California Health Benefit Exchange

Stakeholder Input:
Statewide Assisters Program
June 7, 2012

The California Health Benefit Exchange, the Department of Health Care Services, and the Managed Risk Medical Insurance Board (collectively, the Project Sponsors), solicited written stakeholder comments on the proposed design of the Statewide Assisters Program which was presented to the public at the May 22nd Exchange Board meeting. The proposal is detailed in a draft report available on the Exchange website entitled *"Statewide Assisters Program Design Options and Recommendations Report for the California Health Benefits Marketplace."* Feedback was solicited in six specific issue areas as well as other general comments. Forty-one organizations submitted comments using a stakeholder input form provided on the Exchange website and eleven organization submitted comments in separate letters. Comments received on input forms have been compiled in the tables below. Letters will be posted separately on the Exchange stakeholder webpage. Stakeholder comments will be used for consideration of revisions to the Statewide Assisters Program Report. The Project Sponsors thank all stakeholders for their valuable comments that will assist in the planning and implementation of this program.

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ISSUE 1

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2-1-1 California	2-1-1 California generally agrees with the roles and structures as recommend by RHA. The distinction between compensated assisters is important, but it is our opinion that it will be hard for the Exchange to ensure that all assisters adhere to the same training and performance standards, if some are compensated and others are not. We also recommend that RHA and the project sponsors carefully reconsider who is considered a Direct Beneficiary Assister, so as to not exclude safety-net organizations, which are critical to this enrollment effort. 2-1-1 California agrees with the recommendation that organizations have the option to target specific markets and populations, but we strongly recommend that it required that compensated assisters have the capacity to help anyone who enters their door. Targeting specific populations or markets, while beneficial in leveraging existing infrastructure may create negative service patterns of exclusion.
AIDS Health Consortia	The draft plan calls for the project to "leverage existing public and private health distribution channels and funding sources outside the Marketplace to achieve enrollment goals, while still maintaining common program standards for all individuals assisting with the enrollment in Marketplace products." Serving people with HIV/AIDS through Ryan White programs has demonstrated that some people with HIV will need higher than average levels of linkage, engagement and retention services to effectively utilize new coverage options and maintain optimum health outcomes and reduce the risk of HIV transmission. In order to fully leverage funding provided through the Ryan White program. Whatever structure and roles are finally chosen by the project sponsors will need to be clearly defined. Services necessary to people with HIV/AIDS that are not offered under the program may continue to be funded through Ryan White if it is very clear that those services are not offered through the program. The draft plan raises concerns that Direct Benefit Assisters, such as providers, community health clinics and hospitals, who maintain relationships with particular health plans and may have a business interest in enrolling consumers in particular plans, may not be able to provide fair and impartial information to consumers without steering or conflict of interest (p. 15). The draft plan raises this area as one that merits additional analysis. As that analysis is done, we request that the specific needs of people with HIV/AIDS and other chronic conditions be taken into account. While we recognize the dangers of inappropriate steering that could arise with health insurance agents and in the hospital setting, provider and clinic assistance is essential for many with HIV and other chronic conditions. Many people with HIV/AIDS have come to rely on their experienced provider and clinic and appropriately seek to remain with that provider. Research indicates that provider relationship is at least as important in maintaining optimum health outcomes as coverage. Experience indicates that a client's comfort level with his or her provider can engage and keep vulnerable people in care. Given the need to ensure engagement in and access to care for this patient population, we would request that providers and community clinics be analyzed as their own category for benefits as well as potential concerns.

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	In Assisters Roles and Services the draft plan states that Entities employing Navigators must: 2. "acknowledge other health programs." We urge the project sponsors to consider ensuring that Entities and Navigators are aware of Ryan White services when they are applicable. The draft plan does not recommend that Navigators and Assisters services include post-enrollment services, such as utilization and renewals, in order to enhance cost effectiveness of the program. It assumes that plans might have an interest in keeping people in care and therefore these services may not be necessary (p.17). Experience has shown us that plans do not have systems for or perhaps interest in keeping "high cost" enrolled in care. Many people living with HIV/AIDS will have difficulty adhering to necessary levels of care for optimum health outcomes without assistance. We urge the project sponsors to consider the needs of people with chronic health conditions in the design of the navigator and assister roles and services.
Alameda County Medical Center	We are pleased that public hospitals and community clinics will have a role in the Assisters Program as Direct Benefit Assisters (not compensated by the Exchange). Given the relationships we have with the diverse communities we serve, ACMC's ability to serve as a Direct Benefit Assister will be critical to achieve the goal of increasing coverage among Alameda County's uninsured population. We support the recommendations that include the following: • Ability of Direct Benefit Assisters to be compensated by other sources • Having a business interest in enrolling people • Conducting enrollment as part of our community service mission • Support efforts by the Exchange to secure funding to offset the cost of training for Navigators and Assisters given our limited resources to provide additional training • Offering trainings, education, eligibility and enrollment services, certification, etc., that are consistent with those offered to Navigators and will help ensure all eligible staff are effectively trained Through our experience in serving low-income and uninsured patients, we have first-hand knowledge of the realty that many individuals enroll in coverage at the point of care. County eligibility workers and public hospital staff have gained significant experience in connecting patients with health coverage options. Public hospital systems have also played a major role in developing and implementing coverage expansion programs. Through the Low Income Health Program (LIHP), ACMC together with the County, the Alameda Health Consortium and the Alameda Alliance for have helped lead efforts to enroll 40,000 uninsured individuals. As California prepares for reform implementation, it is important that the Assisters program build upon this expertise in enrollment in public hospital systems in helping to connect the uninsured to overage options. We therefore support the overall proposed Assisters framework and believe it will allow public hospital systems to serve as an important touch point for individuals to enroll in coverage. Recommendations:

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	• Amend the proposal to include the addition of a hybrid model that provides grant funding to qualified safety net and community leaders who can effectively work harder to reach populations and assist with outreach and enrollment efforts. Given the unique and mission driven role of public hospital systems and community clinics, these safety net providers should be eligible and allowed to compete for these grant funds. • Provide for an adequate financial investment in the Grant Program funding (referenced in outreach plan) that will complement pay for enrollment funding mechanisms to maximize awareness about enrollment efforts and participation in affordable health insurance options. • Develop an alignment system between Assisters Program, Direct Benefit Assisters and other aspects of outreach plan in order to provide a "no wrong door" and seamless and streamlined consumer experience.
AltaMed Health Services Corporation	• AltaMed Health Services Corporation is a federally qualified health center that provides primary health care services to over 125,000 patients through its 44 delivery sites in Los Angeles County and Orange County. • We are one of the leading community-based providers of quality health care and human services. As providers we promote wellness and advocate from strong and healthy communities. • AltaMed strongly **opposes** the recently released Statewide Assisters Program Design Options and Recommendation report by Richard Health and Associates. • AltaMed is a trusted community resource with a long and established with the Exchange target market. AltaMed has offered enrollment assistance for years and it is dependent on funding in order to continue offering this service. • As a community health clinic we are not independently supported in our outreach and applications assistance efforts. We have to apply for grants that help us fund outreach, enrollment, utilization, retention, and renewal activities. We are not directly incentivized to enroll since our enrollment services are mandated to ensure all provider options are presented for full choice by the enrollees. We enroll many persons who do not choose us. • To continue to be the voice of our communities and promote wellness and strong and health healthy communities we need to be compensated for the application assistance and enrollment activities under the Navigators under the Exchange. • If we do not receive any support from the Exchange as Navigators and Direct Benefit Assisters this will strongly affect the number of eligible individuals we can potentially outreach and enroll. • If we do not receive the proper reimbursement for all the steps we go through to get these individuals through eligibility and redetermination, the Exchange will be setting up a policy with perverse incentive for clinics to determine which patients would only choose us and our networks and do the applications for those individuals only leaving out the

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	others who could qualify to seek application assistance elsewhere. • AltaMed is extremely concerned from the regulatory side of fraud prevention from paid navigators who have no investment in the community. • The Exchange has to enroll in a very short period of time 2.8 million people, the Exchange is going to need as many Navigators and Direct Benefit Assisters to assist with the enrollment process. • The educated assumption by Richard Health and Associates regarding the enrollment process of 4-6 application in day for a full-time Assister will **not** help the Exchange meet the deadline of enrolling 2.8 million people without a compensated and robust Navigators and Assisters program. • Providing a robust paid Navigator and Assisters program through community clinics will be critical to the success of the Exchange because of the relationship and trust we have in the community. • By providing less media and more outreach through the community clinics you are positioning the Exchange to able to perform at its highest level. Community clinics with the compensated assistance of the Exchange would be able to reach to millions of newly eligible individuals in underserved communities. • AltaMed truly believes in the Exchange vision of the "No wrong door experience". AltaMed core values is to encourage process of excellence and innovation for quality outcomes by always offering the highest level of integrity, honesty, and respect in all of our endeavors. • Community health clinics as Navigators and Direct Benefit Assisters will educate on more than enrollment, but preventative care, and help to eliminate unnecessary and costly visits to the Emergency Room. • Community health clinics as Navigators and Direct Benefit Assisters will also assist with retention of coverage and ensuring individuals understand how to use the care they have been provided. • Community health clinics as Navigators and Direct Benefit Assisters will be the liaison between community based organizations and the medically underserved populations. We urge to please include community health clinics as Navigators, eligible for compensation for application assistance services.
Anthem Blue Cross	Anthem supports the goals of the California Health Benefit Exchange and believes the assister program will be critical to ensure meaningful enrollment in the Exchange. We look forward to working with the Exchange to ensure the marketplace builds trust with consumers and we are able to meet the need for assistance, particularly during open enrollment in 2013. We ask that the Exchange continue to closely collaborate with stakeholders during the development of this program. Stakeholders will need additional detail regarding how the exchange plans to raise awareness and comfort with this new marketplace. Anthem supports the proposed compensation tier model, as a cost effective approach to address the constraints imposed by

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	the Affordable Care Act (ACA). We agree with California's proposed approach to have two kinds of assisters: Direct Benefit Assisters (DBAs) and ACA mandated Navigators. We would like to ensure that the only difference between DBAs and Navigators is who they are compensated by. Additionally, given Navigators will be paid by the Exchange, which will be funded by user fees, we believe this proposed approach will be the most cost effective way of ensuring all enrollees receive adequate assistance through a combination of Navigators and DBAs. Anthem would like to seek clarity regarding the estimated number of agents. The report references an estimated 8,000 agents would be potential DBAs. Is there a source for this estimate? Currently, Anthem has over 14,000 active agents that play a critical role in assisting individuals learn about and enroll in Anthem's health insurance products.
Asian Pacific American Legal Center of Southern California (APALC)	**Proposed Tiered Model for the Assisters Program** **Assisters (Pg.14)** • We believe that insurance agents should be considered DBAs if they receive commissions from health insurers when they enroll individuals into health plans and need not be compensated separately. However, the report recommends that agents may serve as navigators but not receive compensation from carriers. (See P. 14) Regardless of whether agents are Navigators or DBAs, we agree that there must be proper monitoring of the agents to avoid any pattern of "steering" into certain health plans and to avoid any potential conflicts of interest due to the commission which agents may receive from the plans • With regard to the options offered, we support the option "to allow a subset of organizations that are not compensated by other sources or do not derive a financial benefit from enrolling people to fulfill the role of Navigators and receive compensation from the Exchange." This allows the maximum number of entities to become Navigators without any inherent conflicts of interests. • Although there may be a need for a tiered system of Assisters, it is not clear that the division recommended by the report into "Navigators" and "Direct Benefits Assisters" (DBAs) is the best way to distinguish between those who may benefit from enrollment v. those who do not. We do not agree that health care providers, hospitals and clinics necessarily derive a direct benefit any more than any other navigator. Organizations that conduct enrollment because it's part of their community service mission, such as community clinics and non-profit and public hospitals, should not be considered as DBAs. Community health clinics in particular play a unique role in targeting hard-to-reach communities because they provide linguistic and cultural competent health care to community members that would otherwise not seek service or assistance in other health care settings. They often play a hybrid role of providing health services as well as other needed social services. Therefore, community clinics, along with other assisters such as community-based agencies, should be fairly compensated. • We agree with the report's recommendations that all assister should be required to complete education, eligibility, and enrollment activities and sufficiently trained in all Marketplace coverage options and subsidies and assist with the selection of and enrollment in a plan. We would also require retention and utilization responsibilities as well and

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	additional compensation for these activities. We also strongly support that assisters have the option to target specific markets or populations, if they have the expertise to do so, especially the cultural and linguistic competence for certain immigrant and LEP populations. **Enrollment in Other Programs** • We would recommend that assisters be required to help enroll eligible individuals into other public programs by screening applicants and understanding public program eligibility requirements. The final determinations would be made by the Exchange or appropriate state agency, i.e., the Dept. of Health Care Services, but the initial application can be completed with the help of the assister. If a determination is later made that the individual is not eligible for Medi-Cal or another publicly funded program, the assister should continue to help the person find an appropriate health plan in the Exchange. (P.18)
California Association of Health Plans	CAHP understands that a robust enrollment strategy is vital to the success of the Exchange. Therefore, we are interested in knowing more about the rationale behind requiring all Assisters, including the Direct Benefit Assisters (DBAs), to provide an individual with options to choose any QHP. We believe that it makes sense for Navigators, who are compensated by the Exchange, to focus on providing individuals with all of their options. However, we would recommend that the Exchange examine the feasibility of requiring DBAs, who are working under different compensation arrangements with different incentives, to offer all available options. In particular, we are concerned that requiring health plans themselves to provide information on their competitors' products would reduce their incentive to engage in direct marketing and thereby undermine the Exchange's goal of maximizing enrollment. We understand that more detailed recommendations regarding the role of health plans and their captive agents in marketing QHPs is forthcoming and we hope that those recommendations will account for the need to maintain strong incentives for plans to engage in direct marketing. Additionally, CAHP would like to request that the Exchange provide additional information on how they intend to operationalize the requirement that all Assisters offer all products in the Exchange. Specifically, we would like to better understand how this will work when an individual comes to an Assister and it is determined that they are eligible for Medi-Cal or Healthy Families. Will the assisters be able to directly enroll them in the public program? Will assisters be compensated for that enrollment?
California Association of Public Hospitals and Health Systems	The California Association of Public Hospitals and Health Systems (CAPH) appreciates the hard work of the Exchange and RHA to develop the proposed Assisters program. Overall, we are in agreement with the proposed structure and offer our suggested recommendations and comments below for the Exchange to consider in their final recommendations and approved Assisters structure. As you know, public hospital systems play a critical role in serving the uninsured and low-income populations in California. Although just 6% of all hospitals statewide, public hospital systems provide roughly half of all hospital-based care to California's uninsured. Through our experience in serving low-income and uninsured patients, we have first-hand knowledge of

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	the reality that many individuals enroll in coverage at the point of care. County eligibility workers and public hospital staff have gained significant experience in connecting patients to health coverage options. Public hospital systems have also played a major role in developing and implementing coverage expansion programs. Through the Low Income Health Program (LIHP), counties and their public hospital systems have helped lead efforts to enroll over 400,000 uninsured individuals. As California prepares for reform implementation, it is important that the Assisters program build upon this expertise in enrollment in public hospital systems in helping to connect the uninsured to coverage options. We therefore support the overall proposed Assisters framework and believe it will allow public hospital systems to serve as an important touch point for individuals to enroll in coverage. In addition to the role public hospital systems can play as Assisters within the Exchange, we believe there is also a role for safety net providers to assist with targeted outreach and enrollment efforts for specific populations. Therefore, we recommend the Exchange amend the current proposed framework to include the addition of a hybrid model that provides grant funding to qualified community leaders who can effectively work harder to reach populations and assist with outreach and enrollment efforts. Given the unique and mission driven role of public hospital systems and community clinics, these safety net providers should be eligible and allowed to compete for these additional grant funds.
California Consumer Advocate Navigator Workgroup	**A. We appreciate that a consumer-focused approach is one of the Exchange's core values, and that the Exchange is committed to offering a consumer-friendly experience that is accessible to all Californians, recognizing the diverse cultural, language, economic educational and health status needs of consumers.** Furthermore, we believe that the navigator program should not only be logistically workable but also adaptive to local communities. CCAN agrees that the program should be consumer driven and grounded in the Exchange's "guiding principles" and suggest that the Exchange keep these principles in mind as they construct a program that addresses the human and community component of the program and is structured to effectively meet the diverse needs of all California consumers. **B. The navigator program should be designed to serve various populations that traditionally lack coverage in a manner that is culturally competent and linguistically appropriate to that population.** **C. As discussions continue regarding the development of call centers, the website portal, other in-person assistance, and other components of the system we recommend that where ever assistance is offered to consumers a connection be established to the navigator program.** Consumers should be offered a link to a local phone or in-person navigator whenever they seek assistance in applying for Exchange product coverage. **D. CCAN recommends that there be three tiers of navigators and that each tier should be compensated for their work.** In many populations and communities, the process of reaching and engaging consumers will be just as complex and time-intensive as the plan selection and enrollment assistance process. Furthermore, helping consumers to utilize their benefits and retain their coverage will be crucial to the ongoing success of the Exchange. Each successive level

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	of navigation assistance requires a more advanced set of skills, training, and qualifications. Therefore, we recommend that the Exchange consider developing a navigator program that acknowledges these skill sets by creating a tiered structure that categorizes navigators into three tiers based on the functions in which they specialize. An individual carrying out the duties of a navigator would fall under one of three tiers. An organization or entity that employs navigators would not be classified by tier, and may employ multiple navigators functioning in several tiers or only one tier. If an organization does not employ navigators functioning at all three tiers, it must demonstrate strong linkages and relationships with entities employing navigators at the other tiers, thus ensuring that consumers have integrated, seamless access to the full spectrum of support services. ***Tier 1 – Application Assistance, Case Management, Problem Solving & Technical Assistance*** Tier 1 navigators are highly trained and capable of training other navigators, adept at problem solving enrollment and access issues, and able to provide case management through to completion and solution of a problem. Tier 1 navigator responsibilities: a. Be able to provide the functions outlined in Tiers 2 and 3 b. Provide consumer assistance in the Individual Exchange, public coverage options, and the SHOP c. Address complex coverage issues such as clients transitioning between coverage programs inside or outside of the Exchange, families utilizing multiple coverage options, and clients with sudden job loss d. Provide case management, in-depth problem solving, and technical assistance for both consumers and other navigators e. Establish relationships with the Exchange and the Service Center f. Master trainer for Tiers 2 and 3 g. Support clients in filing a grievance, compliant, or resolving issues with coverage by providing referrals to the OPA or the applicable office or agency ***Tier 2 – Application Assistance*** Tier 2 navigators have established a reputation in the community as trusted sources of culturally competent education and assistance for health or other human services. Tier 2 navigator responsibilities: a. Be able to provide the functions outlined in Tier 3 b. Assist the consumer in completing and submitting an application – in person or by phone. c. Provide access to the CalHEERS system and be able to submit an application by proxy. d. Complete the initial screening process, assist in submitting an application, explain eligibility requirements, coverage options, and plan selection e. Verify that pre-populated data in applications automatically initiated by the State is correct

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	f. Access the CalHEERS system and be able to check a client's application status g. Provide post enrollment support to ensure clients utilize and retain coverage h. Make referrals to coverage options outside the Exchange when consumers do not qualify through the Exchange i. Provide limited trouble shooting on applications through access to the Service Center j. Refer clients to Tier 1 for more complicated issues. Must have partnerships or be able to easily connect to Tier 1 and 3 navigators. ***Tier 3 – Outreach and Public Education*** Tier 3 navigators are immersed in a geographic or population-based community or provide a unique avenue to coverage. They have established a reputation in the community as a trusted source of culturally competent information and education regarding health and other human services. Tier 3 navigators provide robust outreach, are capable of screening, and may provide access to the Exchange portal in the field. Tier 3 navigators have established contacts in their communities and in many instances will be the primary and initial point of contact with the Exchange. There will be an ongoing long-term need for funding Tier 3 navigators in order for the Exchange to adequately leverage these trusted ambassadors in communities across California. Tier 3 navigator responsibilities: a. Provide fair and unbiased information to consumers about public and Exchange based health care options. b. Provide information on how to access the Exchange (online, phone, mail). Tier 3 navigators may not be connected to the CalHEERS system but should have familiarity with the system and may provide technology access to the system for consumers. c. Refer clients to Tier 2 navigators for application assistance. Must have partnerships or be able to easily connect to Tier 2 navigators. d. Make referrals to consumer assistance and other appropriate agencies, including consumer legal advocates **E. CCAN agrees with and commends the thinking behind the proposal to require all assisters, including navigators and direct benefit assisters, be subject to the same training, certification and registration requirements**. This levels the playing field so to speak. We believe that the best way to assure a standardized, high quality assisters program is to make sure that all assisters receive the same comprehensive training, and are required to be certified and register with the Exchange. We further commend the strong recommendations related to monitoring of assister activities, quality assurance standards, data reporting and other activities that will ensure that inappropriate steering and other malfeasance is minimized and addressed when it does occur. We are in favor of the requirements that all assisters sign a Code of Conduct and Confidentiality and Assister Guidelines Agreement. **F. CCAN recommends that the Exchange clarify that each enrollment entity, rather than individual navigators, will be required to perform ACA mandated functions.** While we are supportive of the recommendation that all

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	navigators be associated with an enrollment entity, the report was unclear whether or not the proposed plan recommended that the "required roles" of outreach, education, eligibility and enrollment relate to individual navigators or navigator entities. To give enrollment entities flexibility in how they assist individuals and achieve maximum enrollment, navigator entities should be ultimately responsible for ensuring that these services are offered to consumers. While we think most entities will conduct the full spectrum of outreach and enrollment services, some organizations will only have the capacity and expertise to able to do a portion of these activities such as education and screening (our proposed Tier 3 navigator). When an organization does not perform all activities it should demonstrate strong linkages and relationships with entities employing navigators that can, thus ensuring that consumers have integrated, seamless access to the full spectrum of support services. **G. CCAN is concerned about the recommendation that agents be required to provide enrollment into public programs such as Medi-Cal and Healthy Families regardless of whether they are paid for such enrollment.** Our concerns are twofold. First, the Agent community has repeatedly stated that they are not interested in doing Medi-Cal and Healthy Families enrollments. If agents are expected to do so, and without compensation, many families who seek assistance from an agent may simply not get the help they need to enroll in a public program. They may fall through the cracks and not be connected with anyone willing to assist them with this enrollment. Second, if no referral system is set up to connect Californians eligible for public programs with a paid navigator for enrollment assistance, DBAs may direct applicants to coverage outside of the Exchange for which they receive compensation or have some other business incentive. As an alternative, we recommend that DBAs who choose not to do public program enrollment as a paid navigator be required to establish strong relationships with navigator entities and be required to refer those eligible for public programs to a navigator for enrollment. **H. CCAN commends the recommendation that navigators be compensated for retention activities.** While we do not support the level of compensation or payment model that was proposed, the proposal is wise to recommend that compensation be made for assisting with retention in coverage. Current community based assisters are all too familiar with the ways in which consumers fall off coverage. Incentivizing navigators to work on retention by compensating for this activity will go a long way to keeping Californians enrolled in coverage. However, we would like to remind the Exchange that the best way to guarantee retention is enrollment follow up that encourages consumers to utilize their coverage by choosing a primary care provider and scheduling their preventive care appointments. **I. CCAN recommends that the role of the navigator should include conducting a follow-up call with consumer to encourage utilization of health care services.** Utilization is a KEY strategy to ensure retention. Providing post enrollment support to ensure that consumers have chosen their primary care provider and are accessing preventive and episodic care is critical not only to improving the health of Californians but also to maintaining coverage. **J. CCAN applauds the adoption of the Market Integration approach as the best method for ensuring that all existing avenues of enrollment are fully utilized and leveraged.** When analyzing the possible models for the assister program we came to the same conclusion as RHA. We expect that navigators should, and will, be one of the

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	primary conduits to finding coverage for Californians but that other assisters can be useful and should be leveraged as the Exchange seeks to enroll as many Californians as possible.
California Coverage and Health Initiatives	• **CCHI supports all of the recommendations and separate set of comments contained in the CCAN Work Group Comments on the Assistors Program.** We highlight here areas of particular interest and concern to CCHI and its member and partner organizations. • **CCHI supports the RHA recommendation that Navigators and Direct Benefit Assistors (DBAs) understand all coverage options and health affordability programs but are concerned about the requirement put on agents and brokers to enroll in public programs.** We are concerned about the recommendation that agents and brokers, who may have no interest in working with low-income people or public coverage programs, may be expected to assist this population. Many Californians being assisted by an agent or broker may not get the help they need to enroll in public coverage and will remain uninsured if the agent or broker is not interested in doing public program enrollment. If the Exchange determines that DBAs are expected to assist low income beneficiaries in enrolling in public coverage then there should be very careful monitoring and follow up to ensure that these Californians receive assistance to enroll in the appropriate program. Alternatively, the Exchange should consider making such public coverage enrollment optional for DBAs and require DBAs who choose not to do such enrollment to provide a "warm hand-off" to an organization that will assist with this enrollment. • **CCHI requests that the CHBE clarify the difference between the roles of enrollment entities, versus individual navigators.** While we support the recommendation that all navigators be associated with an enrollment entity, the report was unclear whether or not the proposed plan recommended that the "required roles" of outreach, education, eligibility and enrollment relate to individual navigators or navigator entities. CCHI recommends that any requirement about the scope of the navigator functions should apply to enrollment entities (and not individual navigators). We further recommend, as is discussed below, that the program should allow flexibility for some enrollment entities to specialize in particular navigator functions. • **CCHI supports a tiered system of navigators to help ensure that the skills necessary to reach all populations can be deployed in a way that best suits the needs of local communities.** The three tiered navigator structure developed by the CCAN Workgroup is CCHI's recommended structure as it will engage the needed organizations in the navigator system to reach all the hard-to-reach populations. Each level of navigation assistance requires a unique set of skills, training, and qualifications. Therefore, we recommend that the Exchange consider developing a navigator program that acknowledges these skill sets by creating a tiered structure that categorizes navigators into three tiers based on the functions in which they specialize. An individual carrying out the duties of a navigator would fall under one of three tiers. An organization or entity that employs navigators would not be classified by tier, and may employ multiple navigators functioning in several tiers or only one tier. If an organization does not employ navigators functioning at all three tiers, it must demonstrate strong linkages and relationships with entities employing navigators at the other tiers, thus ensuring that consumers have integrated, seamless access to the full spectrum of support services as

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	recommended in the CCAN recommendations. • **CCHI supports the concept proposed by CCAN that Navigators should be allowed to conduct a subset of outreach, education, enrollment, and retention, and should be allowed to specialize.** Under CCAN's tiered navigator program, some navigators and even navigator entities will be focused on outreach and education and may not want to engage in enrollment assistance. Other entities or navigators may want to focus on the difficult technical issues such as troubleshooting and dealing with complex enrollment situations has proposed three tiers of Navigators. We encourage the Exchange to consider allowing enrollment entities the flexibility to focus their work on the functions they do well and provide warm hand-offs to other entities or navigators for the functions they do not provide. • **Retention.** CCHI agrees that retention should be compensated however we do not support the level of payment proposed for the retention activities. We recommend that the exchange do a rigorous analysis of the cost of retention activities and set the payment accordingly. • **Utilization.** CCHI commends RHA for the recognition that utilization activities or helping consumers access and learn to use their care, are an important function. However, we believe that such activities should be compensated. At a minimum assisting a consumer with making their first appointment at a medical home and learning the basics about how to use their coverage should be compensated. These activities are an absolutely crucial component to the long term success of the Exchange and are is critical link in retaining consumers in coverage.
California Family Health Council	California Family Health Council (CFHC) appreciates the effort of the Exchange to outline the Assister structure and the opportunity the Exchange has provided for stakeholder input. Members of CFHC's Title X provider network are well positioned to be a part of the Exchange's success in terms of educating consumers about the Exchange and facilitating enrollment. CFHC's diverse provider network includes 77 health care organizations operating more than 340 health centers serving more than 1 million patients annually from San Diego to the Oregon border. Title X funded providers are Federally Qualified Health Centers and look-alikes, universities, hospitals, counties, school-based health centers, Planned Parenthoods and stand-alone family planning clinics. Overall, CFHC supports the proposal of a two-tiered structure of Navigators and Direct Benefit Assisters. However, we believe that the lines between the two tiers should be more fluid and that compensation should be available for both Navigators and Direct Benefit Assisters. All members of CFHC's Title X provider network are mission based and the goals of an overwhelming majority of these providers go well beyond providing direct services to their patients. Many Title X funded health centers also have community outreach programs, including Promotoras, as part of their umbrella of programs and should be granted consideration to be certified Navigators as well as Direct Benefit Assisters.
California Hospital Association	There is no reason to tier the role of the assister. All assisters that meet the certification requirements and can fulfill the roles required by the Affordable Care Act should be considered equally. The education and certification requirements should only be required for assisters of enrollment entities that have agreed to serve in such capacity. There should be no mandate for any entity to be an enrollment entity or to maintain a minimum number of assisters. Any trained and certified assister should be included in the compensation structure finalized by the Exchange.
California Pan-	• **HOS agrees with the recommendation that all assisters (Navigators and Direct Benefit Assisters) be required**

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Ethnic Health Network and Having Our Say Coalition	**to conduct Affordable Care Act mandated activities.** This requirement will help to ensure that all Assisters are able to perform the basic functions of an Assister including the requirement to provide culturally and linguistically appropriate assistance appropriate to the needs of the population being served by the Marketplace. • **HOS supports an Assisters model that includes those receiving compensation and those not receiving compensation.** We need all hands on deck if we are to ensure that everyone who is eligible for coverage is enrolled in coverage in 2014. That said the Assister program should include protections to guarantee against the potential for steering on behalf of DBAs who have other sources of compensation or a business interest in enrolling people. • **DBAs should be required to disclose their potential conflict of interest when enrolling applicants for health coverage.** For the Health Benefit Exchange to succeed, it will be important to include strong protections against inappropriate steering on behalf of DBAs who may assist people with enrollment but have other sources of compensation or have a business interest in enrolling people. • **HOS supports the requirement that DBAs and Navigators be certified and re-certified, sign a code of conduct, confidentiality and assister guideline agreements and meet quality assurance standards.** We agree with the requirements above. If an Assister violates the code of conduct, confidentiality and assister guideline agreements, that individual or entity should be barred from contracting with the Exchange or any other health program to provide enrollment assistance in the future. Additionally, Assisters should be provided with a badge or identification number in order to demonstrate that they are working in an official capacity with the Exchange. • **Assisters should be required to report to the Exchange on the demographics of those accessing their services.** In order to more accurately measure the effectiveness of the Assister program at providing targeted outreach and enrollment assistance to California's diverse communities, it will be necessary to measure not only the number of applications submitted, but the ability of the assister program to conduct ACA mandated activities including the requirement to provide culturally and linguistically appropriate assistance appropriate to the needs of the population being served. • **The Exchange should consider allowing safety net primary care providers to participate at some level in the Navigator program.** Public hospitals, community health centers including Federally Qualified Health Centers, Rural Health Clinics, and Indian Health Clinics – referred to collectively as safety-net providers – have traditionally been the primary source of care for low-income communities of color and the uninsured. While these entities may have a business interest in enrolling people into coverage, these institutions are at the forefront of providing culturally and linguistically appropriate services and play an important role in conducting outreach and education, and enrollment assistance not only to those eligible but those ineligible for coverage under the ACA
California Primary Care Association	The success of the Health Benefit Exchange and California's achievement of the Affordable Care Act's (ACA) broad goals is predicated upon having a robust Navigator program that supports outreach, education, and enrollment throughout California. While the level of enrollment that we must meet is an unprecedented challenge, there are many active and accomplished

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	entities performing outreach, education, and enrollment activities around the state, specifically in the most diverse, hard-to-reach communities, and the Navigator program must both build upon and reinforce these existing efforts. Currently, California's Community Clinics and Health Centers (CCHCs) as well as other community-based safety-net providers are performing these outreach and enrollment functions through successful partnerships throughout the state. **The California Primary Care Association (CPCA) recommends that the Exchange take advantage of this existing infrastructure by including community-based safety net primary care providers as entities eligible for Navigator status.** **Definition:** Safety net providers include 1204a licensed community clinics, Federally Qualified Health Centers, Rural Health Clinics, and Indian Health Clinics. Please see Attachment A for a full definition of these provider types. The safety net primary care providers listed above have trusted relationships within the communities of low-income and vulnerable populations they serve. Patients seek care at these locations because they know there will be providers who understand their unique circumstances and will treat them with dignity and respect. As coverage becomes available to an even greater number of individuals, it is the safety net providers that will be the most trusted source of information when it comes to outreach and enrollment. As such, it is important that safety-net providers are eligible for Navigator status and have the opportunity to support robust and effective enrollment program. **Comments:** ***Safety-Net Primary Care Providers Are Critical Partners for Enrollment*:** The report presented by Richard Heath and Associates (RHA) claims that there are 632 licensed community clinics in the state of California, however according to the California Department of Public Health, as of April 2011, there are 1,104. The vast number of safety net primary care sites represents an enormous opportunity to reach eligible individuals in a way and in a location that is not only convenient, but makes sense to consumers as the clinic is the first place they turn for health care information and services. In 2010, CCHCs served nearly 5 million patients in California, the majority of who come from the linguistically and culturally diverse, low-income, and medically underserved communities that constitute the target markets for Exchange services. Since 1990, when Congress mandated that states establish outstationed Medicaid enrollment programs at all FQHCs, community clinics and health centers have been extremely effective at increasing enrollment for eligible beneficiaries of public programs. The RHA report cites California's Children's Health Insurance program, Healthy Families Program (HFP), as a model for designing the compensation structure for the Navigator program. In 2002, the state's Managed Risk Medical Insurance Board reviewed the effectiveness of its community-based enrollment efforts for the HFP and found that CCHCs represented the largest category of top-producing enrollment entities in its outreach campaign. In fact, one-third of the top performing community-based enrollment efforts were led by CCHCs. The community-provider based outreach efforts that have

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	successfully enrolled hundreds of thousands of children into the HFP should serve as a best practice model for enrolling individuals under the Exchange. Another successful partnership includes Healthy San Francisco, which worked exclusively with CCHCs to enroll a target of 60,000 low-income San Francisco city residents. Within 15 months of launching the program, Healthy San Francisco had exceeded 50 percent of its overall program target, and, at this time, has reached more than 56,000 of its 60,000-person target (current enrollment 46,000; 10,000 enrollees moved to SF PATH), and at minimal cost. CCHCs offer community-based outreach and enrollment programs focused on person-to-person assistance provided to current patients as well as community members who may be eligible for coverage. CCHCs, by definition, exist in underserved communities and serve diverse populations in a manner that is local, in-person, linguistically appropriate, and culturally sensitive. The inclusion of CCHCs in the Navigator program ensures the participation of CCHC-based promotoras and other community health workers, including American Indian/Alaska Native (AI/AN) Community Health Representatives, who are key to reaching AI/AN populations about health programs outside the Indian Health Service. CCHCS have been successful partners in enrollment for years for a variety of programs, and have developed the infrastructure and expertise necessary to reach the individuals within their service areas. However, it's important to note that CCHCs have not and cannot support these efforts on their thin operating margins alone. These campaigns and programs require outside funding, and to date successful efforts have resulted from funding from public agencies, foundations, and the state and federal government. CCHCs can and will conduct the necessary and effective outreach/enrollment programs that will ensure the HBEX is successful, but only if CCHCs are eligible to be Navigators. **CPCA recommends that the Exchange take advantage of these proven outreach and enrollment capabilities by including safety net primary care clinics in the Navigator Program.** ***Safety-Net Primary Care Providers Do Not Have the Resources to Offer Assistance Without Support:*** California's CCHCs are currently running enrollment programs in partnership with funding from partners at the federal, state, and county level, but these enrollment programs, as they're currently funded, will not allow CCHCs to expand and develop the capacity necessary to enroll the enormous number of individuals who will become eligible for pubic programs and subsidized insurance in 2014. The Healthy Families Program, at its inception, recognized that without funding their partners would be unable to provide application assistance services at the necessary levels. Therefore, for their initial enrollment push, MRMIB created a per-head enrollment compensation structure that allowed their community-based partners to invest in the development of enrollment programs with adequate staff to quickly and efficiently meet the demand for HFP application assistance. Since MRMIB discontinued its enrollment funding, many CCHCs have reported significant reductions to their application assistance programs, and many have eliminated this assistance altogether. CPCA member Clinica Sierra Vista writes that the cessation

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	of MRMIB enrollment funding: *"creates a significant barrier to care for our patients whose first exposure to the concept of enrollment is often at the health center front counter. Health centers are not capitalized to provide assister services. In fact, these services are specifically excluded by statute from our cost reporting that creates our prospective payment rate for Medi-Cal."* Those CCHCs that have kept programs have done so only because they have found alternate funding sources to support the efforts. RHA is not correct in assuming that CCHCs are willing and able to support application assistance programs based only upon perceived "direct benefit." The following illustrates just a few of the funding mechanisms CCHCs have used and are using to support their enrollment programs : • The California Endowment created grant programs to bolster CCHC enrollment efforts, however, these grants have waned in recent years, resulting in the downsizing of many enrollment programs and a reduction in staff at CCHCs around the state. • The California Primary Care Association has received federal CHIPRA funding, which it distributes to CCHCs in 21 counties through the state's network of regional CCHC consortia. The funding is to support the enrollment of children into the Medi-Cal and Healthy Families Programs, however, the grant will not be available to subsidize enrollment programs for the Exchange as it will conclude before 2014. • In Orange County, the local CCHC consortium receives funding from a variety of sources including the Children and Families Commission the County of Orange, and The California Endowment to operate enrollment programs and hire Certified Application Assistants for their member CCHCs. • The First 5 Commission in many counties funds CCHCs and CBOs to conduct outreach and enrollment programs. CCHCs in San Diego, Sonoma, Napa, Marin and Yolo, among others, all benefit from this funding source. • AltaMed Health Services Corp., the largest CCHC in California, receives a Children's Health Outreach Initiative grant that covers the cost of their enrollment program. • La Maestra Community Clinic receives per-head funding from the Susan G. Komen foundation to bring women over 40 into the health center for services. While CCHCs in California have created an enrollment and application assistance system that leverages their trusted position as culturally and linguistically competent health care providers within their communities, it's important to acknowledge that this work has been made possible through the generous support of outside partners. If CCHCs are expected to enroll an influx of newly eligible individuals, funding must be available to help cover that cost. **In order to efficiently allocate the resources needed to create adequate application assistance capacity in low-income communities served by CPCA recommends that the Exchange include safety-net primary care providers as entities eligible for Navigator status.** ***Direct Benefit Assisters and Steering:*** RHA recommends that providers, including CCHCs, serve as Direct Benefit Assisters rather than Navigators because they will derive a "direct benefit" from enrollment. Their recommendation is based on the

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	assumption that applicants aided by an Assister who is employed or otherwise subsidized by a provider will join a plan that contracts with that provider, and will then become a patient utilizing reimbursable services. In other words, the "direct benefit" comes *only* from steering the newly insured patients into a plan that is lucrative for the provider offering enrollment services. CPCA believes that the issue of steering is a grave concern, and is something that the Exchange must examine closely and control for to the fullest extent possible. However, prohibiting providers from serving as Navigators will only incentivize steering, as the only compensation available then for "Direct Benefit Assisters" is through enrolling applicants in plans that are most lucrative to the provider. Compensating safety net primary care providers for providing application assistance independent of the plan chosen by the applicant would largely remove this perverse incentive for steering. **As such, CPCA recommends that the Exchange include critical safety-net primary care providers as Navigators eligible for application assistance compensation regardless of the plan selected by the applicant.** ***The Exclusion of Mission-Driven Entities:*** RHA mentions that some organizations may be Direct Benefit Assisters because they'll be willing to conduct enrollment as a "part of their community service mission." This is undoubtedly true of safety-net primary care providers, as there are examples around the state of CCHCs helping to subsidize the cost of hiring or contracting for enrollment staff and running outreach programs to offer these services to their target populations. However, expecting non-profit, community based organizations (CBOs) to perform a function pro bono while paying for-profit, revenue-driven organizations for the same function does not account for the economic realities of non-profit CBOs, including CCHCs, the importance of the work that they do, and the structure of their partnerships that support the outreach/enrollment work. **In order to ensure active participation from CBOs who already have firm and trusted networks within underserved communities, CPCA recommends that mission-driven organizations be included as eligible entities to serve as Navigators and receive remuneration.**
California School Health Centers Association	**A. CSHC recommends that school-based health centers (SBHCs) be eligible to serve as compensated Navigators.** With funding and support, SBHCs can play a key role in this effort. Young adults make up a disproportionate share of the state's uninsured population. Because they are more likely to be healthy than older Californians, their participation will help ensure a balanced risk pool. It is important to reach these young adults with information about health coverage and enrollment while they are still in high school. This will build a "culture of coverage" among a population that all too often thinks of itself as "invincible," and it will also ensure that they are engaged in the health care system before aging out of Healthy Families and Medi-Cal. Schools provide an ideal location for connecting with adolescents; once they leave the educational system, it is far harder to reach them. More than 50% of SBHCs in California serve high-school age students, and they are consistently seen as trusted resources. They are well-positioned to reach adolescents with key messages, through patient visits, classroom presentations, assemblies, youth development programs, and many other channels. SBHCs can also reach family members and other community members. Given that fully 1/3 of uninsured adults in California have children, SBHCs are an important venue for reaching not only adolescents but also

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	adults. SBHCs should be eligible to serve as compensated Navigators because they often derive no direct benefit from a patient's enrollment in a health plan. Unlike other providers, most SBHCs follow an open door model, meaning that they see all comers regardless of insurance status or assigned primary care provider. If a patient enrolls in a non-contracted health plan or chooses a different primary care provider, an SBHC will continue to serve him or her as needed. Many providers turn patients away if they have another assigned provider, but the SBHC model is premised on the provision of universal care. Further, SBHCs, like other safety net providers, strive to meet all of their patients' diverse and wide ranging needs within very tight budgets. The reality is that it takes both time and money to provide these services. While some SBHCs may be able to contribute in limited ways to outreach and enrollment initiatives without additional funding, financial support will be needed to maximize their potential. Past experiences—such as with CAA and school-based outreach and enrollment funding—as well as Los Angeles Unified School District's current CHIPRA grant demonstrate the key role that SBHCs, and other school-based providers, can play in this work. We are disappointed that the proposed definition of Direct Benefit Assister (DBA) appears to include SBHCs, meaning that they would be uncompensated for conducting outreach and enrollment. Given their open door model and limited resources, classifying SBHCs as DBAs would preclude many SBHCs from participating in the Assister program. We therefore urge the Exchange Board to recognize the valuable contribution that SBHCs can make and to adjust the Navigator eligibility guidelines to allow them to be compensated for enrollment activities, particularly if they derive little or no direct benefit from enrollments. **B. CSHC urges the Exchange to recognize the important and proven role that schools can play in outreach and enrollment efforts, and to maximize their participation in the Navigator program.** California's 10,000 schools are trusted messengers deeply embedded in communities. They have a long history of successful participation in outreach and enrollment efforts, and they are a convenient and logical place to provide coverage information and enrollment assistance. We strongly recommend that the Exchange consider how schools can contribute not only to marketing efforts but also to the success of the Navigator program. **C. CSHC recommends a tiered Navigator program, in which different tiers perform different functions, and does not agree that all Assisters should be required to complete all ACA mandated services.** The success of the Assister program will depend upon its ability to engage a diverse group of many partners working in communities across the state. It will be essential to reach deep into hard-to-reach communities, relying upon the credibility and expertise of trusted organizations. Some of these organizations will not have the capacity to take on the full complement of ACA mandated functions, but their engagement will be critical to the success of the marketing, outreach, and enrollment aspects of the Exchange roll-out. In order to ensure that these organizations are able to participate, we strongly urge the Exchange to adopt the tiered approach described in the California Consumer Advocates Navigator Work Group (CCAN) comments, to which CSHC has signed on. The tiered approach would require organizations employing only lower tier Navigators to demonstrate strong connections to and relationships with organizations employing both higher tier Navigators. This will ensure a smooth consumer experience while also

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	leveraging diverse networks.
California State Rural Health Association	The RHA report makes a clear-cut recommendation that Health insurance agents not be allowed to serve as Navigators. We agree that this is a cost effective way to operate within the ACA constraints. As we understand it, this means that agents may still receive compensation from health insurance carriers for enrollment in Qualified Health Plans. CSRHA supports the policy rationale for a seamless "No wrong door" approach, which in turn would require of all Direct Benefit Assisters, including agents, to maintain expertise in public programs and assist with enrollment into Medi-Cal. However, we share a similar concern expressed by CCAN (see their Item (G)), that agents may not do a good job at enrolling people in Medi-Cal or steer applicants into a private qualified plan with the Exchange. We recommend that DBAs who are licensed agents be required to sign a duty of "good faith" in the Assister Code of Conduct, and furthermore, that DBAs be ready to demonstrate or establish relationships with navigator entities or other DBAs with greater expertise in public programs and be required to make appropriate referrals. Another alternative, touted by Community Health Councils, is that agents/brokers must obtain written verification from the consumer, acknowledging that he/she was informed and willfully declined public coverage or qualified coverage, with or without subsidy (presuming one is eligible). We support that Navigators be paid a fee for conducting renewals, or to somehow incentivize retention activities. The fee could be lower (e.g., $25) relative to the basic fee per enrollment. CSHRA views that health plans are naturally predisposed and motivated to carry out Utilization services. Therefore RHA's recommendation to reserve compensation of Navigators for enrollment activities would save funds better used elsewhere. RHA exults the Project Sponsors to consider whether specific types of organizations should be excluded from performing the role of Navigators. Stated in the report as an issue worthy of additional analysis, is the extent to which DBAs can provide fair and impartial information to consumers without steering or conflict of interest. The examples provided were those of a hospital or clinic in a pre-existing relationship with a plan and how that could militate to attempt keeping the patient in-network. We believe that here it is prudent to consider certain exceptions for DBAs that would be well suited as Navigators. Many uninsured Californians who will be eligible for the ACA seek care at community health centers and rural clinics. Those safety net providers have strong ties within the communities they serve and are heavily trusted. They may have a track record attesting to their impartiality in previous health programs, and in some rural areas, they are the only assistance available in a 50-mile radius. Furthermore, often times they are the only providers in the region that hire qualified language interpreters. In order to ensure the involvement of critical partners in those cases where a lack of resources or rural isolation may preclude participation in enrollment assistance, CSRHA recommends that the CHBE consider the inclusion of safety-net clinics in the Navigator program. This is all the more crucial if the clinic is able to provide evidence of competency in language access.
Community Health Councils	We agree with a tiered approach to the assisters program; however, would like to express concern and request further clarification regarding which entities may be considered Navigators or DBAs, and consequently eligible for funding, under the assisters program. We would like to express concern regarding the exclusion of community clinics and providers as eligible for

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	compensation in the assisters program. In Massachusetts, community clinics and health centers were critical messengers and partners for increasing the number of insured individuals under the state's health reform efforts. The Massachusetts outreach- and education grant program funds various organizations that interact with and serve uninsured and potentially eligible populations. In California, while some providers do have the resources to support eligibility and enrollment work within their organization, many do not or are unable to sustain funding for enrollment support for consumers. We strongly recommend that the Exchange, MRMIB, and DHCS include community health centers and clinics as entities eligible for Navigator grants, particularly when these providers are located in under-served, under-resourced communities. Additionally, we request that the Exchange, MRMIB, and DHCS further clarify entities considered to be DBAs. The definition offered for DBA organizations (pg. 14 of the report) creates concern in that the reference to organizations that "conduct enrollment because it is part of their community service mission" could encompass many organizations that currently assist with enrollment, and therefore exclude them from being eligible for Navigator funding. For example, in Los Angeles County, since 1997 the Dept. of Public Health Children's Health Outreach Initiative (CHOI) has contracted with various organizations to conduct outreach, enrollment, retention and utilization (OERU) assistance for consumers for various local and state public coverage programs. Funding for CHOI is provided by the First 5 Commission of LA County, and organizations receiving funding for OERU assistance include community-based organizations, school districts, and community health centers and clinics. Under the DBA description provided in the report, it is our understanding that many organizations currently funded by CHOI could be excluded from receiving Navigator grants if those entities also receive First 5 funding. While we understand the requirement that organizations should not be allowed to "double claim" funding for assistance provided to consumers, prohibiting organizations from supplementing their existing enrollment activity funding with Navigator grant funding could leave many organizations with extensive OERU experience out of the Navigator program. Additionally, depriving organizations of additional resources could prevent them from expanding and improving their enrollment support operations. Given the complex enrollment needs consumers will have in 2014, we strongly recommend that the project sponsors allow organizations currently conducting OERU assistance to be eligible for additional Navigator funding and require those organizations to clearly document services provided and distinguish clients served by each funding source. We strongly recommend that utilization and retention support be required services under the assisters program. In addition to expanding access to health coverage for all Americans, two other important goals of the Affordable Care Act are to reduce and contain escalating healthcare costs and eliminate disparities in health. Providing individuals with health coverage is but one part of the equation in fostering healthier communities. Making sure people use and keep their health coverage is integral to bending the healthcare cost curve and addressing racial disparities. In FY 2010-2011, the Los Angeles County CHOI contract enrollment entities provided a significant amount of retention and utilization support to families in public coverage programs in the community. Over 35% of assistance provided to families was for support with redeterminations and over 11% of support

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was for utilization support.1

Table 1. Distribution of issue types by client age group FY 2010-11

Issue Type	0-5	6-18	19+	Total
Post Application	1283	1393	2386	5062
Post Enrollment	1306	1266	1863	4435
Utilization	583	697	801	2081
Redetermination	1472	3426	1465	6363
Total	4,644	6,782	6,515	17,941

Table 1 breaks down the types of routine issues encountered and solved by the agencies by age group. “Issues” are problems tackled by, or assistance given by, agency staff to clients. Issue types are categorized by when the assistance occurs: after the application was submitted (Post Application), after the client has been enrolled in the program (Post Enrollment), when the client needs assistance with renewal tasks (Redetermination), and whenever a client has a problem using their benefits (Utilization). Every agency is required to re-contact every client mid-year to ensure utilization of services and to determine whether clients need assistance with making appointments, changing providers, or other service access problems requiring advocacy or troubleshooting. The Outreach Partnership helped resolve almost 18,000 client problems. These efforts are over and above the application assistance and routine follow-up they provide to their clients.

While we recognize that the project sponsors must balance the need to enroll as many individuals into coverage in 2014 with the need to contain costs for the Navigator program, we believe it is crucial that all assisters be required to provide utilization and retention support. At a minimum, Navigator assisters should be required to provide OERU assistance. If the project sponsors feel that requiring DBAs to perform all of the above duties would pose a significant burden to recruiting DBAs, then DBAs should at the very least be required to offer enrollment and retention support and refer consumers needing utilization support to Navigator assisters in the community.

We recommend Navigator assisters be required to fulfill the following roles which can be seen in fuller detail in our policy report “Bridging the Health Divide: Designing the Navigator System in California” (page 17) http://www.chcinc.org/downloads/PB%20Navigator%20Report.pdf:

- Enrollment and Retention Assistance: In addition to assisting with the application process, Navigators should help applicants with any post enrollment and renewal activities to ensure they are able to maintain ongoing coverage.
- Case Management & Client Support: Upon completion of initial application assistance, Navigators should follow-up with clients at prescribed intervals to ensure successful enrollment, determine utilization status, identify barriers, and work

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	with them to resolve issues. • Information and Outreach: Navigators should provide information on all available health programs including enrollment procedures, required documentation, benefits, any applicable cost sharing, and appeals processes. Navigators should provide information to communities about coverage options in a variety of settings (e.g., fairs, schools, farmers markets). • Support Clients in Accessing Other Non-Health Social Service Programs: Considering the multiple factors that impact health, such as access to healthy food, a safe living environment, and income security, Navigators should provide families with as much support as they need to have a healthy quality of life. We agree with the recommendation that assisters have the option to target specific markets or populations, provided the project sponsors can ensure that registered/ certified assisters are providing comprehensive support to the diverse populations across the state. We know that not all assisters will be able to meet the needs of all communities eligible for coverage through the Exchange and public programs. Therefore, we agree with the recommendation that assisters be allowed to target specific populations, particularly if assisters can document a successful history of providing OERU support to specific groups. That said, we believe this flexibility requires that the project sponsors institute a rigorous monitoring and recruitment plan to ensure that the state's diverse populations are receiving the support they need to obtain, use, and retain health coverage.
Consumers Union	Consumers Union supports creation of the two categories of Assisters, those paid by the Exchange to assist with education, eligibility and enrollment (Navigators) and those who directly benefit from the successful assistance that they provide (Direct Benefit Assisters). Consumers Union endorses the idea that all Assisters (Navigators and Direct Benefit Assisters) will be required to register with and be certified by the Exchange. Consumers Union applauds the entity-based approach requiring that all individual Assisters must be associated with an organization or enrollment entity that is registered with the Exchange. This helps avoid the "rogue assister" problem, and ensures some liability protection.
County Welfare Directors Association	The role of Navigators and assisters is very important to the successful implementation of the Affordable Care Act in California. County human services agencies view Navigators and assisters as our partners in helping assure accurate applications and aiding in program understanding and retention, and particularly in reaching harder-to-reach populations (of extreme importance in a state as large and diverse as California). We value the relationships we have developed locally between our eligibility work staff and the existing networks of Certified Application Assisters and promotoras. As the Exchange crafts and implements its Navigator/assister program, it makes sense to build upon the existing foundation and infrastructure already in place to the extent possible. California has a robust outreach network that includes public hospital

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	systems, community clinics, Certified Application Assisters, promotoras, community based organizations and many others. In order to achieve the broader goals of expanding coverage to all eligible Californians, including both Medi-Cal and the Exchange, it is essential that the proposed Navigator/assister framework work in partnership with and complement the work done by county human services-based eligibility workers who will be processing the applications received by those departments for subsidized health coverage. As both sets of roles are more fully developed, we look forward to working in partnership with the Exchange, the Administration, and the assister network to ensure the development of a system that provides excellent customer service to all Californians seeking coverage, across all pathways.
The Greenlining Institute	The Greenlining Institute is part of the California Consumer Advocates Navigator Work Group (CCAN) and has signed on to those comments. Rather than submitting duplicate comments, we are submitting brief comments on a few key elements of RHA's draft recommendations for your consideration. **We appreciate that a consumer-focused approach is one of the Exchange's core values, and that the Exchange is committed to offering a consumer-friendly experience that is accessible to all Californians, recognizing the diverse cultural, language, economic, educational and health status needs of consumers.** Furthermore, we believe that the navigator program should not only be logistically workable but also adaptive to local communities. Greenlining strongly agrees that the program should be consumer driven and grounded in the Exchange's "guiding principles" and suggest that the Exchange keep these principles in mind as they construct a program that addresses the human and community component of the program and is structured to effectively meet the diverse needs of all California consumers. **The navigator program must be designed to serve various populations that traditionally lack coverage in a manner that is culturally competent and linguistically appropriate to that population.** **As discussions continue regarding the development of call centers, the website portal, other in-person assistance, and other components of the system, we recommend that where ever assistance is offered to consumers a connection be established to the navigator program.** Consumers should be offered a link to a local phone or in-person navigator whenever they seek assistance in applying for Exchange product coverage. It is also imperative that all assistance be available in the appropriate language for the consumer.
Health Access	• Health Access asks what evidence exists to support the projections of the percentage of applications requiring assistance? Are there extrapolations from other programs or other types of coverage? The projections of 33%, 50% and 75% appear to lack a basis in evidence. This is critical because the cost of the program is closely tied to the number of enrollees requiring assistance. Health Access supports requiring navigators to be entities that retain individuals rather than allowing individuals Health Access supports the vision of multiple tiers of assistance

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	• Health Access supports the concept of "direct benefit assisters", that is entities that directly benefit from increased enrollment in coverage, including hospitals, clinics, insurers/health plans and insurance agents. • We ask whether individual physician offices should be included since many will lack the staff capacity to provide enrollment assistance. • Any individual or entity which states that it provides or has provided uncompensated care should be regarded as a direct benefit assister • We question the estimates of potential direct benefit assisters: our understanding was that the number of agents was significantly greater than 8,000 while we question whether every hospital and every physician office will choose to participate in providing enrollment assistance.
Health Consumer Alliance	**Tiered Model for Assisters/Roles and Structure**. We support the tiering of Navigators, who would be compensated by the Exchange, and Direct Benefit Assisters, who would not be compensated by the Exchange. However, Direct Benefit Assisters will need significant oversight by either the Exchange or the proper regulatory body (Department of Managed Health Care or Department of Insurance) to avoid steering issues. And although eligibility processes changes should eliminate steering between programs (Medi-Cal, Healthy Families, the possibility of a Basic Health Plan, and Exchange products), there should still be oversight in that regard to ensure families and individuals are enrolled in the correct coverage option. All Assisters should be required to go through the training, and there should not be grandfathering exceptions for groups that already engage in this kind of work, such as Certified Application Assisters (CAAs), brokers, and agents. They should complete the same training as new Entities and Assisters. Assisters should be selected based on their experience and track record of working with specific populations, and special emphasis should be placed on geographic areas with different needs, such as language and cultural, age groups, persons with disabilities, the homeless, and areas of high rates of uninsured. While CAAs should be required to do the training as programs will have changed, they should be given preference or extra points in their application or credentialing to credit their demonstrated expertise in the programs and experience with outreach and enrollment activities as relevant and helpful. Additionally, Project Sponsors should consider a role for Consumer Assistance Programs or ombuds-type services and ways to encourage interaction between Navigator-Assisters and existing Consumer Assistance Programs, which provide start-to-finish services, including grievance and appeals. Building on Ombuds programs as an additional level, such as the HCA or HICAPs, will ensure a seamless experience for consumers. Project Sponsors should also consider how all of the purchasers and regulators should interact. We expect the Office of the Patient Advocate to be expanding their duties in the next year and that office could serve as a natural coordinator for consumer-oriented duties. A thorough referral process must be agreed to so that no consumer falls through the cracks when seeking assistance at any point of their experience in the health care system. This also calls into question the Call Center that will be developed for the Exchange. Project Sponsors should consider leveraging existing hotlines to minimize duplication of services and the possibility of additional consumer confusion.

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Healthy Kids Sonoma County	**1. Healthy Kids Sonoma County strongly recommends that the Board for the California Health Benefits Exchange invest in strengthening the outreach, enrollment and retention capacity at Community Health Clinics by including safety net primary care clinics as eligible entities for Navigator status.** Healthy Kids Sonoma County is the Children's Health Initiative in Sonoma County. Our Steering Committee includes representatives from the following organizations: First 5 Sonoma County, United Way of the Wine Country, Community Foundation of Sonoma County, Sonoma County Department of Human Services, Sonoma County Department of Health Services, 8 Community Health Clinics, St. Joseph Health System, Sutter Medical Foundation, Kaiser Permanente, Sonoma County Office of Education, and Community Action Partnership of Sonoma County. Sonoma County is well positioned to reap myriad benefits from the Affordable Care Act. Certified Application Assistants at community health centers have been able to cut the number of uninsured children nearly in half. The success of the California Health Benefit Exchange and California's achievement of the Affordable Care Act's (ACA) broad goals is predicated upon having a robust Navigator program that utilizes a *No-Wrong-Door* approach to outreach, education, and enrollment. In Sonoma County, it would be difficult to develop a consumer-focused *No-Wrong-Door* outreach and enrollment strategy without including Community Health Centers as entities eligible for Navigation status. The 8 Community Health Centers in Sonoma County provide health care to 1 out of every 4 people in our community. In 2011, these community health clinics in Sonoma County provided approximately 380,000 health care visits to over 117,000 people. Federally Qualified Health Centers are required under federal law to be located in communities that are federally-designated as Medically Underserved Areas. As such, they serve diverse populations in a manner that is local, in-person, linguistically appropriate, and culturally sensitive. The inclusion of Federally-Qualified Health Centers and other safety-net primary care providers in the Navigator program ensures the participation of our the 24 Certified Application Assistants, and will allow the health centers recruit, hire and train more Certified Application Assistants. Community Health Centers in our region have been successful partners in enrollment for years for a variety of programs, and have developed the infrastructure and expertise necessary to reach hard-to-reach uninsured individuals, especially those in rural communities. However, it is important to note that Community Health Centers have not and cannot support these efforts on their thin operating margins alone. These campaigns and programs require significant outside funding, and to date successful efforts have resulted from funding from private donors, public agencies, foundations, and the state and federal government. Safety Net Primary Care Clinics must secure Navigation status to be able to expand their effective outreach and enrollment infrastructure. Withholding Navigator status will irreparably harm the ability of uninsured people in rural and medically underserved areas to receive application assistance, which is counter to the stated goals of the ACA and of the California

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	Health Benefits Exchange.
Insure the Uninsured Project	ITUP supports the tiered approach to the assisters program, with agents, health plans, providers, hospitals and clinics acting as potential DBAs. In addition, since outreach/enrollment of very diverse and fragmented populations is imperative, the Navigators should reflect this diversity as well, not only in cultural, linguistic, and ethnic backgrounds, but also in terms of prior work experience (clinics, small business, hospital etc.).
Kaiser Permanente	• We applaud the recommendations regarding "direct benefit assisters," and the recognition that such assistance should not be compensated. With regard to health plan assisters, we recommend that contracting plans be regarded as partners to the exchange in enrolling both current subsidy-eligible members, and new members that the plan identifies as part of the plan's ongoing marketing efforts. This is a cost-effective means to provide as much as half of the Exchange's projected first-year enrollment. • We recommend that health plan assisters pre-screen individual market enrollees for eligibility for subsidized coverage in the exchange, or state programs, and transmit pre-populated applications and a "warm hand-off" to Exchange staff to complete enrollment. We recommend this hand-off occur just prior to plan selection, so that final selection occurs in a neutral environment. • Specific to assisting members under the chart on page 17, any role that an Agent can assume should be available to Health Plans. • Regarding Community Clinics, Providers and Hospitals, we recommend clarification that a customer service unit or specific employees need to be certified. Unlike Navigators, Agents and Health Plans, providing rates, benefits and market choices is not a core function of providers. The Exchange should clarify what it means by the "enrollment" service. Only a Health Plan or the Exchange itself (acting as the TPA for the Health Plan) can complete an enrollment. We propose "Apply for Coverage" as the nomenclature for this service.
LGBT Health Consortia	We encourage the HBEX to consider the adoption of Assister strategies that permit targeting specific markets and populations, and would also encourage participation of LGBT-focused community and service organizations as Assisters.
Los Angeles County Department of Public Health, Children Health Outreach Initiatives	• Children Health Outreach Initiatives (CHOI), a program within the Los Angeles County Department of Public Health, recognizes the Exchange for its thorough process in developing the two-tiered Assister Program, and supports the inclusion of Certified Application Assisters (CAAs) as Navigators who are compensated for performing the ACA-mandated duties. As stated in the report from Richard Heath and Associates (RHA), between 50-75% of consumers will need in-person assistance to enroll into the Exchange. Compensation for this indispensable task is crucial to the success of the Exchange. • It is strongly recommended that in addition to performing education and enrollment duties, Navigators should also be

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	required to conduct follow-up retention/utilization activities. In Los Angeles County, the CHOI Program contracts with 15 community agencies who employ CAAs to conduct outreach, enrollment, retention and utilization (OERU) activities to help low-income families gain and retain health insurance coverage in Medi-Cal, Healthy Families, Healthy Kids and other insurance and health access programs. Families who are assisted through CHOI-contracted CAAs and receive follow-up post application, post-enrollment and at renewal periods have **a retention rate of 78% 14 months after initial enrollment.** This recognized success is due in large part to the follow-up on each application that is required by contracted agencies in order to receive funding. The influx of individuals and families into the Exchange will require assistance and navigation beyond enrollment. For the Exchange to truly employ its *Results* value of expanding coverage ***and*** access, retention must be a key objective and activity. While the Exchange sees the Health Plans as having a direct benefit in retention, the same is not true for Medi-Cal and Healthy Families, and it will be these lower-income individuals and families who are more likely to lose coverage without dedicated retention assistance.
Maternal and Child Health Access	• MCHA supports the idea that Navigators and Direct Benefit Assistors (DBAs) alike know about all coverage options, but we are troubled by the idea that brokers who may have no interest in working with low-income people or public coverage programs may be expected to assist this population. Historically, Certified Application Assistor work has been mission-driven, and at the risk of stereotyping, brokers have been compensated by the insurance industry on commission and generally assist businesses and the individual. We would suggest strong monitoring mechanisms and follow-up on individuals and families who come through the Exchange portal but don't follow through with enrollment requirements, or drop off, especially if low-income. MCHA would want to be sure that if DBAs are expected to assist Medi-Cal/low income beneficiaries, the DBAs may instead be allowed to provide a warm hand-off to an organization who wants to assist this population. • MCHA supports the idea that Navigators should be allowed to conduct a subset of outreach, education, enrollment, and retention, and should be allowed to specialize, as proposed by the California Coverage Advocates Navigator Workgroup (CCAN). CCAN has proposed three tiers of Navigators, which MCHA supports. Some navigators may be more comfortable encouraging enrollment and participation in health coverage and publicizing the existence of coverage than actually enrolling someone. Likewise, groups exist who can conduct extensive troubleshooting, assistance with transfers between programs, urgent assistance and case management. • MCHA disagrees that "retention" is strictly re-enrollment or renewal. A set of issues is often overlooked which occurs connected with enrollment in the program or in the plan which may cause loss of coverage, but the activities necessary to ensure that this doesn't happen, or to correct if it does are not counted as "retention". • For the above reason, MCHA supports recognition that Enrollment Entities and Navigators already assist with utilization activities, and that these activities should be recognized and supported. When someone can't get what they expected or need from a health plan, they turn to the person or agency who helped get them enrolled. These services and this time must be accounted for in planning. • Without recognition of the full complement of work done by Navigators, it is impossible to justify funding amounts, and

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	assumptions made about how many applications may be completed per time period are faulty. Individual Navigators or DBAs who contact beneficiaries only yearly often miss the fact that their clients need assistance and are going elsewhere because the help is simply not provided with the original Navigator. In situations in which the only work done is for the original application, it may be easier to calculate a cost-per-enrollment, but it is not an accurate portrayal of cost.
PEACH	While we support establishing a cost-effective two-tiered Assister Program that delineates Navigators, who can be compensated by the Exchange, and Direct Benefit Assisters, who would not be compensated, we urge the Exchange to reject the proposal to categorize hospitals as Direct Benefit Assisters. As critical providers of care to low-income and uninsured Californians, community safety net hospitals are vital, trusted community partners that provide both point of service eligibility screening and enrollment assistance, and proactive outreach and education in the culturally and linguistically diverse communities that will be eligible for Exchange coverage. As part of the Exchange's "no wrong door" approach, we urge the Exchange to include community safety net hospitals and other critical access hospital providers as Navigators and provide appropriate funding for education, outreach and training that will allow them to continue to provide enrollment assistance to a significant portion of the Exchange's target market. Given that 50-75 percent of the 2.8 million anticipated Exchange enrollees will need assistance, we urge the exchange to fully leverage existing health insurance distribution channels and provide safety net hospitals with the resources to adequately bolster and expand their current enrollment assistance efforts. Many community safety net hospitals offer culturally sensitive, "one-stop" screening and enrollment assistance, as well as multi-lingual Certified Application Assisters to help enroll uninsured and underinsured individuals in health coverage and other public programs (e.g., Medicare, Supplemental Security Income, CalFresh, etc.). These hospitals often have close working relationships with County eligibility and enrollment partners and have high application success rates—averaging 95 percent in some cases. Community safety net hospitals also offer post-enrollment services such as follow-up technical assistance to ensure health care utilization and coverage retention. Given the magnitude of anticipated exchange enrollees, we are greatly concerned that, if the Exchange chooses not to include community safety net hospitals as Navigators, these critical access hospitals will not have the resources to meet the increased enrollment demand and this vital part of the health care safety net will not be fully realized as a viable door to Exchange coverage. We therefore urge the Exchange to designate as Navigators community safety net hospitals and other hospital providers that serve a considerable portion of the Exchange's target market.
Planned	It is very important to implement a consumer enrollment and assistance structure that will achieve the goal of a "no wrong

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Parenthood Affiliates of California	door" system, where consumers can get accurate, culturally competent information no matter what access point they use and are able to easily enter the system with whatever level of assistance is needed. Community clinics are uniquely positioned to play an important part of this enrollment and assistance system, as thousands of newly-eligible consumers walk in our doors every day for health care services. We are very concerned with the proposed assister structure that would create two tiers of assisters under the same requirements and obligations, with few exceptions, but are not treated equally in terms of compensation. Both tiers would be responsible for education, eligibility, enrollment, and plan selection activities, and the only activities undertaken solely by Navigators would be consumer outreach and potentially retention. We are especially concerned with the proposal that community clinics would be considered Direct Benefit Assisters (DBAs) rather than Navigators, and would be barred from being from any level of compensation.
Redwood Community Health Coalition	**1. In an effort to promote a consumer-focused No-Wrong-Door outreach and enrollment strategy in rural and medically-underserved communities, Redwood Community Health Coalition strongly urges the Board of the California Health Benefit Exchange to include community-based safety net primary care clinics as entities eligible for Navigator status.** **2. Redwood Community Health Coalition strongly recommends that the Exchange invest in strengthening the outreach, enrollment and retention capacity at Community Health Clinics by including safety net primary care clinics in the Navigator Program.** **A Historic Opportunity** Thanks to the Affordable Care Act, over 32 million currently uninsured people nationwide will be eligible for subsidized health insurance in 2014. They will be able to enroll starting in October 2013, just over a year from now. More than 120,000 of those people live in Sonoma, Marin, Napa and Yolo counties, and more than two-thirds of them – more than 80,000 people -- are estimated to be low- to moderate-income individuals. Enrolling such a large number of uninsured people in a relatively short amount of time will be a challenge. Fortunately, our region is well positioned to reap myriad benefits from the Affordable Care Act. Since Redwood Community Health Coalition began coordinating outreach and enrollment activities for health centers in our region in 1998, Certified Application Assistants at community health centers have processed almost 130,000 health insurance applications or renewals for families.

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	The success of the California Health Benefit Exchange and California's achievement of the Affordable Care Act's (ACA) broad goals is predicated upon having a robust Navigator program that utilizes a *No-Wrong-Door* approach to outreach, education, and enrollment. In our region, which is the approximately the size of New Hampshire and largely rural, it would be difficult to develop a Consumer-focused No-Wrong-Door outreach and enrollment strategy without including Community Health Centers as entities eligible for Navigation status. The 16 Community Health Centers in Sonoma, Marin, Napa and Yolo counties have 52 clinic sites that provide care to 1 out of every 5 people in the region. Further, over 70% of Latino women and children in our region get their health care at community clinics. In 2011, these community health clinics provided approximately 620,000 health care visits to over 195,000 people. Community Health Centers, by definition, exist in underserved communities and serve diverse populations in a manner that is local, in-person, linguistically appropriate, and culturally sensitive. The inclusion of Community Health Centers in the Navigator program ensures the participation of our the 24 Certified Application Assistants, and will allow the health centers recruit, hire and train more Certified Application Assistants. Community Health Centers in our region have been successful partners in enrollment for years for a variety of programs, and have developed the infrastructure and expertise necessary to reach hard-to-reach uninsured individuals. However, it's important to note that Community Health Centers have not and cannot support these efforts on their thin operating margins alone. These campaigns and programs require significant outside funding, and to date successful efforts have resulted from funding from private donors, public agencies, foundations, and the state and federal government. Safety Net Primary Care Clinics in rural and medically-underserved areas, such as those served by Redwood Community Health Coalition, must secure Navigation status to be able to expand their effective outreach and enrollment infrastructure. Withholding Navigator status will irreparably harm the ability of uninsured people in rural and medically underserved areas to receive application assistance, which is counter to the stated goals of the ACA and of the California Health Benefits Exchange.
San Mateo County	The County of San Mateo's local health coverage network has always relied on community-based clinics as an integral part of our outreach and enrollment strategy because of their deep knowledge of culturally and linguistically diverse populations. We encourage the Exchange Board to allow community clinics to serve as Navigators. We believe sufficient quality assurance standards and protocols, coupled with periodic evaluations of the Assisters program, can negate the potential for steering.
San Mateo Labor Council	• Role of Brokers / Agents – should be limited to SHOP • Confidentiality issues – Brokers should not be doing eligibility • Community Clinics should be Navigators, not DBA's

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	• Embed, highlight, elevate the role of labor • Ensure connection to all relevant programs, i.e. CalFresh, especially for low income populations • Promote/ensure retention of existing coverage • Call Centers don't work for everyone • Careful consideration should be given to which assisters are best suited to reach and engage specific demographics and vulnerable populations; assisters should not be able to target populations without vetting. • Need clear integration with Marking and Outreach plan
SEIU	We agree with the recommendation that all assisters complete mandated ACA Navigator roles. However, there appears to be overlapping definitions for "eligibility determination" which has different connotations in public programs vs. private insurance. It is unclear in the proposal what it means to "complete education and enrollment activities" and to require assisters to assist individuals in "completing eligibility requirements for all Marketplace coverage options." In particular, it would be helpful to define "eligibility activities," "enrollment activities" and the process for "completing eligibility requirements" (particularly in the context of public programs), to clarify how the assisters work to support clients, county eligibility workers and the Exchange. Eligibility workers strongly support navigators and assisters and value the assistance they can provide. We urge the HBEX to work with stakeholders to develop a process where information and workflow can be handed off seamlessly from navigators to the appropriate entity.
Signature Health Insurance Services	The Assisters need to be educators and sales people. I have been selling health insurance since 1994. I am currently a broker in Nevada County where the majority of the people are very conservative and of lower to moderate incomes. When I discuss insurance plans with individuals or small business's it is almost always the cost of the plan that prevents people from going forward. I have discussed the healthcare reform with many people and most of the people immediately say they don't like the idea. They don't know much about it but they know they don't like it. But when you discuss the plans and give them a little education it becomes more palatable.
United Ways of California	**A. United Ways of California (UWCA) recommends that rather than require a navigator to do all of the following to be entitled to payment as a navigator: outreach, education, eligibility assessment, application for enrollment - the CHBE adopt a tiered framework for navigators.** In general, we support RHAs recommended distinction between Navigators and Direct Benefit Assisters. We would encourage the Project Sponsors to consider compensation based on functions and not just enrollment, as many organizations will likely do outreach and education that will lead to enrollment in the long-run and would not be compensated for it. As an example, many United Ways and 2-1-1s, and others pre-screen for need and eligibility. An eligible but uninsured client would be identified by one of these programs, educated about their options and referred to an enrollment entity. Under this scenario, unless the organization doing the outreach and screening is an enrollment entity they would not receive compensation, even though they are driving individuals into the enrollment system, and in many cases, individuals who would otherwise not enter. Consequently, the navigator/enrollment entity receiving those referrals would be funded having not done any of the education and

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	outreach. The same example applies to Family Resource Centers, Promotoras and other CBOs. If instead the intention is for the Project Sponsors to work only through entities that can provide all navigator functions and then leave it up to those entities to subcontract with others as needed, including through collaborative agreements with organizations that perform some, but not all required functions, then the Project Sponsors should provide statewide guidance around the valuation of the various activities, so as to avoid wide variations in compensation which could impact quality, design, performance, and results. Each level of navigation assistance requires a unique set of skills, training, and qualifications, and allowing payment directly to organizations that have expertise only in outreach and education, for example, will be critical to effectively serving all the hard to reach populations. Therefore, we recommend that the CHBE consider developing a navigator program that acknowledges these skill sets by creating a tiered structure that categorizes navigators into three tiers based on the functions in which they specialize. An individual carrying out the duties of a navigator would fall under one of three tiers. An organization or entity that employs navigators would not be classified by tier, and may employ multiple navigators functioning in several tiers or only one tier. If an organization does not employ navigators functioning at all three tiers, it must demonstrate strong linkages and relationships with entities employing navigators at the other tiers, thus ensuring that consumers have integrated, seamless access to the full spectrum of support services. UWCA helped the California Consumer Advocates Navigator Workgroup (CCAN) develop its proposal for this tiered framework, summarized below: Tier 1 – Application Assistance, Case Management, Problem Solving & Technical Assistance Tier 1 navigators are highly trained and capable of training other navigators, adept at problem solving enrollment and access issues, and able to provide case management through to completion and solution of a problem. Tier 1 navigator responsibilities: a. Be able to provide the functions outlined in Tiers 2 and 3 b. Provide consumer assistance in the Individual Exchange, public coverage options, and the SHOP c. Address complex coverage issues such as clients transitioning between coverage programs inside or outside of the Exchange, families utilizing multiple coverage options, and clients with sudden job loss d. Provide case management, in-depth problem solving, and technical assistance for both consumers and other navigators e. Establish relationships with the Exchange and the Service Center f. Master trainer for Tiers 2 and 3 g. Support clients in filing a grievance, compliant, or resolving issues with coverage by providing referrals to the OPA or the applicable office or agency Tier 2 – Application Assistance Tier 2 navigators have established a reputation in the community as trusted sources of culturally competent education and

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	assistance for health or other human services. Tier 2 navigator responsibilities: a. Be able to provide the functions outlined in Tier 3 b. Assist the consumer in completing and submitting an application – in person or by phone. c. Provide access to the CalHEERS system and be able to submit an application by proxy. d) Complete the initial screening process, assist in submitting an application, explain eligibility requirements, coverage options, and plan selection d. Verify that pre-populated data in applications automatically initiated by the State is correct e. Access the CalHEERS system and be able to check a client's application status f. Provide post enrollment support to ensure clients utilize and retain coverage g. Make referrals to coverage options outside the Exchange when consumers do not qualify through the Exchange h. Provide limited trouble shooting on applications through access to the Service Center i. Refer clients to Tier 1 for more complicated issues. Must have partnerships or be able to easily connect to Tier 1 and 3 navigators. Tier 3 – Outreach and Public Education Tier 3 navigators are immersed in a geographic or population-based community or provide a unique avenue to coverage. They have established a reputation in the community as a trusted source of culturally competent information and education regarding health and other human services. Tier 3 navigators provide robust outreach, are capable of screening, and may provide access to the Exchange portal in the field. Tier 3 navigators have established contacts in their communities and in many instances will be the primary and initial point of contact with the Exchange. There will be an ongoing long-term need for funding Tier 3 navigators in order for the Exchange to adequately leverage these trusted ambassadors in communities across California. Tier 3 navigator responsibilities: a. Provide fair and unbiased information to consumers about public and Exchange based health care options. b. Provide information on how to access the Exchange (online, phone, mail). Tier 3 navigators may not be connected to the CalHEERS system but should have familiarity with the system and may provide technology access to the system for consumers. c. Refer clients to Tier 2 navigators for application assistance. Must have partnerships or be able to easily connect to Tier 2 navigators. d. Make referrals to consumer assistance and other appropriate agencies, including consumer legal advocates **B. UWCA agrees with the proposal to require all assisters, including navigators and direct benefit assisters, be subject to the same training, certification and registration requirements**. We believe that the best way to assure a standardized, high quality Assisters Program is to make sure that all Assisters receive the same comprehensive training, and are required to be certified and register with the CHBE. We further commend the strong recommendations related to monitoring of Assister activities, quality assurance standards, data reporting and other activities that will

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	ensure that inappropriate steering and other malfeasance is minimized and addressed when it does occur. We are in favor of the requirements that all Assisters sign a Code of Conduct and Confidentiality and Assister Guidelines Agreement. We note, however, that it may be difficult to gain cooperation from, or enforce compliance by uncompensated Direct Benefit Assisters. **C. UWCA requests that the CHBE clarify the difference between roles of enrollment entities serving as navigators and individuals performing some or all navigator functions.** While we support the recommendation that all navigators be associated with an enrollment entity, the report was unclear whether or not the proposed plan recommended that the "required roles" of outreach, education, eligibility and enrollment relate to individuals serving as navigators or navigator entities. UWCA recommends that each entity serving as a navigator, rather than individuals performing one or more navigator functions, be required to perform all ACA-mandated functions. To give enrollment entities flexibility in how they assist individuals and achieve maximum enrollment, navigator entities should be ultimately responsible for ensuring that these services are offered to consumers. While we think most entities will conduct the full spectrum of outreach and enrollment services, some organizations will only have the capacity and expertise to able to do a portion of these activities such as education and screening (our proposed Tier 3 navigator). When an organization does not perform all activities it must demonstrate strong linkages and relationships with entities employing (Tiers 1 & 2) navigators that can, thus ensuring that consumers have integrated, seamless access to the full spectrum of support services. **D. UWCA recommends that one of the navigators' activities include conducting a follow-up call with consumer to encourage utilization of health care services.** Utilization is a key strategy to ensure retention. Providing post enrollment support to ensure that consumers have chosen their primary care provider and are accessing preventive and episodic care is critical not only to improving the health of Californians but also to maintaining coverage. **E. UWCA agrees wholeheartedly with the recommendation that navigators be compensated for retention activities.** The proposed plan recognizes that many consumers, especially those who originally utilized a navigator to enroll, will want to go back to a navigator to reenroll. The proposal is wise to recommend that compensation be made for assisting with the reenrollment. We hope that the process will be easier for consumers making this a rare thing, but if time is taken to reenroll someone, then just compensation should be given. Incentivizing navigators to work on retention by compensating for this activity will go a long way to keeping Californians enrolled in coverage. **F. UWCA recommends the hybrid approach of compensation – a mix of pay for enrollment and grants to navigators – and also urges CHBE to consider other methods, such as bonus payments in the first year, for example, to incentivize navigators to ramp up and enroll as many people as possible as early as possible.** The more that enrollment can be frontloaded the lower the risk of the pool, the greater the leverage CHBE will gain from its paid and free media and marketing efforts, and the more likely CHBE will be viewed as a success. **G. Links to either in-person or phone navigators should be offered wherever assistance is offered to the consumer.** These links or referrals should always be addressed as the development of call centers, the website portal,

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	other in-person assistance, and other components of the system continues.

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2-1-1 California	2-1-1 California is a network that has engaged locally in helping people navigate through systems. As a system, 2-1-1s know that it is extremely important that the design of the Exchange navigation program include a uniform way of guiding consumers through the enrollment process. 2-1-1 California recommends that the Exchange consider the geographic scope of assisters and enrollment entities as an important component of design. We encourage the Exchange to give serious consideration to the impact that geographic scope can have on consistency of quality, responsiveness, and training from region to region. California and the Marketplace would benefit from partnering with navigator entities that can work throughout the State, to ensure that throughout the various regions of the state, navigators have consistent forms of training, technical assistance and

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	professional development. 2-1-1 California supports the notion of navigators that are certified through the Marketplace and signatories to a Code of Conduct, Confidentiality and Assister Guidelines Agreements.
Anthem Blue Cross	QHP issuers are an important and successful distribution channel and should be included in the list of potential DBAs. QHP issuers could play an integral role in encouraging enrollment in the Exchange. We ask that the California Exchange include outreach as an optional activity QHP issuers could perform. Additionally, Anthem asks that the California Exchange provide additional guidance regarding how carriers should differentiate full-time employees of health insurance companies, vendors of issuers and other contractual arrangements that we will make with external entities in order to address the expected surge in volume during open enrollment versus independent external sales agents. Today, internal employees are typically compensated at lower rates than external agents and are well versed in and enroll applicants in that health plan's products. We believe requiring internal associates to be versed in all QHPs would drive up costs and remove a low cost distribution channel, thereby inadvertently increasing premiums for consumers.
Asian Pacific American Legal Center of Southern California (APALC)	**Summary of Recommendations on Eligibility & Standards** (P. 18) • We support some of the recommendations: 1) eligible assisters must be affiliated with an organization and annually registered; 2) certification and trainings must be completed but not necessarily annually (but not licensing) I 3) organizations and assisters should sign a Code of Conduct, Confidentiality and Assister Guidelines Agreements and 4) the Project Sponsors should provide ongoing technical assistance to assisters. Although we believe that assisters should be affiliated with an organization, it need not be an "enrollment entity" with liability insurance. • In addition the list of ACA guidelines for Navigators, we would add: Navigators must "provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange." **Organizational Eligibility** (P.19) • We recommend that examples be provided of potential Navigators and DBAs to clarify the distinction between the two. It is not clear which Navigators must be licensed, i.e., only insurance agents. . • It would also be helpful to clearly state that Navigators can only be non-profit organizations or public entities if that is a requirement. We would include community clinics, non-profit and public hospitals as possible Navigators, as well as non-profit community-based organizations or advocacy groups. **Certification** (P. 20) We agree that assisters should not be licensed like health insurance agents but would certify all assisters.
California Consumer Advocate	**A. In order to ensure the involvement of critical partners who without resources will likely be precluded from participation in enrollment assistance, CCAN recommends that the Exchange consider the inclusion of safety-net clinics in the navigator program.** It is crucial that the navigator program leverage existing avenues to

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Navigator Workgroup	health coverage by taking full advantage of established resources within the communities where the uninsured eligible are likely to reside or seek assistance. Many uninsured Californians, who will be eligible for coverage through the Exchange, seek care at primary care clinics where safety-net providers have built strong ties within communities they serve. We ask that the Exchange further explore the issue of safety net clinics being categorized as direct benefit assisters and consider their inclusion in the navigator program. **B. CCAN is concerned that the definitions of direct benefit assister and navigator are somewhat vague and potentially confusing**. Specifically, there should be clarification as to what organizations are considered to "conduct enrollment because it is part of their community service mission" as it relates to DBAs. Many CBOs that should be part of the paid navigator system could claim that part of their community service mission is to enroll or connect people to health coverage and care. The eligibility requirements to be a DBA and what qualifies an organization to be a navigator entity should be spelled out in clear and unambiguous terms. **C. CCAN strongly supports the requirement that all assisters sign a code of conduct and confidentiality agreement and Assisters Guidelines Agreement as a requirement of certification.**
California Coverage and Health Initiatives	• **CCHI supports the following recommendations related to eligibility and standards in the RHA report:** o All navigators must be associated with an enrollment entity. o All assisters sign a code of conduct, confidentiality agreement and Assisters Guidelines Agreement as a requirement of certification. o Annual renewal of certification and registration with the exchange. o Careful and rigorous monitoring of all Assisters to ensure that inappropriate steering is not occurring and to ensure that consumers are being assisted as envisioned by the program. o Appropriate technical assistance be provided to assisters including a navigator portal on the CalHEERS System, a 1-800 number for certified assisters, and ongoing re-training and additional training on specialized topics. • **CCHI urges clarification of the definitions of direct benefit assister and navigator as currently they are vague and open to interpretation**.
California Family Health Council	The eligibility and standards outlined in the Assister Program proposal should be modified to allow a health care organization to be both a Navigator and Direct Benefit Assister. For example, organizations that provide direct health care services and have a community education program/component should be allowed to be Navigators AND Direct Benefit Assisters and should be compensated for their efforts in both categories.
California Hospital Association	CHA supports assisters being affiliated with an enrollment entity. Enrollment entities should include hospitals that are willing to participate in the Statewide Assisters Program. CHA supports certification of assisters including training and annual recertification. CHA supports certification to include a signed Code of Conduct and a Confidentiality and Assister Guideline Agreement. All assisters should be treated equally and should participate in a standardized compensation plan by the Exchange.

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California Pan-Ethnic Health Network and Having Our Say Coalition	• **HOS applauds the requirement that eligible Assisters be affiliated with an enrollment entity and that individual Assisters are not eligible for enrolling individuals.** Requiring assisters to affiliate with an enrollment entity will help to deter deceptive marketing scams aimed at taking advantage of vulnerable seniors, disabled, limited-English proficient (LEP) communities, immigrants, and communities of color who may not know about the law and their rights as consumers. HOS supports efforts to provide the Health Benefit Exchange with the necessary tools needed to enforce the guidelines and standards recommended by RHA related to enrollment entities. • **HOS is concerned about the lack of clarity around the governance structure for the Navigator/Assister program.** In order to promote accountability and transparency, HOS recommends that there be a Memorandum of Understanding (MOU) between the Exchange, MRMIB, and DHCS with clearly delineated responsibilities outlining which agency will be responsible for overseeing eligibility and standards for assisters, the training curriculum etc.
California State Rural Health Association	**Which type of organizations will be eligible to employ Navigators**? CSRHA is concerned that the role definitions of Direct Benefit Assister and Navigator are somewhat vague and potentially confusing. Specifically, there should be clarification as to what organizations are considered to "conduct enrollment because it is part of their community service mission" as it relates to DBAs. We agree with the statement in the RHA report that excluding certain specific types of organizations from serving as Navigator entities would limit the overall size of the network or reduce access to assistance. We wish to emphasize, therefore, that CSRHA supports the notion of allowing as many type organizations as feasible to serve as Navigator entities, consistent with program integrity.
Community Clinic Association of LA County	**CCALAC recommends the Board to designate clinics as Navigators in the Assisters Program.** CCALAC urges the Board to reconsider the recommendation, as outlined in the Report, to not designate clinics as compensated Navigators for enrollment assistance into Medi-Cal, Healthy Families, or the private Qualified Health Plans available through the Exchange. It is critical to the success of the Exchange and the Board's achievement of its seamless, "no-wrong door" vision "to achieve the goal of increasing coverage among California's uninsured" that clinics be included as compensated Navigators in the Exchange's Assisters Program. Clinics are integral to maximizing the delivery of much-needed outreach and enrollment services, by virtue of their placement within hard-to-reach communities and the diverse populations that are intended to benefit through the Exchange. CCALAC's clinic membership is comprised of Federally Qualified Health Centers (FQHC), FQHC Look-Alikes, community clinics, and free clinics. FQHCs receive federal grants under Section 330 of the Public Health Service Act to provide primary health care services to underserved and uninsured populations. FQHC Look-Alikes are required to follow all of the FQHC program requirements but do not receive any federal grants. Community and free clinics, along with FQHCs and Look-Alikes, are licensed and recognized by the State of California as primary care clinics. They share a common mission of serving everyone regardless of their ability to pay, making them medical homes and service providers for many low-income, uninsured individuals.

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	I. The Board Should Designate Clinics as Navigators in the Assisters Program CCALAC urges the Board, in its decision making on the design of the Exchange's Assisters Program, to reconsider the recommendation set forth in the Report to exclude clinics from the Navigator designation for enrollment and application assistance into Medi-Cal, Healthy Families, or the Qualified Health Plans available through the Exchange. CCALAC requests for the Board to consider the following comments on why it is important for clinics to be designated as Navigators rather than DBAs: a. ***Clinics do not and will not, through the Exchange, derive a direct benefit in assisting individuals with enrollment and providing health care to individuals with coverage.*** CCALAC believes that the recommended DBA structure within the Assisters Program, as proposed by RHA, will cause the unwanted consequence of steering. The underlying assumption of clinics' "direct benefit" from enrollment is that any person aided by an Assister who is employed or otherwise subsidized by a clinic will join a plan that contracts with that clinic, and will then become a patient utilizing reimbursable services. The direct benefit is then gained by the clinic because the aided person is now a patient of the clinic providing enrollment services. CCALAC agrees with the Board that the issue of steering by any Assister is a serious, ethical concern that the Board should control for, to the fullest extent possible. The undue incentives inherent in the DBA structure run counter to the Board's effort to acknowledge and prevent steering within the Exchange. Under the recommendations put forth by RHA, the only compensation available for provider-based Assisters, not exclusive to only clinics, is through steering individuals towards becoming patients of that provider once they are insured. This policy should provide the opposite incentive structure in order to avoid fraud, abuse, and undue influence under the Navigator program. CCALAC recommends that the Exchange not adopt an Assisters structure that inevitably creates undue incentives for steering. CCALAC rejects the assumption that clinics will derive a direct benefit in assisting with enrollment and providing health care to newly enrolled individuals with coverage and thus justifies their categorization as DBAs within the Assisters Program. Providers that currently partner with enrollment and application assistance entities in LA County do not, in fact, receive a direct benefit through those the entities help enroll. Get Enrollment Moving (GEM) is a non-profit, community-based organization that provides vital outreach and enrollment assistance services to communities throughout East Los Angeles. GEM is funded by Citrus Valley Health Partners, a non-profit hospital that serves low-income communities and many without insurance or with Medi-Cal coverage. GEM, like other enrollment entities, is not exclusive to Citrus Valley Health Partners' hospital operations: it does not enroll people only to have them go seek services at Citrus Valley Health Partners. Once GEM staff assist people with benefit eligibility and enrollment, they refer their clients to local health care sources that are most appropriate for the enrollees including clinics, school-based wellness centers, and other hospitals. GEM seeks to respect and

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	accommodate to the health care and social services needs of the community. Therefore, it is faulty for RHA to conclude that clinics, and providers in general, would inherently derive a direct benefit in providing care to individuals after they have utilized clinics' enrollment and application assistance services. b. ***Clinics are not compensated for current enrollment efforts nor do they currently have "built-in" financial incentives to do so. Clinics have to seek outside funding sources or allocate part of their operational budgets to support outreach and enrollment efforts.*** CCALAC opposes the claim that clinics have built-in financial incentives to provide Navigator-like services and, therefore, justifies for the Exchange to not compensate clinics for enrollment and application assistance services. Many clinics have patients for whom they are not reimbursed through insurance. Clinics must bill a variety of programs to get paid for their services, and must secure additional funding sources to maintain costs for serving a patient population largely comprised of uninsured patients and those that rely on Medicaid. A regression analysis conducted in 2008 by CCALAC concluded that once FQHCs exceed 34.5 percent of visits from uninsured patients, they must seek additional subsidies (such as local indigent programs and outside grants) to supplement their funding streams. Clinics are not directly funded for enrollment and application services from the various major revenue sources that support them. **330 Federal Grants**: The federal grants under Section 330 of the Public Health Service Act do not cover enrollment and application assistance services. Per 42 USC § 254b, the 330 funds cover "required primary health services, patient case management services (including counseling, referral, and follow-up services) and other services designed to assist health centers in establishing eligibility for and gaining access to Federal, State, and local programs that provide or financially support the provision of medical, social, housing, education, or other related services," and "services that enable individuals to use the services of the health center (including outreach and transportation services and, if a substantial number of the individuals in the population served by a center are of limited English-speaking ability…" The outreach services intended by the 330 grants are to enable clinics to do as much as they can for their uninsured indigent patients. While 330 grants support some enabling services, they do not necessarily cover enrollment and application assistance services. **Medi-Cal & Healthy Families:** Clinics are not reimbursed by public programs, such as Medi-Cal and the Healthy Families Program (HFP), for providing enrollment and application assistance services in their communities. Medi-Cal operates a unique reimbursement system with California's FQHCs and FQHC Look-Alikes because FQHC services are a mandatory, covered Medicaid benefit. The Medicaid program's Prospective Payment System (PPS), which is structured to provide FQHCs fair, site-specific reimbursement for treating Medicaid patients, is a critical revenue source for clinics since they serve large populations of Medicaid beneficiaries. In 2010, 35 percent of LA County's average clinic revenue was made up of Medi-Cal dollars.

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	FQHCs and FQHC Look-Alikes negotiate their site-specific PPS rates directly with the state based on what services are offered and what Medicaid will cover. Covered services, according to the Medicaid statute, include "Federally-qualified health center services" and "any other ambulatory services offered by a federally qualified health center and which are otherwise included in the [State Medicaid] plan." The historical issue with PPS has been that it does not cover many other important FQHC but non-allowable (by Medicaid) services that are common and integral to FQHCs, like enrollment and application assistance services. The state does not allow health centers to include enrollment staff as part of their PPS calculation. Therefore, health centers are not paid for this type of enrollment and outreach work through PPS and their contracting with Medicaid. Contrary to RHA's understanding that clinics should be able to provide enrollment services as DBAs in the Assisters Program for free since they have been providing HFP enrollment for free, clinics traditionally have not and remain unable to support these efforts alone. Since reimbursement for HFP enrollment and application assistance ended a couple of years ago, the number of the program's Certified Application Assistants (CAA) among LA County clinics has dropped precipitously. Clinics conducting HFP enrollment assistance have had to get paid for by outside grants or contracts with local county agencies to provide services on their behalf. **Other Funding Sources:** The Report's recommendation to designate clinics as DBAs is based on the understanding that clinics have a mission-driven incentive to enroll individuals and do not need additional resources for this work. While clinics highly value enrollment assistance and outreach to be instrumental to their operations and their patients, the Report inaccurately assumes that they are able to independently support robust and active outreach and application assistance programs without remuneration. Clinics in LA County continue to seek and rely on outside funding sources to increase their enrollment assistance workforce and/or fund outreach efforts. The Children's Health Outreach Initiatives (CHOI) of LADPH currently funds 15 agencies and 4 subcontracting agencies in LA County to provide outreach, enrollment, retention, utilization (OERU) and training services for enrolling children and families into public programs. Seven of CHOI's contracted entities are either clinics or hospitals, while the other contracted community-based organizations (such as schools, the Los Angeles Unified School District, Los Angeles Office of Education, and the cities of Long Beach and Pasadena) also partner with clinics to help enroll clients. Clinics have been successful CHOI partners in enrollment. Between July 2010 and June 2011, 60 percent of the 31,115 applications submitted for public and private health programs were from clinics or hospitals. The staff provide outreach, enrollment, and follow-up with each client at the 30- and 90-day mark post application to verify enrollment, at the 4-6 month mark to make sure they are not having problems with utilizing their benefits, and again at 11 months to remind him or her

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	about renewal materials and other assistance. CHOI-funded enrollment staff also assist intermittently with additional utilization assistance and referrals as needed. Without the current grant funding by CHOI to pay for clinic staff to provide these services full time, clients would not be able to obtain the help they need from busy front office or billing staff. CHOI also stations assisters at additional clinic or Women, Infants, and Children (WIC) office sites because they cannot afford to pay for a CAA on their staff. In addition to the currently contracted clinics, LADPH has contracted in the past with CCALAC members Northeast Valley, Valley Community Clinic, QueensCare Family Clinics, and The Children's Clinic. Unfortunately, there is not enough CAA funding available to keep all of these clinics frequented by the uninsured. Funding opportunities exist for CAA recruitment and training but not necessarily for ongoing enrollment activities. CCAALC is a subcontractor for the California Primary Care Association's federal CHIPRA grant, funded by the Centers for Medicare and Medicaid Services, to strengthen children-focused outreach and enrollment at LA County clinics. While the grant supports a number of components related to CAA recruitment, training, and certification, it does not necessarily support the actual enrollment activities done by these newly certified CAAs. While clinics are interested in growing their enrollment workforce, sporadic funding sources undermine their ability to retain their assister positions and maintain robust enrollment programs. It is important for the Board to note that clinics cannot self-support enrollment and application assistance efforts for eligible Exchange beneficiaries. Clinics have to rely on partnerships with and financial support from local counties and foundations to subsidize such services. CCALAC member Tarzana Treatment Centers (TTC) is a community clinic network that designates staff for benefit assistance at its Tarzana, Reseda, Northridge, Long Beach, and Lancaster sites. TTC relies on its own operating budget and other funding sources to make staff available for benefit assistance. TCC has benefit enrollers for HIV/AIDS patients, funded through LADPH. TCC is also grant-funded by CHOI to cover some of the cost of its outreach and assistance work with children and their families. TCC's own dollars only go towards enrollment for LA County's Low-Income Health Program (LIHP), Healthy Way LA, which has been a struggle since TCC had to provide the resources well in advance of generating enough patient volume to cover the investment. A little more than ten months after Healthy Way LA's implementation has TCC now begun to break even on that effort. While some clinics manage to obtain outside funding and/or squeeze some of their own operational funds towards enrollment and outreach services, many simply do not have unlimited access to funds and indeed operate on razor-thin financial margins. Northeast Valley Community Health Center (NEVHC), another CCALAC member, serves medically underserved residents in the San Fernando and Santa Clarita Valleys. As a large, managed care provider with over 43,000 managed care members, NEVHC have regarded the provision of application assistance as a vital and necessary service in order to link its

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	patients to benefits. In the past, NEVHC enjoyed grant funds (now gone) and assister fees (now gone) in order to fund CAA positions in its clinics. Now it does not have dedicated grant or county revenues for enrollment efforts, and funds assisters from its slim operating budget. With previous budget cuts and historically slim profit margins, NEVHC has had to reduce an enrollment coordinator position and have since been unable to restore it. Due to three years of back-to-back cuts in state funding and the loss of a promised federal service expansion grant last year, NEVHC implemented budget cuts this year including a reduction in staff. NEVHC has managed to retain the assister positions at the cost of other positions being cut from its operating budget. Another example is Valley Community Clinic (VCC), a FQHC that has been serving residents of the San Fernando Valley. VCC was initially funded in 1999 to conduct outreach activities in northeast San Fernando Valley and adjacent to actively raise awareness about available coverage and health plans through public education. Once with a staff of 11 Promotoras (CAAs), VCC outreached to and enrolled over 10,000 families into health care programs during the first five years of operation. The years that followed were plagued with few and far-between funding opportunities. In 2006, the state provided grant funding for three years to conduct OERU activities. The program was short lived. The state had pulled the money for 22 state outreach grants. Within five months of the program launch, VCC lost 5 of the 8 staff that were hired. VCC too, like all other clinics, are in need of support to continue to do what it does best to meet the enrollment needs of its community. c. ***Clinics are inundated by major systems and program changes that have diminished their ability to serve their patients and offer services they would typically like to offer.*** Clinics in LA County have been inundated with major systems and program changes at the local level. They have been engaged in many initiatives including ramping up efforts for patient-centered medical home designation, implementing electronic medical records, launching LA County's LIHP program and participating in an effort to decompress LA County's specialty care system. Each of these efforts has come with their own challenges and, combined, have caused significant financial strain on clinics. While clinics want to remain partners throughout the reform process, they are simply unable to support many activities, such as enrollment and application assistance services, without compensation. d. ***Clinics are best positioned to provide enrollment and application assistance services to underserved populations that will be a target market for the Exchange.*** CCALAC urges the Board to build upon and leverage the existing clinic network and classify clinics as compensated Navigators, for they are naturally positioned in underserved areas and/or serving underserved populations that will be a target market for Exchange services. Clinics are trusted providers with proven success of performing outreach, education, and enrollment activities in the most diverse, hard-to-reach communities. Patients prefer and seek care at clinics because they

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	know there will be providers who understand their unique circumstances and offer culturally and linguistically competent services specific to the community's needs. Given the unprecedented task for the state to enroll millions into public and private coverage options, the Board should utilize the existing infrastructure of enrollment entities by including clinics as entities eligible for Navigator status. In light of the four above-stated reasons, CCALAC urges the Board to designate clinics as compensated Navigators. Most clinics will not be able to ramp up and support a DBA system, as outlined in the Report, while meeting all the same requirements as Navigators and enrolling between 172,500 – 217,350 individuals estimated to be served by DBAs in 2014 alone without any sort of compensation. If the Board does not designate clinics as Navigators, the Exchange is likely to have a far less robust outreach and enrollment program where far fewer eligible individuals will be enrolled in coverage.
Community Health Councils	Generally, we would like to express support for all of the eligibility and standards recommendations provided by RHA (pg. 18) with a few recommendations. • In addition to coordinating with the Department of Insurance to provide quality assurance, project sponsors should also explore partnerships with the Office of Patient Advocate and state universities or other entities to evaluate and monitor assister activities. We acknowledge that partnering with the DOI to certify, track, and monitor the assisters program seems like a good partnership given the role the DOI currently plays in licensing agents/ brokers; however, we would like to note that partnering with the Office of Patient Advocate may make for a more natural collaboration given the support OPA currently provides to consumers and the OPA's oversight of the consumer assistance program. Housing oversight of the assisters program with the same agency overseeing the consumer assistance program may allow for better coordination between enrollment support and comprehensive post-enrollment support (i.e. appeals and grievance support). • In addition to the eligibility and standards outlined by RHA, project sponsors should require that Navigator assisters exhibit previous experience and expertise in enrolling individuals or small businesses into coverage. We believe that by requiring potential contracting agencies to document their expertise and experience in enrolling and providing assistance to individuals, including vulnerable and underserved populations, and/or small businesses, the Exchange, MRMIB, and DHCS can secure a strong network of assisters to provide enrollment support. That said, we would like to note that in communities where there is a lack of organizations with such experience, this requirement should be waived to allow organizations interested in becoming assisters to do so. • Regarding the requirement that enrollment entities maintain a minimum threshold of liability insurance, we request further clarification about the type(s) of liability insurance that entities will be required to obtain. We recognize that many state and county agencies currently obtain commercial general liability insurance as a general cost of doing business; however, it is unclear to us whether entities will be required to purchase such insurance or if other additional liability insurance will be required of enrollment entities (i.e. liability insurance purchased by agents/brokers). We would caution RHA and project sponsors to be clear and specific about the type of liability coverage required for

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	eligibility as an assister organization. RHA and project sponsors should also carefully consider the impact such a requirement would have on the ability to attract a diverse set of organizations for the Navigator program.
Consumers Union	Consumers Union supports the requirement that all Assisters (Navigators and Direct Benefit Assisters) are required to go through the same training and certification to be an "Assister" regardless of any other licensing or certification that might already exist. We appreciate that, regardless of how they are paid, all Assisters would be trained, certified and registered uniformly with the Exchange and would be required to train for all coverage options, including subsidies, tax credits and public coverage options. Consumers Union also applauds the requirement that all Assisters are required to undertake education, eligibility and enrollment activities. While only Navigators should be required to conduct outreach, we understand that the outreach activities would be funded through a new proposal for outreach and education assistance grants, referenced under the Marketing and Outreach proposal (our comments are included in that matrices). Consumers Union agrees with the proposal to hold all Assisters to the guidelines and requirements adopted under the ACA federal regulations for Navigators, another standard that will provide uniformity and consistency throughout the Assister program. While there is mention of a code of conduct, confidentiality, and Assister Guideline Agreements, there are no references to developing conflict of interest standards. The federal regulations require Exchanges to have conflict of interest standards for Navigators and HHS/CMS spells out in the federal preamble some of the important things that the conflict of interest standards must address. We believe that this requirement on Project Sponsors should be spelled out as a requirement for the Assister program, with a timeline for development of the standards no later than July 2013, when recruitment and training of Assisters should be actively moving forward.
Delta Dental	On page 21, the Recommendations Report suggests that the Project Sponsor coordinate quality assurance for the Assisters Program with the California Department of Insurance (CDI). As a Knox-Keene licensee, Delta Dental would suggest that the Department of Managed Health Care (DMHC) be equally partnered with for this necessary oversight responsibility. The DMHC regulates managed care entities, and operates under a different statutory framework (the Health & Safety Code) than does the CDI, who enforces the Insurance Code. While there is some overlap between the two agencies, there are also many areas where the regulatory requirements differ, and a successful quality assurance program for the Assisters Program should include input from both of these regulatory agencies.
Fresno Healthy Communities Access Partners (HCAP)	• FQHC clinics have long been our partners in Fresno County and have demonstrated partnership in all aspects of OERU and should be paid for enrollments. They are not for-profit entities and serve the same population we do and share our same goals.

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The Greenlining Institute	**Navigator entities must be direct service organizations that have a proven ability to reach California's diverse communities.** Greenlining is concerned that the recommendations do not set a standard for if the navigator role can be contracted out from a lead navigator entity to a subentity. Currently the California Public Utilities Commission allows for agencies that help with enrollment into the CARE and Lifeline programs, which serve mainly low-income and communities of color, to subcontract out enrollment services. These subcontracts are often a much reduced rate, and in some instances those enrolling people receive only $5 per successful enrollment. This practice has occurred and remains viable for the lead contract because many of the subcontractors are happy to receive any compensation for this work. While we prefer that designated navigator entities not have the ability to subcontract, we do understand that in some instances, this may be necessary. We would therefore suggest that if HBEX plans to allow for such subcontracting, then the HBEX needs to set a market rate or designated grant amount to ensure that those taking the subcontracts are receiving fair payment for their work.
Health Access	California has a sad history of steering in Medi-Cal managed care led to Health Care Options Project: some Medi-Cal managed care plans signed up consumers in areas in which the plan lacked any service capacity (allowing the plan to collect capitation payments without providing care), misleading information was provided in languages other than English, and other abuses occurred. This is why for Medi-Cal managed care enrollment in a managed care plan is separate from eligibility determination, Medi-Cal managed care plans are prohibited from marketing directly to eligible consumers and Medi-Cal managed care materials are reviewed, approved and provided by DHCS, not the carriers. Monitoring of steering alone is not sufficient. Health Access proposes several different standards to address steering: ○ First, we concur that navigators should be required to be neutral, to provide impartial information on all options and to receive no compensation from insurers, providers or agents for enrollment assistance. ○ Second, direct benefit assisters have an inherent financial interest in steering consumers: will a community clinic provide a consumer with assistance to enroll in a plan that does not include that clinic? Will an insurance agent provide information about a product for a carrier that the agent does not represent? Conversely, if a consumer is at a community clinic or a doctor's office and wants to continue to receive care from that provider, the consumer may well seek the advice of the clinic staff about how to keep coming there. For direct benefit assisters, we propose the following: ○ Direct benefit assisters may provide advice to a consumer about how to enroll with the contracting carrier for that assister. However if the consumer seeks to enroll with another carrier, the assister must provide information on that as well. ○ Contracting carriers must be prohibited from compensating providers (hospitals, clinics, physicians) for steering consumers to the carrier. • Insurance agents should be required to disclose to consumers that insurance agent is an agent of a carrier or carriers and paid by the carrier. Carriers should be required to disclose to the Exchange the compensation arrangements used for agents and solicitors.

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	• Health Access strongly supports a prohibition on any individual or entity disciplined by DMHC or CDI as a solicitor or agency or by DHCS or CMS for fraud from becoming a navigator or navigator entity.
Health Consumer Alliance	We support the concept that all Assisters be affiliated with an Enrollment Entity, which should be responsible for furnishing reports to its oversight body on their activities and outcomes. We support annual certification for both the Entity and Assisters, and ongoing communications with Project Sponsors on program updates and changes. Entities and Assisters should sign contracts and agreements with the Exchange.
Insure the Uninsured Project	ITUP supports the assister eligibility and standards recommendations made by RHA to the board.
Kaiser Permanente	• We concur with the recommendation that plans pay agent commissions in the individual market, and we strongly recommend that these commissions must be the same for the same product sold in and out of the Exchange. We recommend this protection be expanded in significant respects. First, the requirement that agent compensation be the same in and out of the Exchange should extend to all forms of compensation – monetary as well as non-monetary incentives or considerations. Similarly, the principle should be applied to all bonuses, "overrides," and similar programs that reward high-volume agents and brokers. Such programs must calculate eligibility for bonuses equally, without regard to whether the enrolled lives are in Exchange or non-Exchange products. We also recommend the Exchange prohibit, by contract, participating issuers from paying product-specific bonuses in or out of the exchange. Such bonuses, if targeted for example only at non-exchange offerings, could thwart the goal of requiring that commissions be equal in and out of the Exchange. • We support the requirement that assisters be prepared to help individuals enroll in any form of coverage for which they are eligible (Medi-Cal, Healthy Families, or subsidized coverage in the Exchange). We request clarification, however, regarding how this approach will fit with current rules regarding applications for Medi-Cal – in particular, Medi-Cal managed care in the two-plan counties.
LGBT Health Consortia	The code of conduct for organizations and enrollment entities should include nondiscrimination guidelines inclusive of sexual orientation and gender identity, as required by HHS Final Rule released in March.
Los Angeles County Department of Public Health, Children Health Outreach Initiatives	• It is strongly urged that the Exchange allow public and private hospitals and clinics to become full Navigators in the Assisters Program, and to be compensated for enrollment and retention activities for the Exchange. Of the 15 agencies contracted with the CHOI program, half of them (7) are community clinics and/or hospitals. • CHOI contracts with these health care providers because without a dedicated source of funding to conduct OERU activities, this critical work would not be done, plain and simple. The needs are highly evident across all community health providers, yet without specific funding, there is no extra capacity for staff that are already stretched thin. With state and federal budget cuts and funds shrinking for safety net providers in particular, these organizations, just like other community agencies, do not have the luxury of funding staff to work on OERU activities, a full-time workload. CHOI implores the Exchange to recognize the wealth and opportunity that lies in allowing hospitals and clinics to

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	become Exchange Navigators and be compensated for assisting clients enroll and retain coverage in the Exchange.
Maternal and Child Health Access	MCHA supports the following stated RHA recommendations: • Eligible assistors must be affiliated with an enrollment entity, • All assisters should be certified after completing required trainings and this certification be annually renewed (see below) • All organizations and assistors must, not should, sign a Code of Conduct, Confidentiality and Assistor Guidelines Agreement. We further recommend that more active monitoring of Navigators and Direct Benefit Assistors (DBA) take place by the Sponsors than has currently under the Certified Application Assistor (CAA) program. A reporting requirement should be built in for those Navigators and DBAs approached to work on behalf of specific health plans. Frequent spot-checks, secret shoppers, and monitoring of sites where enrollment takes place and surveys of beneficiaries who call to disenroll should be done, as noted on p. 21 of the 5/18/12 version of the Draft Recommendations. If a beneficiary states s/he does not know how enrollment took place, an investigation should be done. To our knowledge, this does not take place currently in Medi-Cal or Denti-Cal. • The Project Sponsors or their designated entity should provide technical assistance (TA) and professional development to all assistors. MCHA would elaborate that the TA take the form of transparent business rules for the CalHEERS mechanism(s), policies and procedures, and stakeholder meetings at least monthly, initially, at which issues about enrollment could be raised and returned to networks of Navigators/DBAs. It is critical that everyone be on the same page with knowledge and that the eligibility and enrollment rules be applied accurately, to the extent possible.
San Mateo County Union Community Alliance	RHA recommends: • Eligible assisters must be affiliated with an enrollment entity. • All assisters should be certified through the Marketplace after completing required trainings. Certification should be renewed annually. • All orgs and enrollment entities must sign a Code of Conduct. • The Project Sponsors or its designated entity should provide technical assistance and professional development to all assisters. SMCUCA is concerned that the recommended eligibility standards could set up a bi-furcated system of Certified Application Assisters working for the Exchange and a separate system of Certified Application Assisters working for the County of San Mateo. (See the attached white paper outlining these concerns from the San Mateo County Board of Supervisors Community Health Reform Advocacy Committee.) Utilizing a combination of County health employees and community based organizations as CAAs. The San Mateo County Health Coverage Unit currently reaches approximately 41,000 uninsured residents in San Mateo County. Many of these residents will be eligible for the Exchange or will have family members who

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	are eligible for the Exchange. If the County is not coordinating the "enrollment entities" for all CAAs in the County, then there will be two groups of navigators with different training, different outreach strategies and a different range of program offerings. Depending on the level of the proposed minimum threshold of liability insurance, this requirement could be a bar to many of the current community based organizations who are working as Certified Application Assisters for the County's Health Coverage Unit. This problem could be alleviated by allowing the County to serve as the enrollment entity with subcontracts to the community-based organizations working under its auspices.
San Mateo Labor Council	• Counties should be given preferred/priority status as Enrollment Entities. • Strongly agree that assisters should be affiliated with an Enrollment Entity. • Re brokers – if not restricted to the SHOP, need strongest protection against conflict of interest driven by compensation; appearance of influence. I express strong concern re extent to which DBA's, brokers in particular, cannot provide fair and impartial information and referral to consumers without steering or conflict of interest. • Resist insurance industry pressure to institute licensure of Navigators • Resist insurance industry pressure to require navigators to have any insurance beyond what a county contract usually requires. • Community Clinics should be Navigators, not DBA's
SEIU	At the last hearing, HBEX heard numerous community clinics and lean budget safety net providers testify that they did not feel they could provide the assister function without compensation and that it was inaccurate that they have a vested interest in the enrollment. We agree with their concerns and urge HBEX to consider if safety net providers should be included as potential navigator enrollment entities considering these entities provide care currently for the uninsured and underinsured. If they are not eligible to be enrollment entities, we encourage HBEX to consider strategies to help partner enrollment entities and safety net providers. "Enrollment entity" is not clearly defined – can any organization be an enrollment entity so long as they meet certain requirements, including for-profit entities? Other than the annual enrollment requirement, what other training, licensure, etc. requirements or standards do enrollment entities need to meet? Who has oversight responsibility for enrollment entities? Some counties employ assisters and greeters who provide application assistance. It is unclear if they would be considered assisters.
Signature Health Insurance Services	The Navigators need to have experience in the Exchange Plans and plans offered by the insurance companies, so they are able to make valid comparisons and make appropriate recommendations.
United Ways of California	**A. UWCA supports the recommendation that all navigators must be associated with an enrollment entity**.

Issue #2: Eligibility and standards	
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	B. UWCA recommends that the CHBE more clearly distinguish between individuals serving navigator functions and the navigator entities for which they work so it is more clear what standards and requirements apply to each. **C. UWCA strongly recommends that some navigator entities be permitted to employ navigators who only perform the outreach and screening functions and activities** with the proper training (CCAN's proposed Tier 3 navigator functions). However, as stated above under structure, these entities would have to demonstrate clear, strong relationships with and access to Tier 2 and Tier 1 navigators in the community. **D. UWCA supports the requirement that all assisters sign a code of conduct, confidentiality agreement and Assisters Guidelines Agreement as a requirement of certification.** **E. UWCA urges clarification of the definitions of Direct Benefit Assister and navigator as currently they are too vague and open to interpretation**. It is not clear how to apply the criterion that Direct Benefit Assister organizations are those "conduct(ing) enrollment because it is part of their community service mission." Many CBOs that should be part of the paid navigator system, including United Way, could claim that it is part of their community service mission. We think the CHBE means more direct health care or coverage providers but again, that is not clear. The eligibility requirements to be a Direct Benefit Assister, a navigator or a navigator entity should be spelled out in unambiguous terms.

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Issue #3: Training	
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2-1-1 California	Training and quality assurance is a critical component to ensuring early success. 2-1-1 programs work within the constructs of national standards and have a great understanding of the importance of training and quality assurance and recommends that the Exchange consider the following, based on our support of the Tiered Navigation Model as referenced in the CCAN comments: o Individual certification/credentialing would be the most flexible option for working with both individual navigators and entities employing navigators. This would allow larger-scale organizations to allocate the appropriate staffing resources and ensure that they are certified and trained to provide quality service. Many will cite the CAA certification as the most closely aligned certification program in place, 2-1-1s would agree that the CAA certification process is a good process to build upon. It will be important to develop a distinct level of training and certification for individuals and entities that are not enrolling individuals versus those that are. We recommend that the Exchange

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	Certification for Navigators include a strong information and referral training component for organizations without that specific experience, in order to equip staff with the tools to assist individuals as they make personal choices, based on the realm of beneficial options. This training would go a long towards helping to minimize steering towards any one type of insurance, and would help the Exchange in developing a more uniform set of standards for referring and enrolling the uninsured in coverage that meets their individual needs and life circumstances. 2-1-1 California recommends that on-going training modules be considered as to way to ensure consistency. While annual certification is a good approach to ensure that navigators are equipped to assist Californians, we know that it is often the case that more consistent training actually leads to greater quality in service. 2-1-1 California supports the concept of acknowledging the expertise of organizations already providing assistance functions, but encourages the development of a strong comprehensive assessment to ensure that individuals are truly equipped to provide the navigation function. It is our belief that the assistance needed under this navigation program, will be unlike what has been performed in California and that consumers will need strong assistance in determining the most beneficial option.
AIDS Health Consortia	The draft plan offers a training program outline (p. 23) that covers many basic state programs and discusses some specialized patient needs. The plan also suggests some general categories for additional and specialized training (p. 24). At a minimum, the state should offer HIV/AIDS-specific specialized training that addresses the importance of linkage to HIV experienced providers, issues with pharmaceutical coverage and out of pocket costs, and routes of access to HIV specific services that support linkage, engagement and retention in care. Further, the mandatory two-day training should include a component that discusses unique needs of clients with chronic conditions, particularly those who may experience stigma in the health care setting, including people with HIV/AIDS, in order to develop navigator competence when assisting these patient populations.
Anthem Blue Cross	Anthem would like additional details regarding training for assisters. While we support the Exchange's efforts to ensure all Navigators and DBAs receive comprehensive training, we believe the California Exchange should closely collaborate with QHP issuers to ensure training is adequate. We would like additional clarification regarding how this training will differ from the initial and continuous education currently required of all licensed insurance agents. Currently, typical continuing education (CE) of health insurance agents is approximately 2-4 days a year. The California Exchange should consider how assisters, both Navigators and DBAs, will gain and maintain competency of all health plans offered in California. Further, Anthem suggests that the Exchange provide this training, as opposed to having assisters undergo training with each QHP issuer. This training should be filed as a CE course (with respect to the non-issuer specific content) so that agents may count this training towards the CE requirement to maintain the agent license. We believe the Exchange could have a critical role providing certification for agents and brokers. We believe health plans should not be doing this function, as some standardization will help ensure all consumers receive adequate support in a consistent manner, regardless of an agent's compensation. Furthermore, Anthem would strongly encourage the Exchange to

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	go beyond certification requirements for assisters. Specifically, while the ACA does not allow the Exchange to require Navigators to be licensed agents and brokers, we believe California should develop exchange licensure requirements for all assisters. Anthem supports the requirement to ensure any assister, including an agent who is paid by a health plan, inform consumers that other enrollment options exist. However, we are concerned that stringent requirements that ensure agents fully represent all QHPs available to a consumer will likely eliminate the QHP agent channel, which we believe will be one of the most effective distribution channels for enrollment in the Exchange. Additionally, while we understand that this is a federal requirement, we are concerned that the Exchange expects every assister to be an expert in every available QHP. Based on our experience in the market today, we do not believe this is likely, particularly given the breadth of products that an enrollee could be eligible for, both on and off the Exchange.
Asian Pacific American Legal Center of Southern California (APALC)	**Required Training** • We recommend more than a two-day training for assisters. In order to understand the complexity of the existing and new health care system, it would take much longer than two days. From our training experience, learning about the private marketplace and the federal subsidies, and the expanded Medi-Cal and other publicly-funded programs will take at least three to five days of training. However, we agree that some assisters, as identified in the report, may not need such an extensive training. • We support on-going training and review but recommend that testing be offered to take the place of attending trainings. • We would require the same training for all assisters –both Navigators and DBAs – except those who have been previously trained and are active assisters currently (and could attend a shorter training). • We would include a section on the training on the antidiscrimination provisions in the ACA as well as the cultural and linguistic requirements under federal law. Including Title VI of the 1964 Civil Rights Act and other cultural and language access standards. • We support that recommendation that the training should be offered in English and Spanish at a minimum, but would add at least two additional Asian languages – Mandarin and Cantonese – and phase in additional languages based on the need as determined with community input. (Pg.22)
Blue Shield of California	Regarding training, we recommend the following: • Navigators and Direct Benefit Assisters should be associated with an appropriate entity and should receive training, certification and registration • Costs associated with such training should be paid through Exchange establishment grant funds as is permitted under the ACA.
California Association of	Developing a robust training program for all Navigators and Assisters is essential to ensuring that the Assisters program is able to provide clear, comprehensive and consistent information to eligible enrollees. Public hospital systems strongly support

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Public Hospitals and Health Systems	efforts by the Exchange to secure funding to offset the cost of training for Navigators and Assisters, which will help ensure all eligible staff are effectively trained. Given the severe funding constraints for public hospital systems, resources available for additional training are very limited. By covering the cost of training, the Exchange will help leverage a comprehensive outreach and enrollment effort under reform.
California Consumer Advocate Navigator Workgroup	**A. CCAN agrees that all types of assisters be required to attend the same initial training and to that an abbreviated training be offered for certain categories of individuals who are already performing some assistance functions.** All assisters should be trained and have comprehensive knowledge in all marketplace coverage options and subsidies. Providing a "No Wrong Door" system for consumers will require that DBAs also have such knowledge and are able to help all consumers, even those who qualify for public programs, find their way into coverage. A test should be required to opt out of the full training. We are also supportive of the annual recertification requirement coupled with an annual retraining on specified topics. **B. CCAN would also like to see the Exchange offer a simple training for community groups and volunteers who will not be certified assisters but want to help spread the message that health options are available within their communities.** This simple "Health Options 101" type of course will ensure that even non-certified community messengers have the correct information and are in alignment with the messaging that is ultimately created for the Exchange and other health coverage programs. **C. Training should be available in the top Medi-Cal threshold languages, not just English and Spanish.** We commend RHA's recommendation that training be offered in English and Spanish at a minimum. However, in order to truly ensure that all assisters have access to the training, and that those entities providing assistance truly represent the demographic of the populations they are trying to reach, these trainings should also be available to assisters in the top Medi-Cal threshold languages. Some of the organizations who would best be able to reach hard-to-reach target populations may not have staff that would be able to attend a training session in English or Spanish. The availability of the training in the top Medi-Cal threshold languages should be advertised to potential navigators and assisters to ensure that language access does not become a barrier for some entities. **D. CCAN recommends training for all assisters, especially paid navigators, on the other health and human services programs for which individuals may qualify be added to the list of topics to be covered by the initial training.** While not all navigators will assist with enrollment in these programs, it would be a great help to the consumers to be efficiently guided to services that will help support their health and wellness, and would be a huge stride toward a no wrong door enrollment system for all types of public benefits. **E. In recognition of the robust list of topics that will be covered during the initial training of assisters, we recommend that the duration for the training not be set by duration (i.e. 2 days), but instead be determined by the content that must be covered.** The training modules should be developed first, and the length of the training should then be set based on the amount of time required to fully cover each of the topics.

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California Coverage and Health Initiatives	**CCHI agrees with RHA's recommendation that all types of assisters be required to attend the same initial training and to offer an abbreviated training for certain categories of individuals** who are already performing some assistance functions (CAAs, health insurance agents, county eligibility workers, etc.). A test would be required to be able to opt out of the full training. • **CCHI recommends that the Exchange implement a monthly or quarterly training/meeting opportunity for navigators.** Particularly in the early months and years, as the navigator work force is being developed, there will be great demand and need for regular training and program updates for Assisters of all types. In the current CAA system, most local outreach networks and Enrollment Entities provide a monthly opportunity for CAAs to get together, coordinate their services, share best practices and program changes, and learn from each other. These opportunities are invaluable and help to ensure that the CAA network is meeting the needs of the local areas and populations as well as ensuring the CAAs are appropriately trained and up-to-date on current program issues. This structure encourages a tight local network of assisters and helps to forge strong linkages between enrollment entities within a given region. We recommend that the Exchange consider implementing such a program as part of the navigator program. • **CCHI supports the recommendation of an annual recertification training.** • **CCHI recommends that there be a "master trainer" component in the training model.** The RHA report does not go into sufficient detail about how the training program would be structured to ensure that an adequate workforce of well-trained navigators is prepared to meet the enrollment challenges in 2013-2014. The experience of CCHI members with the "master trainer" concept has been very positive. It will help ensure that the Exchange has on the ground master trainers in communities across the state to provide rapid response, training and troubleshooting when and where it is needed. While there is an important role for on-line training, we believe that the complexities inherent in the content of navigator training will be best communicated in in-person trainings in local communities. RHA has extensive experience with the master trainer concept and CCHI recommends that concept to the Exchange. • **CCHI recommends training include knowledge of other health and human service options outside the Health Benefits Exchange, particularly local coverage options for those not eligible for coverage (public or private) through the Exchange.** Many families face complex situations where some members are eligible for coverage inside the Exchange and others will need to look beyond the Exchange. Some individuals applying for coverage will simply not be eligible for Exchange coverage. There are local coverage opportunities such as Healthy Kids programs, county indigent coverage programs, and other access to care initiatives that could serve these Californians. It should be part of the scope of required navigator and assister functions to provide referral to these and other coverage options outside of the Exchange.
California Family Health Council	CFHC supports the proposal that new Navigators and Direct Benefit Assisters receive mandatory training and that already engaged Navigators and Direct Benefit Assisters receive an abridged refresher course annually. We are interested in seeing more details around who will conduct the training, what topics would be covered, how often the trainings will be conducted and where, etc. We encourage additional stakeholder participation in the form of a workgroup to flush out these details and others

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	related to the Assister program.
California Hospital Association	CHA supports the training requirements for the Assisters Program. No entity or employee of any entity should be mandated to participate in a training and certification program unless the entity specifically requests to be considered by the Exchange as an enrollment entity. Any assister working for or affiliated with an enrollment entity should be treated equally with respect to education, certification and compensation for enrollment.
California Pan-Ethnic Health Network and Having Our Say Coalition	• **HOS applauds the recommendation that all Navigators and Assisters take part in the same two-day training.** Standardizing the training curriculum will allow the Exchange to establish basic training principles for all Assisters. Additionally, this requirement will help the Exchange evaluate and identify best practices and ensure quality control with respect to Assister training. Because this is a new program, HOS feels that all entities, even prior CAAs, HICAPs, and other Assister entities, should be required to take part in the same two-day training. We agree with the recommendation that Assisters be required to participate in additional training as needed on a yearly basis. • **HOS recommends that Assisters training and curriculum be available in all of the Medi-Cal Managed Care threshold languages.** We commend RHA for recommending that training be provided in English and Spanish and calling for funds for translation services in Spanish and four Asian languages. However the diversity of our state necessitates that California goes further. In order to ensure that assister entities are capable of providing outreach and enrollment assistance to California's diverse communities, it is important that the state provide training, technical assistance, and curricula in all of the Medi-Cal Managed Care threshold languages. The ability to be trained in a person's primary language will help increase efficiency and reduce the potential for errors and misinformation. • **HOS recommends that Assisters training include basic training on other health and human services programs.** Assisters should be able to identify potential eligibility for other health and human services programs. This is especially important for consumers where enrollment in one program is linked to enrollment in another program, for example: between Medi-Cal, CalFresh, and CalWORKs. Assisters should be able to help consumers seamlessly and quickly access CalFresh, CalWORKs, and WIC benefits after applying for health coverage – and vice versa. The role of Assisters should include expanding or creating two-way connections between health coverage and other health and wellness supports – such as working family tax credits, child care and pre-school subsidies, In-Home Supportive Services, and more – in a targeted and phased in manner.
California State Rural Health Association	**We join CCAN in the following two recommendations:** **1.** <u>The Navigator program should be designed to serve various populations that traditionally lack coverage in a manner that is culturally competent and linguistically appropriate to that population.</u>

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	2. Training should be available in the top Medi-Cal threshold languages, not just English and Spanish. We commend RHA's recommendation that training be offered in English and Spanish at a minimum. However, in order to truly ensure that all assisters have access to the training, and that those entities providing assistance truly represent the demographic of the populations they are trying to reach, these trainings should also be available to assisters in the top Medi-Cal threshold languages. Some of the organizations who would best be able to reach hard-to-reach target populations may not have staff that would be able to attend a training session in English or Spanish. The availability of the training in the top Medi-Cal threshold languages should be advertised to potential navigators and assisters to ensure that language access does not become a barrier for some entities. In addition, we wish to make the following recommendation: The options in the Training section of the report is missing one key ingredient, namely how to identify and make appropriate referrals for consumer assistance, either to an ombudsman or appropriate state agency, for any enrollee with a grievance, complaint or question about coverage or utilization. As pointed out on p.16 of the report, mandated activities under the ACA include providing "referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the PHS Act," or other appropriate State agencies, which in California would include the CA Dept. of Insurance, Office of the Patient Advocate (OPA) and Department of Managed of Health Care, and the Medi-Cal Managed Care Division within DHCS. Here it is important to note new provisions enacted into law by SB 922 (Monning), Chapter 552, Statutes of 2011, which purports to integrate and consolidate many of the assistance activities under OPA. Project Sponsors ought to explore coordination with OPA/DMHC in the development of a training curriculum for the consumer assistance function. That could be accomplished with initial training and/or additional specialized training required for Annual re-training or recertification as laid out in pp.23-24. **CSRHA's recommendation is to include basic training on consumer referrals for the initial certification, and adopt a more intensive module for subsequent trainings.** It is highly advisable that Navigators know what the Patient Advocate does and how to access consumer assistance locally and at the state level. A cross-training curriculum could be administered by the OPA, through an interagency agreement or such mechanism. Training would be ongoing and provided for Navigators, to go beyond the initial training for certification and include issues such as consumer appeal's rights, ombudsman legal requirements, and an ethics component.
Centro Binacional Para El Desarollo Indigena Oaxaqueño	• We absolutely must have the 2 day training for all assisters regardless of previous training under the CAA model. The training is imperative to educate the assisters with all the needed information to be able to answer all questions appropriately. • DBA's should complete the two day training as well as navigators since it was stated that they will have the same knowledge as the navigators. In terms of the training, no distinction should be made between assisters and navigators. • Besides the yearly training for assisters we suggest that a refresher is offered throughout the year to provide assisters

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	with any new information, updates or relevant information. • The trainings will be offered in English and Spanish, however we would also like to ask that these trainings be held in Asian languages as well to be able to reach all populations. • Make sure that the trainer is able to clearly communicate and explain the material specifically when it's in a language other than Spanish. The use of simple terms to explain to ensure navigators understanding and then being able to relate this information to the community member.
Community Health Councils	We commend and support the training requirements outlined by RHA (pg. 23). We especially support the recommendation of additional and specialized training. This training should include areas related to non-health public programs, utilization of coverage (i.e., prevention and wellness), medical home education, and so forth to promote broader awareness among consumers about overall health and well-being. Additionally, just as proposed by RHA under their technical assistance recommendations (pg. 21), project sponsors should make materials or training videos available for reference and use on the online technical assistance portal and/ or provide such updates and training opportunities through monthly webinars/ calls/ conferences as necessary. A list of master trainers should also be posted to help organizations seeking specialized training for their staff. We strongly urge the project sponsors to require that training for the assisters program be available in all threshold languages. We recommend training for the assisters program build off existing enrollment, outreach, retention, and utilization training curriculums. We urge RHA and project sponsors to review materials developed by LA County CHOI regarding contracted agencies' scope of work, objectives, deliverables and sample reporting activities. RHA and project sponsors should also review data gathered by CHOI's OERU database, which captures information about every outreach, application, enrollment, retention and utilization activity conducted by CHOI contracted agencies in Los Angeles.
Consumers Union	Consumers Union urges that, at least in the first 3 to 5 years, rigorous training and certification be required for all Assisters. Health reform will usher in a new and more complicated world, adding the need to understand commercial products to what current Assisters (e.g. CAAs) have already had to master. In addition to the *initial and annual 2 day training*, there should be ongoing education required of all Assisters, occurring throughout the year. This could be 12 hours per year (average of one hour per month) for Exchange process updates, new program information, and could be offered via a webinar or online PPT, so it is not too much of a burden or cost to the Project Sponsors and Assisters. Ongoing education requirements will be especially important as the monitoring entity identifies global problems with assistance, wrinkles it needs to iron out, education for specific populations it wants to provide, or specific aspects of the eligibility or enrollment system it needs to tweak. The suggestion that the Project Sponsors may offer an abbreviated training for those already providing assistance—agents, CAAs, HICAPs—seems ill advised given the complications of the new system and programs, e.g., premium tax credits, cost-sharing, actuarial value concepts, MAGI standard for new Medicaid recipients, mastery of the commercial market, etc. Even those individuals and entities who have been doing this for many years will need the 2 day training – there will be new conflict

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	of interest standards, new substantive programs to learn about, new online systems to work with, etc. Consumers Union endorses the idea that all Assister trainings will be offered in English and Spanish at a minimum. We also believe that trainings should be offered in additional languages as needed, as the proposal suggests. Consumers Union appreciates the commitment to translation services in Spanish and at least 4 other languages initially and that information be delivered in a manner that is culturally and linguistically appropriate to the population served (e.g. LEP individuals and people with disabilities). We also encourage efforts to increase translation offerings to encompass all threshold languages after the initial time period. Consumers Union supports the proposal recommendation that Navigators and Direct Benefit Assisters be offered training in other programs for which consumers may be eligible (e.g. CalFresh, CalWorks etc.).
County Welfare Directors Association	• Training needs to be sufficiently robust to ensure accurate information and advice is given. The provision of both initial and ongoing/refresher training should be considered. • Given that we know separate (likely more detailed) training materials will need to be developed for county eligibility workers, we would be glad to partner with the Exchange, Administration and the assister network to ensure the development of complementary and consistent materials.
Fresno Healthy Communities Access Partners (HCAP)	• Possibly a volunteer advocate group should be developed as part of the training strategy for the most effective outreach to the large numbers in the first few years of the Exchange. Investment in this volunteer workforce can leverage the work of the CAAs very effectively.
Health Access	We question whether two days of training is sufficient: most application assisters for Healthy Families, a far simpler program, receive more training even though not required.
Health Consumer Alliance	We do not support the concept of two-day training, which could be insufficient. We support the concept of a training module for all assisters that is designed without timeframes as a component. There are significant changes to eligibility systems, income calculation, tax credits, benefits design, etc. HCA partners have experience in providing such trainings, and many are designed and administered on an issue-by-issue basis. Altogether, two days would not be enough time to cover a curriculum that explains all the changes taking place as well as how health coverage is delivered in the coming years. The training needs to build upon well-established methods of training which include imparting tools and troubleshooting skills as well as resources and substantive knowledge, using a very interactive and tools-based approach. The proposed outline for a curriculum is thorough and well thought out. The Project Sponsors should also consider who should

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	provide training, and whichever entity is chosen should not be associated with a Direct Benefit Assister.
Insure the Uninsured Project	ITUP supports the training recommendations made by RHA to the board. We would also like to underscore the importance of providing training in languages other than English and Spanish, as well as ensuring all assisters be educated on public and private programs.
LGBT Health Consortia	The Assisters training program requirement ensuring that Assisters are capable of meeting the needs of vulnerable and underserved populations should include a cultural competency training element with LBGT-inclusive curricula.
Los Angeles County Department of Public Health, Children Health Outreach Initiatives	• CHOI fully supports the recommendation of RHA that Navigators and Direct Benefit Assistors (DBAs) be offered and encouraged to be trained in other public assistance programs where consumers may be eligible (e.g.; CalFresh, CalWorks, etc.). This furthers the Exchange's values of being consumer-focused and willing partners with other agencies in bettering the health and well-being of all Californians. Offering enrollment assistance and referrals to these other programs also aligns the Exchange with current and proposed enrollment systems that allow for seamless enrollment across these programs. • CHOI support RHA's recommendation that Navigators and DBAs be associated with an enrollment entity, be required to attend a full two-day training and be required to adopt and comply with an Assister Code of Conduct Agreement, Assister Confidentiality Agreement and Assister Guidelines Agreement • CHOI strongly recommends that the topics of health coverage utilization, trouble-shooting, retention and referrals be addressed in the Assisters Training. At a very minimum, all Assisters must be trained on how to assist consumers with enrollment issues and be provided a comprehensive list of resources to refer consumers who need additional assistance with more complex trouble-shooting and retention issues. An additional, more in-depth specialized training on utilization and retention should be offered and incentivized for CAAs who work with populations that are at a higher-risk for churning and losing coverage. As will be evident in upcoming months with increased enrollment into Medi-Cal, more complicated cases will result as families begin to utilize Medi-Cal managed care systems and need to transition between managed care and fee-for-service Medi-Cal for specialty care or dental needs. Families will need assistance for the complicated work necessary in order to use their benefits and receive medical care.
Maternal and Child Health Access	MCHA has trained in California since the beginning of the Certified Application Assistors program and several of our staff were Master Trainers under RHA. • MCHA supports the recommendation of a two-day Assistors Training attended by both Navigators and Direct Benefit Assistors. • MCHA recommends that additional training take place within 1-2 months of initial training to ensure follow-up to questions Navigators encounter. • MCHA supports the recommendation of annual recertification training. • MCHA supports the idea that a specific number of application assistance be provided in the prior 12 months in order to maintain certification. We do NOT support the idea of a monthly number. • MCHA supports the Quality Assurance/Control point that additional trainings should be held based on issues found

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	with applications from an Entity, but believes such training should be required and not simply offered if there are problems with an EE's applications. • MCHA supports a real certification process that is not simply designed to be sure that everyone becomes a Navigator. We would hope that the Sponsors engage existing CAAs and others in the creation of a certification process. • MCHA strongly recommends against the possibility of a one-day or abbreviated training take place for "currently certified and active" CAAs and others for the following reasons: 1) the certifications differ for CAAs, HICAP, and health insurance agents and the definition of "active" is difficult to standardize among the types of trained individuals. 2) Enough changes are taking place with existing programs that it will be well worth everyone's time to attend two days. In our 16 years of training, we have found two days to be minimal to train on the myriad programs that exist for low income people in California in an interactive way that supports learning and real interest in doing the best possible job one can as an Assistor. • MCHA recommends that trainings be tailored to at least a few different subgroups and by regions. Insurance agents come from a different background than do non-profit organization staff. Those brokers who want to learn about public programs should be able to do so in a climate that acknowledges what they already know. Similarly, non-profit staff may not know much about commercial insurance offered to individuals and should be able to be taught at a level that acknowledges that fact and allows trainees to ask questions in a supportive atmosphere. • MCHA supports "Additional and Specialized Training" but this topic needs more exploration as to whether the trainings will be required and not merely offered when there are ACA regulatory changes and at other times.
PEACH	We support the overall structure of the proposed two-day annual training, annual re-training and certification for the Assistors Program and that the Exchange make available technical assistance for assisters through a toll-free phone number, online portal, webinars, and other communications and specialized training sessions as needed. In order to maximize the number of potential assisters, we urge the Exchange to offer these trainings and certifications at little or no cost. We also support the RHA recommendation that assisters be offered training in other programs for which consumers might be eligible, such as CalFresh and CalWorks. Although it should not be required of assisters to enroll individuals in these other public programs, we believe it is an important benefit to consumers that assisters be able to do so if they so choose.
Planned Parenthood Affiliates of California	We understand that given the complexity of the new programs and subsidies offered in the Exchange there needs to be a single standard that ensures consumer protection but it is concerning that DBAs would undergo the exact level of training as Navigators, but without any compensation. We recommend that web-based training be made available and that any required in-person training be held in multiple locations around the state to be easily accessible geographically, in order to avoid placing additional barriers on potential assister organizations.

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San Mateo County Union Community Alliance	RHA recommends: • Two-day Assisters Training Program. with abbreviated training for current Certified Application Assistors • Annual re-training and re-certification. SMCUCA agrees that consistent statewide training should be offered for all CAAs. But in San Mateo, unless the training is coordinated by the County, there will be duplicative training, or inconsistencies between the statewide CAA training and the robust training and certification programs currently offered by the San Mateo County Health Coverage Unit.
San Mateo Labor Council	• Consideration should be given to counties, such as San Mateo, where a robust assister training program is in place. Duplicative or inconsistent training should be avoided at all costs. • Abbreviated training should not be considered. There is much to learn about the public and private insurance markets for all assisters. Incorporate successful, relevant elements of existing training. • Agree with minimum of annual retraining and recertification requirements. Ongoing assessment of the need for periodic skill upgrade workshops should be considered and conducted as needed.
SEIU	We agree with the recommendation that all assisters meet the same training requirement to ensure that all assisters have a common understanding and baseline ability to support consumers. However, we believe assisters will need to have enough knowledge of both public programs and private insurance coverage to accurately present information to consumers and help them with their application choices. The training assisters program outlines over 16 topics, many of which are extremely complex that may not be fully understood in a short two day training course (p 23). While it's understood that too many training courses can deter groups from wanting to be assisters, we also would assert that program knowledge and efficiency is important to ensuring application information is accurate and consumers fully understand their options and choices. Assisters may need more hours of training beyond the two day training course to fully understand and be prepared to assist consumers.
United Ways of California	**A. UWCA agrees with RHA's recommendation that all types of Assisters be required to attend the same initial training and to offer an abbreviated training for certain categories of individuals** who are already performing some assistance functions (CAAs, health insurance agents, county eligibility workers, etc.). A comprehensive test on the various modules would be required to be able to opt out of the full training. **B. UWCA supports the annual recertification requirement** coupled with an annual retraining on specified topics. **C.** In recognition of the robust list of topics that will be covered during the initial training of assisters, **UWCA recommend that the length of the training not be determined by duration (i.e. 2 days), but instead be focused on the content that must be covered.** The training modules should be developed first, and the length of the training should then be set based on the amount of time required to fully cover each of the topics. **D. UWCA strongly recommends training on the other health and human services programs for which individuals may qualify be added to the list of topics covered in the initial training.** While not all navigators will assist with

Issue #3: Training	
Organization	**Comments**
	enrollment in these services, all would be better able to give adequate service to consumers if they had an understanding of the relationships consumers may have to other programs. Also, where possible, it would be beneficial to consumers to be efficiently guided/screened for or enrolled in other programs that will support their health and wellness, and this would be a huge stride toward a no wrong door enrollment system for all types of public benefits. **E. UWCA recommends that the CHBE offer a simple training for community groups and volunteers who will not be certified assisters but want to help spread the message that health options are available within their communities.** This simple "health options 101" type of course will ensure that even non-certified community messengers have the correct information and are in alignment with the messaging that is ultimately created for the exchange and other health coverage programs.

ISSUE 4

Issue #4: Assisters network recruitment and monitoring	
Organization	**Comments**
2-1-1 California	2-1-1 California encourages the Exchange to consider existing mission-driven organizations with experience to provide support statewide. We believe it is easier and more cost effective to expand existing capacity as opposed to investing in new,

Issue #4: Assisters network recruitment and monitoring	
Organization	**Comments**
	redundant systems. Those savings are better focused on the development of technical assistance to Assisters. We encourage the Exchange to partner with organizations that meet a pre-requisite level of experience, especially in the context of work in the health and human services continuum in order to quickly develop the navigation program in time for the pre-enrollment phase in October of 2013. 2-1-1 California believes that quality assurance is a critical component to successful implementation. We recommend that the Exchange develop the same standards for all navigator entities. Based on the recommendation detailed in the CCAN comments, we recommend that standards be tiered depending on the types of services sets of entities are providing, but they should consistent and clearly delineated within sets of entities performing the same type of assistance. We also recommend that standard reporting metrics, which include metrics on trainings and updates, so that progress can be tracked over the baseline, be developed as the program is designed. If there is a distinction between navigating entities and individual navigators, we recommend that quality assurance measures be clear between the two. 2-1-1 California strongly recommends that navigators be required to have a follow-up mechanism, as a means for assessing quality assurance and tracking individual outcomes, which can then be compared to State-level assessments and data.
AIDS Health Consortia	The draft plan states that recruiting a broad network of trained assisters with reach into diverse markets throughout California will be critical to ensuring the Program's success. While people currently living with HIV represent only around 110,000 Californians, they are a unique group with the challenge of transitioning from Ryan White programs to new forms of coverage. We urge the project sponsors to consider mechanisms for reaching the communities of those with chronic conditions, including people with HIV/AIDS, as well as geographic, cultural and linguistic target markets.
Anthem Blue Cross	Anthem supports the need for a robust plan to monitor the assisters program. We believe project sponsors should consider not only program quality and compliance, but should also consider the effectiveness of the assisters in successfully enrolling individuals into QHPs. Project sponsors should identify and address conflicts of interest, steering, and fraud, but it is critically important that given limited resources, project sponsors also consider the effectiveness of assisters when evaluating the program. Additional details should be provided regarding how this will be done. For example, will the Exchange use secret shoppers or monitor calls? Additionally, the Exchange should consider whether it would want to implement auditing that would track whether preferential plan enrollment is occurring. Lastly, the Exchange should consider who the determining entity will be on adherence and accurate representation of all plan benefit designs for all QHPs. We ask the California Exchange to consider how quality standards will be measured. Given ACA's restrictions surrounding the Exchange's ability to require navigators to have Errors and Omission coverage, we ask the Exchange consider setting standards to address what would happen in the event that a Navigator misquotes benefits. Additionally, we believe the Exchange should set standards that would trigger the termination of assister status.

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Organization	**Comments**
	Anthem would like to seek additional clarification about who would be considered an enrollment entity for purposes of the requirement that eligible assisters be affiliated with an enrollment entity. We are concerned that this requirement could conflict with the requirement that a DBA be "fair and impartial." Finally, Anthem would like to seek clarification regarding whether the Exchange will recruit new DBAs that may or may not already be affiliated with one or more health insurance carriers. Is the Exchange envisioning that sponsor recruitment will be different than the appointment process already conducted by health insurance carriers today?
Asian Pacific American Legal Center of Southern California (APALC)	**Network Recruitment** • We strongly support the two recommendations that the Project Sponsors: 1) recruit and monitor the Assister Network to ensure that the program maintains geographic, cultural and linguistic access to target populations; and 2) implement a robust plan for monitoring the Assisters Program to ensure program quality and compliance and to address conflicts of interest and fraud. (P. 24) • We appreciate the report's recognition of the diversity of California and we reiterate the importance of ensuring that: o There is geographic access to in-person assistance in each county. o Hard-to-reach groups, especially cultural and linguistic groups, have access to in-person assistance o Newly eligibles have access to assistance though channels that are familiar and aligned with their preferences. (Pg.25) **Recruitment Activities** (Pg.26) **Phase 1: Broad Outreach to Eligible Entities** • While we support the general recruitment activities listed in the report, we particularly like #4, which ensures that the assister's network is equipped to meet its responsibilities (Analysis of assisters network resources: Assess level of access to assistance and identify gaps in the network based on: a. Regions served b. Demographic served c. Languages d. Target markets and product coverage e. Level of capacity to provide assistance) **Phase 2: Targeted Approach** • We agree that "recruitment specialists" (as described in #5) could reach out to community based organization that have the experience and skills to reach out to potential CBOs and coalitions to be part of the assister's networks, such as the

Issue #4: Assisters network recruitment and monitoring	
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	Asian Pacific American Legal Center's Health Justice Network, the Southeast Asian Resource Center's Coalition, or California Pan-Ethnic Health Network's Having Our Say Coalition. These are statewide networks of organizations serving hard to reach communities and would become part of the network if they are not already. • With regard to #6, we recommend that the network be evaluated for its effectiveness in outreach and enrollment in hard-to-reach populations in its services area.
California Consumer Advocate Navigator Workgroup	**A. The proposal lacks structures that will ensure adequate program coverage across diverse populations.** The plan proposed by RHA does not build a program structure that will ensure that the navigator network adequately addresses the diverse populations within California. Nor does it address the need to create a program that builds in accountability for entities to understand local assistance needs and the flexibility to address the unique regional and even local context in deploying the right blend of navigator skills and resources within a geographic region. RHA envisions a system where any entity can apply and be certified as a navigator provided it meets the qualification requirements. The onus is then on the Project Sponsors or designated entity to recruit and monitor the network of DBAs and navigators to ensure that in every region of California, assisters are present and available to meet local assistance needs. We believe that the navigator program can be structured in such a way as to ensure that local and regional assistance needs can be met by relying on organizations present in those communities to identify and coordinate navigation. **B. CCAN recommends utilizing existing statewide networks that also have the local touch and accountability through affiliates or members to ensure that the more effective outreach and enrollment happens in each region of the state -- statewide reach, local touch.** Within a hybrid model blending the efficiency of a statewide grants model with the flexibility of a regional approach, navigator entities should be responsible for collaborating on an ongoing basis to analyze their collective ability to serve each region and sub-population. Where gaps in coverage or capacity are identified, grantee organizations could subcontract with other local community-based organizations that are able to reach targeted underserved consumer populations, and effectively supplement the existing program. Navigator entities would be accountable to the Exchange to provide effective coverage for the areas and populations that they serve.
California Hospital Association	CHA supports the goals of ensuring the Assister network includes geographic, cultural and linguistic access to target markets. Further, the Exchange should include in the Assister network includes any willing hospital that chooses to be an enrollment entity. Despite the comprehensiveness of a robust enrollment, outreach and education program – often the first time an uninsured individual comes in contact with the health care system is when they are clutching their chest in pain in a hospital emergency room. Therefore, it is imperative that hospitals willing to serve as enrollment entities be included in the Assister network as full, equal partners, with access to training, resources and compensation that is equal to all other Assisters across the state.
California Pan-	• **HOS recommends a regional approach to setting up the Navigator program as was done with the Naturalization**

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Organization	**Comments**
Ethnic Health Network and Having Our Say Coalition	**Services Program (NSP) which allowed local organizations to identify and fill racial, ethnic, and geographic gaps in assistance.** Outreach and enrollment efforts must take into account the unique ethnic, racial, and geographic needs of each region. It will be important for the Exchange Assister program to design an outreach and enrollment recruitment structure that is capable of ensuring that the unique needs of a community can be met.
California State Rural Health Association	**The proposal lacks policies and procedures that will ensure adequate program coverage across diverse populations.** The plan proposed by RHA does not build a program structure that will ensure that the Navigator network is adequate to reach and assist the state's diverse population in a culturally appropriate manner. Nor does it address the need to create a program that builds in accountability for entities to understand local assistance needs and the flexibility to address the unique regional and even local context in deploying the right blend of navigator skills and resources, say within a RURAL geographic region. The Navigator program ought to be structured in such a way as to ensure that local and regional assistance needs can be met by relying on organizations present in those communities to identify and coordinate navigation.
Centro Binacional Para El Desarollo Indigena Oaxaqueño	• It is important to be critical in the organizations or individuals that are invited to participate. We don't want to leave out organizations that have been reaching those hard populations. • We are a vital organization in this process as we outreach to the indigenous populations that speak *Mixtec, Zapotec, Trique* amongst other languages. • It's important to take into account the trust and credibility barrier that a new organization has when outreaching to the community. Make sure that these organizations that have that trust and credibility already established are part of this process.

Clinica Sierra Vista	• Health center assisters are the ultimate neutral third party enroller. As all federal and state funder insurance programs are required by law to allow their clients to access health center care, we have no vested interest in which product a patient enrolls in but rather can help a patient make the best decision for their individual and family needs.
	• The issue of productivity was raised.
	  ○ Our health center CAA's regularly process 10-12 application and/or renewals a day. Taking and processing applications at this level requires a level of oversight and quality control that few organizations can support but this kind of quality is woven into the health center culture.
	• Assistor competency.
	  ○ We are very concerned about competency in the community in a volume driven application environment. We have established a cross training program with our county based assistors to ensure our applications have a minimal rejection rate (<98%) which is evaluated by the county quarterly. None of the other CAA groups in the community while well intentioned are willing to commit to those standards. We expect that this board will require this kind of commitment to excellence.

Community	We commend the inclusion of language that requires project sponsors, or their designated entity, to ensure the assisters

Issue #4: Assisters network recruitment and monitoring	
Organization	**Comments**
Health Councils	program maintains geographic, linguistic, and cultural access. With close to 5 million residents enrolling in coverage in 2014, some for the first time in a very long time, California must utilize the assisters program to maximize access to assistance based on population and demand throughout the state. The project sponsors' recruitment strategies will ultimately determine if the assisters program succeeds of fails in providing access to enrollment support for diverse communities across the state. We agree with the recruitment activities outlined by RHA (pg. 25), but recommend an assessment of the pool of potentially eligible individuals (for public, subsidized or unsubsidized health coverage) be included in the criteria on pg. 25.
Consumers Union	Consumers Union appreciates the commitment to ongoing evaluation and a comprehensive review of the Assister program's impact and costs after the first year to inform any mid-course corrections. Consumers Union, however, is concerned that the plans for monitoring and oversight are too vague in the RHA proposal. Though it is mentioned, we would like to see more description of how the Project Sponsors will provide oversight and monitoring of the Assister program. This will be important for tracking steering and other potential problems AND for building on what's working well. For example: • How will Project Sponsors track Navigators and Direct Benefit Assisters? E.g. each entity should have an entity certification number and individuals working on behalf of that entity should have their own certification numbers that create an identifier that can track them as an individual Assister but also track them back to the entity they are associated with. • Which of the Project Sponsors will be primarily responsible for oversight? As with CALHEERS governance, we believe it is vital to spell this out the governance and accountability structure anticipated for the Assister program. A numerical minimum of enrollments, as proposed, showing the previous provision of assistance in order to renew certification is logical, but the example of 5-10 enrollments per year seems extremely low. A higher expectation should be set to ensure that Assister program resources, including training and certification, are placed with those entities that can maintain and provide robust and vigorous assistance throughout the year. At the same time, we recognize that special, harder to serve populations may take a good deal more time to enroll and warrant a lower volume expectation
County Welfare Directors Association	• It is important that an up to date listing of trained available assisters be made readily available to county eligibility staff as well as to the broader public and potential customers and maintained, including regular updates. • The oversight mechanisms and which of the project sponsors have responsibility for oversight should be more clearly elucidated.
Health Consumer Alliance	We are glad to see the concept of Network Adequacy applied to Assisters. Metrics to assess adequate networks should be developed. They should incorporate factors such as capacity to serve diverse communities, geographic location, existing ties and trust from the community, and levels of expertise in helping people obtain health care. Those levels should be weighted should the Project Sponsors have to award Entities on a competitive basis.

Issue #4: Assisters network recruitment and monitoring	
Organization	**Comments**
	Also, there should be a priority to recruit Assisters who perform enrollment in the Low-Income Health Program, FPACT, Medi-Cal, Healthy Families, other programs used by low-income health consumers and other state programs where many enrollees will transition to Medi-Cal in January 2014. These groups will have access to those enrollees and should be accounted for.
Insure the Uninsured Project	ITUP supports the assister network recruitment and monitoring recommendations made by RHA to the board, particularly its emphasis on recruitment based on geographic, cultural/linguistic, and market segment access.
Kaiser Permanente	Ensuring a robust network of navigators is important; we do not believe this function should extend to direct benefit assisters, however.
LGBT Health Consortia	Monitoring by Project Sponsors to ensure cultural and linguistic access should include a survey of the effectiveness of Assister program activities in serving and engaging the LGBT community.
Los Angeles County Department of Public Health, Children Health Outreach Initiatives	• CHOI supports RHA's recommendation that assister resources be more heavily targeted in areas where the greatest opportunity exists. Particular heavy recruitment should take place in Los Angeles County, which has the largest number of uninsured, Exchange-eligible consumers in the state and also the greatest number of newly eligible cultural and linguistic groups who would not enroll without assistance. • It is in the Exchange's and RHA's interest to partner with Los Angeles County Department of Public Health to help facilitate general and targeted outreach to existing assistance resources/Enrollment Entities in this area. With 10 years of experience contracting and auditing community agencies in the area of health coverage outreach, enrollment, utilization and retention (OERU), CHOI has helped build a network of enrollment experts who are a trusted source of assistance and information in their communities.
Maternal and Child Health Access	• MCHA agrees with CCAN that the proposed plan needs to better address geographic and population diversity. The Assistor networks should be regional, feeding into a statewide network. • MCHA believes the Assistor network should be much more interactive and interlocked than it is currently for Medi-Cal and Healthy Families. Handoffs to other Assistors should be monitored and outcomes reported. Agreements between and among groups with varying experience or that specialize must be real and not just on paper. • MCHA agrees with RHA that the Project Sponsors should implement a robust plan for monitoring the Assistors Program to ensure quality, compliance and to identify and address conflicts of interest, steering and fraud. MCHA believes the Sponsors should engage current CAAs and stakeholders for their ideas as the CalHEERS electronic portal is built and solicit ideas for the RFP for the entity that will oversee and engage Assistors.
PEACH	Ensuring that assisters provide fair and impartial information to enrollees is critical to ensuring consumers receive the coverage that best meets their needs and preferences. PEACH fully supports the development of a strong plan for monitoring the assisters program to protect against conflicts of interest, "steering," and fraud. PEACH recommends that this plan be developed with stakeholder input, including the hospital community, to ensure the appropriate monitoring and accountability measures are established.

Issue #4: Assisters network recruitment and monitoring	
Organization	**Comments**
San Mateo County Union Community Alliance	RHA recommends: • The Exchange will recruit and monitor the Assister's network, including both Direct Benefit Assisters and Navigators to ensure that the program maintains geographic, cultural and linguistic access to target markets. • The Exchange will ensure program quality and compliance and to identify and address conflicts of interest, steering and fraud. As noted above in the "Eligibility and Standards" comment and in the attached CHRAC White Paper, if the Assister's network in San Mateo County is comprised of a different set of community-based navigators and direct benefit assisters, then there will be inconsistencies and inefficiencies in the system. While we recognize that most counties do not have as robust a system of certified application assisters and outreach programs as San Mateo, the recommendations should be amended to allow the County to serve as the coordinator of enrollment entities and should play a strong roll in recruiting and monitoring those navigators who are working in San Mateo County.
San Mateo Labor Council	• With oversight and directive from the Exchange, county government should be designated to recruit and monitor the assisters network. This is of particular importance in counties, such as San Mateo, where a robust assister network exists. • Build on and leverage existing successful local networks
SEIU	p. 17—For those counties who employ eligibility workers, CAAs and greeters to provide application assistance, will those workers have to be "certified" by the "Marketplace"? P. 24 – it is not clear who would be responsible for oversight and ensuring accountability over the assisters program.
United Ways of California	**UWCA recommends utilizing existing statewide networks that also have the local touch and accountability through affiliates or members to ensure that the more effective outreach and enrollment happens in each region of the state--statewide reach, local touch**. An important factor will be the geographic scope of Navigator entities. We encourage the CHBE/Project Sponsors to give serious consideration to the impact of geographic scope to the consistency of quality, responsiveness, training, and performance from region to region. California and the marketplace would benefit from partnering with navigator entities that can work throughout the State or that can deliver a consistent level of effective, high quality service across the state with attention to the dynamics of local markets. Accordingly, UWCA urges CHBE/Project Sponsors to seek to use existing statewide networks that also have the local touch and accountability through affiliates or members to ensure that the more effective outreach and enrollment happens in each region of the state. Examples of this type of organization include, but is not limited to, 2-1-1CA, CFRA, CCHI, UWCA, Promotores, CSRHA, etc.) The current proposal lacks structures that will ensure adequate program coverage across diverse

Issue #4: Assisters network recruitment and monitoring	
Organization	**Comments**
	geographic and population coverage by organizations that both know the regions and can hold their members accountable to both the CHBE and their local communities. Flexibility to address the unique regional and even local context in deploying the right blend of navigator skills and resources within a geographic region is also needed. RHA envisions a system where any entity can apply and be certified as a navigator provided it meets the qualification requirements. The onus is then on the Project Sponsors or designated entity to recruit and monitor the network of DBAs and navigators to ensure that in every region of California, assisters are present and available to meet local assistance needs. UWCA believes that the navigator program can be structured in such a way as to ensure that local and regional assistance needs can be met by relying on organizations present in those communities to identify and coordinate navigation.

ISSUE 5

Issue #5: Timeline for implementation	
Organization	**Comments**
2-1-1 California	2-1-1 California supports the CCAN recommendation that the Exchange consider offering start-up grants to navigator entities to cover startup costs in 2013. In order for navigators to hit enrollment targets in Fall 2013 and Spring of 2014 the Exchange

Issue #5: Timeline for implementation	
Organization	**Comments**
	should compensate organizations for project startup costs.
Asian Pacific American Legal Center of Southern California (APALC)	**Payment** • We are seriously concerned about the issue raised in the report regarding the timing of the payment to Navigators so late in the process. CBOs and other non-profits cannot be expected to carry out the enrollment activities without any funding or compensation. If payment is not provided until February 14, 2014, at least 3 months after Navigator's provide assistance, or even later if they begin sooner in 2013, other incentives, including grants, should be provided to drive enrollment during this period. In fact, we would want enrollment to begin as early as possible. **Actions (**P. 27) • We recommend that the recruitment activities be included in the timeline since they are such a critical component of an effective implementation plan.
California Consumer Advocate Navigator Workgroup	**(A) CCAN recommends that the Exchange consider offering start-up grants to navigator entities to cover startup costs in 2013**. In order for navigators to hit enrollment targets in Fall 2013 and Spring of 2014 the Exchange should compensate organizations for project startup costs. It is unrealistic to expect community-based organizations and navigator entities to shoulder the costs of conducting navigation activities for months without compensation.
California Coverage and Health Initiatives	**CCHI recommends that the Exchange consider offering start-up grants to navigator entities to cover startup costs in 2013-2014**. In order for navigators to hit enrollment targets starting in Fall 2013, the Exchange should compensate organizations for project startup costs. It is unrealistic to expect community-based organizations and navigator entities to shoulder the costs of conducting navigation preparation and activities for months without compensation.
California Family Health Council	The timeline is unclear regarding an application process or certification for being a Navigator or Direct Benefit Assister. More information is needed to give community organizations and health providers sufficient notice so they may fully consider if and when to build these pieces into their work plans.
California Hospital Association	CHA supports the draft timeline outlined in the Design Options document.
California Pan-Ethnic Health Network and Having Our Say Coalition	• **HOS recommends that the Exchange provide funding or establishment grants well ahead of enrollment periods in 2013 and 2014.** In order to maximize enrollment, the Navigator program should be established and fully funded in advance of the October 2013 enrollment date. This will help to ensure that enrollment entities can hire and train staff and begin to conduct navigation activities leading up to enrollment. This is especially important for small, community-based organizations that will be unable to shoulder start-up costs without proper reimbursement. Ensuring that Navigators are trained and provided with the necessary resources early will additionally help to dispel any myths or confusion as a result of deceptive marketing practices leading up to the open enrollment period in October 2013.
California State	**CSRHA supports CCAN's recommendation that the Exchange consider offering start-up grants to navigator entities**

Issue #5: Timeline for implementation	
Organization	**Comments**
Rural Health Association	**to cover startup costs in 2013**. In order for navigators to hit enrollment targets in Fall 2013 and Spring of 2014 the Exchange should compensate organizations for project start-up costs. It is unrealistic to expect community-based organizations and navigator entities to shoulder the costs of conducting navigation activities for months without compensation.
Centro Binacional Para El Desarollo Indigena Oaxaqueño	• Need to fund and train Navigators ahead of 2013 • For some small CBO's it might be difficult to afford to pay up front. • Making the outreach and enrollment money available for this. • After the first year rolls out, suggesting that compensation is given upon completion of enrollment.
Community Health Councils	We recommend compensation for the assisters program begin in the summer of 2013 (to help organizations build capacity to support OERU assistance) and that payment for assisters begin in October 2013. Given that there may be significant startup costs, many organizations may not have initial reserves to wait until February 2014 to receive payments. In order to ensure their staff participate in trainings during the summer and are ready to conduct activities in October 2013, organizations will need to receive some initial funding.
Consumers Union	It will be important to hire and train people to provide assistance prior to October 2013. As noted below (#6 compensation), we think that expecting entity organizations to be able to hire, train and provide assistance at least six months before any compensation is available (not until February 2014) is problematic for many organizations. We support a hybrid model of compensation based primarily on grant funding to ensure that the timing for implementation for the initial enrollment period allows California to reach out to and help as many people as possible get health coverage.
Health Consumer Alliance	As media efforts roll out, it will be important to have Assisters ready to prior enrollment kickoff. It is noted in the report that compensation should start February 1, 2014; compensation should begin at Enrollment start dates, as it has been recommended that there be an open enrollment period before January 2014. Finding ways to fund Assisters with a dearth of federal funding will be important. Tapping into existing state funding streams that currently fund assistance in the regulatory agencies, and private foundations should be considered.
Insure the Uninsured Project	ITUP supports the timeline for implementation recommendations made by RHA to the board.
Los Angeles County Department of Public Health, Children Health Outreach Initiatives	• The length of time for curriculum development (3-4 months) can be made more efficient by reviewing existing CAA curriculums and funder's Scopes of Work with agencies who conduct health coverage outreach, enrollment, retention and utilization (OERU). CHOI would be glad to share information regarding its scope of work, objectives, deliverables and sample reporting activities with RHA and the Exchange to help facilitate this process. CHOI would also be glad to share information on its OERU database, which collects and monitors every outreach, application, enrollment, retention and utilization activity conducted by its contractors.

Issue #5: Timeline for implementation	
Organization	**Comments**
Maternal and Child Health Access	The timeline appears very ambitious and start-up costs for the process will be necessary. Pre-enrollment must be carefully handled to avoid confusion and inaccurate expectations. The Children's Health Outreach Initiative in Los Angeles, of which MCHA is a part, has extensive experience with creating "interest lists" and groups such as these should be consulted more directly as the pre-enrollment period gets closer.
SEIU	Given the short timeframe needed to identify and establish the network of assisters as well as establish the training and curriculum requirements, we encourage HBEX to establish a workgroup ASAP to begin work on implementation that can leverage existing resources that includes but not limited to representatives from labor, consumer advocates, health care industry and workers, counties, and all other key stakeholders.
United Ways of California	**UWCA recommends that the CHBE consider offering establishment grants to navigator entities to cover startup costs in 2013**. In order for navigators to hit enrollment targets starting in Fall 2013, the Exchange should compensate organizations for project startup costs. It is unrealistic to expect community-based organizations and navigator entities to shoulder the costs of conducting navigation preparation and activities for months without compensation.

ISSUE 6

Issue #6: Navigator compensation design options	
Organization	**Comments**
2-1-1 California	2-1-1 California supports the comments and recommendations made by CCAN and UWCA around compensation. Additionally, we encourage the Exchange and RHA to consider the compensation amount as an incentive to greater

Issue #6: Navigator compensation design options	
Organization	**Comments**
	enrollment/participation in the first years. Implementation of the Affordable Care Act affords California with a tremendous opportunity. We believe that compensation be thought of as way to capitalize on the momentum around availability of insurance through the Marketplace and the expansion of Medicaid, and increase enrollment dramatically. The free media and momentum of 2014 are so great that it provides all stakeholders with the opportunity to make a concerted enrollment effort in the first couple of years. A great and successful enrollment effort will address the issue of broadening the risk-pool and could also incentivize the creation of robust systems and practices on the part of navigators, which can bear fruit in later years. We encourage the Exchange to consider mechanisms for enrolling quickly and broadly, and use funding as one of those mechanisms for incentivizing navigators to successfully enroll applicants in the first couple of years.
AIDS Consortia	The draft plan recommends that the project sponsors consider a pay for enrollment option for the compensation of Navigators where successful enrollment in an Exchange program or plan results in a fixed fee payment to the enrollment entity. We believe that a compensation design that is tied solely to successful enrollment will not be sufficient to engage and retain people with HIV/AIDS and other vulnerable Californians in new insurance coverage. The draft plan's proposed one-size-fits-all compensation could encourage enrollment entities to encourage navigators to spend less time per-patient in order to increase the number of patients enrolled overall, and, therefore, increase compensation. Without an appropriate focus on quality of effort given to each new enrollee and lacking compensation for post-enrollment utilization and retention services, the recommendation could lead to enrollment into plans without the necessary consideration for network adequacy, access to services, and pharmacy sufficiency that are all key considerations for people with HIV/AIDS. These concerns lead us to make three specific recommendations for changes in the draft plan's proposed compensation design. First, we recommend that the state consider the "hybrid model" (p. 6 and p. 32) which was RHA's number two recommendation behind set compensation based on successful enrollment. We believe that utilizing targeted grants coupled with direct compensation could allow some current Ryan White providers to participate in the Navigator program, thereby leveraging the experience that has been developed over the last 20 years reaching out to and serving people with HIV/AIDS. We also recommend that people with HIV/AIDS and other chronic conditions be included in targeted populations. Second, we recommend that the state consider compensation for engagement and other post-enrollment activities, at a minimum for particularly vulnerable sub-populations, such as some people living with HIV and other chronic conditions as well as healthy populations with additional navigation needs. Although it would require an initial investment, we believe that it will result in long term program success and, ultimately decreased administrative cost for re-enrollment and engagement, as well as better health outcomes for newly insured Californians. Third, while the draft plan recommends further consideration of compensation for re-enrollment, we recommend that re-

Issue #6: Navigator compensation design options	
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	enrollment be compensated at least for certain chronic condition patient populations, including people with HIV/AIDS, and for other vulnerable populations.
Anthem Blue Cross	Anthem supports a pay for enrollment model; however, we strongly discourage the Exchange from implementing a pay for renewal model or a hybrid of the two models. We are concerned that setting renewal rates lower than the application fee would lead Navigators to not pursue renewals; this could lead to beneficiary disruption if Navigators encourage enrollees to change plans every year. Additionally, the report suggests that while post-enrollment services are optional, they are encouraged. We are concerned that at the proposed compensation levels, these entities will not have the wherewithal to conduct activities beyond actual enrollment. Anthem is also concerned about the proposed compensation scheme of $58 per enrollee. The report predicts that enrollment in 2014 will exceed over 1,000,000 with 25,000 entities assisting with enrollments. Based our experience in the current market, that approximately 20 percent of agents sell 80 percent of the business, we believe there will likely be roughly 5,000 assisters serving 800,000 enrollees. This means each assister will roughly enroll 160 individuals at $58 per enrollment; assisters will make less than $10,000 a year. We concerned about the livelihood of assisters; under this model this could not be the sole focus or job of any assister. Furthermore, beyond 2014, enrollment is expected to decline, so while renewal streams are possible, the available projected market is expected to fall by close to two thirds, providing even less opportunity for sustaining a livelihood in this space. Anthem is concerned about the significant resources the California Exchange is devoting to the Navigator program. Specifically, we would like to ensure that the Exchange consider that although a significant number of enrollees will need assistance during the initial open enrollment for the 2014 plan year, we are not anticipating the same amount of resources will be needed in subsequent years. We ask that the Exchange carefully consider how to best spend the $4.8 million dollars currently allocated to Navigator recruitment and development given the potential for significantly less resources post-2014. We want to ensure the exchange considers what the role of Navigators will be once the need for assistance drops significantly. We are concerned that agents assisting Medi-Cal enrollment are not being compensated, and thus caution a model where agents would be required to promote enrollment in a program without any financial incentives. As the number of individuals eligible for Medi-Cal increases, and agents are able to receive compensation through other channels, they will not be able to afford to devote resources to uncompensated enrollment. We believe that unless agents are appropriately compensated, ensuring individuals are referred to Medi-Cal could pose a challenge. Agents should have direct financial incentives to assist with any services they provide to facilitate enrollment. We strongly believe this should not be considered a cost of doing business.
Asian Pacific American Legal	**Payment Options** • We would recommend a higher payment than the recommended $58, which does not truly pay for the time and

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Center of Southern California (APALC)	resources that are needed to assist an individual through the entire enrollment process. Although it is hoped that the enrollment can be done in "real-time," many enrollees will take much more time to determine the appropriate program or plan for them. Even the higher fee of $87 may not adequately compensate the assister, given the experience of current Certified Application Assisters but would be closer to fair payment to the assister. • We would also support a renewal fee to encourage retention of enrollees, which is a serious problem with many new enrollees, especially if this is the first time they have had health insurance. **Additional Compensation Model** • We strongly support the hybrid model that includes both the grants model and the pay for enrollment. We believe that this may be a way to provide compensation if the Exchange had to wait until 2014 to pay for Navigators to assist enrollees. Many CBOs and non-profit organizations would conduct enrollment activities if provided funding through grants.
Blue Shield of California	Blue Shield of California supports the following proposed recommendations in regards to Navigators and Direct Benefit Assisters (DBAs). • A per enrollment fee of $58 for Navigators is reasonable and mirrors the successful process established for CAA's in the Healthy Families program when it was first launched. • A $25/renewal fee is warranted initially and will encourage continuous enrollment in the Exchange. Continuation of such renewal fees should be re-evaluated after the first few years to determine whether these fees are cost effective. • Those with a direct business interest in enrolling individuals should not be compensated. Richard Heath and Associates estimate that number of applicants needing assistance will be high, especially in the early years, ranging from 50-75% of applicants. These same estimates project that a $58/enrollment fee would cost between $45-72 million in 2014. Several stakeholders have argued that direct benefit assisters should be compensated and that a per enrollment fee is not sufficient and should be supplemented by additional grants to select Navigator organizations. • Any supplemental grants should be awarded through the marketing campaign discussed below and funded primarily through California foundations and grant making organizations which have historically provided funding for such purposes. • The Exchange needs to continually bear in mind that administrative costs not funded through Federal grants or through non-profit grant making organizations will ultimately be borne by the consumers purchasing products through the Exchange.
California Association of	CAHP would like additional information and clarification on the rationale behind the requirement for parity in compensation inside and outside of the Exchange. Including information on the authority of the Exchange to implement such a requirement

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Health Plans	and the impact it will have on the payment arrangements plans will have with agents. CAHP believes that the enrollment strategy should be based on Assisters receiving compensation per each successful enrollment into a QHP.
California Consumer Advocate Navigator Workgroup	**A. CCAN strongly recommends the Exchange consider the Hybrid model for navigator compensation**. The RHA paper presents a viability and feasibility analysis based on the extent to which each design option contributes towards the achievement of the primary goals of the assisters program. Five key criteria were established. We believe that the RHA analysis of the Hybrid compensation model demonstrates the superiority of the Hybrid model over all others, offering the most benefit with the fewest drawbacks; a. Enrollment. Likely to result in higher enrollment relative to no compensation and other two compensation models. Assistance level matches assistance need, resulting in the lowest assistance gap of all models. b. Cost effectiveness. More cost effective than Grants only, but there is no mechanism for recovering grant funds if performance criteria are not met for the portion allocated to grants. c. Target Market Access. Allows for greater targeting of resources and broader participation of organizations with established relationships with market segments. d. Consumer Experience. Produces the largest navigator pool; likely to improve the "no wrong door" consumer experience and create a minimal assistance gap. e. Quality Assurance. Project Sponsors have greater authority to establish, monitor and hold assisters accountable to stringent QA. **B. A compensation program that relies solely on a pay per enrollment model creates barriers for both consumers and navigators in hard-to-reach populations therefore navigators should be compensated through a combination of grants and enrollment fees.** Enrollment fees can be used in combination with grants as a way of encouraging navigators to meet certain benchmarks around hard-to-reach populations. A compensation program that relies solely on a pay per enrollment model creates barriers for both consumers and navigators in hard-to-reach populations. a. Pay for enrollment creates a disincentive to serve hard-to-reach consumers. Compensating navigators with one fixed reimbursement rate per successful enrollment creates a disincentive to serve hard-to-reach consumers who require disproportionate time and staff resources. b. Pay for enrollment disproportionately excludes organizations serving the underserved. The pay for enrollment compensation model delays the navigator's receipt of compensation, requiring more up-front investment by the navigator or navigator entity. This is a barrier for many organizations that would otherwise participate in the navigator program, but cannot afford to cover infrastructure and staffing costs up front. This will disproportionately exclude those organizations with access and expertise in serving the underserved and hard-to-reach. This model would also require robust IT systems to properly track transactions, execute payments,

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	and conduct regular system audits. Organizations with access to hard to-reach or target markets may not have the necessary IT systems and infrastructure to participate in this type of compensation model. **C. The justification for a Pay for Enrollment model requires deeper analysis.** The current RHA analysis does not adequately explore the benefits of a Hybrid model. a. Inadequate evaluation of alternative models. The RHA presentation fails to demonstrate the superiority of the Pay for Enrollment model in comparison to the Hybrid model. The report lists the benefits of the Pay for Enrollment model in comparison to a No Compensation model, however the benefits of the Pay for Enrollment model in comparison to the Hybrid model are not adequately explored. We believe that a thoughtfully designed Hybrid model would create a robust network of navigators while also adequately controlling costs and ensuring a manageable infrastructure. b. Benefits and drawbacks of the model require further explanation. The RHA presentation states that the challenges associated with the Pay for Enrollment model include, "Assisters may focus on easy to reach consumers and those with more complicated cases may have less access to assistance." The likelihood that consumers most in need of assistance would be left out under a Pay for Enrollment model should be a deterrent to adopting it. Many assisters are on the brink of financial sustainability, and if serving the hard-to-reach consumer is a net financial loss, they are simply not able to do so and keep their doors open. We believe the Hybrid model would dramatically reduce this type of consumer neglect by removing the financial disincentive, and potentially introducing incentives, to serve the hard-to- reach. c. Does not account for diverse consumer assistance needs. A compensation model that offers one fixed reimbursement rate per enrollee assumes a fixed average investment of navigator time and resources per enrollee. This model fails to adequately account for the wide variation in consumer assistance needs among California's diverse populations. We believe a more appropriate model would acknowledge the broad range of time and resources navigators will be required to invest in different consumer subpopulations. A Grants model, Hybrid model, or even a Pay for Enrollment model offering variable reimbursement rates would ensure more adequate and equitable compensation among navigators serving high-needs populations. **D. The Pay for Enrollment model does not adequately reflect the full range of services performed by navigators.** a. Outreach to consumers to initiate enrollment process. In many communities, significant amounts of local, in-person outreach will be required before consumers are willing to initiate the enrollment process. Navigators will engage in this ongoing function as a necessity for driving enrollment in many regions, and the costs they will incur while doing so are not reflected in the reimbursement rate calculation made by RHA. b. Promote utilization of coverage. Navigators will also perform the vital work of promoting utilization of health coverage for their clients. It is reasonable to assume that clients who rely on navigator assistance to complete their application for coverage will also need assistance in understanding how, when, and where they can use their coverage. They will also likely be the resource consumers go to for information and assistance around

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	other health and wellness services and supports, and for answers to simple questions as they receive paperwork by mail from plans. c. Promote retention of coverage. Consumers who receive navigator assistance to enroll in health coverage are likely to prefer to work with the same entity or individual for renewal of coverage. The RHA paper suggests that the health plans will be financially motivated to support retention. However, this alone will be insufficient to meet the needs of many consumers, especially those who tend to churn in and out of coverage. Most health plans will not have the capacity and cultural and linguistic competence to perform the in-depth assistance needed by many consumers. Furthermore, many consumers will feel more comfortable going to a navigator who has earned their trust. **E. The methodology utilized to set the level of enrollment fee in the RHA recommendations lacks rigor, transparency, and incorporates unverified assumptions.** Overall, RHA's enrollment projections and reimbursement rate calculations do not accurately reflect the realities of assisters. a. The productivity assumptions do not take into account that many assisters work part-time. Most outreach and education staff work part-time or may only devote a portion of their working hours to actual health insurance application assistance. This is unlikely to change under a $58/application Pay for Enrollment model, and it is unclear whether the assumptions in the RHA calculations of enrollment productivity adequately reflect this and bear out its consequences for meeting enrollment goals. b. The actual cost of conducting a successful enrollment is well above $200 per enrollment. A survey of numerous existing enrollment entities in the current public and private coverage systems reveals that the actual cost of conducting activities up to and through enrollment is well above $200 per enrollment. With costs of more than $200/per enrollment, the recommended $58 fee does not "fully cover the cost" of employing navigators as suggested by RHA. Even the highest fee proposed by RHA ($87) would only defray roughly 43% of the cost of conducting an enrollment. c. The RHA methodology makes unverified assumptions about the costs of employing navigators and time spent completing the application. The methodology does not appear to consider a diverse range of navigators and client needs, or account for the time spent acquiring a client. The resulting recommended enrollment fee, thus, bears little relationship to the actual cost of employing navigators and engaging in outreach and enrollment assistance in the new health care system. **F. CCAN recommends that, if a per enrollment fee is to be set, the Exchange engage the appropriate experts and stakeholders to develop a more rigorous, evidenced-based methodology to ensure a fee that fairly compensates navigators.** At a minimum, such a methodology must: a. Take into account the true and complete cost to an entity of doing an enrollment, including the time, expenses, salaries and overhead expended in conducting education, outreach, and enrollment assistance up to the point of the actual enrollment, time spent providing information on utilization and retention of coverage, and

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	miscellaneous tasks such as troubleshooting enrollment glitches; b. Consider the added complexities and time demands resulting from bringing new electronic systems on line, counseling on complex new coverage options, explaining and assisting with calculation of advance premium tax credits, and unforeseen new system complexities; and c. Set a fee level only after thorough and transparent evaluation of actual costs incurred by existing assisters, and projected costs for a variety of potential navigator entities. Enrollment fees should be reevaluated on an annual or bi annual basis and adjusted to reflect the realities of current market conditions. Most importantly, enrollment fees should reflect the actual and complete cost to navigator entities of delivering an enrollment to the Exchange. **G. CCAN strongly recommends that, if the Pay for Enrollment model is adopted, the fee is paid per person successfully enrolled.** The Exchange should clarify whether the compensation models are based on a pay per application or pay per enrollment basis. The report is ambiguous as to whether the "Pay for Enrollment" model recommended will be a payment per person enrolled or per application. This distinction is very important. While the cost modeling appears to indicate a fee of $29, $58, or $87 would be paid to an enrollment entity per person enrolled, the text actually uses the term "per application." When families enroll it is frequently the case that several family members will be included on one application. Therefore, it is important to make clear whether the Pay for Enrollment program will compensate an enrollment entity for each person successfully enrolled as opposed to payment for a successful application (which might result in multiple successful enrollments.) Large family applications can take significantly longer to assist. Therefore, CCAN strongly recommends that, if the Pay for Enrollment model is adopted, the fee is paid per person successfully enrolled.
California Coverage and Health Initiatives	**Navigators should be compensated through a combination of grants and enrollment fees.** While CCHI acknowledges and appreciates that RHA recommends a grant program as part of the marketing effort, CCHI recommends that a grant program be part of the navigator program as well. We encourage the Exchange to consider adoption of the Hybrid Compensation Model presented by RHA in the addendum rather than only the Pay for Enrollment model. To have a navigator program that can fully reach all the populations who will need to enroll, including vulnerable and hard-to-reach populations, organizations will need incentives to go after the hard-to-reach. The pure Pay for Enrollment program provides a disincentive to work with hard-to-reach populations. Moreover, CCHI believes that the education and outreach aspect of the navigator program should be closely linked and connected with the enrollment assistance and other components of the program. We believe that the current recommendation which provides grants only through the Marketing program creates an artificial schism between these important sets of navigator activities. Finally, we are concerned that a grants program housed only within the Marketing program and funded with short term federal funds, would not provide a stable, long term funding source for grants related to navigator education and outreach activities. We recommend that the Exchange consider the Hybrid Model and create a grant program as part of

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	the navigator program. **Setting the appropriate level of compensation for enrollment fees.** The methodology utilized to set the level of enrollment fee in the RHA recommendations lacks rigor and transparency. The RHA methodology incorporates unverified assumptions about the costs of employing navigators and time spent completing the application. The methodology does not appear to consider or account for the time spent acquiring a client. The resulting recommended enrollment fee, thus, bears little relationship to the actual cost of employing navigators and engaging in outreach and enrollment assistance in the new health care system. We recommend that if a per enrollment fee is going to be set, the HBEX engage the appropriate experts to develop a rigorous, evidenced based methodology and then set a fee that fairly compensates navigators for the work they do conducting education, outreach and enrollment assistance. At a minimum, such a methodology must: • Compensate for the true and complete cost to an entity of doing an enrollment (which includes the time, expenses, salaries and overhead expended in conducting education, outreach, and enrollment assistance up to the point of the actual enrollment) • Compensate an entity for time spent troubleshooting enrollment glitches • Project enrollment cost estimates and set a fee level only after thorough and transparent examination and analysis of actual costs incurred by existing assistors and discussion and data from a variety of potential navigator entities • Take into account the simplifications that will ensue as a result of the new electronic portal, Medi-Cal simplifications and electronic verification • Take into account the added complexities and time demands resulting from bringing new electronic systems on line, counseling on complex new coverage options, explaining and assisting with calculation of advance premium tax credits, and unforeseen new system complexities Surveying of numerous existing enrollment entities in the current public and private coverage systems reveals that the actual cost of conducting activities up to and through enrollment is well above $200 per enrollment. With costs of more than $200/per enrollment, the recommend $58 fee does not “fully cover the cost” of employing navigators as suggested by RHA. Even the highest fee proposed by RHA ($87) would only defray roughly 43% of the cost of conducting an enrollment. CCHI recommends that enrollment fees be set according to a sophisticated methodology developed by appropriate experts. Enrollment fees should be reevaluated on an annual or bi-annual basis and adjusted to reflect the realities of current market conditions. Most importantly, enrollment fees should reflect the actual and complete cost to navigator entities of delivering an enrollment to the Exchange.
California Family	Both Navigators and Direct Benefit Assisters should be compensated for any staff time dedicated to outreach and enrollment.

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Health Council	Non-profit health organizations are guided by missions to best meet the needs of their patient populations. Therefore, the assertion that there would be a conflict of interest across the board is a false one and should not restrict the ability of all Direct Benefit Assisters from being compensated for staff time associated with training and enrollment.
California Hospital Association	CHA is disappointed to see that there is no option for compensating hospital-based Assisters. From day one, CHA has been a strong supporter of the "no wrong door" philosophy embraced by the Exchange. Hospitals come into contact with many of the uninsured through their emergency rooms – often the only entry point to the health care system for this population. Hospitals have the experience and expertise to assist individuals with finding the most appropriate form of health care coverage. With the goal of moving more than 4 million Californians into an expanded Medi-Cal program or into the Exchange for subsidized or non-subsidized coverage – not recognizing hospitals as a full partner in the enrollment process is a disservice to all Californians. Many hospitals currently have processes in place to help consumers find coverage – but with millions more coming through the door we need to be sure hospitals have the resources they need to not turn away the uninsured. The Exchange needs to ensure the hospital door is not a wrong door, and the Exchange needs to recognize the important role of the hospital in meeting coverage goals by compensating hospital-based assisters equally and on par with the compensation program being offered to other assisters in the statewide program.
California Pan-Ethnic Health Network and Having Our Say Coalition	**HOS recommends a hybrid approach to Navigator compensation of fee for enrollment and a grant program.** While a fee-for-enrollment compensation structure is a common approach to funding application assistance and one we have recommended in the past, we also think it important for the state to provide grants to organizations that serve hard-to-reach populations in order to ensure that *everyone* who is eligible is enrolled into coverage. A fee-for-enrollment-only model could actually be a disincentive for organizations to target hard-to-reach populations that require intensive outreach and consumer assistance to navigate the health insurance arena. California's low-income, seniors, disabled, limited-English proficient (LEP) communities, immigrants, and communities of color may be least likely to enroll without additional assistance. In California, a majority of immigrant families live in mixed status families where individual family members may or may not be eligible for coverage under the ACA. Providing grants to enrollment entities will encourage outreach to these families and individuals despite the potential for lower enrollment numbers. **HOS believes the enrollment fee is too low for organizations to provide quality consumer assistance.** We question the validity of RHA's estimate that it will cost only $58 dollars for an entity to enroll a consumer into health coverage. A compensation fee that is too low may make it difficult for small community-based-organizations that serve a particular demographic from participating as an assister entity in the Exchange. The cost per enrollment does not include the provision of other services. For many application assisters, the work does not end with an enrollment. Often a client will call with questions about utilization or request help with retaining their coverage. We would urge the Exchange to consider a higher compensation amount to help offset other administrative costs borne by enrollment entities. A survey of enrollment entities

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	suggests the costs of enrollment may be as high as $200 per enrollment. We urge the Exchange to revisit the compensation amount. We also request clarification (should the fee per enrollment recommendation move forward) as to whether the compensation amount would be tied to the application or to the number of individuals enrolled. This clarification is important given that one single application can include many family members.
California Primary Care Association	**CPCA Recommends the Hybrid Model of Grants and Per-Head Enrollment Compensation** To ensure ease of access to application assistance, the entities funded with federal Level II Grant funds for outreach and education under the marketing plan should be able to provide the full continuum of services to their communities which includes offering application and enrollment services. While CPCA understands that federal dollars are not available to fund Navigator services for the Exchange, we urge the Board to consider approving a hybrid model that includes the use of Exchange funds for enrollment service grants and the pay-for-enrollment compensation recommended in the report. Under this model, most organizations would be compensated through pay-for-enrollment and a subset would be awarded grant funding based on their access to target markets. One of the challenges outlined in the recommendation report if the Board only approves funding a pay-for-enrollment model is that “some organizations with access to specific market segments will require start-up or ongoing operating funds to participate and may elect not to participate under a pay for enrollment model.” This is will be true for CCHCs and other CBOs that are serving the hardest-to-reach populations. As a consequence, these populations will likely be ignored by Navigators who will target the easiest to reach populations, and only reach out to populations that are harder to reach if it is determined to be financially sound. Only those mission driven organizations, such as CCHCs who have mandates to serve any and all populations and are located in the areas of most unmet need, will strive to outreach and enroll the hardest to serve. Also, the report notes that the pay-for-enrollment model would “require robust IT systems to properly track transactions, execute payments, and conduct regular system audits. Organizations with access to hard-to-reach or target markets may not have the infrastructure to participate in this type of compensation model because they need up front dollars to cover staffing costs.” While CPCA recognizes that start-up costs for an application assistance program will be a barrier for some organizations, California CCHC’s success with HFP enrollment using the One-e-App and Health-e-App systems provides an existing infrastructure that can be leveraged as we prepared for a huge increase in enrollments in 2014. In addition, many CCHCs have recently implemented robust electronic health records (EHR) systems with extensive tracking and data reporting capabilities, and CPCA expects nearly 70 percent to have EHR systems in place by 2014. While some investment would still surely need to be made to prepare community-based CCHCs for expanded application assistance programs, we hope the Exchange will take advantage of the significant investment already made by the Medical Risk Management Insurance Board, individual counties, agencies, and non-profit foundations and other supporters.

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	We recognize that "the Marketplace must balance the interest of enrolling as many uninsured Californians in affordable health care coverage with the need to control program costs, given the funding constraints imposed by the Affordable Care Act." As such, we hope that the Exchange will follow the example of the Healthy Families Program, Healthy San Francisco, and other programs that have utilized the state's vast network of CCHCs to reach into underserved communities and reach those individuals most in need of assistance.
California School Health Centers Association	**CSHC urges the Exchange to adopt a hybrid Navigator compensation model, using a combination of enrollment fees and grants.** We wish to underscore the comments provided by the California Consumer Advocates Navigator Work Group (CCAN) and emphasize our strong support for a hybrid compensation model, consisting of both enrollment fees and grants. Grants will ensure that hard-to-reach populations are a focus of the Exchange roll-out: they will allow under resourced organizations located in hard-to-reach communities to participate in the Navigator program, and they will ensure that outreach, education, utilization, and retention efforts targeting hard-to-reach populations are prioritized. By contrast, a compensation model based solely on enrollment fees will incentivize a narrow focus on enrolling the easiest-to reach Californians. Finally, while we do agree that enrollment fees should comprise a portion of the compensation model, we urge the Exchange to consider a variable fee scale, with higher payments enrolling certain hard-to-reach demographic groups, including young adults.
California State Rural Health Association	1. **Navigators should be compensated through a combination of grants and enrollment fees.** A compensation program that relies solely on a pay per enrollment model creates barriers for both consumers and navigators in hard-to-reach populations. Therefore navigators should be compensated through a combination of grants and enrollment fees. Enrollment fees can be used in combination with grants as a way of encouraging navigators to meet certain benchmarks around hard-to-reach populations. a. Pay for enrollment creates a disincentive to serve hard-to-reach consumers. Compensating navigators with one fixed reimbursement rate per successful enrollment creates a disincentive to serve hard-to-reach consumers who require disproportionate time and staff resources. b. Pay for enrollment disproportionately excludes organizations serving the underserved. The pay for enrollment compensation model delays the navigator's receipt of compensation, requiring more up-front investment by the navigator or navigator entity. This is a barrier for many organizations that would otherwise participate in the navigator program, but cannot afford to cover infrastructure and staffing costs upfront. This will disproportionately exclude those organizations with access and expertise in serving the underserved and hard-to-reach. 2. **We agree with CCAN that the justification for a Pay for Enrollment model requires deeper analysis.** The current RHA analysis does not adequately explore the benefits of a Hybrid model. As intimated above, the experience with the Healthy Families Program bears out how a combination of grants and enrollment fees, coupled with the work of agents and brokers, managed to get eventually high enrollment numbers from the CAAs, effective outreach and inclusion of hard-to-reach populations into coverage, and vast geographic dispersion with the network of individual agents.

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	Granted, allowing for grant-based compensation would somewhat reduce the pool of Navigators. Nevertheless, that risk is negated by substantial benefits to be gained. The challenge for the Project Sponsors is simply one of achieving the right balance in funding allocations for one activity versus the other, and thus achieve simultaneous operational goals. 3. **CSRHA joins CCAN in recommending** that, if a per enrollment fee is to be set, the Exchange engage the appropriate experts and stakeholders to develop a more rigorous, evidenced-based methodology to ensure a fee that fairly compensates navigators.
Central Valley Health Network	Central Valley Health Network (CVHN), a non-profit membership organization comprised of over 100 federally qualified health center (FQHC) sites in 20 counties, which provides preventive primary care services to over 550,000 individuals and more than 2.4 million patient visits each year, opposes the proposal to single out community health centers, hospitals and other providers as the only entities not eligible to receive compensation for application assistance and enrollment activities as Navigators under the Exchange. CVHN members and other community health centers around the state are currently serving the patient demographic the HBEX is hoping to enroll. Community Health Centers are in hard to reach populations and are best positioned to perform outreach, enrollment and application assistance to the newly eligible population. The report notes that "excluding specific types of organizations from serving as Navigator entities may reduce the overall size of the network and reduce access to assisters." If community health centers are not able to participate as Navigators the result will be a far less robust outreach and enrollment program where far fewer eligible individuals will be enrolled in coverage. The Report's recommendation is based on the assertion that community health centers have an incentive to enroll individuals and thus do not need additional resources for this work. The report inaccurately assumes that community health centers are able to independently support robust and active outreach and application assistance programs without compensation. Many of CVHN's member health centers have dropped or decreased the number of Assisters due to funding cuts and those that have Assisters, have received grants that help fund the program. Also, few health centers have dedicated assisters and those who assist patients in the health centers, do it on top of their health education, outreach or other health center tasks. Best practices demonstrate that full-time, dedicated assisters develop the skills needed to successfully enroll clients in health coverage. If an assister only does a few applications a week, they are less efficient and often spend time correcting errors or having to recall the client to complete additional paperwork. Assistors are very critical to helping individuals and families complete the applications. Assisters spend a majority of their time explaining the process and the required documents to patients prior and after appointments. They are often contacting county eligibility offices to track down enrollment status and they spend time assisting families with appeals when denied. Additionally, family applications can be very complicated. There are rules regarding who is considered family for the

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	income with single, divorced and separated parents, step-children in households part-time, extended family living in homes, child support, etc. and it takes additional time to sort through all these scenarios. Also, self-employment and constantly changing income takes additional time to review and obtain correct documentation.
Centro Binacional Para El Desarollo Indigena Oaxaqueño	• We feel that the $58 pay per enrollment and $25 for re-enrollment are not adequate prices when you take into consideration the amount of time invested. From the initial contact to set up an appointment, do the application, follow up calls and any questions they might have and that doesn't include the outreach portion. • If we are not able to push for the "Hybrid Model" then we suggest that Navigators/CAAs should be paid a minimum of $70/enrollment in the first year with $30 for renewals. However, grants should be provided to target outreach to hard to reach populations and those providing additional services such as education and utilization assistance and provision of other non-health social services. Perhaps the 2006 state Outreach grants formula for allocation by geographic concentration may be the best approach. • In the second year, the fee of $60/enrollment would be appropriate with continued grants for special populations along with the $30 for renewals. • Community Clinics should be paid also for enrollments.
Centro La Familia Advocacy Services	• Centro is advocating that CAAs be paid a minimum of $70/enrollment in the first year with $30 for renewals. • We are also recommending that grants be awarded to advocacy organizations with proven track records in conducting targeted outreach within hard-to-reach populations (such as non-English speaking residents, particularly those within unincorporated rural areas). • Grants would have an additional objective to help to providing additional services such as education and utilization assistance, as well as the provision of other non-health social services (yet related to health, such as food and nutrition assistance, healthy housing – lead and pest free environments). • A grant making approach that is effective is one which bases allocation by geographic and demographic concentration. For example, Fresno County has the dubious distinction of being the 'most poor' in the state – poverty is coupled with needing assistance in understanding public benefits and what the process is for obtaining and utilizing those benefits. This all takes time, energy and money to address. • Centro is further advocating that in the second year, a $60/enrollment fee for CAAs, with continued grants for assistance with special populations (such as isolated rural communities, the non-English speaking elderly). • Grant funding should be allocated to focus on helping families to find a medical home along with the goal of improving health. It is possible to efficiently provide assistance with utilization and education as part of the application process. • One important point we would like to address is nomenclature -- in the document, clarification needs to address application and enrollment words. For example, one application can result in several *enrollments*. CAAs are exceptionally good at understanding these distinctions. • As the accurate tracking of applications and enrollments is of primary importance, we are recommending that DHCS

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	and MRMIB be required to share data electronically to EEs. • A volunteer advocacy group should be encouraged and be actively included as part of training for effective outreach, perhaps this provision could be integrated into a grant RFP. • And finally, Community Health Clinics should also be paid for enrollments.
Clinica Sierra Vista	Clinica Sierra Vista currently employs Eligibility Assistance Workers who help anyone who walks in our doors complete and submit applications to programs like Medi-Cal, Healthy Families, CalFresh, etc. These assistors are entirely funded through a combination of CalFresh funding and local grant money. Should this funding no longer be available, these staff would be lost and these services would no longer be offered to the community. Our Eligibility Assistance Workers conduct ongoing case management to ensure families are approved, maintain enrollment and know how to utilize their new benefits. We have found that having Eligibility Assistance Workers in our health centers improves health care access and reduces health care costs for consumers and ultimately the state, since a majority of new enrollees are enrolled in Medi-Cal. In addition, we see improvement in disease management and an increase in the number of community members who are medically served. Contrary to the recommendation that Community Health Centers should provide uncompensated enrollment assistance because it is already part of our mission and commitment to the community, we must remember and consider that Community Health Centers: 1) are not reimbursed for providing enrollment assistance and are constantly struggling to maintain the current level of services 2) are constantly facing cuts to our Medi-Cal reimbursement rates due to the state and federal budgets 3) enrollment expenses are not reimbursed through any state and federal mechanisms. Our Eligibility Assistance Workers put a human face to health care reform, are culturally and linguistically aligned with the communities we serve, and have established relationships with the community. It therefore makes sense that Community Health Center Eligibility Assistance Workers serve in a full Navigator capacity. • The main argument seems to be that CHC's are somehow "incentivized" to do enrollment and therefore do not need or should not be, reimbursed. I find this both inaccurate and disturbing. ○ Community health centers receive no incentive for enrolling patients in health insurance. To the contrary, other than the subjective conclusion on someone's part that because an enrollment represents a patient with a payer that should be adequate which is absolutely false. We have no funding to support these services and in fact, since application reimbursement and MAA funding have been radically reduced and/or eliminated by state budget, we no longer have even one assister at each of our health centers. We have in fact reduced this workforce by 50%. This creates a significant barrier to care for our patients whose first exposure to the concept of enrollment is often at the health center front counter. • Health centers are not capitalized to provide assister services. In fact, these services are specifically excluded by

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	statute from our cost reporting that creates our prospective payment rate for Media-Cal. • In conclusion we request that health center Patient Navigator/Assistor's be reimbursed at the same rate as all other's.
Community Clinic Association of LA County	**CCALAC Recommends the Hybrid Model as the Compensation Structure of the Assisters Program** CCALAC recommends that the Board adopt the Hybrid Model option, which includes both Pay for Enrollment and Grants, as the compensation structure of the Assisters Program, as defined in the Report. The Hybrid Model would maximize the benefits associated with both Pay for Enrollment, while enabling select entities with the additional resources and flexibility necessary to ramp up and target specific populations for enrollment through the Grants approach.
Community Health Councils	We express strong opposition of the pay-for-enrollment Navigator compensation model. CHC and our partners strongly recommend that the Navigator program be funded through performance-based grants. A complimentary pay-for enrollment payment structure should be pursued and provided only if there are resources available for such funding AFTER Navigator contractors have been adequately funded for their work. We recommend Navigator compensation be linked to performance-based grants because local experience shows that such contracting has proven extremely successful in securing public coverage for uninsured children. In Los Angeles County, the Dept. of Public Health's Children's Health Outreach Initiative (CHOI) provides a highly successful example of the benefits of funding OERU activities through a grant-based model: • The capacity of the enrollment entities to support OERU activities among its staff is greatly increased, providing a stable, supportive environment for high output of enrollment activities. CAA staff cannot survive on enrollment fees alone. The stability of grant funding for an organization and the supportive infrastructure that comes with the grant will recruit Navigators who are dedicated to the task and less likely to focus only on submitting large quantity, easy enrollments. It will also ensure that outreach and enrollment messages and activities are coordinated throughout the organization, resulting in increased capacity and higher rates of referrals, enrollment and follow-up. • Grant-based enrollment models help provide a local network of support and resources for the CAA/Navigator. Whether the grant is administered by a local community organization or at a higher level via a regional grant administered by a public agency or consortium, the CAAs/Navigators have a built-in, local network of colleagues conducting the same work. The value of this localized network in sharing information and best practices, working through challenging cases, troubleshooting system problems that arise and collaborating with local County Medi-Cal enrollment agencies is irreplaceable. The support of a local network helps expedite enrollment and follow-up, making the entire enrollment process more efficient and effective. • Grant-based enrollment models allow for stronger, local accountability to ensure the enrollment process is thorough and consistent. A grant to a local enrollment entity, regional consortium or public agency that contains specific objectives and deliverables in turns sets a specific monitoring process in place for the CAAs/Navigators to ensure that enrollment objectives are being met. The grant-receiving agency has a real stake in ensuring that the Navigators under their grant are performing. Any inefficiencies or problems that arise are recognized, addressed and corrected early and quickly. This is in comparison to a statewide only network and administration process that is large and more likely to

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	experience gaps in Navigator reporting and slower response times to address problems. Furthermore, by instituting a grant-based program the project sponsors wouldn't need to worry about funding retention services separately as that could be a requirement of grant contractors. RHA notes consistently throughout the report that a pay for enrollment payment structure could result in high need populations receiving limited enrollment assistance as Navigator assisters would prioritize easy cases compared to more complex cases to obtain the maximum amount of payment for their services. We feel that such a significant flaw in the pay-for-enrollment payment structure should raise serious concerns for the project sponsors as it runs completely counter to the goals of the ACA. We recommend the project sponsors oppose the pay for enrollment structure and instead adopt a performance-based grant structure to ensure all Californians receive the support they need to obtain coverage. A complimentary pay-for-enrollment payment structure should be pursued and provided only if there are resources available for such funding AFTER Navigator contractors have been adequately funded for their work. We believe a pay-for-enrollment structure should be used to incentivize eligible non-grant funded organizations (those in the DBA category or those who because of potential financial limitations on the amounts of grants awarded) to assist consumers with enrollment into the Exchange and public coverage programs. Health plans should not be allowed to receive funding for enrolling qualified individuals and small business owners into qualified health plans. We recommend RHA provide an analysis of costs associated with the hybrid model if the model were flipped, meaning assuming the project sponsors pursue a performance-based grant program complemented by a complimentary pay-for-enrollment structure. Finally, we recommend that any state funds provided for enrollment into Medi-Cal are matched either locally or at the statewide level to obtain Title V Medi-Cal Administrative Activity (MAA) dollars.
Consumers Union	We need to create a strong infrastructure of Assisters. The entity-based approach suggested by the proposal supports that, but the recommended structure, emphasizing compensation only after successful enrollment, will make it difficult for organizations to staff, train, gain expertise, and stabilize. This may be especially important during the startup of and initial enrollment into the Exchange. An alternative hybrid model that Consumers Union urges you to consider would be a hybrid that emphasizes organizational contracts with an allowance (set aside) for pay-per-enrollment. Initially, the grants could be limited to entity organizations with a good track record – requiring an RFP process with identified minimum number of enrollments, for example, as a deliverable. Unlike the pure grant model, this would not limit the organizations/entities able to provide assistance, since any organization not receiving a contract through the RFP process could still register with the Exchange and be paid on the per-enrollment basis. In addition, the start-up contracts could be structured with minimum enrollment requirements and anything above the initial goal would be compensable through the pay-per-enrollment function.

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	This structure would allow Project Sponsors to establish trusted and long-lasting relationships with enrollment entities and track and report on patterns. As the system becomes more predictable and reliable, the Project Sponsors could consider moving to a greater emphasis on per-enrollment fees. For example, after monitoring and evaluation, the Exchange could decide based on performance evidence to recalibrate the emphasis on grants and move more resources to pay-per-enrollment, starting say with 60% of the funding going to contracting organizations and 40% for pay-for-enrollment and over time adjusting the percentages based on experience. In summary, providing some allowance for organizational contracts would ensure that mission-driven organizations become steadfast partners with the Exchange and have adequate resources to responsibly staff up and train for the big job ahead. If pay-per-enrollment is the model adopted by the Project Sponsors, Consumers Union urges that RHA gather more rigorous research and surveys of consumer assistance programs to support the per enrollment fee proposed in the plan. The Project Sponsors should look beyond gross salary and fringe benefits and consider the costs to the organizations/entities to train, supervise, monitor, and house Assister staff. We understand the real financial constraints on the Exchange in determining compensation levels for Assisters and the challenge of hitting the right fee. We note that Massachusetts, a state with less diversity than California and arguably a more longstanding culture of coverage, pays $68 per application. The proposed $58/successful enrollment here may be too low. When the Healthy Families program offered only $50 per successful application, for example, California still had hundreds of thousands of Healthy Families-eligible but unenrolled children going without coverage. If the pay-per-enrollment model is adopted, we believe that Assisters should be compensated for providing assistance with re-enrollment. The suggestion in the proposal that plans have an incentive to keep people enrolled may not be valid. If there are consumers with profiles that plans would rather not insure, they could simply let coverage for those individuals lapse without undertaking any effort to re-enroll them. We recognize that may change in years to come with guaranteed issue etc., but caution that we not make assumptions about that.
Fresno Healthy Communities Access Partners (HCAP)	• CAAs should be paid a minimum of $70/enrollment in the first year with $30 for renewals. However, grants should be provided to target outreach for hard to reach populations and those providing additional services such as education, utilization assistance and provision of other non-health social services. Perhaps the 2006 state Outreach grants formula for allocation by geographic concentration may be a model methodology for these grants. • In the second year, the fee of $60/enrollment would be appropriate with continued grants for special populations. • Grants funding pilot projects on a regional basis should be considered to focus more on the vision of improving health

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	through the connection and use of a medical home. We are currently demonstrating that it is possible to efficiently provide assistance with utilization and education and retention as part of the application process, i.e. it does not need to be a separate step from application assistance. This can be more cost effective and efficient.
Golden Valley Health Centers	Golden Valley Health Centers (GVHC) is a private nonprofit Federally Qualified Health Center serving Merced and Stanislaus Counties' residents through a network of 21 medical and 8 dental centers, which are strategically located from Riverbank CA in the north to Dos Palos CA in the south. Our first center opened its doors in 1972, and we have grown from serving 1,500 patients that first year to serving 97,877 patients in 2011. Throughout these 40 years of service, Golden Valley Health Centers has earned the trust of the communities we serve and has developed strong and productive relationships with a wide variety of partnering organizations. GVHC mission is to improve the health of our patients by providing quality, primary health care services to people in the communities we serve regardless of language, financial or cultural barriers. And the constant work to fulfil our mission with those same populations that will need to be reached and enrolled into the available health insurance plans makes our centers very effective and practical infrastructure to accomplish the job. After reading the Statewide Assisters Program Design Options and Recommendations Report by Richard Heath and Associates, it was clear that Golden Valley Health Centers cannot accept it as proposed for several very important reasons. First, the report makes the erroneous assumption that the current already limited resources of Community Health Centers like GVHC will be sufficient to sustain the added work load that is expected from us without the same compensation suggested for Navigators. As a matter of fact, the considerable loss of funding that our centers have endured in past years has forced us to diversify the job responsibilities of our CAA's reducing the amount of time they spend doing program outreach, enrollment and retention activities. Second, the limited proposed role for "Direct Benefit Assisters" would not take full advantage of the existing relationships and skills our staff has to conduct outreach and enrolling those eligible residents. Finally, the unique characteristics of the populations we serve also need to be considered; particularly the multiple needs and transportation limitations of our patients. Many times our staff has to complete several program applications or enroll several family members during the same visit to meet their needs or to avoid having them come back to the clinic multiple times and go through the hassle and expense of finding transportation to get here.
Health Access	The proposal fails to take into account much higher reimbursement provided to health insurance agents, estimated at 6% 7% of premium for first year. No evidence that lower compensation for certified application assisters has reduced insurance agent compensation for kids' coverage. Considerable evidence that different compensation for insurance agents under HIPC along with different rules than the market created adverse selection. The proposal for compensation fails to take into account need for steady funding for non-profits. Health Access supports a combination of grants with performance standards and pay for enrollment. Pay for enrollment fails to take into account hard to

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	reach communities and instead targets easy to enroll communities or populations.
Health Consumer Alliance	We support the idea that compensation for Navigators be compensated by the Exchange, and that Direct Benefit Assisters not receive compensation from the Exchange. We would support the concept of a hybrid compensation design. Many organizations that should be considered as Enrollment Entities are mission-driven and a per capita per application payment could undermine the high level of labor it takes to work in and with a community to not only perform the outreach that leads to successful enrollment, but also the utilization and education activities that lead to reenrollment and an induction into the culture of coverage. Compensation should also be awarded for successful enrollment as well as reenrollment, as opposed to the receipt of an application. Project Sponsors should consider that different populations will need different levels of labor to complete enrollment. Whereas a family with solid income tax information and stable housing should not take high levels of labor, there are groups like homeless people, Limited English Proficient communities, and those with different income documentation that need additional help.
Insure the Uninsured Project	We would like to express our support for the excellent suggestions contained in the Richard Health and Associates (RHA) report on the assisters program. We strongly encourage the broadest possible range of assistance to outreach, explain and enroll eligible individuals the new program. Since the cost of the Exchange, the Navigators, the Assistors and the insurance agents are ultimately reflected in the cost of the premium to the subscriber and thus the levels of their participation in coverage, we agree with the RHA suggestions to pay as navigators only those who have no direct financial incentives to steer individuals into particular plans, providers and provider networks. We agree that the Direct Benefit Assisters (plans, agents and providers) should be compensated for their important contributions by the plans and providers, rather than through the Exchange. We agree that all Navigators and Assisters should have access to the same training and certification process. We support the moderate fee options of $58 for successful enrollment and $25 for successful renewals by Navigators.
Kaiser Permanente	We are in general support of the approach described. Beginning January 1, 2014, however, we recommend that all navigator programs be compensated only on a per-successful-application basis. We also believe retention is an important function, and should be compensated by the exchange. We strongly believe that health plan assessments to fund navigator activities should be based on the enrollment that plans receive from navigators. If navigators are compensated at $58 per successful application, we believe plans should be assessed at $58 per navigator-assisted enrollee.
La Maestra Community Health Centers	1. Funding for our outreach workers – No. We do not get funding for our outreach workers/eligibility workers. We pay them out of our clinic operations. Since we have a very ethnically diverse patient population, it is imperative that we have workers that first, come from the population we serve and speak the language our population speak (we speak now 23 languages). BTW, translation (which we are mandated to provide) is also a NON-REIMBUREABLE COST under the PPS rate. Sign language is though.

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	2. Healthy Families/LIPH. Under the Health E App before, La Maestra Family Clinic was one of the pilot sites for this. Back then we were paid $50 per approved application under the Health E App. We inform parents of eligible children what Healthy Families was all about and help them fill up the Healthy Families application as well a Medi-Cal Application. We worked with elementary schools near our clinic sites. Right now we are in 4 elementary and high schools providing medical and dental services. With our new Medical/Dental Mobile unit, we will be working with more than 18 schools around San Diego County. The payment was discontinued a few years back. With LIPH – our outreach/eligibility workers help translate and fill out the application for our patients but the patients bring and submit them to the resource centers. We are not paid for this service. 3. Number of workers: It has gotten smaller through the years. Funding is partly the reason. We are down to 2 but there is a great need out there. 4. We can do a lot more outreach if we get paid - We are able to inform the community about health care issues as, e.g. cancer early detection, need for prenatal care, education on nutrition to solve obesity problems specially the children and teens, new state programs etc. Right now, we got a grant from Komen to give stipend ($20 per) for Promotoras to recruit, educate and schedule clinical breast exam and mammograms for women 40 and over. These promotoras/outreach workers come from different ethnic background and communities. Without the help from Komen, we are not able to go out into the community to inform and educate women on the importance of early detection. 5. Already we have been seeing a large increase in UNINSURED patients coming through our door. Some do not even have money to pay. We cannot really pay out-of-pocket the entire cost of running an application and enrollment program. Believe me, THEY WILL BE COMING TO US FOR ASSISTANCE.
LifeLong Medical Care	Community Health Centers have always assisted in navigating patients to newly designed systems and were initially compensated for it, including Healthy Families and were discontinued from payment because of state funding issues and we then saw a decrease in our Healthy Families enrollment. This incentive adds additional stability to our infrastructure, that should be focusing on health care delivery but has to focus on enrollment and provides convenience to the customers. If our goal is to fully provide information and instruction to those who qualify under the new Exchange, it seems illogical not to include health centers and other safety net providers as a key element to this process. This would be a grave mistake not to include the true stakeholders in this process.
Los Angeles County Department of Public Health, Children Health Outreach Initiatives	• CHOI urges RHA and the Exchange to fund Navigator Compensation under the Hybrid Model, with more weight given to grant-based compensation, followed by pay-per enrollment. CHOI's highly successful experience in funding OERU activities through a grant-based model demonstrates the following: • The capacity of the enrollment entities to support OERU activities among its staff is greatly increased, providing a stable, supportive environment for high output of enrollment activities. CAA staff cannot survive on enrollment fees alone. The stability of grant funding for an organization and the supportive infrastructure that comes with the grant will recruit Navigators that are dedicated to the task and less likely to focus only on submitting large quantity, easy enrollments. It will also ensure that outreach and enrollment messages and activities are coordinated throughout the

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	organization, resulting in increased capacity and higher rates of referrals, enrollment and follow-up. • Grant-based enrollment models help provide a local network of support and resources for the CAA/Navigator. Whether the grant is administered by a local community organization or at a higher level via a regional grant administered by a public agency or consortium, the CAAs/Navigators have a built-in, local network of colleagues conducting the same work. The value of this localized network in sharing information and best practices, working through challenging cases, troubleshooting system problems that arise and collaborating with local County Medi-Cal enrollment agencies is irreplaceable. The support of a local network helps expedite enrollment and follow-up, making the entire enrollment process more efficient and effective. • Grant-based enrollment models allow for stronger, local accountability to ensure the enrollment process is thorough and consistent. A grant to a local enrollment entity, regional consortium or public agency that contains specific objectives and deliverables in turns sets a specific monitoring process in place for the CAAs/Navigators to ensure that enrollment objectives are being met. The grant-receiving agency has a real stake in ensuring that the Navigators under their grant are performing. Any inefficiencies or problems that arise are recognized, addressed and corrected early and quickly. This is in comparison to a state-wide only network and administration process that is large and more likely to experience gaps in Navigator reporting and slower response times to address problems. • CHOI also recommends the Hybrid-model payment compensation to off-set the issue of delayed payment to Navigators until February 2014, which could result in a real drop-off of Navigators during the most critical start-up enrollment period. Grant-based compensation will ensure that the Exchange has a dedicated force of Navigators enrolling consumers from the start of enrollment. • CHOI recommends that Navigators be compensated at minimum at the moderate ($58) per successful enrollment. If the Exchange chooses to only fund compensation through the pay-per-enrollment model, then the compensation per enrollment must be at the high ($87) payment level, with additional, more comprehensive post-enrollment retention and utilization follow-up duties required to trigger payment to the Navigator. • CHOI strongly supports Navigator payment of $25 per renewal of enrollment to encourage follow-up/retention efforts. • CHOI recommends that any State funds provided for enrollment into Medi-Cal are matched either locally or at the statewide level to obtain Title V Medi-Cal Administrative Activity (MAA) dollars.
Maternal and Child Health Access	• MCHA agrees with other commenting organizations that Navigators should be compensated through a combination of grants and enrollment fees. However, we feel very strongly that the bulk of the funding should be provided to mission-driven organizations in the form of grants, and that enrollment fees should be utilized in very limited circumstances. 300 organizations receiving funding statewide is highly competitive and contributes to the “Assistance Gap” of not enough assistors for the need. • RHA writes of an assumption that “large” organizations have a track record of productivity while “small” organizations have access to target populations. There is no explanation of large and small organizations and no basis for this assumption.

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	• RHA assumes the "easy to engage and persuade" will be enrolled in the first year. Yet there are many policy decisions to be made about who actually has to enroll versus some situations of conversion or automatic enrollment into programs – how these will be counted and compensated, if at all, may affect this assumption and many others. • MCHA does not support a per-head or per-application enrollment fee structure. Like CCAN, we are troubled by the assumptions made in the recommendation for a $58 reimbursement fee. The salary, level of experience, scope of work and overhead costs are not at all explained. Many assistors have been working for 10 years or more and carry benefits of a minimum of 25%. This is a level of experience California should be attempting to maintain in its programs. We are most concerned about the recognition of yet lack of exploration around the fact that "Assistors may focus on easy to reach consumers and those with more complicated cases may have less access to assistance". This is known as "cherry-picking" or "skimming" and occurs all too frequently. If pay-for-performance exists side by side with grant-funded assistance, we can predict that the enrollment will be "skimmed" by Navigators paid per head, then the issues with the application referred to someone else or another agency because "We don't do that". It already happens and has the potential to be made worse or continued with this kind of fee structure and without adequate oversight, which has not been described. We agree with CCAN that the pay for performance models require much more exploration and thought than time has allowed for so far. • MCHA also believes that the assumption of four applications per day is not well explained and seems to assume lines of people waiting with documentation in hand. In our experience, initial outreach is done, the application process takes place and follow-up takes place to ensure that additional documentation is submitted. • We agree that renewal activities should be compensated, otherwise the characterization of renewal is that it is "unpaid", even if the Sponsors believe that the renewal compensation is built into the original application fee. If health plans are seen as having an interest in renewal and perhaps suited for renewal activities, let them contribute funding for this effort into a giant pot for distribution to Entities.
National Health Services	National Health Services, Inc strongly opposes the recently released Statewide Assisters Program Design Options and Recommendations Report by Richard Heath and Associates, which proposes to single out community clinics, hospitals, and other providers as the only entities not eligible to receive compensation for application assistance and enrollment activities as Navigators under the Exchange. The California Health Benefit Exchange hopes to enroll a patient demographic that is already being served by CCHCs, including the currently uninsured, individuals who are culturally and linguistically diverse, Limited English Proficient and low-literacy, and live in rural and urban areas. As CCHCs are already serving these hard-to-reach populations, we are best positioned to perform outreach, enrollment, and application assistance to these newly eligible individuals.
Northeastern Rural Health Clinics	We fully support the use of navigators to enroll potential patients into the Exchange but object to the assumption that clinics should not be compensated for this service, while other entities receive remuneration. Clinics will see many of these patients because other providers will not accept them. However, clinics are already pushed to the brink trying to provide required

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	services as reimbursement continues to shrink. This proposal would only further burden clinics with services that we are expected to find funding to support – people cost money – in an environment where we are already hanging on by a thread. I would urge the Exchange to reconsider this issue and provide compensation to the very agencies who are going to make the Exchange a success and expand access to care for patients who do not currently have it. The safety net in California is extremely fragile and assuming that unfunded requirements can continue to be layered on it is ultimately leading to its disintegration.
PEACH	PEACH supports the Hybrid option in which Navigators are compensated a moderate amount of $58 per successful application and $25 compensation for successful renewals, and would also provide grants for a subset of organizations that could access targeted populations and markets. This model would provide the largest, most robust pool of assisters to help the Exchange attain its ambitious enrollment and coverage retention goals, and allow for strategic and targeted grants to organizations with proven experience and expertise in reaching specific populations. We support such grants, with payment distribution based on measurable results, to community based organizations, providers and other community partners.
Planned Parenthood Affiliates of California	It will be extremely difficult for our clinics to hire assisters and act as enrollment sites without any level of compensation. The requirements and obligations for assisters and enrollment entities will be substantial, including training, certification, supervision, liability, quality checks, and labor costs. Community clinics operate on very small margins and will not be able to engage in enrollment activities without funding for those activities. We understand the need to balance the promotion of robust enrollment with the cost of providing assistance. Our health centers provide an excellent chance to reach the thousands of (generally healthy) patients who will first encounter their new coverage options when they walk through our doors. Not facilitating community clinic's ability to act as enrollment sites will be a missed opportunity to bring many more consumers into the new health care system and is in opposition to the "no wrong door" model being envisioned for California.
San Mateo County	Based upon our experience with our local health coverage network, we believe a Hybrid compensation model will offer the Exchange more flexibility to tailor a program that maximizes enrollment among the entire spectrum of the uninsured population. As the draft report notes, a pay for enrollment model incentivizes a focus on enrolling easy-to-reach consumers, presumably one reason why the report estimates a lower projected enrollment in the Exchange's first year of operation under this model. We note that the cost-effectiveness methodology used to evaluate the compensation models ignores the benefits that might accrue to Exchange participants in the form of lower premiums if enrollment in the Exchange is maximized (a larger pool minimizes the risk of adverse selection, making it less costly to insure). At minimum, the Exchange should employ a hybrid compensation model in its first year of operation in order to maximize enrollment.
San Mateo County Union Community	RHA recommends compensation of $58 per successful application. RHA considered and rejected a grant model for compensation and a hybrid model for compensation.

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Alliance	For the same reasons given in SMCUCA's comments on the "Eligibility and Standards" and the "Assisters network" comment, SMCUCA believes that a "per application fee" model will create a bi-furcated system of application assisters in San Mateo County--County funded application assisters who work through the County's Health Coverage Unit will be compensated differently than those who are employed through the Exchange's Assisters network. The hybrid model for compensation would both incentivize enrollments in subsidized and unsubsidized products offered by the Exchange and provide the County with the necessary dollars to expand its Health Coverage Unit to include these new programs. RHA's own estimates of enrollees under the hybrid model are higher than any other compensation model considered (page 6, RHA draft recommendations 5/24/12).
San Mateo Labor Council	Strongly support hybrid model for compensation.
SEIU	We agree that assisters should be paid for enrollment vs. per application and agree with the premises this recommendation is based on (i.e.: incentivizes enrollment, more likely to lead to compliant and high quality program, etc.). Compensation Levels – We also agree that payments should be the same regardless of program to prevent steerage. However, given that agents/brokers are recommended to be DBAs who receive compensation directly from insurers and plans, we caution HBEX to consider that such agent/broker compensation may be different between plans offered inside vs. outside the exchange. Compensation Amounts – We believe that whatever level best balances the resources available while maximizing the most uninsured receive assistance is appropriate. Renewal compensation – While we agree that additional analysis is needed, providing renewal compensation may encourage steering of consumers to stay within the same plan, which may not be the best for them. Furthermore, it is unclear what actions and support would be required by an assister for those who passively renew. Given that plans benefit from retaining individuals in coverage and should support retention, we recommend HBEX consider options for sharing costs with plans for active renewals which require engagement and specific services/support provided by an assister.
Signature Health Insurance Services	The compensation should be similar to the Healthy Families Program. $60 for the first year and $50 for renewal. I think the grant program could add to the expense and may not provide any results. Maybe a grant after reaching certain enrollment levels would make sense. The current insurance companies sure don't pay any grants. I think the Navigators could share their compensation with the direct enrollment assisters. This way schools, social organizations, and others would be more interested in helping.
United Ways of California	A. **UWCA strongly recommends the hybrid model of navigator compensation – a mix of pay for enrollment and grants to navigators – and also urges CHBE to consider other methods, such as bonus payments in the first**

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	year, for example, to incentivize navigators to ramp up and enroll as many people as possible as early as possible. The more that enrollment can be frontloaded the lower the risk of the pool, the greater the leverage CHBE will gain from its paid and free media and marketing efforts, and the more likely CHBE will be viewed as a success. B. The RHA paper presents a viability and feasibility analysis based on the extent to which each design option contributes towards the achievement of the primary goals of the assisters program. Based on RHA's own five key criteria, UWCA concludes the hybrid model would best serve the consumer and the navigator entities: a. Enrollment. Likely to result in higher enrollment relative to no compensation and other two compensation models. It would result in the lowest assistance gap of all models. b. Cost effectiveness. More cost effective than grants only. c. Target Market Access. Allows for greater targeting of resources and broader participation of organizations with established relationships with hard-to-reach market segments. d. Consumer Experience. Produces the largest navigator pool; likely to improve the "no wrong door" consumer experience and create a minimal assistance gap. e. Quality Assurance. Project Sponsors have greater authority to establish, monitor and hold assisters accountable by setting grant outcome measurements based on broad goals. C. **A compensation program that relies solely on a pay per enrollment model creates barriers for both consumers and navigators in hard-to-reach populations therefore navigators should be compensated through a combination of grants and enrollment fees.** a. Compensating navigators with one fixed reimbursement rate per successful enrollment creates a disincentive to serve hard-to-reach consumers who require disproportionate time and staff resources. b. Pay for enrollment disproportionately excludes organizations serving the underserved. The pay for enrollment compensation model delays the navigator's receipt of compensation, requiring more up-front investment by the navigator or navigator entity. This is a barrier for many organizations that would otherwise participate in the navigator program, but cannot afford to cover infrastructure and staffing costs up front. This will disproportionately exclude those organizations with access and expertise in serving the underserved and hard-to-reach. D. **The justification for a Pay for Enrollment model requires deeper analysis.** The current RHA analysis does not adequately explore the benefits of a hybrid model. a. Inadequate evaluation of alternative models. The RHA presentation fails to demonstrate the superiority of the Pay for Enrollment model in comparison to the Hybrid model. The report lists the benefits of the Pay for Enrollment model in comparison to a No Compensation model, however the benefits of the Pay for Enrollment model in comparison to the Hybrid model are not adequately explored. We believe that a thoughtfully designed Hybrid model would create a robust network of navigators while also adequately controlling costs and ensuring a manageable infrastructure.

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	b. Benefits and drawbacks of the model require further explanation. The RHA presentation states that the challenges associated with the Pay for Enrollment model include, "Assisters may focus on easy to reach consumers and those with more complicated cases may have less access to assistance." This statement alone should make the CHBE reconsider the sole use of this model. The likelihood that consumers most in need of assistance would be left out under a Pay for Enrollment model should be a deterrent to adopting it. c. For many navigator entities, if serving the hard-to-reach consumer is a net financial loss, they will not have the staff or financial capacity to do so. United Way funds CBOs across the state and has seen the strain of funding cuts from both the private and public sectors on these organizations. We believe the Hybrid model would dramatically reduce this type of consumer neglect by removing the financial disincentive, and introducing incentives, to serve the hard-to reach. Staff needed to reach these populations would be retained. d. Does not account for diverse consumer assistance needs. A compensation model that offers one fixed reimbursement rate per enrollee assumes a fixed average investment of navigator time and resources per enrollee. This model fails to adequately account for the wide variation in consumer assistance needs among California's diverse populations. We believe a more appropriate model would acknowledge the broad range of time and resources navigators will be required to invest in different consumer subpopulations. California needs a compensation system that acknowledges this challenge and variance in time and effort to enroll. E. **The methodology utilized to set the level of enrollment fee in the RHA recommendations lacks rigor, transparency, and incorporates unverified assumptions.** Overall, RHA's enrollment projections and reimbursement rate calculations do not accurately reflect the realities of assisters. a. The productivity assumptions do not take into account that many assisters work part-time. Most current CAAs work part-time or may only devote a portion of their working hours to actual health insurance application assistance. This is unlikely to change under a $58/application Pay for Enrollment model, and it is unclear whether the assumptions in the RHA calculations of enrollment productivity adequately reflect this and bear out its consequences for meeting enrollment goals. b. The RHA methodology makes unverified assumptions about the costs of employing navigators and time spent completing the application. The methodology does not appear to consider a diverse range of navigators and client needs, or account for the time spent acquiring a client. c. We recommend much more rigorous evaluation of potential costs to enrollment entity acknowledging current costs as well as potential future efficiencies based on a simplified **application** and enrollment process. But while these will hopefully improve, the human factors of working with hard to reach populations will remain. At a minimum, such a methodology must: i. Take into account the true and complete cost to an entity of doing an enrollment, including the time, expenses, salaries and overhead expended in conducting education, outreach, and enrollment assistance up to the point of the actual enrollment, time spent providing information on utilization and

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	retention of coverage, and miscellaneous tasks such as troubleshooting enrollment glitches; ii. Consider the added complexities and time demands resulting from bringing new electronic systems on line, counseling on complex new coverage options, explaining and assisting with calculation of advance premium tax credits, and unforeseen new system complexities; and iii. Set a fee level only after thorough and transparent evaluation of actual costs incurred by existing assisters, and projected costs for a variety of potential navigator entities, including phone, place-based or field enrollment, all of which will take different time and resources. F. **UWCA strongly recommends that, if the Pay for Enrollment model is adopted as part of the compensation plan, the fee is paid per person successfully enrolled.** The CHBE should clarify whether the compensation models are based on a pay per application or pay per enrollment basis. The report is ambiguous as to whether the "Pay for Enrollment" model recommended will be a payment per person enrolled or per application.

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The 100% Campaign	The 100% Campaign, comprised of The Children's Partnership, Children Now, and Children's Defense Fund-California, appreciates this opportunity to comment on the Richard Heath & Associates (RHA) draft report, as submitted to the California Health Benefit Exchange (Exchange) on May 22, 2012 and revised on May 24, 2012.

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	First, we wish to associate our remarks with those submitted by the California Coverage Navigator Work Group (CCAN). Our organizations have been deeply involved in the work developed by CCAN and support the recommendations and comments submitted by that coalition. As the Exchange proceeds to implement an assisters program, we especially want to endorse the CCAN recommendations to fully leverage existing community-based avenues to achieving maximum health coverage "by taking full advantage of community resources and working with health and human service organizations that have established trust and built effective channels of communication with their target communities". We would also like to express our support for the "market integration" approach suggested by RHA. This model provides for a primary role to be assumed by navigators, while also outlining appropriate roles for other assisters, including agents and other "DBAs". Additionally, we support recommendations that specify that navigators should not only play a prominent role in the Individual Exchange, but should also be readily available to provide coverage and assistance in the Small Employer Health Options Program (SHOP). As we have previously suggested, we believe that the SHOP has a critical role to play in reaching maximum enrollment goals and satisfying the "no wrong door" objective. We also, however, recommend that the Exchange invest additional attention to the portions of the RHA report dealing with navigator recruitment, training, credentialing/certification, and accountability. It is unclear what the basis is for the RHA recommendation that navigators will require only two days of training; further, it is our view that the training framework suggested is likely incomplete. Professional certification programs typically involve the conduct of in depth "occupational analyses," with training parameters and modules subsequently developed to ensure that appropriate, specific skills, and knowledge are identified and addressed through instruction. Test instruments and certification requirements and qualifications must also be adopted. We are pleased that RHA recognizes the importance of training and certification, but we recommend that the Board establish a process for further developing this part of a navigator program. While we support the RHA recommendation that all assisters sign a Code of Conduct and Confidentiality and Assister Guidelines Agreement, the RHA report does not appear to directly address the accountability and public protection elements implicit in a state certification program. While in our view navigators must ultimately be accountable to the Exchange, we are inclined to think the testing and certification process would best be administered by an established state entity already equipped with a testing and certification infrastructure. Such an entity should also be prepared to conduct oversight and "enforcement" of navigator functions, and thereby ensure a level of consumer protection. Given the extraordinary demands currently on the Exchange to develop multiple other "programs", we believe consideration should be given to contracting out these functions to another state entity. In closing, we want to emphasize the critical importance of designing and overseeing a comprehensive, effective Navigator Program within the Exchange. California's diverse populations, geographic distinctions and complex family situations can only be well-served by a robust, accessible network of committed, well-trained assisters who possess the special skills that come in

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	large part from community-based expertise and relationships. We continue to be struck by the many enrollment challenges we face meeting the needs of California's complex family situations. The Urban Institute recently shared a new report that includes instructive information: 1.8 million California families are comprised of Medicaid or Healthy Family eligible children who have potentially Exchange eligible parents; another 0.7 million Medicaid or Healthy Family eligible children have parents who are not Exchange eligible; and an alarming 3.0 million children are in families with at least one absent parent, where access to health coverage is unknown. These are the children we are trying to reach. An effective Navigator Program must be designed with these targets in mind.
2-1-1 California	2-1-1 California encourages the Exchange to ensure that the development of the Call Center(s), Outreach Plan and Assisters Program be cohesive and complementary to one another's functions. It is possible that as these are being developed and implemented by different entities that they can become fragmented.
AIDS Health Consortia	People with HIV/AIDS face a unique set of challenges, and the decades-long response by the Federal, State, and local government to combating the spread of this disease has included both public health and health care coverage components. As a chronic health condition that is also communicable, HIV/AIDS requires a comprehensive response that includes engagement and retention in care, ongoing access to life-saving medications, and competent treatment from HIV experienced providers. Many studies have demonstrated that access to and retention with a HIV experienced provider dramatically improves individual health outcomes and also lowers the risk of transmission and new infections. Currently, most uninsured people with HIV/AIDS access their health care services through the Ryan White system, which includes a broad network of providers and pharmacies. Because Ryan White is a payer of last resort, people with HIV/AIDS will be required to enroll in the new insurance products in order to access health care. People living with HIV will be one of the only populations moving from one system of care to a new form of coverage, possibly having to transition from long term health care providers to new ones. In addition, because most people with HIV/AIDS have been kept out of private insurance due to pre-existing conditions and required to become disabled in order to access Medi-Cal or Medicare, they are new to insurance complexity and navigation. Given all these factors and the concern that the most vulnerable people with HIV could be lost to care during an unassisted transition, we believe that the statewide assisters' program must specifically address the needs of people with HIV/AIDS and that they should be explicitly included as a "target" or vulnerable population.
Asian Pacific American Legal Center of Southern California (APALC)	In conclusion, APALC would like to reiterate our willingness to work with the Exchange to ensure access to the Asian American. Native Hawaiian and Pacific Islander communities through the Health Justice Network. Within HJN, there are many community based organizations that have the language and cultural proficiency to outreach throughout the state. Finally, we fully support the comments submitted by the California Pan-Ethnic Health Network on behalf of the Having Our Say Coalition.

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California Consumer Advocate Navigator Workgroup	**A. CCAN strongly recommends that the Exchange include a robust two-way horizontal human services integration component in the assisters program as well as the marketing and outreach plan.** Every year millions of people seek out programs and services to meet their critical needs such as food, shelter, income supports, and child care. Even though there may be health needs, health is often not the presenting need as it may not be the most immediate threat to an individual, child or family. However, many of these millions are part of the target population the Exchange needs to reach to achieve enrollment goals. We appreciate the tremendous effort the State is currently undertaking to build an assisters program, a marketing plan, and an eligibility, enrollment & retention system in a very compressed timeframe. We know that reaching people through integration with other human services programs is a crucial element of all three systems. We believe based on experience and data from our partner organizations, that human services integration is the key to success in reaching all Californians for health insurance. We strongly recommend that the Exchange include a robust two-way horizontal human services integration component in the assisters program as well as the marketing and outreach plan. Two-way horizontal integration means a system where 1) those applying for health insurance are also assisted or guided into other programs for which they may qualify, and 2) those who are seeking other nutrition, housing, or income support programs would be educated, screened, and guided into health coverage. We recommend that the State's plans commit to three specific goals for integration: a. Protect and modernize the current connections between health and human services – such as Medi-Cal, CalFresh, and CalWORKs -- as the new systems and processes are built. All assisters should have basic knowledge about other public benefit programs and be able to efficiently assist consumers in accessing these programs. The training curriculum should include elements on eligibility for other programs. b. Vice versa, expand or create connections to health coverage from other public benefit programs that support health and overall wellness in a targeted and phased manner - (Examples: CalFresh, CalWORKS, WIC, working family tax credits, child care and pre-school subsidies, In Home Supportive Services, and federal programs such as EITC, LIHEAP, VITA). Individuals at CBOs or public agencies who currently enroll individuals into these public benefits should have a seamless process for educating, screening and assisting the individual in accessing health coverage programs provided through the Exchange. c. Secure federal funds for the implementation of effective two-way horizontal integration by including it into federal establishment grants. As part of the paid navigator program, the assisters who enroll in other benefits should be strongly considered for navigator compensation to incentivize them. **B. Assister Online Portal and 1-800 Line.** Creating an accessible assister or navigator portal with all materials available will significantly improve functionality for the enrollment system. However, we would recommend that rather than creating a new electronic portal, that this be a component of the CalHEERS system accessible by certified navigators and DBAs. In addition, we wholeheartedly agree with the recommendation the Exchange create a 1-800 technical assistance line for navigators. Direct access to help with technical, problem solving, data and other enrollment issues will improve efficiency and make the enrollment process more accessible for Californians.

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	C. CCAN also supports the recommendation that technical assistance be provided via several avenues to assisters. This assistance should be provided through but not limited to the following avenues: phone support, a website, regular calls, webinars, and conferences. **D. Mechanisms and protections should be implemented to protect consumers from bad actors.** Individual certified paid navigators should be fingerprinted or have appropriate background checks by the entity they work for. In addition we need to protect consumers from bad actors. Navigators should be required to wear a friendly nametag (not a badge) with their certification number and enrollment entity anytime they are outside their entity's offices. Require Entities to display a certification certificate in their lobby or front window – could create an official "Insurance Help Happens Here" type of sticker or plaque for entities to display indicating that they are officially recognized by the state.
California Coverage and Health Initiatives	**CCHI strongly recommends that the Exchange include a robust two-way horizontal human services integration component in the assisters program as well as the marketing and outreach plan.**
California Family Health Council	Trusted providers like those in CFHC's Title X network want to be a part of the Exchange's success and they are well positioned to support the success of the Exchange as both Navigators and Direct Benefit Assisters. But adequate compensation must be available for all related staff time including training, outreach and enrollment under both categories. CFHC also urges the Exchange to establish a workgroup reflecting the diversity of the state and including community providers to determine details related to reimbursement, compensation and training.
California Hospital Association	Thank you for the opportunity to comment on this very key issue. CHA is supportive of a successful Exchange where many people will have access to many choices in health care coverage. We would also be happy to arrange for the management and staff of the Exchange to visit a hospital with a program in place that currently assists individuals find access to health care coverage. Please let us know if there are any questions you have or additional information you need.
California Pan-Ethnic Health Network and Having Our Say Coalition	**HOS recommends that Assisters training include basic training on other health and human services programs.** Assisters should be able to identify potential eligibility for other health and human services programs. This is especially important for consumers where enrollment in one program is linked to enrollment in another program, for example: between Medi-Cal, CalFresh, and CalWORKs. Assisters should be able to help consumers seamlessly and quickly access CalFresh, CalWORKs, and WIC benefits after applying for health coverage – and vice versa. The role of Assisters should include expanding or creating two-way connections between health coverage and other health and wellness supports – such as working family tax credits, child care and pre-school subsidies, In-Home Supportive Services, and more – in a targeted and phased in manner.
California School Health Centers Association	**As a member of the California Consumer Advocates Navigator Work Group (CCAN), CSHC urges the Exchange to consider the comprehensive comments submitted by that group, in addition to those submitted here.** We believe that CSHC's individual comments are complementary to CCAN's, and we hope to see them reflected in the Assister program.
California State Rural Health	CSHRA applauds the short mention of coordination with Department of Insurance, although this is an area clearly in need of further shape and clarification. We reserve the privilege of addressing this issue in subsequent communications with the

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Association	CHBE board and in additional public hearings. Similarly, our recommendations above regarding the Office of the Patient Advocate and Dept. of Managed Health Care can be further developed and submitted to the board. CSRHA cautions that the Exchange should be careful not to disrupt other agencies' administrative pieces already in place, or add unnecessarily to further fragmentation of accountability over the health care and health insurance systems.
Centro Binacional Para El Desarollo Indigena Oaxaqueño	• In the document, clarification needs to occur regarding application and enrollment words. One application can result in several enrollments. • The ability for DHCS and MRMIB to share data electronically to EEs should be required. The accurate tracking of applications and enrollments is critical. • Clarification on the compensation after completion. Compensation is after successful completion but what if they are not enrolled for some reason then there is no compensation for all the previous work done?
Centro La Familia Advocacy Services	Centro la Familia Advocacy Services (Centro) ensures that low income families have access to life sustaining resources. We have been serving about 3000 Fresno families annually with culturally competent advocacy and direct services since 1972. We have been active in convening similar agencies and others interested in health care issues since the health care reform act was initiated in California. Centro is very much aware of the unique challenges in reaching the very poor and non-English speaking populations, especially when introducing new programs or services. We have been active in conducting public education and outreach activities to raise awareness of the Exchange, QHPs, public health insurance plans like Medi-Cal and the availability of premium tax credits and cost sharing subsidies. We understand the essential role of Certified Applicant Assistors (CAAs) in assisting the uninsured with education, outreach, enrollment and navigation for the HBEx and we concur with the Exchange that the most important considerations are the needs of consumers. The consumers most in need of CAA guidance in these new procedures are those who are culturally and socioeconomically diverse, these also tend to be the most undeserved. The Certified Application Assisters in California comprise the nucleus of the Distribution Channel. The CAA is often the key person that participants interact with in terms of health care services and from whom they gain an understanding of what is available within a particular health plan. CAAs have proven their success and experience in educating and assisting individuals and families with health coverage enrollment for many years in California. The HBEX will need a pool of skilled and knowledgeable individuals who can guide families through these new benefits, processes and eligibility requirements.
Consumers Union	Seamlessness: The proposal does not directly address the problem of achieving continuity and streamlined assistance. In instances where an Assister is unable to provide the particular assistance required (e.g. a very complex Medi-Cal case), what will be the requirements and process for transfer so as not to disrupt the family and to provide continuity in assistance? The proposal needs to develop a plan that outlines how transfers will occur without disrupting the experience or making family start over – and describe how the Project Sponsors will monitor that process.

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	Also, the RHA proposal (p. 14) restating the federal regulation on agent compensation should be corrected. The proposal states that federal guidelines require that agents "may not receive *compensation* from carriers for enrollment in the Marketplace products." But the federal regulations actually say agents may not, "Receive *any consideration* directly or indirectly from any health insurance issuer in connection with the enrollment *of any individuals or employees in a QHP or a non-QHP.* " The proposal should be corrected to reflect that the federal regulations require not only a ban on compensation, but on all consideration, and, that the restriction on agent receipt of any carrier consideration applies to all products, both offered in the Exchange and outside it. Overall, it is important to look at the Assister program in the context of the entire fabric of the enrollment system-to-come, including the "call center." While we understand that the conversation about call center development is forthcoming, we think it is important to recognize that California will need to have a stable, robust call center, centrally located and staffed, that will answer questions, and provide important basic assistance. While the call center may not be able to provide the kind of in-person, detailed help offered by the Assister program, it will be a central place for Californians to learn about and get assistance from the Exchange. For example, trained staff of the call center should be able to quickly help someone fill-out an online application when they have no access to a computer. In the bigger picture, the call center will be the direct interface between the Exchange and the purchasing public—the Exchange's sales center. While it is wise to get "all hands on deck" to help maximize enrollment particularly in the crucial start-up years of the Exchange, we urge the Exchange to build its enrollment apparatus ever cognizant of the long-term goal of establishing a strong, credible direct sales function at the Exchange that will both minimize sales costs, maximize impartial assistance over time, and build "stickiness" for consumers with the Exchange.
County Welfare Directors Association	**Data issues/assumptions.** It is not clear what the assumptions of 25%/50%/75% needing assistance are based on, or how they mesh with other assumptions used in other materials presented to the Exchange board regarding numbers of enrollees expected; the number of likely pre-enrollees into Medicaid from other sources such as LIHP and CalFresh; or the number or percent who will use other pathways on their own such as online, in-person at county offices, phone, and mail. It seems important to reconcile the various assumptions.
Fresno Healthy Communities Access Partners (HCAP)	• We noted in the document that clarification needs to occur regarding the use of "application "and "enrollment". One application can result in several enrollments and this distinction is important in the payment formulas. Payment should be based upon an enrollment basis. • DHCS and MRMIB need to be required to hare data electronically to EEs. The accurate tracking of applications and enrollments is critical. The CAAs need to be supported in serving these families with that information. We also have concerns that duplication of counting because of paper applications and electronic submissions may occur if not accurately and promptly tracked and reported.
Health Access	Market saturation is a misplaced concept given the probably turnover in Exchange enrollment: in the current market, half the uninsured are uninsured for less than a year and about half the individual market turns over in a period of two years. The

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	Exchange provides residual coverage for those who are not covered by affordable, employment-based coverage or eligible for Medi- Cal/Healthy Families. In a multi-payer system, some churn is inevitable and so is the need for assistance. Health Access supports efforts to improve retention in employment-based coverage as well as Medi-Cal/Healthy Families: we also support retention in the Exchange of those who lack access to affordable, employment-based coverage (as defined in federal law and rules/guidance/regulations) or to Medi-Cal/Healthy Families.
Health Consumer Alliance	Thank you for the thoughtful work to date on developing plans for the Assistor Program in California. We look forward to partnering with you on this critical effort. In anticipation of the Exchange staff's report on Consumer Assistance/Ombudsman Options in June, HCA provides the following principles based on our 14 year experience providing consumer assistance in California. Since October 2011, the HCA has served as the statewide grantee of California's Department of Managed Health Care (DMHC) for the federal Consumer Assistance Program (CAP) through the Federal Center for Consumer Information and Insurance Oversight (CCIIO). This CAP grant is a trial for just the sort of program the Exchange is now considering. HCA's experience should be incorporated and relied upon in the planning for Exchange consumer assistance services. HCA is very interested in building on the structure used for the DMHC program to provide consumer assistance services to consumers using the Exchange. Many of those who will become eligible for the health insurance through the ACA have been uninsured for at least a year and the Exchange must meet the needs of this population. Many will likely be low-income, will not have had access to employer-based coverage, will not meet the criteria to qualify for public health coverage, and will have limited English proficiency. While a number of consumers will have no problems accessing services via the phone or internet, many health consumers will need an in-person encounter in order to adequately serve their needs or will need to talk to a bilingual advocate who works in the community and can help them navigate local resources. A need will remain for access to in-person and locally-based Exchange consumer assistance. We recommend that the Exchange arrange for that assistance to be provided by existing consumer assistance programs or community-based organizations. The newly eligible will need additional assistance in obtaining answers to general questions about coverage, helping to get enrolled in the right program, choosing the most appropriate health plan for their needs, accessing care, and staying enrolled. In fact, all consumers may need these services. The best way to receive these services is through independent consumer assistance that can provide vigorous advocacy and can utilize the individual experiences to identify and address systemic barriers that will help many people at once. We recommend that the Exchange provide some consumer assistance through referrals to independent non-profit agencies, such as HCA, and prioritize referrals of certain vulnerable populations for this assistance, such as low-income populations that require assistance with public and newly available private health insurance options. Independent consumer assistance should be provided by organizations that have a history of successfully

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	working on health care access issues for these populations, have capacity for providing legal assistance, and can work on system-wide barriers. Local in-person assistance should be available. These independent non-profit agencies should cover three essential pillars for effective consumer assistance: independence; legal experience; and a focus on systems change. The non-profit agencies must have a history of successful independent advocacy on behalf of low-income health care consumers, must be able to offer legal assistance including in-person assistance, and must have capacity to work on system-wide barriers that affect low-income consumers. Locally-based consumer assistance duties should include, but not be limited to, the following: • Assisting consumers in navigating the local health care system; • Advising consumers regarding their health care coverage options and helping enroll consumers in and retain health care coverage; • Assisting consumers with problems in accessing health care services; • Assisting consumers with appeals and grievances to get coverage and services • Serving consumers with special needs, such as those with limited English language proficiency, people requiring culturally competent services such as refugees and elderly immigrants, low-income communities, persons with disabilities, consumers with low literacy rates, homeless individuals and persons with multiple or chronic health conditions; and • Collecting and reporting data on the consumers they assist. Important data elements include: information on subgroup categories of race, ethnicity, language preference, income, and information on the types of health care coverage problems consumers face, the resolution of their problems, and timeliness of responses to requests for help.
Insure the Uninsured Project	In our view one of the keys to the success of the Exchange and Medi-Cal expansions will be its branding and adoption of simple and consumer friendly procedures to enroll. We urge reliance on multiple open doors to the new IT system and vendor for automated enrollment of Exchange and Medi-Cal MAGI eligibles, rather than relying primarily on the 58 county social services offices. Similarly, we would urge your support of a state-wide call center, rather than the checkerboard of 58 local welfare offices with varying levels of commitment and capacity to assist up to 6 million new ACA eligibles. We do not believe ACA implementation will be well-served if small business owners' and moderate and middle income working families' introduction to resolving the inherent difficulties, questions and confusion about the new program is through the local county welfare worker. We do think that county social services offices will play a vital role with the 2-3 million individuals newly eligible for Medi-Cal, be fully engaged in the Navigator and Assister roles under the ACA, and will be urgently needed to help decipher, explain and sort through the interface between MAGI and non-MAGI Medi-Cal for individual applicants.
Kaiser Permanente	We see two related areas of enhancement. For an enrollment (or "sales") and retention program to be successful, the sponsors must ensure that the various components are integrated, with different roles filling the different needs of the market.

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	We recommend the Exchange itself play a critical role in its own promotion and distribution, and that it must include a direct sales function. The role of the Exchange Direct Sales function would be to follow-up on the leads generated by the Exchange's advertising and direct marketing campaigns, assist applicants in selecting the plan most suitable to the family's needs, and ensure each applicant understands the benefits they are selecting and the rate to which they are agreeing. Relative to the other Assisters, the Exchange could coordinate these efforts with Navigators - developing protocols about the types of leads that would be managed by Navigators v the Exchange's Direct Sales staff. The Exchange may wish to jointly market with a Navigator, and allow the Navigator to manage the lead and assist the applicant. If the Exchange does not develop a Direct Sales function, the Exchange should explicitly assign this role to Navigators, and spell out how leads that are generated by the advertising and direct marketing will be directed to the Navigator. In that case, there should be a reporting mechanism between Navigators and the Exchange to identify Navigator sales that originated from the Exchange, v which were developed through a Navigator's own outreach efforts. This feedback will help the Exchange market more efficiently, and understand which of their outreach efforts are effective. Second, we believe there is opportunity for cooperation between the Exchange and assisters. Specifically, we believe that Health Plans and their agents will be marketing their products to all segments of the individual market, including individuals who may be eligible for a subsidy through the exchange. We propose the Exchange allow enrollments to transfer in from Health Plans and Agents for individuals eligible for a subsidy. Indeed, we believe this form of joint effort should be part of the Exchange/plan selective contracting process. Finally, there is a substantial focus in the recommendations regarding the issue of steerage. While we understand this concern, it needs to be balanced against a far greater concern, particularly in the early years of the Exchange: the need to successfully enroll individuals on a massive scale. The failure to achieve very substantial participation rates in the Exchange will, more than any other single factor, undermine the viability of the Exchange, and force premiums up. It must be recognized that direct benefit assisters will have a financial incentive to enroll individuals in a particular way. Health plans will not extend great effort to enroll people into competing health plans. Providers will not generally enroll individuals into plans that exclude the provider from their networks. We think this must be recognized – and we would suggest accepted. Instead of attempting to eradicate the natural tendency of private actors to enroll individuals in their own systems, the Exchange might choose instead to embrace this incentive to generate the massive enrollment that will be needed for the Exchange to succeed.

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	It must be recognized that direct benefit assisters will have a financial incentive to enroll individuals in a particular way. Health plans will not extend great effort to enroll people into competing health plans. Providers will not generally enroll individuals into plans that exclude the provider from their networks. We think this must be recognized – and we would suggest accepted. Instead of attempting to eradicate the natural tendency of private actors to enroll individuals in their own systems, the Exchange might choose instead to embrace this incentive to generate the massive enrollment that will be needed for California's Exchange to succeed. The best path, in our view, to managing steerage is to allow direct benefit assisters to enroll vigorously, but to focus concurrently on building a strong navigator program, rigorously oriented toward measurable success metrics, with compensation depending on achieving those success points, and building the Exchange's own direct enrollment staff. In addition, requirements that direct benefit assisters inform prospective enrollees of cheaper options – including when those options are available through competitors -- and use approved marketing materials, are entirely appropriate protections in all cases, however, and should be enforced.
Maternal and Child Health Access	The various "Assistance Gap" created by the funding availability is an opportunity to integrate with higher education, vocational schools and elsewhere with public education. MCHA hopes this will be explored. MCHA agrees with CCAN that the Exchange should clarify whether the compensation models are based on a pay per application or pay per enrollment basis, since the report is ambiguous and concurs with CCAN that, if any Pay for Enrollment model is adopted, or the Hybrid model is adopted, the fee is paid per person successfully enrolled.
National Health Services	The Report's recommendation is based on the assertion that CCHCs have an incentive to enroll individuals and thus do not need additional resources for this work. The report inaccurately assumes that CCHCs are able to independently support robust and active outreach and application assistance programs without remuneration. For many CCHCs in California, compensation for application assistance is necessary to support an outreach and enrollment program that is adequate for the millions of newly eligible individuals in underserved communities. The Report's recommendation is based on the assertion that CCHCs have an incentive to enroll individuals and thus do not need additional resources for this work. The report inaccurately assumes that CCHCs are able to independently support robust and active outreach and application assistance programs without remuneration. For many CCHCs in California, compensation for application assistance is necessary to support an outreach and enrollment program that is adequate for the millions of newly eligible individuals in underserved communities. The report notes that "Excluding specific types of organizations from serving as Navigator entities may reduce the overall size of the network and reduce access to assistance." If the HBEX does not allow safety net clinics to participate as Navigators the result will be a far less robust outreach and enrollment program where far fewer eligible individuals will be enrolled in coverage.
Planned	Planned Parenthood is committed to ensuring robust enrollment in the new coverage options to provide lower cost

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Parenthood Affiliates of California	comprehensive health care to millions of Californians. We plan to actively engage in outreach and education to the populations that we serve. We stand ready to partner with the Exchange and State Departments to provide targeted outreach to these vulnerable and often hard-to-reach populations. We look forward to engaging in the proposed partnership and grant options outlined in the Discussion Draft of the Statewide Marketing, Outreach & Education and Assisters Program Workplan submitted on May 17. We appreciate the speed with which the Exchange and contractors are working to tackle the enormous job of implementing the Affordable Care Act and understand the need for timely stakeholder input. These are preliminary responses to the assister program as proposed in the document dated May 24. Planned Parenthood is currently discussing the assister proposal with our patient services and health center administration to better understand its implications. We look forward to responding more fully after considering the proposal in greater detail, and will do so as quickly as possible.
San Mateo County Union Community Alliance	*"Enrollment in Other Programs:* RHA recommends that Navigators and Direct Benefit Assisters be offered training in other programs for which consumers may be eligible (e.g. CalFresh, CalWorks etc.). It is not recommended that enrollment in other public programs be required of Navigators nor Direct Benefit Assisters." SMCUCA notes that in San Mateo County, it is critically important that the Navigators and the Direct Benefit Assisters be trained and certified to enroll residents in the County's Health Coverage initiative (ACE) and in its "dual eligibles" pilot (that is currently being developed). These programs stand with Medi-Cal, Healthy Families, Medicare, the subsidized and unsubsidized plans offered by the Exchange and private insurance to ensure that everyone in the County getting the health care that they need. If the Exchange's Navigators and Direct Benefit Assisters are only trained and certified to enroll people in "insurance" then the Exchange will be tearing holes in San Mateo County's carefully woven health safety net that includes the coverage initiative, the public health insurances and the private insurance market and its comprehensive network of health care providers.
SEIU	We appreciate the thought and effort that HBEX has undertaken to ensure that there is a robust effort in California to provide application assistance. We agree with the HBEX proposal's underlying premise that navigators and direct benefit assisters (assisters) can provide fair and impartial information to consumers. Since eligibility workers are mentioned on page one, but not seemingly included in the definition of either navigators or DBAs, it is curious to see the emphasis on eligibility. While we acknowledge that there is a clear relationship between assisters and eligibility workers, there is not a lot of clarity on how these two types of workers will interact and support consumers to meet their coverage needs. SEIU believes that there is a clear relationship between eligibility workers and assisters, and see the assister's role as an important piece to ensuring that application information is accurate so that the work of eligibility workers are facilitated. It is important to ensure that each step and role in the process be clearly articulated to establish a warm handoff process between assisters and eligibility workers. This would facilitate a high level of coordination that can support

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	"real-time" eligibility determinations envisioned by the ACA. P. 10 notes that assisters will be particularly needed at in the early years of the program. While there may be a surge at the beginning, there will continually be people in and out of these products. We urge HBEX to consider the implications that these long term needs have in terms of certification and budgeting. Thank you so much for the solid thinking that went into this draft proposal. It reflects a lot of the work done by HBEX staff and consultants. We offer some general and some specific comments in order to strengthen the final product. As always, SEIU's goal is the successful enrollment in health coverage of as many un and underinsured Californians as possible January 1, 2014 and beyond. This success of this plan is absolutely central to the success of the Affordable Care Act.
United Ways of California	**A. UWCA strongly recommends that the CHBE include a robust two-way horizontal human services integration component in the assisters program as well as the marketing and outreach plan.** Every year millions of people seek out programs and services to meet their critical needs such as food, shelter, income supports, and child care. Even though there may be health needs, health is often not the presenting need as it may not be the most immediate threat to an individual, child or family. However, many of these millions are part of the target population the CHBE needs to reach to achieve enrollment goals. We appreciate the tremendous effort the State is currently undertaking to build an Assisters Program, a Marketing plan, and an Eligibility, Enrollment & Retention System in a very compressed timeframe. We know that reaching people through integration with other human services programs is a crucial element of all three systems. We believe based on experience and data from our partner organizations, that human services integration is the key to success in reaching all Californians for health insurance. We strongly recommend that the CHBE include a robust two-way horizontal human services integration component in the assisters program as well as the marketing and outreach plan. Two-way horizontal integration means a system where 1) those applying for health insurance are also assisted or guided into other programs for which they may qualify, and 2) those who are seeking other nutrition, housing, or income support programs would be educated, screened, and guided into health coverage. We recommend that the State's plans commit to three specific goals for integration: a. Protect and modernize the current connections between health and human services – such as Medi-Cal, CalFresh, and CalWORKs -- as the new systems and processes are built. All assisters should have basic knowledge about other public benefit programs and be able to efficiently assist consumers in accessing these programs. The training curriculum should include elements on eligibility for other programs. b. Vice versa, expand or create connections to health coverage from other public benefit programs that support health and overall wellness in a targeted and phased manner - (Examples: CalFresh, CalWORKS, WIC, working family tax credits, child care and pre-school subsidies, In Home Supportive Services, and federal programs such as EITC, LIHEAP, VITA). Individuals at CBOs or public agencies who currently enroll individuals into these public benefits should have a seamless process for educating, screening and assisting the individual

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	in accessing health coverage programs provided through the CHBE. c. Secure federal funds for the implementation of effective two-way horizontal integration by including it into federal establishment grants. As part of the paid navigator program, the Assisters who enroll in other benefits should be strongly considered for navigator compensation to incentivize them. **B. UWCA agrees that enrollment entities should have an adequate level of liability insurance**. **C. Tie marketing strategies and tactics to enrollment through a code, number or drop-down menu on application.** UWCA recommends the CHBE explore ways to link the various outreach strategies and tactics to the enrollment that ensures from them as many in the private market already successfully do. It would be a valuable to measure ad value and placement and various outreach materials such as cash sleeves, gas pump, etc. to see what is ultimately successful. The CalHEERS app could ask for a code or ask how they found out about program with options listed on a drop down menu. By analyzing this data, the CHBE would know how to shift investments and where to invest in the future. **D. Mechanisms and protections should be implemented to protect consumers from bad actors.** Individual certified paid navigators should be fingerprinted or have appropriate background checks by the entity for which they work. In addition we need to protect consumers from bad actors. Navigators should be required to wear a friendly nametag (not a badge) with their certification number and enrollment entity anytime they are outside their entity's offices. Likewise, entities should be required to display a certificate in their lobby or front window indicating they are properly designated as an enrollment entity by the state. The CHBE could create an official "Insurance Help Happens Here" type of sticker or plaque for display indicating that they are officially recognized.