility for MAGI Medi-Cal using only the information initially provided, and are able to verify the accuracy of the submitted information without further staff review, Covered California and DHCS are required to determine that applicant’s eligibility for the Medi-Cal program. The process described above for applications submitted directly through CalHEERS that are complete, error-free, and require no additional verification or other assistance is in effect until July 1, 2015.

If an individual calls the Covered California customer service center to apply for coverage, Covered California uses a workflow transfer protocol referred to as the “quick sort” in which only those questions essential to ascertain whether the household appears to include individuals

potentially eligible for Medi-Cal benefits are asked. If Covered California determines that the caller’s household appears to include one or more individuals who are potentially eligible for MAGI Medi-Cal, Covered California is required to transfer the caller to his or her county of residence or other appropriate county resource for completion of the assessment (this process is referred to as the “warm handoff”). The county is then required to proceed with the assessment, and also perform any required eligibility determination.

The Medi-Cal Backlog

The number of new Medi-Cal applications has far exceeded expectations, and California has had a significant backlog of individuals awaiting an eligibility determination for their applications for coverage beyond the required 45 day time limit. The number of Medi-Cal applications pending for over 45 days in 2014 was as follows:

<u>March</u>	<u>June</u>	<u>July</u>	<u>August</u>	<u>September</u>	<u>October 15, 2014</u>
900,000	600,000	487,000	401,000	350,000	171,681

In June 2014, Cindy Mann, the Director of the federal Centers for Medicare and Medicaid Services (CMS) wrote to DHCS Director Douglas requesting DHCS to provide CMS, for its review and approval, updated documentation of the application and enrollment processing delays experienced by California consumers and the state’s mitigation plan to resolve each of these issues. In his reply to CMS of July 2014, DHCS Director Toby Douglas indicated three key factors contributed to the delays in processing applications, and that it had taken significant steps to address each of these factors:

- **Large volume of applications, particularly in March and April.** DHCS indicates over 600,000 individuals’ submitted applications for Medi-Cal coverage in March 2014, well over twice the normal monthly number of Medi-Cal applicants. In addition, over 400,000 individuals submitted applications for Medi-Cal in April, which DHCS indicates was significantly higher than usual. DHCS stated that, while the state and counties worked together prior to October 2013, to ensure sufficient hiring and training statewide, the interaction of the application volume and the expedited system development and deployment of the CalHEERS caused delays in data processing, and required manual workarounds for certain cases. Additionally, DHCS indicated many of the applications received since October were duplicate applications, further compounding the processing delays. To address this significant volume, in late March DHCS removed the requirement for paper verification of state residency, instead allowing for the use of self-attestation, which expedited enrollment for hundreds of thousands of applicants.

- **Technology issues associated with a quick design and launch of CalHEERS, including the electronic Health Information Transfer (eHIT) interface.** CalHEERS, including the eHIT interface component between CalHEERS and the county eligibility systems, (collectively known as the Statewide Automated Welfare Systems or SAWS), was built in an expedited timeframe. However, DHCS indicated additional work is still needed to improve and complete certain system functionality, and it had dedicated teams in all systems working to identify and fix defects, improve speed and transaction success, and enhance system design and functionality. DHCS states those teams are working collaboratively on solutions and have successfully identified workarounds and alternate processes for use until system

defects are removed, developed desk aids for county workers, implemented automated “batch” processes that apply data fixes for certain types of verifications and expedited enrollment for applicants where income and other key information has been verified. This includes a weekly batch process to administratively verify residency for those with in-state addresses. In addition, DHCS states the final system design for CalHEERS and eHIT was informed by extensive discussions with the federal government to help ensure consistency with federal requirements and to address specific concerns, (e.g., security, environments, project schedule and risks). For consumers without coverage, DHCS indicates it enabled counties to expeditiously enroll individuals with immediate medical needs, and expanded the use of that process to any individual whose application could not be completed due to technology issues. DHCS indicated it would also begin sending letters to pending consumers, providing information about their options to access care until their application is processed, and how to contact their county to request the expedited process for immediate medical needs.

- **Duplicate cases and data entry errors from consumers using the self-service online portal.** DHCS indicates many consumers entered applications themselves, without assistance, directly through the CalHEERS portal. Although many applications were complete and correct, a number of applications had errors due to misunderstanding of the MAGI rules, mis-keyed information, or missing information. DHCS states some applicants also submitted two or more applications, which resulted in additional work for counties to process and reconcile those applications. DHCS states approximately 10% of current MAGI applications, including those with enrolled or pending consumers, are duplicates. To address this issue, DHCS indicates it was in the process of adding new messaging for consumers on the self-service portal to encourage careful data entry and to avoid submitting duplicate applications, and it is working on automated processes to identify and remove duplicate applications.

Reports on Enrollment Process for Medi-Cal and Covered California Overdue

AB 1 X1 (Welfare and Institutions Code Section 14102.5) required DHCS to report to the Legislature and the public about the enrollment process for all insurance affordability programs beginning 30 days after the end of each quarter (April 2014 and July 2014 would have been when the first and second reports were due). Information required to be included in the report includes the following:

- The number of applications received through each venue, and the number of applicants included on those applications.
- Applicant demographics, including, but not limited to, gender, age, race, ethnicity, and primary language.
- The disposition of applications, including all of the following:
 - The number of eligibility determinations that resulted in an approval for coverage;
 - The program or programs for which the individuals were determined eligible; and,
 - The number of applications that were denied for any coverage, and the reason or reasons for the denials.

- The number of days for eligibility determinations to be completed.
- For annual redeterminations conducted for beneficiaries, all of the following:
 - The number of redeterminations processed;
 - The number of redeterminations that resulted in continued eligibility for the same insurance affordability program;
 - The number of redeterminations that resulted in a change in eligibility to a different insurance affordability program;
 - The number of redeterminations that resulted in a finding of ineligibility for any program, and the reason or reasons for the findings of ineligibility; and,
 - The number of days for redeterminations to be completed.
- With regard to disenrollment not related to a redetermination of eligibility, all of the following:
 - The number of disenrollments;
 - The reasons for the disenrollments;
 - The number of disenrollments that are caused by an individual disenrolling from one insurance affordability program and enrolling into another;
 - The number of applications for insurance affordability programs that were filed with the help of an assister or navigator; and,
 - The total number of grievances and appeals filed by applicants and enrollees regarding eligibility for insurance affordability programs, the basis for the grievance, and the outcomes of the appeals.

DHCS has not released the report with the information above, and has not published statewide information on Medi-Cal enrolled service metrics like Covered California has, and the way the Managed Risk Medical Insurance Board did previously for the health care programs it administered. One area where Medi-Cal application processing has been publicly reported on is by Covered California on calls that were transferred to the counties as part of the “warm handoff” process. In contrast to Covered California customer service center performance metrics, data from those Medi-Cal applications that were transferred from CalHEERS to counties via the “warm handoff” showed that consumers did not receive busy signals, very small numbers of calls were abandoned (e.g., .3 to 1.4 percent) and more than 95 percent of calls (and as high as 99 percent in some counties) met the service level standard of being answered within 30 seconds.

State Policies Simplified Medi-Cal Enrollment, But More Can Be Done

The ACA, as well as CMS policy guidance to states, provided state options to facilitate enrollment and re-enrollment in Medi-Cal coverage. The Legislature adopted some of these options through SB 1 X1 (Hernandez and Steinberg) and AB 1 X1 (John A. Perez). These include:

- Eliminating the deprivation requirement in Medi-Cal (deprivation meant at least one parent in the family must be absent, deceased or disabled, or the principal wage earner must be unemployed or underemployed);

- Allowing former foster youth to remain on fee-for-service Medi-Cal after a redetermination form is returned as undeliverable and the county is otherwise unable to establish contact;
- Allowing beneficiaries to use projected annual household income, and allowing applicants and beneficiaries to use reasonably predictable annual income when determining their eligibility for Medi-Cal benefit;
- Requiring DHCS to seek any federal waivers necessary to use the eligibility information of non-disabled individuals under age 65 who have been determined eligible for the CalFresh program to determine their Medi-Cal eligibility; and,
- Requiring DHCS to seek any federal waivers necessary to automatically enroll parents who apply for Medi-Cal benefits and have one or more children who are eligible for Medi-Cal benefits based upon a determined income level that is at or below the applicable income standard.

In addition, DHCS has taken administrative actions to facilitate enrollment in Medi-Cal, including granting presumptive eligibility in December 2013 to 180,000 applicants waiting for coverage, implementing self-attestation of residency to relieve the use of paper verifications, and a time-limited delay of annual renewals. However, DHCS has not taken other steps that would help relieve the backlog, such as allowing counties to use accelerated enrollment to enroll children in coverage more quickly, and granting presumptive eligibility to applications that have exceeded the 45 day application processing timeframe. In addition, updates to CalHEERS to correct errors or omissions have taken much longer than anticipated, and in some cases are on-going. For example, former foster youth are categorically eligible for Medi-Cal up to age 26, irrespective of their income, but the programming in CalHEERS requires these individuals to have to complete the full on-line application and provide income information irrelevant to their eligibility. This has resulted in their being determined ineligible for Medi-Cal and eligible for Covered California instead.

Litigation Filed Against Department of Health Care Services

On September 17, 2014, a coalition of legal services organizations and community healthcare advocates, including Bay Area Legal Aid, Central California Legal Services, Multiforum Advocacy Solutions, National Health Law Program, Neighborhood Legal Services of Los Angeles County, and Western Center on Law & Poverty filed a lawsuit against DHCS in Alameda County accusing the State of California of leaving hundreds of thousands of low-income applicants to wait for months without the healthcare. The plaintiffs in the case are seeking a writ of mandate prohibiting DHCS from:

- Failing to determine Medi-Cal eligibility for applicants who have submitted complete applications or failing to provide applicants notice as quickly as possible, but in no more than 45 days of the application date;
- Delaying the granting of Medi-Cal benefits until after income has been verified to otherwise eligible applicants; and,
- Failing to provide applicants with notice of their right to a state administrative fair hearing whenever the 45-day promptness requirement is not met.

The plaintiffs in the lawsuit indicate the state has until October 31st to file its answer to the petition.

Key Elements of Covered California Outreach and Assistance Strategy

The second Covered California open enrollment period begins November 15, 2014 and goes through February 15, 2015. The target audience for 2015 is existing Covered California members, uninsured Californians who are subsidy eligible adults age 18-64, and uninsured with household income up to \$100,000, regardless of subsidy level. On October 16, 2014, Covered California announced the following improvements for this second open enrollment period:

- Double the number of service center representatives (1,300 representatives including state employees and two private vendors compared to 381 representatives at the beginning of the initial open enrollment and 709 at the close of the first open enrollment period).
- 254 Service Center representatives to assist callers in Spanish, Chinese and other languages without interpretation services (compares to 55 during open enrollment 2013-14).
- Expanded Service Center hours of 8 a.m. to 8 p.m. Monday-Friday, 8 a.m. to 6 p.m. Saturdays and Sundays from November 16 through December 15.
- Online capability to pay first premium payment.
- \$22.6 million upgrade to enrollment portal infrastructure for greater user capacity and speedier page loads.
- Redesigned interactive voice response system.
- Improvements to consumer notices in English and Spanish.
- Advertising by real Californians speaking about their personal experiences.
- Enhanced and expanded tools, webinars, trainings and newsletter for Certified Enrollment Counselors and Certified Insurance Agents.
- Expanded dedicated call lines to help Certified Insurance Agents and Certified Enrollment Counselors with consumer application issues.
- Opening 200 storefronts in retail locations;
- 12,000 Certified Insurance Agents, 10,000 county eligibility workers, and 6,400 Certified Enrollment Counselors.
- Targeted advertising, navigator grants and engagement of churches to reach African-Americans, Latinos and Asian-Americans.