Medi-Cal Health Navigator Project

Lessons Learned in Medi-Cal Outreach and Enrollment in Rural Northern California

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THE CENTER
at Sierra Health Foundation

Medi-Cal
HEALTH
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PROJECT
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EXECUTIVE SUMMARY

In California, more than 13 million people are enrolled in Medi-Cal, California's Medicaid program, yet there remains a percentage of Californians who are eligible but unenrolled, and a group of people who go on and off the program. Many of these individuals are from hard-to-reach populations, those who live in extremely rural areas and lack transportation, have unstable housing, are reluctant to enroll due to their immigration status, may have limited English proficiency, or may have physical disability or behavioral health needs. Navigators are one way to reach and enroll those individuals and populations who are eligible for Medi-Cal but have not enrolled. They are trained individuals or organizations that are able to outreach to consumers to facilitate the enrollment process.

The California Legislature passed the Medi-Cal Health Enrollment Navigators Project, which was intended to enroll hard-to-reach, vulnerable populations in Medi-Cal, and the project was administered by the Department of Health Care Services (DHCS), the state agency responsible for Medi-Cal. Counties had the option to participate in this enrollment effort and receive a funding allocation to engage in outreach and enrollment activities, but in some counties, community-based organizations (CBOs) stepped in to serve as navigators if a county did not opt to participate.

The Center at Sierra Health Foundation (The Center) is an independent nonprofit organization that establishes funding partnerships with public and private funders, community members, community organizations, government agencies, nonprofits and businesses. The Center worked with four CBO partners to help facilitate Medi-Cal enrollment and retention efforts in four northern California counties where the county government chose not to participate in the State's Medi-Cal Health Enrollment Navigators Project: Amador, Calaveras, Lassen and Solano.

Before conducting outreach and enrollment in these counties, the CBOs had to hire and train new staff, establish data-sharing agreements and confidentiality measures, form partnerships and conduct outreach, establish workflows that allowed for both in-person and virtual assistance during the pandemic, and establish relationships with the county eligibility offices. They faced challenges along the way related to launch and ramp-up time, different expectations of DHCS and the counties, as well as difficulties implementing and operating during a pandemic and harsh wildfire season.

The Center's Medi-Cal Health Navigator Project revealed several lessons for those hoping to conduct outreach and enrollment work. This paper highlights the perspectives and lessons learned from The Center and the CBOs participating in the project. Most importantly, it showed that a critical element for success is collaboration between state and local government, the need for relationship building and coordination with county eligibility offices, and that the trusted messenger voice is vital in order to bridge the inequities in communities and ensure that vulnerable populations get enrolled in health coverage so they can ultimately access the care they need.

Over the next year, California will implement some important coverage initiatives, including expanding Medi-Cal eligibility to seniors 50 years and over regardless of immigration status, and removing the asset test in Medi-Cal for older adults and people with disabilities. Medi-Cal redeterminations have been on pause until the COVID-19 public health emergency ends; once it does, there will be a tremendous amount of work for

the state and counties to begin administering renewals for all Medi-Cal recipients. Although the Medi-Cal Health Enrollment Navigators Project is scheduled to end in 2022, these initiatives present opportunities for the navigators to both help enroll the newly eligible and assist individuals with their renewal paperwork.

The experiences of The Center and its partner CBOs highlight some considerations for changes to the project if California can continue it past mid-2022. These recommendations include:

- **Facilitate relationships and coordination between CBOs who employ trusted messengers and county eligibility offices.** While some of the CBOs highlighted here have developed strong relationships with county eligibility offices over the years, some did not have established connections with them; bridging this gap where needed would save time and resources. Without partnerships and coordination between these entities, CBOs found it challenging to get information where a client was in relation to gaining Medicaid eligibility and this had implications for data reporting requirements. To ensure future success, DHCS should actively facilitate relationships between CBO and county eligibility offices and, as a stipulation, require that county eligibility offices work with CBOs.
- **Fund the project on a long-term basis and develop a stable workforce model.** Building the infrastructure and capacity of these CBOs to engage in the outreach and enrollment activities took an enormous amount of time. While many of the CBOs would like to continue as navigators, and some may look for other ways to fund the work, without long-term funding it may not be possible for them to continue. Moreover, funding this work in a non-continuous way only contributes to Medi-Cal churn and consumer confusion.
- **Coordinate with Covered California.** Navigators who are able to work with individuals and families eligible for Medi-Cal or marketplace coverage could reach larger numbers of individuals, helping to reduce the state's uninsured population.

The Medi-Cal Health Navigator Project made enormous investments in time and resources to build the infrastructure and capacity of these community organizations to help some of the most vulnerable populations navigate enrollment into Medi-Cal. Ending the project now reinforces inequities already plaguing these hard-to-reach groups. California won't be able to just "turn on" these processes at a later date without re-establishing the infrastructure that DHCS, CBOs and intermediary groups such as The Center worked so hard to build over the course of this project. With new opportunities for enrolling and retaining populations in Medi-Cal in the near future, California should consider continuing the project and find solutions to permanently fund this work.

INTRODUCTION: MEDI-CAL HEALTH NAVIGATOR PROJECT IN RURAL CALIFORNIA

In California, more than 13 million people are enrolled in Medi-Cal[1], California's Medicaid program. Californians need and deserve access to high-quality health care to live long, happy and healthy lives, and Medi-Cal helps bridge the gap for low-income individuals through this health care safety net. California has generously expanded Medi-Cal and other forms of health coverage. Although the state has a high Medi-Cal take-up rate, there is still a percentage of Californians who are eligible but unenrolled in Medi-Cal, and a group who go on and off of Medi-Cal resulting in costly churn[2] and poor health outcomes. **Many of these individuals are from hard-to-reach populations. They may live in rural areas and lack transportation, have unstable housing, be reluctant to enroll due to immigration status, have limited English proficiency, have difficulty getting to an eligibility office due to a physical disability, or have other physical or mental health issues that contribute to barriers to enrollment.** Furthermore, the COVID-19 pandemic resulted in eligibility staff working remotely or serving far fewer individuals at any given time.

This paper highlights the experiences and lessons learned by The Center at Sierra Health Foundation and four CBOs it oversaw and managed in conducting Medi-Cal outreach and enrollment activities as part of the State's Medi-Cal Health Enrollment Navigator Project. The perspectives shared within this paper are those of The Center at Sierra Health Foundation and its partner CBOs. These views are not necessarily shared by DHCS or CBOs participating in other counties.

Understanding and making sense of Medi-Cal's complex eligibility rules, processes, enrollment systems, documentation deadlines and notices is often too difficult for the average person to navigate on their own.[3] Although the Affordable Care Act sought to create a "No Wrong Door" approach and simplify enrollment processes,[4] even those in charge of Medicaid at the federal level recognize that too often, eligible individuals are deterred by unnecessary administrative burdens when they try to enroll in Medicaid.[5] These individuals often forego important, timely medical care when they lack health coverage, making care far more

1 As of June 2021, 13.98 million individuals were enrolled in Medi-Cal. Department of Health Care Services, Medi-Cal Enrollment, available at https://www.dhcs.ca.gov/dataandstats/Pages/Medi-Cal-Eligibility-Statistics.aspx.

2 Medicaid churn is defined as coverage disruptions and loss of coverage. Churn often occurs among Medicaid beneficiaries due to difficulties navigating state renewal and redetermination procedures, as well as income fluctuations and changing family circumstances. Sugar, Sarah, Peters, Christie, et al, Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic, Assistant Secretary for Planning and Evaluation April 12, 2021, available at https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf.

3 Cordoba, Michele, Lee, Brenda, Mulkey, Marian, and Shaw, Terri. The Medi-Cal Maze: Why Many Eligible Californians Don't Enroll, The California Health Care Foundation, September 2021.

4 Kaiser Commission on Medicaid and the Uninsured, Medicaid Eligibility, Enrollment Simplification, and Coordination under the Affordable Care Act: A Summary of CMS's March 23, 2012 Final Rule, December 2012, available at https://www.kff.org/wp-content/uploads/2013/04/8391.pdf.

5 Brooks-LaSure, Chiquita and Daniel Tsai, A Strategic Vision for Medicaid And The Children's Health Insurance Program (CHIP), Health Affairs Blog, November 16, 2021, available at https://www.healthaffairs.org/do/10.1377/hblog20211115.537685/full/.

expensive when they finally get treatment.[6] **Navigators —trained individuals or organizations that are able to outreach to consumers to facilitate the enrollment process, including understanding the language of health insurance, health literacy and completing enrollment forms[7] —are one way to reach and enroll those individuals and populations who are eligible for Medi-Cal, but have not enrolled.**

The Medi-Cal Health Enrollment Navigators Project was legislatively mandated to enroll harder-to-reach, vulnerable populations in Medi-Cal. Although California already had a low uninsured rate, the Medi-Cal Navigator project was intended to reach uninsured and underinsured individuals across the state to increase coverage and access to care. While these individuals would ultimately be determined eligible for Medi-Cal by county eligibility workers for the purposes of increasing coverage and access in the state, it is widely documented that outreach and enrollment is more successful if conducted by trusted messengers at the community level. This is for myriad reasons, including providing services that are linguistically and culturally responsive to the needs of the communities being served. Counties had the option to participate in this enrollment effort and receive a funding allocation to engage in outreach and enrollment activities, but in some counties, community-based organizations (CBOs) stepped in to serve as navigators if the county chose not to participate. Counties and CBOs were also encouraged to formally partner on the project in order to both receive funding from the Department of Health Care Services (DHCS). On an informal basis, CBOs and county eligibility offices were also encouraged to develop relationships to conduct the work necessary to enroll individuals and families into Medi-Cal.

Although the project got off to a slow start due to the COVID-19 pandemic, it is scheduled to run through June 30, 2022.[8] While the project is not slated to continue past the end of California's 2022 fiscal year, California has several coverage initiatives in the works, including expanding Medi-Cal to undocumented adults aged 50 and older beginning July 2022. Therefore, the Medi-Cal Health Enrollment Navigators Project could be an important way to reach and enroll these eligible individuals. This project required CBOs to create infrastructure, increase staffing capacity and expand their knowledge base to serve as Navigators in underserved counties where they may not have existed before. With so much work put into developing these CBOs as navigators, DHCS and the California Legislature should consider using these CBOs for the enrollment work that is ahead.

6 Anthem Public Policy Institute, Continuity of Medicaid Coverage Improves Outcomes for Beneficiaries and States, June 2018, available at https://www.communityplans.net/wp-content/uploads/2019/04/13_Report_Continuity-of-Medicaid-Coverage-Improves-Outcomes-for-Beneficiaries-and-States.pdf.

7 Navigator definition, Healthcare.gov at https://www.healthcare.gov/glossary/navigator/.

8 Department of Health Services, Bulletin 2021-002 on Project End Date Extension, August 24, 2021, available at https://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/HealthNavigators/HNP-Bulletin2021-002.pdf.

BRIEF BACKGROUND: CONTEXT FOR THIS ENROLLMENT EFFORT

In 2019, Assembly Bill (AB) 74 appropriated $59 million over three fiscal years to provide funding to counties and CBOs to serve hard-to-reach, potentially eligible Medi-Cal populations. Those populations were determined by California's DHCS and included:

- Persons with mental health disorder needs
- Persons with substance use disorder needs
- Persons with other disabilities
- Aged persons
- Persons who are homeless
- Young people of color
- Immigrants and families of mixed immigration status
- Persons with limited English proficiency
- Low-wage workers and their families or dependents
- Uninsured children and youth formerly enrolled in Medi-Cal
- Persons who are in county jail or state prison, on state parole, on county probation, or under post release community supervision

The enrollment-related activities for Navigators to engage in through this project included:

- Outreach
- Application assistance
- Enrollment
- Assistance with accessing and utilizing health care services
- Assistance with troubleshooting
- Retention
- Assistance with redeterminations[9]

The Center at Sierra Health Foundation (The Center) operates as an independent nonprofit, establishing funding partnerships with public and private funders, community members, community organizations, government agencies, nonprofits and businesses. As part of Sierra Health Foundation, whose mission is to promote health, racial equity and racial justice, The Center believes that every person in California should be able to live a healthy life. The Center ventured into outreach and enrollment work in an effort to support the State's Medi-Cal Health Enrollment Navigators Project to facilitate Medi-Cal enrollments in more rural parts of Northern California.

The Medi-Cal Health Navigator Project at The Center began in October 2020 when it awarded sub-grants to a cohort of CBO partners to help facilitate Medi-Cal enrollment and retention in four northern California counties: Amador, Calaveras, Lassen and Solano.

9 Due to the COVID-19 pandemic and the Public Health Emergency declaration, renewals/redeterminations are not currently being conducted by Medicaid agencies. As a result, counties and CBOs have not been engaging in retention and redetermination activities under the Medi-Cal Navigators Project. Department of Health Care Services, Navigator Project CBO Monthly Meeting Minutes, February 18, 2021, https://mcusercontent.com/3cdd7a56ade6fbfd7752f0e74/files/ae991ff9-dcce-4209-815c-f8cbe8d64bd2/Navigators_Project_CBO_MonthlyMeetingMinutes_2.18.2021.pdf.

The four CBOs were chosen due to their deep ties to the communities in which they are located. In some cases, Medi-Cal enrollment was not new to these organizations, while in others, there was a learning curve. The four organizations were:

- Amador Tuolumne Community Action Agency
- Community Health Initiatives Napa
- Nexus Youth & Family Services
- United Way of Northern California

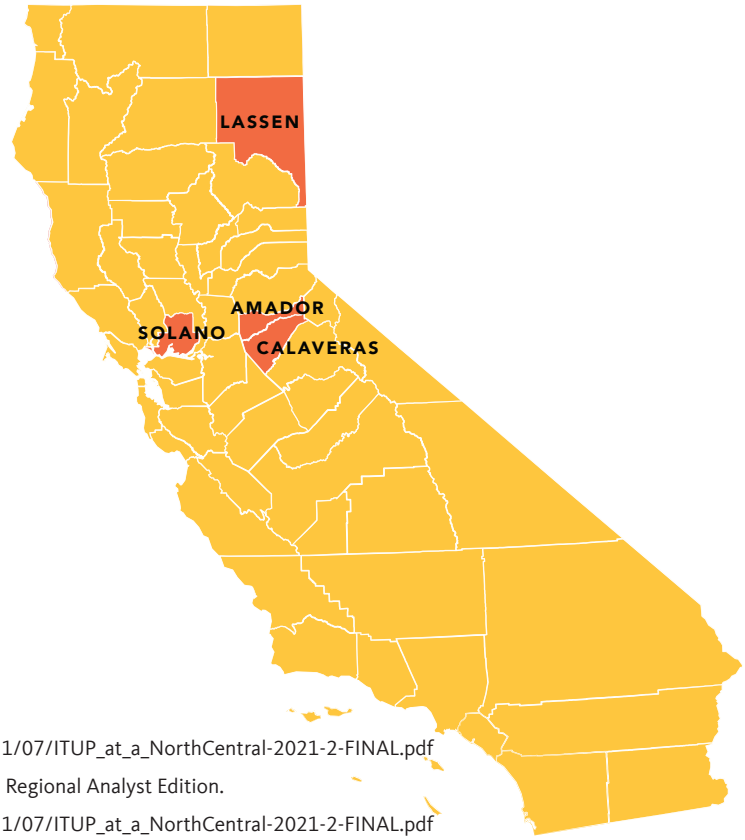
The Center awarded a total of $2.3 million to these four organizations to enroll eligible beneficiaries into—and retain individuals already enrolled in—Medi-Cal in the four counties with information and assistance from a health navigator. The Center also developed a learning community of the four partners, and supported the CBOs with infrastructure and capacity needs to advance the project's enrollment and retention goals.

As part of the infrastructure and capacity support, The Center engaged Transform Health, a health policy consulting firm with Medicaid outreach and enrollment expertise, and Harvey Consulting to assist with data needs.

WHAT DO THESE NORTHERN CALIFORNIA COUNTIES LOOK LIKE?

Amador County– In the north central part of California, at the foothills of the Sierra Nevada mountain range, Amador County has a population of approximately 38,000. As of April 2021, 22.4% of county residents were enrolled in Medi-Cal.[10] It is estimated that 4.7% of Amador County's population is uninsured.[11]

Calaveras County– In the north central part of California, Calaveras County includes areas of the Sierra Nevada mountain range and part of California's historic Gold Country. The county population is approximately 45,500. As of April 2021, 28.4% of county residents were enrolled in Medi-Cal.[12] It is estimated that 4.4% of Calaveras County's population is uninsured.[13]



10 ITUP, North Central Fact Sheet, https://www.itup.org/wp-content/uploads/2021/07/ITUP_at_a_NorthCentral-2021-2-FINAL.pdf

11 2019 ACS data accessed through U.S. Census Bureau, Census Business Builder: Regional Analyst Edition.

12 ITUP, North Central Fact Sheet, https://www.itup.org/wp-content/uploads/2021/07/ITUP_at_a_NorthCentral-2021-2-FINAL.pdf

13 2019 ACS data accessed through U.S. Census Bureau, Census Business Builder: Regional Analyst Edition.

Solano County– In the north central part of California, closer to the Bay Area, Solano County's population is much larger than Amador and Calaveras, at approximately 447,600. As of April 2021, 28.3% of county residents were enrolled in Medi-Cal.[14] The county also has a large Latino population, which makes up 27.3% of its residents.[15] It is estimated that 4.7% of Solano County's population is uninsured.[16]

Lassen County– In the north part of California, Lassen County is extremely rural and sparsely populated, with the lowest population density of all four counties. Its population is approximately 30,000. As of June 2021, more than a quarter of county residents were enrolled in Medi-Cal at 27.5%.[17] It is estimated that 4.4% of Lassen County's population is uninsured.[18]

During implementation in 2020 and 2021, all four of these counties faced the COVID-19 pandemic and extreme fire seasons that displaced generations of individuals and families into other areas of California and beyond. These numbers may continue to evolve as more demographic and socioeconomic data from these years are analyzed and released.

BUILDING THE INFRASTRUCTURE AND CAPACITY FOR OUTREACH AND ENROLLMENT

Trusted messengers from the community are the tried-and-true method for outreach and enrollment. Before beginning to enroll anyone into Medi-Cal, in order to fill the role of community-based navigation support in these rural regions of the state, The Center's CBOs needed to first build their infrastructure and capacity. This took an enormous amount of time, even if an organization had done outreach and enrollment work before. There were reporting requirements and the organizations had to establish data-sharing privacy protocols. In addition, the State required each enrollment reported by the CBOs to be validated by the county Medi-Cal eligibility offices. The time it took to launch and disburse the funds to build out programming, as well as recruit, hire and train staff took months, which meant that the organizations did not launch their enrollment efforts until mid-2021. Key work included:

- **Hiring new staff.** Each of the organizations needed to hire enrollment assisters, preferably trusted messengers who were already well-established and connected in the community, and who were able to provide culturally and linguistically appropriate assistance with the ability to translate health care terms and educate residents about health insurance literacy topics. While finding trusted messengers can be difficult any time, especially in rural areas, the pandemic made it even more challenging.

14 ITUP, *North Central Fact Sheet*, https://www.itup.org/wp-content/uploads/2021/07/ITUP_at_a_NorthCentral-2021-2-FINAL.pdf

15 California Department of Finance 2020 Population Estimate as published in *Solano County Statistical Profile within County of Solano, FY 2020/21 Preliminary Recommended Budget*, available at https://www.solanocounty.com/civicax/filebank/blobdload.aspx?BlobID=32328.

16 2019 ACS data accessed through U.S. Census Bureau, Census Business Builder: Regional Analyst Edition.

17 ITUP, *North Rural Fact Sheet*, https://www.itup.org/wp-content/uploads/2021/08/ITUP_at_a_NorthRural-2021FINAL.pdf

18 2019 ACS data accessed through U.S. Census Bureau, Census Business Builder: Regional Analyst Edition.

> ***"Health insurance enrollment is a very sensitive, private area for people and not just something you can do on the fly. When we hired someone full-time we began to see results, because we had someone who began developing trust with the people we were assisting. A person who you can make a connection with really does matter when dealing with sensitive topics."***
>
> **—Patrick Kane, Program Manager at Amador Tuolumne Community Action Agency**

- **Training new staff.** While it was not an explicit requirement, The Center encouraged each agency to get certified by Covered California, the state-based health insurance exchange, and required organizations to create workflows for outreach, enrollment and follow-up. The CBOs were able to use two pathways: (1) enroll individuals using paper-based applications through DHCS or (2) use Covered California. To use Covered California and its online portal, the CBOs had to be or become a Certified Application Entity and individual navigators had to receive training to become Certified Enrollment Counselors. Using the DHCS application had some advantages in communities facing the digital divide—a lack of internet infrastructure—such as allowing trusted messengers to assist with completing a Medi-Cal application without internet access. However, once a Medi-Cal application was submitted to the local county agency, if the organization's navigator did not have a strong relationship with the county eligibility office, the status of an application was unknown. Local organizations were expected to send data monthly to DHCS on individuals they conducted outreach to and assisted with applications so that DHCS could validate enrollments. Local organizations were required to submit Client Index Numbers of newly enrolled individuals as part of this reporting, and the lack of a relationship with the county eligibility office hindered the CBOs' reporting capabilities.

  The Center provided training and information to the CBOs through learning community meetings on key topics such as finding the uninsured, reaching vulnerable communities, and data collection and security. The learning community also provided a space for CBOs to learn from each other.

- **Establish data sharing agreements and confidentiality measures**. The Center, CBOs and consultants developed Business Associate Agreements to ensure data—including Personal Health Information—was protected according to HIPAA,[19] and to maintain confidentiality of Personally Identifiable Information and Individually Identifiable Health Information.[20] In conjunction with signing these agreements, the CBOs had to ensure they had proper safeguards and security with respect to application handling, as well as the data reports that were required by DHCS.

19 The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the protection of sensitive patient health information from being disclosed without the patient's consent or knowledge. The HIPAA Privacy Rule sets national standards for the protection of individually identifiable health information by covered entities and their business associates. The HIPAA Security Rule sets national standards for protecting the confidentiality of electronic protected health information. For more on HIPAA, see https://www.hhs.gov/hipaa/for-professionals/index.html.

20 Centers on Medicare and Medicaid Services, *Requirements and Best Practices for Assisters on Handling Personally Identifiable Information*, 2017, available at https://marketplace.cms.gov/technical-assistance-resources/assister-programs/best-practices-for-handling-pii-fast-facts.pdf,

- **Outreach and partnerships.** Once the infrastructure was in place, including staff and data safeguards, it was time to get to work. The CBOs established relationships with community organizations to hold in-person outreach events (although many of these took place in later months of the project due to the pandemic) and virtual events through Facebook Live, or partner with other groups to establish a referral pipeline. While many of the CBOs had ties to the communities, it still took time to organize these efforts.
- **Establishing workflows that address in-person and virtual enrollment assistance.** Due to the COVID-19 pandemic, much of the enrollment assistance in the early months of the project had to be virtual, but CBOs had to ensure their workflows could accommodate in-person assistance when they were able to safely switch to in-person encounters.
- **Ongoing relationship with county eligibility offices.** Determining eligibility for Medi-Cal is the responsibility of county eligibility offices. Several of the CBOs chose to use the paper-based application in their enrollment assistance work. As mentioned above, it was difficult for some of the organizations to work with the county offices to receive updates on applications or get Client Index Numbers, which were necessary to submit to DHCS in monthly data reports to get credit for enrolling individuals through the project. Without help from the county eligibility office, there was no way to get the Client Index Number without reaching the client. For applications that may have been held up in the eligibility determination process, there was no way to check the status without either contacting the eligibility office or the client themselves. Some county eligibility offices did not want to share this information with CBOs and individual navigators, despite having signed release of authorization forms on record.

PROJECT SUCCESSES AND CHALLENGES

The CBOs had positive outcomes, including the number of community partnerships they developed in order to conduct outreach. Some successes included:

- **Outreach and In-Reach.** Using their knowledge about who was likely uninsured in the county, the CBOs developed relationships and conducted outreach with a variety of community partners: schools and school districts, food banks and food distribution centers, community colleges, job training sites, churches, homeless outreach groups and shelters, and jails. They also started by reaching the people known to their organizations to ensure they were enrolled in coverage and knew how to access care. During this time, there were several life-threatening wildfires in California, including in Lassen County, and at least one partner organization involved in disaster relief efforts also tried to help uninsured individuals seeking shelter and emergency supplies with enrolling in Medi-Cal.
- **Co-location with county office.** One partner organization, Community Health Initiative Napa, had a strong relationship with the county and was able to establish a Memorandum of Understanding with Solano County to embed a navigator at the Solano County office. This allowed them to provide application assistance to individuals who sought government benefits and were

referred to the CBO for help with enrolling in Medi-Cal. The advantage of co-location is that a navigator is consistently present, so consumers know where to find them, instilling trust that the navigator is reliable and accountable. It is much harder and takes far longer to build trust virtually in harder-to-reach communities.

The CBOs encountered several key challenges, including:

- **Developing accurate estimates and finding the uninsured.** When the CBOs put together initial estimates of the uninsured in their counties, several developed higher estimates. When these figures were compared to the American Community Survey (ACS) estimates published by the Census Bureau,[21] the ACS estimates indicated lower rates of uninsured in these counties. It proved to be much more challenging to find those who lacked Medi-Cal coverage as a result of a lower uninsured rate and led to CBOs having to pivot and double-down locally, since the emphasis for this project was on finding new people to enroll.
- **CBOs were slow to start enrolling people into Medi-Cal.** Building out the infrastructure of each CBO's Navigator program took time, especially when building a virtual enrollment workflow while ensuring a local community-based presence, and partners did not begin to enroll individuals into Medi-Cal until mid-2021.
- **Difficulty establishing relationships and coordinating with county eligibility offices.** As mentioned throughout this paper, a key challenge was developing the necessary relationships and partnerships with county eligibility offices. The relationships between CBOs and the county offices varied, but for those who did not have well-established connections, it was very hard for partners to get key information they needed on application status and Client Identification Numbers, which DHCS required navigators to report monthly to get credit for enrolling individuals into Medi-Cal.
- **Pandemic and natural disaster challenges.** As indicated earlier, implementation during the COVID-19 pandemic challenged the CBOs in conducting in-person events and meeting one-on-one with families and individuals seeking coverage. The California wildfires changed community patterns as well.[22]

LESSONS LEARNED

> ***"Vulnerable populations have a right to high-quality healthcare and should not be overlooked. We should and can assist people to navigate the complex systems that can cause a barrier to receiving the care they deserve."***
> **—The Center**

The Center's Medi-Cal Health Navigator Project revealed several lessons for those looking to do outreach and enrollment work. Most importantly, it showed that a critical element for success is collaboration between state and local government, and must include the trusted messenger voice to bridge the inequities in communities and ensure that vulnerable populations get enrolled in health coverage so they can access the care they need.

21 American Community Survey estimates using the Census Business Builder: Regional Analyst Edition.

22 Covered California, Covered California Lends Support for North State Wildfire Victims, News Release, August 17, 2021, available at https://www.coveredca.com/newsroom/news-releases/2021/08/17/covered-california-lends-support-for-north-state-wildfire-victims/.

Getting Started

- **Analyze the community.** Before going into a new community or embarking on a new type of work in a familiar place, organizations must conduct some level of analysis and take time to understand the community. For example:
    - Who is there? What are the community's demographics? What languages do they speak? What are the rules of engagement in their culture?
    - What is the level of need for these services?
    - Where do people go to get services? Where do they gather?
    - What resources in terms of staffing ratios and level of effort can you provide?

    It is important to use reliable data sources, such as the American Community Survey or the California Health Insurance Survey, to help set enrollment targets and identify demographic characteristics of the target population. Even if you already know the community, demographics change. It is important to check data sources through universities, policy organizations, foundations or other sources of recent research to substantiate and target where to place resources.
- **Know your strategy and tactics.** Outreach and enrollment work requires the ability to advocate with county offices, understanding how to engage local government, and the ability to have hard conversations with county offices to get clients enrolled.

> ***We've found that it is critical to have multiple locations in the community so people know how to get to you. Culturally and linguistically appropriate Navigators in and from the community build trust.***
>
> **—Jesus Rosas, MBA Senior Health Access Specialist for Napa Community Health Initiative**

- **Go where the people are.** Navigator organizations must build relationships and partnerships with a range of community organizations to be successful and meet people where they are, including school districts, food banks, community colleges, job training sites, faith-based organizations, homeless outreach groups and county jails.
- **County relationships.** It is vitally important to have clear roles and responsibilities with county eligibility offices to avoid confusion or misunderstanding. In this work, CBOs are not conducting eligibility determinations; rather, they are assisting individuals and families in completing applications. The CBOs rely on the county eligibility offices to give them updates on the application status of their clients.

Establishing trust in the community is critical to address myriad issues, including addressing the goal of equitable access to affordable health care. Navigator organizations must be a trusted messenger in the community, a "go to" source for the population they are trying to reach. The organization's staff must know the language and culture of the population being enrolled—and ideally come from that community or population. If they are not the trusted messenger, then they must have a relationship with one to receive referrals and keep consumers coming back to stay enrolled.

"Helping community members apply for Medi-Cal is a complex process. It requires trust-building within a community. It takes a lot of time and a lot of effort. It is not a one-and-done. You need to be present, plugged in, and embedded in the community. It has been rewarding to help clients in my local community, who face a lot of barriers."

—Cory-Lynn Hatton, Program Specialist, United Way of Northern California in Lassen County

- **Multiple touches to enroll.** Helping someone enroll into Medi-Cal coverage takes more than one meeting. **On average, the CBOs found that it takes two to four "touches" to get a consumer to enroll from initial outreach to ultimately choosing a plan and understanding what to expect next.** This is during the initial phase of engaging a person, but after the person is enrolled in Medi-Cal, they also need to understand how to access care, as well as how Medi-Cal works and who they will receive notices from, what they need to do about those notices, and much more.
- **Rural areas come with their own set of challenges.** In rural counties where the uninsured rate is low, the hard-to-reach populations are likely on the fringe and very difficult to reach. Rural county governments, in particular eligibility workers, may be more difficult to reach due to limited capacity. The COVID-19 pandemic has exacerbated these challenges. Furthermore, Medi-Cal is an expense for counties[23] and enrollment may not be a priority, even though Medicaid is an entitlement,[24] and may further exacerbate inequities at the local level.
- **Reaching vulnerable populations requires an ongoing commitment of resources, trust and connections.** Reaching the hard-to-reach populations that are uninsured or under-insured, or who may choose to enroll in the wrong types of coverage due to marketing tactics (e.g., short-term "junk" plans),[25] requires ongoing trust and connections to find and compel those individuals to apply for coverage. These same organizations can help consumers stay enrolled in health insurance like Medi-Cal and access health care at the right time to avoid costly emergency room visits. Ongoing training, coaching, capacity building and workforce development are central to the success of trusted messengers who hold the keys to partnerships.
- **Partnerships are essential to ensuring that vulnerable families and individuals enroll.** All avenues must be explored in a community, and that includes consistently and reliably engaging partners who know where the consumers are who need to enroll in coverage. Some examples include faith-based organizations, schools, community colleges, shelters, grocery stores,

23 For more on how counties fund Medi-Cal, see McConville, Shannon, et al, Funding the Medi-Cal Program, Public Policy Institute of California, March 2017, available at https://www.ppic.org/wp-content/uploads/R_0317SMR.pdf.

24 MACPAC, Medicaid 101, available at https://www.macpac.gov/medicaid-101/.

25 ACA Open Enrollment: For Consumers Considering Short-Term Policies, Kaiser Family Foundation, October 25, 2019, available at https://www.kff.org/health-reform/fact-sheet/aca-open-enrollment-for-consumers-considering-short-term-policies/.

community centers, fitness clubs and shopping centers. The decision to partner must be strategic, have milestones and a timeline, and must result in engaging the target population. Furthermore, passive referrals—telling a client who to reach out to and expecting them to do it—do not work.[26] **Having a personalized approach, a relatable story and a person who the consumer can relate to in the enrollment pipeline is everything.**

> ***"I feel grateful that we impacted the people in this community. The small things that we did for these families was very rewarding."***
>
> **—Ivonne Isaac, Navigator with Nexus Family & Youth Services**

Outreach and Enrollment Essentials: A Checklist for Success

Build a culturally and linguistically appropriate trained staff with expertise in enrollment, health insurance, coverage and access to care from the community being served. *Caveats: Hiring and terminating staff is administratively expensive and increases the likelihood of programmatic inefficiency and diminishing returns over time. It is better to keep a trained staff year-round.*	• Develop a ratio for staff based on the amount of time the average enrollment takes for your community x the average number of touches it takes to finalize the enrollment (2-4 touches). • Ensure that training and certifications are up to date with state-based marketplaces and/or the federal marketplace. • Have a job description for every enrollment role and revise it regularly as expertise develops. • Ensure that staff have the core cultural and linguistic competencies to reach the community they are serving.
Conduct a **brief landscape assessment** to narrow down geographic areas and population-based enrollment goals.	• Use reliable data and map that against what you know about the community being served to conclude where to focus outreach and referrals. • Enrollment is local. When it comes to reaching the harder-to-reach groups that are unlikely to enroll, **trusted messengers are essential to include.** • Not all trusted messengers need to be enrollers—trusted messengers can serve as outreach partners, referral partners, conveners, etc., but they must be reflective of the community.
Establish data sharing agreements where required.	• If you are including consultants (such as Transform Health) to help analyze data or outcomes for your efforts, be sure to work with experts in this area who understand the distinctions between HIPAA, PHI and PII and the types of data-sharing agreements and business associate agreements required by law in your state.

26 Kulie, Paige, Steinmetz, Erika, et al, *A health-related social needs referral program for Medicaid beneficiaries treated in an emergency department*, The American Journal of Emergency Medicine, Vol. 47, September 2021, Pages 1119-124.

Outreach and Enrollment Essentials: A Checklist for Success

Enlist and recruit your **outreach referral partners** well in advance and maintain those relationships.	• Partners are **the** way to amplify enrollment. • Partners can include faith-based organizations, community centers, schools, universities, embassies, employment offices, etc. • Partners are the program ambassadors and keep the drumbeat going for your services. Maintain those relationships and assign this as a responsibility for staff.
Enrollment is both an art and a science. Develop a **workflow and individual work plan** with your enrollment staff to understand interdependencies, identify problem areas and meet their goals.	• Numbers can seem daunting unless there is a breakdown of how you will meet your goals. • Include in your workplan the partnership management, number of referrals anticipated and where you will focus your outreach or in-reach. • Make these work plans living documents that you adapt as needs and environs change. • When you look back on all that was accomplished, it will be more realistic to predict future programmatic goals.
Get to **know your local Medicaid agency** (Medi-Cal in California). This is the most overlooked step. It takes time to do this. Prioritize it.	• Every Medicaid agency is different. Get to know how yours is structured and the roles of the staff. Introduce yourself and your role in the community. Help them understand what you bring to the equation that is useful to their work. • Keep at it!
Lead and/or participate in a **learning collaborative.** Learning collaboratives are an essential, often-overlooked component to building the capacity for outreach and enrollment.	• All of the lessons learned get lost if there is not a convener willing to compile and share lessons learned. • Learning collaboratives can be online, in-person or both.
Track problem areas or case issues in your own database. Discuss and review these regularly so that everyone is in the loop with how they are resolved.	• Trends and themes will emerge, track them and the ways to solve them or you might repeat mistakes, which is costlier for both you and the enrollee(s).

OUR CRYSTAL BALL:

Coverage Initiatives Present Potential Opportunities for Medi-Cal Health Enrollment Navigators Project

The California Legislature advanced several important coverage-related initiatives through the 2021-22 budget, and these initiatives pose exciting opportunities to enroll thousands more in Medi-Cal and keep them enrolled. The California Health Care Foundation released an important paper about why eligible Californians don't enroll in Medi-Cal and how to make the program more accessible to those it was designed to serve. The authors argue that the Medi-Cal Health Enrollment Navigators Project should continue because it brings funding and support to community-based assisters who bring trust and cultural connection to target populations.[27] These new coverage initiatives are an opportunity to use the Medi-Cal Navigators to enroll those who will be newly eligible for Medi-Cal. These opportunities include:

- **Expansion of Medi-Cal eligibility to seniors 50 years and over regardless of immigration status**. Effective May 1, 2022, the budget includes funding to expand full-scope Medi-Cal to undocumented adults aged 50 years and older.[28] Governor Newsom's office has estimated that 235,000 individuals are eligible for coverage.[29]
- **Medi-Cal asset test removal.** The budget also includes the gradual removal of the asset test in Medi-Cal for older adults and people with disabilities. The asset limit will increase to $130,000 for an individual (plus $65,000 for each additional household member) July 1, 2022, then will eliminate the test completely by Jan. 1, 2024. It is expected that the elimination of the test will result in 18,000 people newly eligible for the Medi-Cal program.[30]
- **Redeterminations to begin once the COVID-19 public health emergency ends.** States are required to keep people enrolled in Medicaid throughout the COVID-19 public health emergency, which is currently scheduled to remain in effect until at least mid-January 2022, but once the declaration expires, states will need to resume administering renewals for Medicaid eligibility.[31] The Centers for Medicare & Medicaid Services gives states up to 12 months to complete enrollment and eligibility actions after the public health emergency ends.[32] The Build Back Better Act currently being considered by Congress could phase out this continuous enrollment

27 Cordoba, Michele, Lee, Brenda, Mulkey, Marian, and Shaw, Terri. The Medi-Cal Maze: Why Many Eligible Californians Don't Enroll, The California Health Care Foundation, September 2021.

28 Kraynak, Marissa, Nguyen, Mary, and Hernandez, Sandra, California's Final 2021-22 Budget, Insure the Uninsured Project, August 18, 2021, available at https://www.itup.org/itup-blog-californias-final-2021-22-budget/.

29 Gutierrez, Melody, California expands Medi-Cal, offering relief to older immigrants without legal status, July 27, 2021, available at https://www.latimes.com/california/story/2021-07-27/medi-cal-expansion-immigrants-budget-california-newsom-legislature.

30 Kraynak, Marissa, Nguyen, Mary, and Hernandez, Sandra, California's Final 2021-22 Budget, Insure the Uninsured Project, August 18, 2021, available at https://www.itup.org/itup-blog-californias-final-2021-22-budget/.

31 Centers for Medicare & Medicaid Services, SHO#21-002 Letter on Updated Guidance Related to Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency, https://www.medicaid.gov/federal-policy-guidance/downloads/sho-21-002.pdf.

32 Centers for Medicare & Medicaid Services, SHO#21-002 Letter on Updated Guidance Related to Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency, https://www.medicaid.gov/federal-policy-guidance/downloads/sho-21-002.pdf.

requirement beginning April 2022, with additional rules for disenrolling people.[33] While much of the onus of redetermination will be on the state and county eligibility offices, navigators could help individuals who must update paperwork in order to renew their Medicaid eligibility.[34]

KEY RECOMMENDATIONS TO IMPROVE THE MEDI-CAL HEALTH ENROLLMENT NAVIGATORS PROJECT

Based on the experiences of The Center and its partner CBOs, there are a number of ways to make improvements to the Medi-Cal Health Enrollment Navigators Project if it continues in the future. While the project is not scheduled to continue past June 2022, **it is critical to note that funding this work non-continuously only contributes to Medi-Cal churn, consumer confusion and community workforce erosion, and exacerbates the ongoing challenges highlighted throughout this paper.** Following are key recommendations.

- **Facilitating relationships and coordination between community-based organizations that employ trusted messengers and county eligibility offices is a necessary ingredient for overall success.** While some of the CBOs highlighted in this paper have developed strong relationships with county eligibility offices over the years, some do not have established connections with them, and bridging this gap would save time and resources. Some of the CBOs selected to participate were new to Medi-Cal enrollment work but were chosen because of their strong relationships with the project's populations of focus. Other CBOs had deep health navigator experience in other regions but were new to a particular county. For these CBOs, trying to develop relationships with the county eligibility office was difficult for several reasons. Many county eligibility offices did not understand the role that CBOs were to play through the project and how it differed from their role in determining Medicaid eligibility. Furthermore, developing working relationships and establishing trust during the COVID-19 pandemic was extremely difficult, when most eligibility workers and navigators were working from home, at least initially, and unable to meet in person.

  Without partnerships and coordination between these entities, CBOs found it challenging to get information about clients' Medicaid eligibility. As stated earlier, it

Critical Components

- ✓ **Build essential relationships**
- ✓ **Establish trust in the community**
- ✓ **Leverage partners long-term**
- ✓ **Provide sustainable, year-round enrollment funding at the community level**
- ✓ **Create a stable, trained workforce**

33 These additional rules could help reduce churn. See Corallo, Bradley, Garfield, Rachel, Tolbert, Jennifer, and Rudowitz, Robin, Medicaid Enrollment Churn and Implications for Continuous Coverage Policies, Kaiser Family Foundation (December 14, 2021), available at https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/.

34 Centers for Medicare & Medicaid Services, Strategies States and the U.S. Territories Can Adopt to Maintain Coverage of Eligible Individuals as they Return to Normal Operations, November 2021, available at https://www.medicaid.gov/state-resource-center/downloads/strategies-for-covrg-of-indiv.pdf.

was difficult for some of the organizations to work with the county offices to receive updates on applications or get Client Index Numbers, which were necessary to submit to DHCS in monthly data reports. Without help from the county eligibility office, there was no way to get the Client Index Number without reaching the client. For applications that were held up in the eligibility determination process, there was no way to check the status without either contacting the eligibility office or the client themselves. Some CBO navigators found it difficult to obtain information from county eligibility offices despite having signed release of authorization forms on record. This challenge likely extends to other CBOs participating in the State's Medi-Cal Health Enrollment Navigators Project as well.

To ensure future success, DHCS should actively facilitate relationships between CBOs and county eligibility offices and require that county eligibility offices work with CBOs in this project. If the Medi-Cal Health Enrollment Navigators Project does continue on a long-term basis, DHCS may want to consider ways to allow CBOs to have access to application status and Client Index Numbers, such as through an electronic portal.

- **Fund the project on a long-term basis and develop a stable workforce model.** The California Legislature funded this project for three years, and to continue it will require additional funding from the Legislature. Policymakers should consider solutions to permanently fund this work. As noted above, building the infrastructure for the CBOs to engage in the outreach and enrollment work took an enormous amount of time. Furthermore, The Center put in significant time providing oversight and management of the CBOs, developing expertise on enrollment issues along the way. While many of the CBOs would like to continue, and some may look for other ways to fund the work, without long-term funding it may not be possible to continue.

  It is often erroneously assumed that enrolling individuals and families into Medicaid and Medi-Cal, specifically in California, is a "one and done" process and involves little effort; however, that is not the case. Making the decision to enroll in coverage involves making personal decisions that have lasting impact on the lives of individuals and families, and it takes a specialized, trained workforce to help them enroll in coverage. Ensuring continuous funding allows the workforce to continue.

- **Coordinate with Covered California.** Although the Medi-Cal Health Enrollment Navigators Project is focused on enrolling those eligible for Medi-Cal, if the project were to continue, DHCS should consider coordinating with Covered California, the state-based health insurance marketplace. Navigators who work with individuals and families eligible for Medi-Cal or marketplace coverage could reach larger numbers of people, helping to reduce the state's uninsured population.

PHILANTHROPIC FOUNDATIONS HAVE A CRITICAL ROLE TO PLAY IN OUTREACH AND ENROLLMENT WORK

The pervasive challenges identified in this paper also plague navigators and enrollment assisters in other states. Philanthropic foundations play an important role across the country, just as The Center did with the Medi-Cal Health Navigator Project.

Key roles for philanthropic foundations include:

- Pass-on state funding to CBOs
- Assist with capacity building and infrastructure needs
- Play an ongoing convener role and facilitate peer learning opportunities for navigators to learn from each other and subject matter experts
- Provide philanthropic funding, in addition to state and federal funds, that allows navigators to reach more individuals and families, especially as we move toward more whole-person care models to address social determinants of health in a larger health equity landscape

CONCLUSION

The Medi-Cal Health Enrollment Navigators Project made enormous investments in time and resources to build the infrastructure and capacity of communities to employ and embed trusted messengers to help some of the most vulnerable populations navigate enrollment into Medi-Cal. Ending the project now reinforces inequities already plaguing these hard-to-reach groups. California won't be able to just turn on these processes at a later date without re-establishing the infrastructure that DHCS, CBOs and intermediary groups such as The Center worked so hard to build over the course of this project. The State of California should consider continuing the project and employ solutions to permanently fund this work, especially with new opportunities for enrolling individuals into Medi-Cal in the near future.

The people of California deserve the best possible health care safety net and those in hard-to-reach populations should not be overlooked. In times of health and climate crisis, we must put forth our best efforts to serve those most vulnerable to ensure healthy communities across the state. Trusted messengers serving as health navigators are the catalyst for breaking down silos and creating pathways of care between local government agencies and the services they offer.