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I would like to submit additional comments regarding the Discussion Draft outlining RHA's recommendations for the development of a Statewide Assisters network that raises numerous questions and concerns regarding the baseline data that was used and the projected outcomes, especially in comparison to the currently existing Certified Application assister model as utilized by MRMIB for Healthy Families enrollment and as used by most CA Counties for additional enrollment into Medi-Cal, Healthy Kids and other State & local public insurance programs through the One-E-Application system.

As with my previous email, I am going to tie my comments to the draft pages.

As a general comment I would like to point out, though, that the proposed network will shrink the current workforce employed through the CAA model by a significant number (depending on which baseline data is used) and, thus, effectively putting a significant number of non-profit and county workers out of the job starting as early as summer 2013. So, in addition to addressing the build up of the new network, the Exchange may also want to address the expected concerns by current Enrollment Entities about the proposed underfunding of current operations and the necessity for employee layoffs.

Page 2: I would like to point out that education, outreach and marketing are not synonymous functions. Each come along with very specific tasks and my assumption is that this draft takes into consideration the differences between those three. Yet, I would have liked to see a more detailed breakdown of the education tasks RHA assumes as part of the assister role as assister might be compensated for this function, but not for outreach and marketing and the grant section of the Discussion draft from Ogilvie regarding the Marketing & Outreach strategy was too vague in regards to the grant compensation model for those activities which would ultimately fall on the same person, at least at the ground level of community outreach & marketing support. So, one way to fund the assister positions could be by leveraging available outreach funds and by tying those to the time expected for assisters to assist with these efforts.

I would also like to point out that CAAs currently do not need to re-certify annually, not do EEs need to re-register. So, these would be additional administrative overhead costs currently not incurred for the CAA network.

The same is true for the expanded quality compliance and fraud referral and investigation components of the new model. My assumption is that this need arose from the inclusion of health insurance agents into the new assister model who are

currently not part of the CAA model. It'll be interesting, though, how the State wants to hold public and private entities to the same QA standard when both sectors are currently not operating under the same rules & regulations. There is no detail given in the report on how this oversight would be designed and the costs attached to it.

Page 5: The base assumption regarding navigator productivity is actually false. Most of the current CAAs have no influence on the areas their Enrollment Entities conduct outreach to and it would be wrong to assume that individual assisters would try to enroll as many easy-to-reach people as possible due to taking advantage of a relatively high fee per successfully application, simply because most EEs deal with mixed populations where statistically the easy accessed applicants are balanced out be the harder-to-reach ones and the assister would need to be affiliated with an EE which would receive the reimbursement for enrollment and which would most likely pool the fees and distribute the funding among all funded positions instead of offering flexible wages strictly tied to the actual enrollment fees.

Also, the assumption that health plans can deal with the retention from Year 2 of the Exchange forward is incorrect for the simple reason that eligibility for the Exchange programs will still be tied to income levels and with changes in the overall economy and the growth or decline in households (new children being born into recipient households, adults leaving the home for a multitude of reasons) recipients' total countable household incomes may go up and down and may require re-screening for new programs which the health plans which by design are excluded from active and direct participation in the Assisters network won't be able to accomplish. I would also like to mention that in our County e.g. the screening for all public programs is done by CAAs who are mostly public agency employees, yet all, but one, programs are exclusively maintained by just one health plan whereas in other counties a multitude of health plans partner in maintaining the provider network for various public plans, or even components of the same public plan (Medi-Cal). Having the health plans dealing exclusively with renewals is, therefore, impractical.

Page 6: The grant model would require a lot of upfront planning and would prolong the establishment of registered Enrollment Entities due to added steps in the grant approval process. It would also hold the grant partners accountable to outcome goals and performance standards that are difficult to establish as the base data is incoherent and grantees situations may vary depending on the geographic area they serve in relation to the variances in population sizes between rural and urban communities and the socioeconomic and cultural components of those areas.

Page 7: It is not correct to assume that a broad pool of diverse organizations will have the opportunity to participate in the assister network because the Exchange won't have the funding to pay for start-up costs and support the administrative overhead required to maintain the organizational operations as outlined in this draft. However, no new organizations will be founded based on the promise of a purely enrollment fee-based

model as that model would be unsustainable. So, most likely, only those organizations who already have secured funding through other local, State or Federal sources will be able to participate and so, most likely, the Exchange will deal with the very same EEs it already has connections with under the current CAA model.

Given the introductory scenario of 23,000 active CAAs the Pay for Enrollment model would also not be the most cost-effective one. If all current 23,000 CAAs were to become certified assisters and if one would make the reasonable assumption that each assister would be able to take 4 applications/day for a full 5-day-work week over the course of a full month of employment during the first 12 months of Exchange enrollment, then the estimated costs based on a $58/application - fee would be $128,0640,000 Mio. So, obviously - as stated above and as presented later in the draft - to make this model sustainable the number of certified assisters would have to be much smaller which would again jeopardize the existence of some smaller EEs who might only employee less than 5 assisters, yet might be the only entity in their respected area with the required community access (e.g. due to language and other cultural skills and trusted partnerships) needed to reach out to hard-to-reach populations which supposedly make up the majority of currently uninsured Californians.

Again, on this page the assumption is made that assisters may focus on easy to reach target populations, but if enrollment entities are made up of a majority of organizations connected and partially funded by local and State governments they would actually focus their attention on the high utilizers of local & State services such as Community hospitals' Emergency Rooms, General Assistance or other programs and services that stretch funding for those service areas. So, EEs would not be motivated by a high number of enrollees, but by the cost reduction in other funded services areas which are currently funded at unsustainable and underfunded levels.

Page 9: In order to promote the retention of existing insurance coverage in public programs, these very same programs would have to exist in the Exchange. However, programs like MRMIB and PCIP will be replaced through QHP options, other programs like Healthy Kids aren't mentioned in either draft and may no longer be supported by the Exchange. So, current recipients at the minimum will have to adjust to new program names and options, might go from a public to a private plan, will receive new membership cards and informational material from previously unknown entities, all of which will make retention efforts at the initial Exchange start up more difficult, and there is no reimbursement built into the current assister model for tasks related to these initial retention activities. There is the notion that certain pre-identified populations could be moved by the push of a button from one program to another come January 1st, but what if that automated enrollment confuses people and leads them to voluntary drop out of newly assigned plans? There is a lot of resistance against Medi-Cal enrollment due to the current problems with accessing care in the ever decreasing provider networks and the cut back on ancillary benefits so many of those

who will be auto-enrolled into Medi-Cal may actually prefer to pay a premium and select a QHP plan instead.

Also, the role of the CalHEERS Call Center is not described in any detail, nor is there reference to the web portal and its design, both of which might be important components for stakeholders to decide as to which assister model that will come along with both might work for the population they represent.

Page 14: The definition of direct benefit assisters vs. navigators would, in our County, effectively prevent approximately over 90 % of currently active CAAs from becoming navigators due to their association to the Health Services department and its contracted agencies. It would open the door for organizations like Health Advocates to take over current CAA responsibilities.

Page 15: Maryland and Utah are mentioned as integration models and it would be helpful to know if these two States also had a CAA-network prior to building out their Exchange, or if they developed their model from scratch. If they had a similar CAA model, how does the compensation under the old system differ from the new one? And did they experience significant reductions in their workforce assigned to enrollment, education, outreach and marketing tasks? What is their cost for the administrative overhead at the State level necessary to maintain QA, IT and other oversight and support functions? And would there be ways to cut costs in those areas?

On the same page it is mentioned that assisters would facilitate the selection of a QHP. This would be a completely new concept for CAAs who are currently not allowed to assist applicants in the selection of a Healthy Families plan.

Page 16: Will the marketplace also take into consideration the cognitive challenges of those applicants dealing with a Mental Health disability when designing navigator tools and functions, including the built out of the web portal and the Call Center?

Page 17: The tasks listed for assisters under "Specialization" would require current CAAs to be completely retrained in regards to knowledge of coverage costs and covered benefits. Currently, these two components are rarely taken into consideration, and especially if the enrollment is done via electronic tools such as an online screening program with built-in program rule capacity, assisters will not be able to pay close attention to those areas as it requires more in-depth side-by-side comparison of plan options down to actual service level, including co-pay and deductible comparisons between plans. Health Insurance agents are equipped to do this, but those who have been trained and work for a public agency or non-profit do not have the skills to do such type of even low level financial planning. This should be a larger section of the proposed assister training.

Page 18: When screening for other programs, it would be helpful if SSI rules could be integrated due to the large overlap between those qualifying for free Medi-Cal and those in need of other support, not offered through General Assistance, CalWorks or CalFresh due to the respective eligibility rules of these programs.

And even if not integrated in the screening tool, it would be helpful to include a segment into the assister training that explains the program rules for SSI and the difference between Medi-Cal and SSI Medi-Cal, as to my understanding, SSI will still be based on categorical eligibility (age & disability) while Medicaid won't have these rules any longer.

Page 21: Currently, there is no built-in survey in Health-e-App or One-E-App that would provide an accurate account of customer satisfaction identifiers

Page 23: I would strongly advise against a web-based assister training that would require the assister to sit for straight 12 - 16 hours in front of her/his computer to complete all modules. But, if such a training were to be designed I would suggest to review it for any unnecessary duplicate segments as the current CAA online training module includes a lot of duplicate information. Also, many of the exercises, especially those covering the calculation methods to determine income eligibility are too cumbersome and there are only about three versions of the final CAA test. I would also advise to make the final certification exam a personalized exam and not something that can be turned into a group exercise because of the complexity involved with the assister role. The Medi-Cal component should include overviews on SSI Medi-Cal, the 250 % Working Disabled program and Foster Care Medi-Cal, the disability section should include a segment about access standards for individuals with mental health and substance abuse disabilities, and the training should include a segment on other assistance programs. I would include in those not just CalFresh and CalWorks, but also a segment on USCIS programs such as the U-Visa and VAWA, especially since it looks like the Exchange will advertise the marketplace heavenly among the Latino communities where there is a lot of identified need for education about protective services for those immigrants who have become victims of violence while residing on US territory.

Page 24: There should also be thought given to a reinstatement policy for those assisters who can not be re-certified due to their low enrollment numbers, yet who might switch from one EE to another and due to the switch may now have access to a greater applicant pool going forward.

Also, the abbreviated training for those already certified as CAAs can and should not be done in a day. I would like to caution that the current CAA training is developed based on current program rules for Healthy Families and Medi-Cal and these will significantly change with the Exchange, plus there should be greater emphasis given to the training

of evaluation for QHP plans as these will be completely new to all assisters regardless of their previous work history.

Page 26: Since it looks like the Exchange won't have the need for a continued partnership with all current certified EEs I would suggest to first solicit interest from the already certified EEs in becoming part of the Exchange before rolling it out to any new entities to assure that those who have the necessary infrastructure to support all assister functions can be selected first rather than having to compete with new entities. Also, when approving new entities I would suggest to add a component that looks at the entity's financial stability to assure that it will have the funding to a) pay for the expected start up costs, or at least sustain itself until reimbursement through the Exchange for services is received and b) can sustain a workforce without a lot of turnover, as you will not be able to establish trusted relationships with local communities if your enrollment entities to do the actual leg work consistently change. Personal relationships are built over time, so if an entity can't fund itself without the Exchange 100 % support for the duration of the initial 4-year-outreach phase between 2013 and 2016, then it wouldn't be an entity that would work for the assister network. However, yo may also want to have a plan for the event that one entity needs to term out from the network with another one taking over for initial enrollment and/or retention efforts in the same geographic area.

Page 27: The dates for the final training are too late. By October 25th, most counties will be already up and running with their enrollment efforts, and also take note of the marketing plan that recommends starting outreach as early as January 2013. If you start marketing that early with no one at the ground level knowledgeable enough about the basic components of the marketplace, you will fight an uphill battle to convince people to sign up for an Exchange plan. Also, please note that many people who will be contacted by the assisters will have - mostly negative - experiences with certain programs that are now part of the Exchange, particularly Medi-Cal, and it will be the trust built between the assister and the individual that will convince the individual for sign up. Given the financial constraints many of the eligible individuals are already in, facing the insurance mandate and tax penalty for not signing up timely won't be a big incentive.

Also, it will definitely be a problem to start invoicing for services as late as February 5,2014, especially if the board selects the Pay for Enrollment model with a set fee per successful application as some, if not many, of the EEs won't be able to sustain their payroll for four months without appropriate funding. This might force some entities to not hire after February 5th which would, ten, jeopardize the early enrollment efforts.

County entities might be able to tap into MAA funding, but non-County entities might not, or may not know how to if it is made available. So, the Exchange might also want to lend assistance with training for those unfamiliar with tapping into such funding sources.

Page 30: It looks like the base data used to estimate enrollment needs might have been taken from Healthy Families and its Health-E-App network. even if the dat would also include enrollment information from PCIP which is handled by the same CAA network, I would like to caution that the overall enrollment needs are significantly higher because both programs only capture a small percentage of those who will be eligible for all of the marketplace plans. It would be helpful to look in addition at One-E-Application data, although the system may not be used by all 58 CA counties and even among those that utilize it there is a wide variety of programs the systems screens for. In San Mateo e.g. the system is designed to screen for six public programs. San Francisco uses it also as a tool for enrollment into Healthy San Francisco which has its very unique program rules. However, based on the figures listed it looks like there would not be a need for more than max. 15,000 - 16,000 assisters statewide compared to the current 23,000 CAAs, 21,000 Eligibility Workers and 8,000 Insurance Agents cited on page 1 of the draft. This number could drop as low as 2,600 depending on which estimate the board will go with. So already by determining the expected number of assisters statewide there is no solid data available to lend much guidance and when factoring the reimbursement models the data becomes more complex and confusing as the assumptions do not add up. However, one thing becomes very clear, namely that the Exchange will significantly less support than the current CAA model and so the board will face fierce competition among small EEs, especially in areas with large urban populations in which outreach efforts are duplicated by a multitude of small non-profits to select those which might further the desired performance and outcome goals. I believe the last board meeting has already displayed some of this "angst" among community clinics which fear to be left out of the assister network.

Page 37: The numbers are off. Actually, in the real world full-time CAAs do not average 4 applications/ day. They usually process up to 8, but about 6 on an average, or one per hour. However, even the draft figure itself is off by 20 applications/year. 4 applications per day x 5 days/week x 4 weeks/month x 12 months will actually total 960. 960 applications x $58 (recommended level of fee/application) is $55,680. The draft appears to recommend later about approx. 9,000 navigators so the total costs for the Exchange in Year 1 of the recommended outreach would be: $50,1120,000. i don't see this figure anywhere mentioned in the draft and the figure mentioned at the last board meeting of $23 Mio. isn't even half of the above calculation. To get to the $23 Mio. figure you would need to reduce the reimbursable assister positions to about 4,000. So, the numbers don't add up. My assumption is that there is a lot of speculation about utilizing a fair number of additional Direct Benefits Assisters, but I would caution that the ratio between those and the assisters would definitely hamper all expected outreach, marketing & education efforts.

Also, there is no breakdown between the costs estimated for supervision, overhead and labor expenses. It would be helpful to see the actual figures or ratios that led to the annual $54,500-salary figure/ assister position.