California Health Benefit Exchange

Stakeholder Input:
Service Center Potential Approaches to Effective Screenings and Referral Protocols October 30, 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 Service Center potential approaches to effective screenings and referral protocols which were presented to the public at the September 18 Exchange Board meeting. The proposals are detailed in a Presentation available on the Exchange website entitled *Service Center Screening and Referral Protocols*. Feedback was solicited for three (3) Potential Approaches and the Strengths, Weaknesses, and Opportunities of each as well as general comments. Twenty-one organizations submitted comments using a stakeholder input form provided on the Exchange website and two organizations submitted comments in separate letters. Comments received on the input forms and through letter form have been compiled in the tables below. Letters will also be posted separately on the Exchange stakeholder webpage. Stakeholder comments will be used for consideration of revisions to the Service Center Protocols Board Options Brief. 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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Comment Letters Submitted

Consumers Union of the United States

California Pan Ethnic Health Network

Comment Forms Submitted

100% Campaign

Pico California

California Coverage and Health Initiatives

United Ways of California

Robert F. Kennedy Farm Workers Medical Plan

Healthy Kids Mendocino

BHRS San Mateo County

SEIU Local 221

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General Comments on Potential Approaches

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Organization	**Comments**
100% Campaign & Partners (Pico California, California Coverage and Health Initiatives, United Ways of California)	**With regard to all the approaches:** • **Seek CMS/CCIIO Guidance.** We recommend that HBEX and Department of Health Care Services should reach out to CMS to ask for guidance on specifics of Exchange Medicaid assessment compliance: What is the federal legal construct for a "simple sorting" protocol as opposed to an assessment; what questions can be asked in a screen and not duplicated, and what counts as "potential eligibility" for Medicaid. The State agencies should get federal guidance on what is legally allowable under the Affordable Care Act and the regulations before making a decision. • **Any Medicaid assessment (options 2 or 3) or sorting process (option 1) must maintain the streamlined and seamless criteria, and not duplicate questions.** The application/eligibility process will need to meet federal and state eligibility and enrollment requirements of not asking duplicative questions, providing a real time determination, and being streamlined and seamless. For example, the answers a caller provides to sorting or assessment questions must be collected and forwarded or available in real time to the county worker receiving the warm hand off, so the caller does not have to answer these questions again for their Medi-Cal eligibility determination. In addition, regardless of the option chosen, there should be specific protocols in place to ensure a person is able to get the assistance they need in their language, or in the case of a disability, get appropriate accommodations. This should be true whether it's at the state or county level. None of the options in the presentation addresses this question. (See comment below on Limited English Proficiency callers).

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	• **Starting an account and starting an application.** With the caller's consent, the call center or county worker should be able to start an electronic account at the beginning of the process, if the family needs to return to the application (e.g. they needed to locate some essential eligibility information or the applicant needs to end the call). The protocol should also establish the minimal information needed to constitute an application, in order to help the applicant, who has to leave the call (whether with the county or the state call center), to have at least secured an application start date. • **Coordinated enrollee data system and online account access that works for families.** Consumers have the right to apply and renew for health coverage online as well as by phone. Regardless of what "door" they applied through or the program they enrolled in, consumers must be able to access their account online. This online account functionality for all applicants and enrollees will be important for coordination of coverage for all enrollees, particularly for those families with members in multiple programs and for those enrollees transferring from one program to the other. A mixed coverage family should be able to access one online account for all family members. Subcontracting/partnering agencies should follow the same standards for data entry, updating, and retrieval into this shared data system. This approach does not preclude another system from also holding the cases they are responsible for managing. • **Regardless of the option, the *"warm"* hand-off is essential for Medicaid applications taken over the phone to work in this framework.** For a phone application to be seamless, streamlined, and without delay, callers who appear Medi-Cal eligible from an assessment or a sorting mechanism must have a warm hand-off. What we mean by a warm hand-off is that the first customer service representative stays on the line until the second representative is there and transmits electronically to the second representative the information the consumer provided the first representative. The protocol should outline what constitutes reasonable timing for a warm hand-off. (We agree with the HBEX's assumption that the warm hand-off timeliness should be the "80/20" rule whereby 80% of the callers will have a warm hand-off in

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	20 to 30 seconds or less.) Also, the protocol should establish a contingency plan when a warm hand-off is not possible. That contingency protocol should maintain the seamless, streamlined, and "real time" principles. For example, when a warm hand-off is not available, the state call center should go forward with assisting the family with their application and make an eligibility determination as proposed in Option 1 and 2. What should not occur is the Medi-Cal eligible family member being given another phone number for future application assistance or left to wait up to 45 days to hear the results of a determination without immediate coverage (option 3), if such eligibility for Medicaid or Exchange coverage can be made in real time over the phone without delay. We cannot support any two touch option that does not have a warm hand off. • **Contingency protocol when "real time" is not possible.** Whether the county or the state call center is accepting and processing an application, if neither are able to provide "real time" enrollment for an applicant, there should be a contingency protocol for getting as close as possible to "real time" enrollment. For example, approach #3 will need to outline how this protocol option will provide enrollment without delay. We cannot support an option that does not preserve "real time" coverage. • **Due process rights are preserved and protected**. The Exchange and DHCS have to establish clear protocols and standards to ensure that, whether through a quick sort or full Medi-Cal assessment, the caller's due process rights are honored and not bifurcated. A few examples illustrate the complexity bifurcation creates: if callers apply and are erroneously sorted or assessed by the Service Center as over-income for Medi-Cal, how will the system preserve the decision for appeal? Will there be an official determination entered by the Service Center from which the caller can appeal? Would that appeal be the responsibility of the Exchange, DHCS, or the county? How will it be registered with Medi-Cal when there has been no transfer to the Medi-Cal system? Will both the Exchange and Medi-Cal undertake separate

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	"reasonable compatibility" processes? • **Consistent call center performance standards for state call center and all subcontractors.** As counties will be contracting with the state call center, counties, along with the other subcontractors and the state call center itself, should be subject and accountable to the same performance standards as are necessary to comply with federal rules. • **Caseload assessment and readiness plan.** The Exchange and DHCS with its state call center subcontracting partners, like the counties, will need to develop a collective assessment of caseload projections and review and approve plans for how demands will be met (including personnel commitments and technology interface), including contingency plans for immediately responding to unexpected shifts in caseload volume. The Department, counties, and the Exchange (and their respective call centers) will need to agree on caseload projections and have a collective plan (meeting federal approval) that is based on realistic assumptions of readiness to respond to projected caseload demand. • **Specific protocols for assisting Limited English Proficiency (LEP) callers and persons with disabilities.** The Exchange and state call center should put protocols into place to ensure that an LEP consumer and/or a person with a disability is not subjected to longer wait times due to the lack of availability of call center staff or the appropriate technology to help them. The protocols should include specific instructions for helping LEP/disabled consumers and should allow for an assessment of LEP/disabled status. If someone triggers an indicator that they are LEP/disabled, wherever that person is transferred to, there should be a trigger on the application so that the person receives culturally and linguistically appropriate assistance, including written translations and oral language services as required by state and federal laws. Finally, there should be a contingency protocol when "real time" assistance is not possible. The Exchange should require that if a bilingual application assister cannot be found within a "reasonable" amount of time, then that person would be allowed to continue to process their

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	application with the original bilingual agent that is assisting them (see "warm hand-off" for more information). • **Mixed-coverage families.** We understand that the protocol for families eligible for multiple programs is a separate pending issue for a future Board discussion. However, we think the manner in which families eligible for multiple programs are handled must be decided in coordination or at the same time as a decision for which the call center protocol option is chosen. It is important to consider how these families fare in the various protocol approaches and which approach offers them the best opportunity for a seamless, streamlined enrollment. Such a family should be able to have their eligibility determined, be enrolled in coverage, and select a plan with one representative and one process. Additionally, an ongoing case management process must be decided for enrollees, so that there continues to be a first-class post-enrollment consumer experience. We note that Exchange coverage presents new and unique management issues including premium tax credits and related IRS end-of-year reconciliation implications, as well as distinct QHP oversight obligations. • **Attention to consistent training protocols for Exchange premium tax credits.** As mentioned, the unique nature of Exchange premium tax credits, such as the end-of-year reconciliation, as compared to a public program eligibility determination, warrants particular attention to consistent and accurate use of training protocols for all those involved with application assistance—county workers, state call center workers, and navigators. For example, because consumers can apply in-person and can therefore walk into a county office to apply for coverage, county workers will have to be fully trained on Exchange subsidies and cost-sharing reductions and will have to be able to enroll people into Exchange QHPs. • **No "ping ponging" callers.** Because the Administration has decided that Medi-Cal eligibility determinations will be made by the county, those calling the state service center who are likely eligible for Medi-Cal will likely have a "two touch experience." Any sort or assessment, short of

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	a full eligibility determination will, by definition, means that some Medi-Cal eligible people will stay at the state service center and some people eligible for Exchange subsidies will be sent to the county. The former group should have their Medi-Cal enrollment done by the state service center representative and the latter group, who were sent to the county, should have their Exchange enrollment completed by the county representative. Both should also be able to select a plan with the entity who enrolled them into coverage. • **All options should map horizontal integration.** Regardless of which option is chosen, there should be a clear protocol for phone applications regarding how to link applicants to other public programs, including CalFresh and CalWORKs.
Alliance to Transform CalFRESH & Partners (Western Center on Law and Poverty, California Food Policy Advocates, Congress of California Seniors, California Immigrant Policy Center)	**Regardless of the approach chosen, the service center design should have a clear protocol for integration with state public programs serving the same families, including CalFresh, CalWORKS, and other vital services**. This integration has many benefits: it will improve customer satisfaction with the Exchange services; increase enrollment in both health coverage and other under-subscribed supports by streamlining and connecting programs; and boost overall wellness by supporting the nutrition and basic incomes essential to good health. In addition, telephone service should provide the same seamless integration as the on-line application design and the in-person service in County offices, for a consistent, high quality consumer experience. Our groups' two recommendations are: 1. Require that the worker providing the primary assistance to the consumer, whether a Customer Service Agent or County Eligibility Worker depending on the approach, also assists applicants to seamlessly connect to public programs. 2. Require uniform, high-quality standards for the consumer experience in connecting to and applying for CalFresh, CalWORKs, or other public programs, again regardless of approach

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	taken.
Asian Pacific American Legal Center	The Asian Pacific American Legal Center (APALC), a member of the Asian American Center for Advancing Justice, would like to thank the Exchange for their tremendous work on creating a comprehensive service center. APALC's leads a statewide coalition, the Health Justice Network, (HJN) representing over 30 Asian American, Native Hawaiian, and Pacific Islander (AANHPIs) organizations committed to health care reform implementation. Many of our HJN members have had experience assisting limited-English proficient (LEP) clients navigate the current health care system and have had to deal with cultural and linguistic barriers, including delays in accessing public benefits, communication problems with eligibility workers and health plan customer service representatives, and general frustration with dealing with service center lines. For example, one of our regional partners, the Asian Law Alliance (ALA), has provided testimony regarding problems faced by their clients with county eligibility workers in Santa Clara County. They not only have faced access difficulties with their LEP clients but also those with mental and physical disabilities. *See attached* Office of Civil Rights Complaint filed by a disability rights advocacy agency working with ALA). As the cornerstone principle in the Exchange's service center plan of providing "a first class consumer experience," and as acknowledged by the Exchange, the only way to achieve this is to account for California's diverse population of cultures, languages, and health literacy levels through "culturally and linguistically appropriate communication channels," As noted before, Asian Americans, Native Hawaiians and Pacific Islanders trace their heritage to more than 50 countries and speak more than 100 different languages. Data from the U.S. Census Bureau's American Community Survey reveal that more than 3 million people in California speak Asian and Pacific Island languages at home and more than 1.5 million of them are considered LEP. Therefore it is critical whichever partner/site the Exchange decides to contract with, that the service center option provide culturally and linguistically competent services, including but not limited to hiring

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	adequate numbers of bilingual staff or have other methods to provide interpreter services for any LEP caller and providing cultural and linguistic competency training for all staff, We also recommend that before the Exchange contracts with another entity as a service center partner, the Exchange assess, test, and evaluate its capacity to provide to provide timely and accurate culturally and linguistically appropriate access, including interpreter services for any LEP speaker. **Relevant Authorities** We would like to share two additional federal and state statutes that we recommend the Exchange consider as it determines its responsibility to ensure linguistic access to the LEP consumers through its Service Center Options specifically as well as in the general overall operation of HBEX: 1) Section 1557 of the Patient Protection and Affordability Act (ACA), which applies federal anti-discrimination statutes, such as the American with Disabilities Act, Section 504 of the Rehabilitation Act, and Title VI of the 1964 Civil Rights Act (Title VI). As the Exchange is aware, Title VI prohibits discrimination based on race, color, or national origin, which has been interpreted to include discrimination based on language, in the provision of services or benefits of any federally-funded entity to LEP persons. Additional guidance is provided by the Office for Civil Rights, Department of Health and Human Services' (HHS) LEP Guidance (Guidance) under Title VI, which built upon Executive Order 13166 (which required federal agencies to publish guidance on how their recipients can provide meaningful access to LEP persons.) In the Guidance, HHS recognized that the more frequent the contact with a particular language group, the more likely that enhanced language services in that language are needed. (HHS, Office for Civil Rights, *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*, http://www.gpo.gov/fdsys/pkg/FR-2003-08-08/pdf/03-20179.pdf at 47314..) Further, LEP Guidance recognizes that all LEP individuals, regardless of meeting a threshold for translating written documents, must be afforded oral language assistance when needed.

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	(*Id.* at 47319). 2) CA Govt. Code Section 11135 et seq., which prohibits discrimination based on many protected categories, including race, national origin, and ethnic group identification by any program or activity that: 1) is conducted, operated or administered by the state or by any state agency; 2) is funded directly by the state; or 3) is receiving any financial assistance from the state. This statute is sometimes referred to as the state "equivalent" to Title VI of the Civil Rights Act of 1964... The state statute not only applies to the state's political subdivisions, contractors and other state-funded recipients, but it also applies to the state itself and its agencies as well as state-funded entities. The regulations that implement this statute define "ethnic group intimidation" to mean the possession of the racial, cultural or linguistic characteristics common to a racial, cultural, or ethnic group or the country or ethnic group from which the person or his or her forebears originated." (22 Cal. Code of Regulations (CCR) §§ 98000 et seq.) Language-based discrimination is also addressed in the regulations, which provide an extensive list of general discriminatory practices and include specific types of discrimination based on ethnic group identification. One provision states that it is a "discriminatory practice for a recipient to fail to take appropriate steps to ensure that alternative communication services are available to ultimate beneficiaries." (*Id.)*
California Pan-Ethnic Heath Network	CPEHN is a statewide network of multicultural health organizations working together to ensure that all Californians have access to health care and can live healthy lives. Our mission is to eliminate health disparities by advocating for public policies and sufficient resources to address the health needs of communities of color. **General Comments:** California's population is one of the most diverse in the country, with almost 60% comprised of communities of color and over 100 different languages spoken. More than 40% of Californians speak a language other than English at home, and an estimated 6 to 7 million Californians (or one in five)

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	are limited in their English meaning they speak English less than “very well.” In California, over 2.60 million non-elderly adult Californians will be eligible to receive federal tax credits to purchase affordable health coverage in the Exchange in 2013. Of these, 67% (approx. 1.73 million) will be people of color and 40% of the adults (roughly 1.06 million) will speak English less than very well. California must take the appropriate steps to ensure diverse communities including Limited-English-Proficient (LEP) consumers are able to enroll with minimal difficulties into health coverage in the Exchange. CPEHN believes in a single, streamlined eligibility and enrollment system as envisioned by the Patient Protection and Affordable Care Act (ACA). § § 1413 and 2201 of the ACA provide that exchanges will make final determinations of eligibility for *all* insurance affordability programs. This is memorialized in California state law which further clarifies the role of the Exchange in enrolling individuals into the Medi-Cal or Healthy Families programs. We are deeply concerned about the ability of the Exchange operated Service Center to properly serve Californians using a bifurcated eligibility and enrollment process. This is especially important as Exchanges are subject to both Title VI of the Civil Rights Act of 1964 and Section 1557 of the ACA which require that oral communication with Limited-English-Proficient persons (LEP) be in a language that they understand. This oral interpretation requirement is also codified in California's Health Benefit Exchange law which "requires that the Exchange provide oral interpretation in any language." Before the Exchange opts to adopt a bifurcated process, the Exchange should obtain federal guidance on this matter and be able to show that it can comply with regulations put forth by both CMS and CCIIO which require states to offer a seamless consumer experience. Additionally, the Exchange must show how its Service Center will comply with federal and state laws with respect to non-discrimination and the availability of oral interpretation services in *any* language. CPEHN is strongly concerned that the three options under consideration may not adequately satisfy language access laws as well as the ACA requirements for a streamlined, non-duplicative eligibility and enrollment system. If the Exchange decides to move forward with a bifurcated option, staff recommendations

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	must address how LEP populations will access services for all three options: 1) Quick Sort, 2) Partial Assessment and 3) Full Assessment without any undue discrimination **Comments on Potential Approaches:** **CMS/CCIIO approval and guidance must be obtained before a decision is made:** We recommend that the Exchange and Department of Health Care Services reach out to CMS to ask for guidance on what safeguards need to be in place to ensure the Exchange can meet its ACA obligations as well as the specifics of Exchange Medicaid assessment compliance: What is the federal legal construct for a “simple sorting” protocol as opposed to a “full assessment;” what questions can be asked in a screen and not duplicated, and what counts as “potential eligibility” for Medicaid. The State agencies should get federal guidance on what is legally allowable under the Act and the regulations before making a decision. **Staff recommendations must address how language access requirements will be met:** As mentioned above, Exchanges are subject to both Title VI of the Civil Rights Act of 1964 and Section 1557 of the ACA which require that oral communication with Limited-English-Proficient persons (LEP) be in a language that they understand. This oral interpretation requirement is also codified in California's Health Benefit Exchange law which "requires that the Exchange provide oral interpretation in any language." Exchange staff must address how language access requirements will be met through a bifurcated system for all three options presented. In order to ensure the most seamless service, the Exchange must: • **Establish specific protocols for assisting LEP callers and persons with disabilities:** The Exchange should put protocols into place to ensure an LEP consumer and/or a person with a disability is not subjected to longer wait times due to the lack of availability of call center\ staff or the appropriate technology to help them. The protocols should include specific instructions for helping LEP/disabled consumers and should allow for an assessment of LEP/disabled

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	status. If someone triggers an indicator that they are LEP/disabled wherever that person is transferred to, there should be a trigger on the application so that that person receives culturally and linguistically appropriate assistance including written translations and oral language services as required by state and federal laws. Finally, there should be a contingency protocol when "real time" assistance is not possible. The Exchange should require that if a bilingual application assister cannot be found within a "reasonable" amount of time, then that person would be allowed to continue to process their application with the original agent assisting them (see "warm hand-off" below). • **Ensure LEP callers are able to access their records and service center assistance in their primary language:** Regardless of the option chosen, with the caller's consent, the call center should be able to start an electronic account at the beginning of the process through CalHEERs. Callers should be able to access their records if the family needs to return to the application (e.g. they needed to locate some essential eligibility information or the applicant needs to end the call) and make follow-up calls to someone who can assist them in their primary language. • **Obtain the assent of callers to be transferred to another agent:** All callers should have the right not to be transferred to another agent if they wish to continue working with the person who is helping them. CPEHN is deeply concerned that Options 1 & 2 will result in unnecessary delays for LEP callers who must first wait for an interpreter to ask them a short set of 5-8 questions followed by additional wait times for an interpreter at a second call center who will assist them through the rest of the process. Of the three options, Option 3 appears to be the least disruptive option within a bifurcated, two-step framework. • **Call center standards should be consistent across venues to ensure service is the same at the state and/or local level for all callers, including LEP callers:** As counties will be

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	contracting with the state call center, counties, along with the other subcontractors and the state call center itself, should be subject and accountable to the same performance standards as are necessary to comply with federal rules. This performance data should be made publicly available to consumers. • **DHCS and counties should be required to collect the same data on race, ethnicity and primary language as their Exchange counterparts:** The Exchange must collect data on the race, ethnicity and primary language of their applicants. The Service Center, counties and any subcontractors contracting with the Exchange must be required to collect and report this data. The data should be shared across departments and made available to the Exchange and consumers in order to track which populations are enrolling into the various health coverage options and through which channels. This information will help the Exchange evaluate the success of Exchange outreach and education efforts and to meet its goal of reducing health disparities. • **The Exchange must develop a robust evaluation process with stakeholders and consumers to ensure that whatever system is adopted, is working for California consumers including LEP populations:** To ensure cultural and linguistic access there should be a feedback loop and stakeholder engagement in the design and testing process for current and future modifications to call center protocols. The Service Center, counties and any subcontractors contracting with the Exchange must be required to collect and report on internal evaluation measures (e.g. call times) as well as to collect external evaluation measures such as consumer satisfaction surveys in multiple languages in order to measure the quality of the services provided. • **All options should require a *"warm"* hand-off:** For a phone application to be seamless, streamlined, and without delay, callers who appear Medi-Cal eligible from an assessment or a

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	sorting mechanism must have a warm hand off. What we mean by a warm handoff is that the first customer service representative stays on the line until the second representative is there and transmits electronically to the second representative the information the consumer provided the first representative. The protocol should outline what constitutes reasonable timing for a warm hand off. (We agree with the HBEX's assumption that the warm hand off timeliness should be the "80/20" rule whereby 80% of the callers will have a warm hand off in 20 to 30 seconds or less.) Also, the protocol should establish a contingency action plan when a warm hand off is not possible. That contingency protocol should maintain the seamless, streamlined and "real time" principles. For example, when a warm hand off is not available, the Exchange call center should go forward with assisting the family with their application and make an eligibility determination as proposed in Option 1 and 2. What should not occur is the Medi-Cal eligible family member being given another phone number for future application assistance or left to wait up to 45 days to hear the results of a determination without immediate coverage (option 3), if such eligibility for Medicaid or Exchange coverage can be made in real time over the phone without delay. • **All callers should be treated as mixed family cases:** A final decision about which option the Exchange selects should not occur in a vacuum without considering the needs of mixed family cases; rather each option should be assessed with the assumption that *all* applicants are potentially mixed family cases to ensure the option chosen best reflects the needs of families with complicated eligibility status. • **All options should map horizontal integration:** Regardless of which option is chosen, there should be a clear protocol for phone applications regarding how to link applicants to other public programs, including CalFresh and CalWORKs. • **Due process rights must be preserved and protected:** The Exchange and DHCS have to

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	establish clear protocols and standards to ensure that a callers due process rights are honored and not bifurcated. A few examples illustrate the complexity bifurcation creates: if callers apply and are erroneously sorted or assessed by the Service Center as over-income for Medi- Cal, how will the system preserve the decision for appeal? Will there be an official determination entered by the Service Center from which the caller can appeal? Would that appeal be the responsibility of the Exchange, DHCS or the county? How will it be registered with Medi-Cal when there has been no transfer to the Medi-Cal system? Will both the Exchange and Medi-Cal undertake separate "reasonable compatibility" processes?
California Rural Legal Assistance Foundation	CRLAF submits to the California Health Benefit Exchange comments on the potential approaches for the Service Center. Guiding all three potential approaches are principles such as providing both "culturally and linguistically appropriate communication channels" and "clear, accurate, responsive information tailored to the consumers' needs." We sincerely thank you for including the aforementioned in your principles for the consumer experience. CRLAF looks forward to seeing how these principles are translated into the actual implementation of a Service Center that does provide a "first-class consumer experience." In regards to all three approaches: 1. It will be useful to identify the protocol that will be utilized when calls are made by a consumer that may not fall within the parameters of "Are you calling the Exchange to understand your healthcare benefit options?" It is not clear whether those calls would be transferred elsewhere or if a brief explanation of the Exchange will proceed to check whether that consumer might benefit from the Exchange. 2. It will be beneficial to know, regardless of which potential approach is utilized, how the Service Center will be evaluated to ensure that the Exchange is providing a consumer friendly experience to the diverse groups in California.

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	3. CRLAF would like to note that there are mixed immigration status families and it will be useful to note how the Exchange will handle situations where perhaps one member may be eligible for the Exchange and does not wish to disclose family information for those who may not be eligible. 4. Once the Exchange moves forward with either one of the potential options (quick sort, partial assessment, or full assessment completed), will there be room to reshape the approach if it does not work as well in certain areas that may have historically high levels of uninsured and may not be benefiting from programs such as LIHP that are currently providing a bridge to reform.
Clinica Sierra Vista	The ultimate application approval should be an entirely electronic process that allow either assistors and/or navigators to help the applicant through the entire process. "No Wrong Door" should be synonymous with "No More Doors." There is no reason that an applicant with complete documents-of which there are few under the new rules-and someplace to upload or enter it into the system, should not be able to be approved immediately. If fingerprinting is the issue, computer based fingerprinting technology is cheap and widely available. There is no reason for the applicant to make extra trips to a different location that in rural counties may be 50 or 60 miles away. This was clearly evident with the Cal Fresh program and was eliminated. It has since save that program a lot of money. This is clearly an opportunity to overhaul an antiquated and expensive enrollment methodology from top to bottom. We can increase efficiency and decrease wait times, errors, and stop-start enrollment that are so costly to both insurance provider, tax payer and ultimate, the patients.
Consumers Union	Consumers Union writes to offer further comments to the Exchange Board and staff regarding Service Center options for undertaking Medi-Cal eligibility assessments and/or determinations. Overall, Consumers Union believes strongly in California creating a truly streamlined eligibility and enrollment system that ensures, to the maximum extent possible, that consumers calling to apply have the first-class consumer experience the Affordable Care Act (ACA) promises and to which the

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	Exchange has committed. For the reasons set forth below, we are concerned that the options under consideration may not satisfy the quintessential ACA requirements for a streamlined, non-duplicative eligibility and enrollment system. Separating the eligibility process for MAGI Medi-Cal from that for advanced premium tax credits/cost sharing is, we believe, inconsistent with the "no wrong door" eligibility system described in §§1413 and 2201 of the ACA. This bifurcation is likely to make it significantly more difficult for substantial numbers of eligible individuals and families to enroll in appropriate coverage and may cause applicants to drop off in the transfer process. The relevant proposed federal regulations allow states to bifurcate the eligibility determination process only under specific conditions. Before the Exchange makes an official decision to "sort" or "assess" applicants for Medi-Cal eligibility, rather than undertake full eligibility determinations, a number of preliminary issues need to be addressed. We know you are awaiting federal guidance, but urge the Exchange and the Department of Health Care Services (DHCS) staff to reach out to CMS and CCIIO on an expedited basis to obtain guidance on what safeguards the state is required to have in order to be in compliance with the federal regulations, particularly around data collection, avoiding duplication of applicant information, and meeting timeliness standards. In addition, we are deeply concerned that a two-step process will particularly disadvantage California's Limited English Proficient (LEP) population. Before the state adopts any of the options presented at the last Board meeting, the state should determine what safeguards are required to comply with federal and state language access laws, including Title VI of the federal Civil Rights Act of 1964 and Section 1557 of the ACA which require oral communication with LEP populations in a language they understand. This oral interpretation requirement is also codified in California law requiring that the Exchange "provides oral interpretation services in any language for individuals seeking coverage through the Exchange." To meet the Exchange's goal of providing culturally and linguistically appropriate consumer assistance and a first-class consumer experience for all, we urge Exchange staff to describe how it will ensure smooth translation for each of the three options. We urge the following when a consumer calls the Exchange to apply for coverage:

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	• **Calls to the Service Center initiate an application.** With the caller's consent, the Service Center should log a caller's application through CalHEERS. One single, electronic application is necessary for a family to manage their application and return to it to update or correct information and track eligibility, enrollment, and coverage. The protocol for sorting or assessment should establish the minimum inquiry that would constitute an application and thus secure an application start date. This will be particularly important when there is one application for a family, but individual members are eligible for different insurance affordability programs. (*See* more on mixed-eligibility families below.) • **Any assessment or sorting process is seamless and does not duplicate questions.** The application/eligibility process will need to meet federal eligibility and enrollment requirements to ensure that the bifurcated process does not result in duplicative questions; provides a real time eligibility determination; is streamlined and coordinated; does not increase administrative costs and burdens on applicants, enrollees, beneficiaries or application filers; does not increase delays; and maintains confidentiality. • **Questions asked of applicants are robust.** Service Center staff will need sufficient information to accurately identify the caller's potential eligibility for Medi-Cal or for the Exchange. Because the sorting questions under Option 1, by design, are meant to be very minimal, they are not likely to accurately sort everyone into the two categories: those potentially eligible for Medi-Cal and those eligible for the Exchange. For example, income and household composition may be very complex and questions about them can be answered in many different ways, depending on some important details. The Service Center should have specific protocols for how applications will be handled if, for example, an Exchange applicant appears eligible for Medi-Cal during the Exchange eligibility assessment/determination process and vice versa. • **Full access to all the databases for verification.** The Exchange and Medi-Cal agency should have access to the same information for assessing and/or determining eligibility. For

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	the Exchange to accurately screen for Medi-Cal eligibility, it must have access to all the databases used by the Medi-Cal agency to do an eligibility determination. This includes, for example, information that may have been obtained to determine the applicant's eligibility for the Supplemental Nutrition Assistance Program (SNAP) and other information required by §435.948 of the proposed Medicaid eligibility rule. To the extent this is not feasible, the effect on the overall efficiency and timeliness of the eligibility process should be closely examined, and bifurcation should only be allowed when the lack of access to the data will not have a significant impact on the accuracy of the assessments for Medi-Cal eligibility. • ***A "warm* hand-off" will be used, if a hand-off is necessary, for all Medi-Cal applications taken over the phone.** For a phone application to be seamless, streamlined, and without delay, callers who appear Medi-Cal eligible based on an assessment or a sorting system must have a warm hand- off. Current Option 3, however, includes no warm hand-off. By warm hand-off we mean that the original customer service representative stays on the line until the next customer service representative picks up the line, and that the latter is provided electronic access to the applicant's information already provided. What should not occur is that the Medi-Cal- eligible family member/s are provided a different phone number for future application assistance and determination, as this would not comply with the relevant federal rules such as the requirement to provide application assistance over the phone without delay. Similarly, while we understand staff is recommending that Exchange cost-sharing eligibility determinations should be made by the counties if that is where the applicant calls/walks in, we urge consideration of another approach for reasons of data tracking and communication with plans: having those people referred to assisters or the Service Center, also with a warm hand-off. In that scenario, protocols should be in place to set the standards for these types of transfers. • **Contingency protocols are in place when a "real time"enrollment is not possible.** Whether the county or the Service Center is accepting and processing an application, if neither is able to provide "real time" enrollment for a potentially Medi-Cal eligible applicant, there should be a contingency protocol for getting as close as possible to "real time" enrollment.

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	• **"Mixed families" are handled in a unified manner using a single application.** In addition to the suggestion above that a formal application be initiated at first contact with a consumer, clear protocols are needed for processing a *single application* for families in which the members are eligible for different programs. If applications are bifurcated, families with adults eligible for the Exchange and children eligible for Medi-Cal, for example, will have some members get coverage in "real-time," while others may be delayed. This will impact the entire family's ability to secure coverage immediately, their ability to enroll and choose plans and providers, and their ability subsequently to document, without duplicating effort, changes in circumstance that may affect all family members. • **Consistent performance standards for Service Center partners and all subcontractors.** Counties, along with the other subcontractors and the state Service Center itself, should be subject and accountable to the same performance standards, reporting requirements, training protocols, and monitoring to comply with federal rules and to ensure a uniform consumer experience and accountability. • **Due process rights are preserved and protected**. The Exchange and DHCS have to establish clear protocols and standards to ensure that, whether through a quick sort or full Medi-Cal assessment, the caller's due process rights are honored and not bifurcated. A few examples illustrate the complexity bifurcation creates: if callers apply and are erroneously sorted or assessed by the Service Center as over-income for Medi-Cal, how will the system preserve the decision for appeal? Will there be an official determination entered by the Service Center from which the caller can appeal? Would that appeal be the responsibility of the Exchange, DHCS or the county? How will it be registered with Medi-Cal when there has been no transfer to the Medi-Cal system? Will both the Exchange and Medi-Cal undertake separate "reasonable compatibility" processes? • **Storage of applicants' information is consistent with fair information practice principles**

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	to protect consumer privacy and security. So many open, yet key, questions exist for us about technological capabilities, including interoperability of computer systems, that it is impossible to provide a set of recommendations regarding privacy and security protections for stored information under the proposed options. We have multiple concerns, however, about risks posed by a bifurcated system and would welcome a conversation with you so we could offer suggestions to overcome them. • **Increased information sharing on an ongoing basis.** The result of a bifurcated process is that there will be intense pressure on the systems to link seamlessly and provide full access to each other's data. Not only will the Exchange need timely reporting of data collected, but it will need to report that summary data to HHS and track trends to ensure the state avoids discriminatory impact and adverse selection. For family members eligible for different programs, overseen by different agencies, with similar external collaborators (such as QHPs), the system will need to be designed so that the Exchange has access to the data that needs to be reported. Examples of the complexity presented by a bifurcated system abound. For example, if the Medi-Cal agency staff is responsible for making Exchange determinations, will the eligibility determination be stored in the Exchange or in the Medi-Cal system? Additionally, QHPs are prohibited under federal regulations from processing an enrollment directly without first obtaining an eligibility determination from the Exchange. Would the QHP be obligated to reach out to the specific county Medi-Cal office to obtain proof of an official Exchange determination before it could enroll the individual in that QHP? As with information storage issues, we need a greater understanding of the CALHEERS and county IT system technological capabilities before we can make more specific recommendations. We recognize that developing the ideal model for the Service Center in California and achieving smooth eligibility determinations and enrollment with minimal hand-offs is challenging, with many interests and concerns at play. We appreciate your consideration of our suggestions and hope to continue to work with you to make the Service Center a streamlined, easily accessible, trusted, and accountable entity that millions of Californians can turn to for reliable assistance.

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Health Access	• During more than 25 years of experience by Ms. Elizabeth Abbott of personally interviewing people for **initial eligibility** for federal entitlement programs (Social Security retirement, survivors' benefits, disability, Supplemental Security Income (SSI) and Medicare, applicants have very little idea of even the basic information they need to apply for benefits and the documents they will need to submit. This is true for these programs that have existed for decades, with which the public are generally familiar, and form the basis for at least some part of most people's financial planning. Because Social Security and Medicare are not a means-tested program, the applicant pool represents a cross section of the U.S. population, from very successful, well-educated applicants to those much less so who, unfortunately, often have to struggle to establish their entitlement to the nation's principal social insurance systems. Research indicates that the applicants for services from the HBEX will likely be people who may not have health insurance through their employer or from public programs, or may have had insurance but intermittently. It is also likely that they may be low English proficient applicants that could further complicate their understanding and potentially lengthen the interview, particularly in California. In an economic downturn, others may be individuals who have relied on employment-based coverage for decades but have lost it as a result of a down economy and have never expected to obtain coverage from a public program. As a result, the Exchange should anticipate that there will typically be multiple contacts from potential applicants as they look up the necessary information, secure proofs, and confirm eligibility details. This will be accentuated by the fact that this is a new law with eligibility and tax consequences, that will be unfamiliar and require information that will not be at the consumer's fingertips. It should surprise no one if fewer than 5% of the potential applicants would call prepared with their "modified adjusted gross income" from their federal tax returns. More consumers will know their "tax household," but some will find those definitions confusing as well.

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	For context, in Ms. Abbott's direct experience perhaps one applicant out of 1,000 files for Society Security benefits with the information at hand regarding their last year's wages or net self-employment income and could furnish it at the initial interview. Perhaps one-half of the applicants who call or visit their local Social Security office even know their social security number that is required to access their work history and it is a critical key to entry to SSA's information in order to file for benefits. That experience necessitates follow-up visits and calls, mailed-in proofs, and other re contacts for successful applications even for non-controversial program that had been in place for a number of years. Questions about income or household composition have significant tax implications. [The federal hub knows income from the prior tax year, but it will always be at least 15 months out of date and it could easily be 24 months out of date. For example, in March 2014, IRS will have information on income for 2012, but none for 2013, since the return will not have been filed yet.] These detailed amounts change year to year and those numbers and the precise terminology and definitions are often hard for consumers to remember. Consequently, the HBEX, and its contracting counties, should expect to have multiple contacts from consumers for information and requests to apply for subsidies. You should not rely on consumers calling for entitlement information and having every caller prepared with the information needed to make a correct determination. You should expect sequential contacts that are handled by different staff, even at the same service center. It is crucial for these contacts to be handled efficiently and accurately. Consumers will be frustrated and lose patience if they have to repeat information previously furnished. If there is no record of the previous conversation(s), service center personnel and/or their partners or contractors will ask questions that have already been explored –and in many cases, adjudicated. This is particularly important in the circumstance where personnel will be operating from separate

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	physical locations. You will want to be able "to pick up the discussion where it left off" and not re-explore eligibility information or the consumer preferences. If there is no record of the previous conversation(s), these calls will be longer in duration, duplicate the efforts by your staff, and confuse the public. The DMHC has recently instituted an enhanced call and mail tracking mechanism at their service center which enables them to quickly find the record of the call or the letter they have received. This is true even if the consumer called as little as a few hours ago or the problem has been satisfactorily resolved months ago, but has now surfaced again. They believe their ability to find who talked to the consumer, or what the previous resolution was is a significant improvement in their ability to operate efficiently and provide exemplary customer service. • The HBEX has appeared to lump all consumer inquiries into those from initial applicants or those seeking preliminary information prior to entitlement. There seems to be insufficient attention to or planning for another large segment of public contacts. Because the eligibility and enrollment queries have been a principal focus, it would be easy to place less emphasis on other issues that are likely to be raised by consumers. These might include: ○ Is my doctor included in that plan? ○ I cannot get through to my plan. Can you help me? ○ Can I get a referral to a specialist? How does that work? ○ I got a referral to a specialist, but he can't see me for months. Do I have any recourse? ○ My plan will not pay for a procedure I need. Can I appeal that? ○ Am I entitled to a second opinion? ○ My family has moved and we no longer live close to our medical provider network. What options do we have? ○ When can I change plans? ○ My physician is not with my insurer anymore; can I change plans now? (Yes, under CA law,

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	but not for Exchange enrollees.) ○ I got a new job; what do I need to do? ○ My husband and I have separated; does that make a difference to my eligibility? There is a great likelihood that a significant percentage of the inquiries you receive will consist of post-eligibility questions and those surrounding changes and problems. You need to carefully plan for the routing and responsibility for the handling of these types of questions. Should they be handled by post-entitlement specialists? Many of these questions are cyclical, seasonal, recurring, and repeated (even from the same consumer.) Some of the patterns of questions (representing a significant volume of calls) are triggered by news coverage, a human interest story, a church newsletter, advertising campaign, or other impetus for the calls. It does not make any difference whether the event that precipitates the calls is accurate or not. You and your staff are promoting yourselves as the experts delivering first class customer service. It is important to remember that all this information is new to the public (and your staff). You will be able to map out the types of questions asked by cycle after the first year, but it is critical that you be able to quickly and accurately respond to the questions you receive the first year, even if the patterns of calls become more predictable and manageable in subsequent years. Ideally, the public will call their health plans first to answer questions and resolve problems before they contact the HBEX. If it happens, that should siphon off some volume of calls that are resolved satisfactorily. However, because this program is new (to the public, your staff, the counties, the plan personnel), you will be called upon to field questions that really are not “yours.” You have to be prepared for “warm hand-offs” to plans, the regulators, the counties, and other agencies that can take additional time. Even if calls are placed to other agencies and commercial entities, the Exchange will have to be the referee or assist the regulator on the proper resolution of

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	simple consumers' problems to achieve your goal of world class customer service. Just sending the caller to another 800 number is unlikely to impress the public with a high level of customer service. This is particularly true in the area of post-enrollment because real-world problems most often surface once the consumer starts to utilize health care as opposed to the initial application contacts. • The training program regarding the new rules will have to be tailored and specialized and, in some cases, will not be closely aligned with the work currently performed. Other states have drafted tax accountants and health attorneys to serve as instructors and consultants for this very different curriculum. In California, county eligibility workers have achieved expertise in Medi-Cal and other human services programs and will have a very important part of the partnership with the Exchange. That skill is not, however, interchangeable with the knowledge and expertise required for this very new program that requires extensive knowledge of tax issues and the subsequent tax-based reconciliation process. A simple corollary would be that we should not equate knowledge of Medi-Cal eligibility with Medicare entitlement because they are not the same. Similarly both CalWorks and Social Security are income support programs but the knowledge needed to assist consumers with each program is quite different. • Under Potential Service Level Objectives, you list "no busy signals." We clearly support fast access to service center personnel and counties for consumers to receive answers to their questions. We also believe consumers place a premium on the accuracy of those answers which may result in a somewhat longer call duration or time spent in to conduct a "warm handoff" of a call to the county or other contractor/partner. However, you should re-examine the objective of no busy signals. The number of staff on-hand must be calibrated to correspond as closely as possible to the anticipated call volume, as defined down to the hour of the day or even smaller time increments. Every call center operation has to allow for some small percentage of busy signals or the cost of operation to allow for absolutely no busy signals would be astronomical. A

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	"no-busy signal objective" would result in over-staffing through nonpeak hours of the day or the week to achieve completed unfettered access, even at peak hours of high call volume. You should set a very low call not answered percentage and manage to achieve that standard (as well as measure the call abandonment rate) to assure responsive consumer access.
Healthy Kids Mendocino	Please note that Lily Caravello is a Master CAA and has years of experience with client assistance with enrollment by phone and in person.
RFK Farm Workers Medical Plan	I, Patrick Pine, am relatively neutral on the approach, would lean toward Partial or Full Assessment instead of Quick Sort. There did not seem to be any discussion of operating hours for any option. It seems as though that will have a big impact in terms of accessibility and for cost. Based on my own experience would suggest that phones are available seven days a week a minimum of 15 hours per day with limited holiday or other breaks. Suggest only Monday through Friday and/or 7 am to 6 pm is inadequate.
SEIU (Locals 221, 521, 721, & 1021)	On behalf of SEIU California's county unions we appreciate the HBEX's efforts to ensure the successful implementation of the ACA. SEIU Locals 221, 521, 721, and 1021 (SEIU "21" locals) represent over 250,000 public service workers statewide including 25,000 county eligibility workers. The SEIU 21 Locals are committed to partnering with the HBEX to ensure the successful enrollment in health coverage of as many uninsured and underinsured Californians as possible through January 1, 2014 and beyond. After reviewing the three approaches we believe approach 1, the "Quick Sort," is the option that best achieves the Service Center Assessment and Referral Principles that the Health Benefits Exchange Board (HBEX) established for the service center.
Behavioral Health & Recovery Services (BHRS) – San Mateo	Any handover from one call center to another has the potential for dropped calls for a variety of reasons – technical difficulties, wait time, duplicate data gathering etc. -. The important task around the hand over from the State to the counties doesn't appear to be the initial call screening. It looks

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County	like this can be done using a fairly simple script, but to make sure that the caller is, then, transferred on to the correct county phone line. Please note that not all counties have an established call center and are equipped to handle a lot of incoming calls whereas those who have established call centers also have established menu options and automated call scripts. So, in order to route the call from real life person to real life person without an extended in-between wait time for the caller counties who don't have a call center may need to establish one (even if it is just a simple new hotline staffed by a few support people), and those who have one may need to change their IVR protocols to assure that callers who are transferred in from the Exchange are placed in front of the regular wait line (for local callers) or mixed into the local wait line without much delay, or get transferred right away to a separate phone line that bypasses the local call center menu options and, instead, is directed to its own hotline phone line / call center system. In San Mateo County Human Services Agency is also currently undergoing a redesign for the processing of applications and renewals/recertifications, including so-called mail ins, and it would be good if whatever results from this process could be integrated in the redesign environment so that Human Services Agency does not need to reinvent their new processing guidelines a few months after just having gone through an Agency-wide redesign which might confuse our consumers, especially those for whom it is difficult to adapt to new environments, even if it is as simple as a new menu option under the local call center hotline number. For other bigger counties which already have established a lot of standalone processes like L.A. County finding a way for a quick hand over procedure might even more challenging, especially if processes are different from one district or department within the county to another. You don't want to necessarily create a gridlocked system like the one Social Security uses where it can take over 30 minutes to be connected with a customer service representative at the local office. People who call Social Security might have the patience to wait in line for such a long time because their benefits deposit might be dependent on it. People trying to just sign up for health coverage, and especially those who just want to fulfill their individual mandate without an urgent need for immediate access to health coverage may not want to stay on the line for such a long time, and vice versa those

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	who do need immediate access will most likely, then, try to call their local county hotline instead – the number they already know for their county's call center – and might, then, be redirected to the Exchange before receiving the customer service they were looking for. So, in short, whatever the Exchange choses to do would need to fall into place with the counties rather than having the counties find a solution on their back
National Health Law Program & Western Center on Law and Poverty	**With regard to all the approaches:** • **Any assessment or sorting process must maximize a streamlined and seamless customer experience and not duplicate questions.** The application/eligibility process will need to meet federal and state eligibility and enrollment requirements of not asking duplicative questions, providing a real time determination, and being streamlined and seamless. For example, the answers a caller provides to sorting or assessment questions must be collected and forwarded or available in real time to the county worker receiving the warm hand off, so the caller does not have to answer these questions again for their eligibility determination. In addition, regardless of the option chosen, there should be specific protocols in place to ensure a person is able to get the assistance they need in their language, or in the case of a disability, get appropriate accommodations at the state and county levels. (See comment below on Limited English Proficiency callers and callers with a disability). • **Starting an Account and starting an application.** With the caller's consent, the call center or county worker should be able to start an electronic account at the beginning of the process, if the family needs to return to the application (e.g. they needed to locate some essential eligibility information or the applicant needs to end the call). The protocol should also establish the minimal information needed to constitute an application in order to help the applicant who has to leave the call (whether with the county or the state call center) to have at least secured an application start date.

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	• **Online account access that works for families.** Consumers have the right to apply and renew for health coverage online as well as by phone, by mail and in person. Regardless of what "door" they applied through or the program they enrolled in, consumers must be able to access their account online. This online account functionality for all applicants and enrollees will be important for coordination of coverage, particularly for families with members in multiple programs and for those enrollees transferring from one program to the other. A mixed coverage family should be able to access one online account for all family members. Subcontracting/partnering agencies should follow the same standards for data entry, updating and retrieval into this shared data system. This approach does not preclude another system from also holding the cases they are responsible for managing. • **Regardless of the option, the *"warm"* hand-off is essential.** For a phone application to be seamless, streamlined, and without delay, callers who appear Medi-Cal eligible from an assessment or a sorting mechanism must have a warm hand off. What we mean by a warm handoff is that the first customer service representative stays on the line until the second representative is there and transmits electronically to the second representative the information the consumer provided the first representative. The protocol should outline what constitutes reasonable timing for a warm hand off. Also, the protocol should establish a contingency plan when a warm hand off is not possible. That contingency protocol should maintain the seamless, streamlined and "real time" principles. For example, when a warm hand off is not available, the state call center should assist the family with their application and make an eligibility determination. What should not occur is that the Medi-Cal- eligible family member/s are provided a different phone number for future application assistance and determination, as this would not comply with the relevant federal rules such as the requirement to provide application assistance over the phone without delay. • **Contingency Protocol when "real time" is not possible.** Whether the county or the state call center is accepting and processing an application, if neither are able to provide "real time"

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	enrollment for an applicant, there should be a contingency protocol for getting as close as possible to "real time" enrollment. • **Due process rights are preserved and protected**. The Exchange and DHCS have to establish clear protocols and standards to ensure that, whether through a quick sort or full Medi-Cal assessment, the caller's due process rights are protected. While the options presented (whether a sort or assessment) do not appear to constitute a final eligibility determination for Medi-Cal, it must be made clear that any determination of eligibility for Medi-Cal, Exchange coverage, or Advanced Premium Tax Credits must generate a notice of the decision in writing (in the appropriate language) that explains in plain language the reason for the decision and the appeal rights. If a final eligibility determination is made by the Service Center the system must ensure the decision generates such notice and right to appeal. • **Consistent Call Center Performance Standards for state call center and all subcontractors.** The state call center, its subcontracting public entities and the counties should be subject and accountable to the same performance standards as are necessary to comply with federal rules. • **Mixed-coverage families.** The bifurcated application and eligibility system should not create an additional burden for the family by splitting up their family application, their eligibility determination or their plan selection processes. A family should be able to have their eligibility determined, be enrolled in coverage and select a plan with one representative and one process. Additionally, ongoing case management must ensure a first-class post-enrollment consumer experience. For example, families with members in multiple coverage programs must be able to go to one online site to change their address or other information and have it register with their respective coverage programs. They should not be sent multiple renewal notices either. The federal regulations are clear that the state must use information it already has to renew coverage. So, for example, if a parent renews her Exchange subsidies during

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	her open enrollment period that same information must be used to renew her child's Medi-Cal eligibility. • **No "three touch" experiences.** Because the Administration has decided that Medi-Cal eligibility determinations must be made by the county, those calling the state service center who are likely eligible for Medi-Cal will have a "two touch experience." However, no consumer should, after being sent to the county, be sent back up to the state service center if it turns out they are eligible for Exchange subsidies. Because consumers have the right to apply in person and can therefore walk into a county office to apply for coverage, county workers will have to be fully trained on Exchange subsidies and cost-sharing reductions and will have to be able to enroll people into Exchange QHPs. Any sort or assessment, short of a full eligibility determination will, by definition mean that some Medi-Cal eligible people will stay at the state service center and some people eligible for Exchange subsidies will be sent to the county. The former group should have their Medi-Cal enrollment done by the state service center representative and the latter group, who were sent to the county, should have their Exchange enrollment completed by the county representative. Both should also be able to select a plan with the entity who enrolled them into coverage. • **Specific protocols for assisting Limited English Proficiency (LEP) callers and persons with disabilities:** The state call center and counties should have protocols to ensure an LEP consumer and/or a person with a disability is not subjected to longer wait times due to the lack of availability of call center staff or the appropriate technology to help them. The protocols should include specific instructions for helping LEP/disabled consumers and should allow for an assessment of LEP/disabled status. If someone triggers an indicator that they are LEP/disabled wherever that person is transferred, there should be a trigger on the application so that that person receives culturally and linguistically appropriate assistance including written translations and oral language services as required by state and federal laws. Finally, there should be a contingency protocol when "real time" assistance is not possible. If a bilingual

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	customer service representative at either the state service center or county cannot be found within a "reasonable" amount of time, then that person would be allowed to continue to process their application with a bilingual agent that is assisting at the other entity – state service center to county or county to state service center. • **All options should map horizontal integration.** Regardless of which option is chosen, there should be a clear protocol for phone applications regarding how to link applicants to other public programs, including CalFresh and CalWORKs. • **Seek CMS/CCIIO Guidance.** We recommend that the Exchange and Department of Health Care Services reach out to CMS to ask for guidance on the specifics of Exchange Medicaid assessment compliance: What is the federal legal construct for a "simple sorting" protocol as opposed to an assessment; what questions can be asked in a screen and not duplicated, and what counts as "potential eligibility" for Medicaid. The State agencies should get federal guidance on what is legally allowable under the Act and the regulations before making a decision.

Comments on Approach 1

Comments on Approach 1 – Quick Sort	
Organization	**Comments**
100% Campaign & Partners (Pico California, California Coverage and Health Initiatives, United Ways of California)	• **The "Sorting" questions might be too basic to accurately sort Medicaid from Exchange eligible applicants.** Because the sorting questions, by design, are meant to be very basic and minimal, they are likely not going to accurately sort everyone into those potentially eligible for Medi-Cal and those eligible for the Exchange. For example, income and household units are very complex questions and can be answered in many different ways depending on some important details and sub-questions. If the sort is going to attempt to not miss any potential Medi-Cal eligible individuals, the sort might have the result of sending almost all potential applicants to the counties for application processing (e.g. the only ones not sent are single, non-disabled adults above, say 250% of FPL). Whether the sorting rules are overly broad or narrow, the call center protocol should have specific plans for how applications will be handled, if for example, an Exchange applicant in fact appears eligible for Medicaid during the Exchange eligibility process and vice versa (see comment above on "ping ponging"). • **Sorting questions should not be asked twice.** As we mentioned previously, information provided through the sort questions should be collected and available in real time to the counties that receive the warm hand-off in order to avoid making the applicant answer questions twice. In fact, the sorting questions collected in the "simple sort" should start to build an application. • **Warm hand-off and contingency plan.** This option does include the warm hand-off essential in any bifurcated system. Also, the option lays out an important contingency plan if a warm hand-off is not possible. • **ACA compliance.** While CMS/CCIO may ultimately sign off on a Simple Sort approach, the construct of this option is not an approach envisioned in federal Exchange and Medicaid

Comments on Approach 1 – Quick Sort	
	regulations, where the assessment is allowed instead of a full determination made by the Exchange, as opposed to a simple screen. As a result, this option in particular warrants federal review and feedback before it is selected.
Asian Pacific American Legal Center	Weaknesses: • It is likely that hand-offs to the county would involve more than "one touch" and we know that multiple touches can potentially be discouraging for LEP consumers. • The lack of a full assessment could lead to program mis-assignments and ultimately more time spent following up with consumer for more information, which would be problematic for LEP consumers. • Transferring between a service center agent and a county eligibility worker could result in a loss of critical information, especially if the information intake is not housed in one system, such as CalHEERS. As we have noted, there are currently problems with receiving adequate customer services, including interpreter services, at some county eligibility offices and it might not be wise to rely on over-worked county agencies for effective customer services.
Health Access	• If the "quick sort" option 1 is selected, will that information be recorded or will the county worker need to request it a second time? It would appear from the presentation regarding that scenario that the applicant data would not be recorded in CalHEERS. Thus it appears that the county worker would need to duplicate the initial screening criteria asked for at the outset. The presentation implies that a unique tracking indicator would be assigned to record the outcome of the call. It is unclear what information would be transferred to the county "to minimize the duplication of data collection." Does it represent all the screening information asked for during the "quick sort" operation? Would it then have to be re-entered into Cal-HEERS if an application is

Comments on Approach 1 – Quick Sort	
	formally filed? It also is not clear where the information recorded is maintained. It sounds like a nightmare to have multiple, over-lapping tracking mechanisms at the state and county level which may not be mutually retrievable by various partners, other agencies, agents, assisters, and even the consumer/applicant themselves. Some federal agencies are establishing application structures on the web where questionnaires and even applications can be completed in a series of sessions, and updated with status changes entered by different assisters and even the applicant themselves at different times (all the while maintaining privacy and access restrictions.) All of us have had the experience with financial institutions, credit card companies, and retail establishments where we have had to provide threshold information for call routing. It usually takes the form of the caller having to manually enter a lengthy 14-digit credit card number, social security number, merchant account number, dates of service, or the purpose of the call from a long list of options. In addition, it is particularly maddening to find that the customer service representative has no record of the laboriously entered information, and the caller has to furnish it all over again. That duplication of effort does not leave an impression of a high quality customer service experience, nor promote efficiency.
SEIU (Locals 221, 521, 721, & 1021)	The HBEX established six assessment and referral principles to guide the development of the protocols for the Service Center: 1. Conduct assessment, eligibility review and enrollment in a seamless manner for all consumers; 2. Transfer consumers who are potentially MAGI Medi-Cal and non-MAGI Medi-Cal eligible to their County/Consortium as quickly and seamlessly as possible, after the minimal amount of inquiry and/or data collection; 3. Maximize the accuracy of each call and enrollment handled by the Service Center in order to have the fewest possible Exchange eligible individuals referred to Counties, and the fewest possible Medi-Cal individuals served by Service Center; 4. Minimize the duplication of work and effort; 5. Continuous improvement of protocols based on metrics to determine timeliness, accuracy and precision of referrals and service; 6. The Exchange, the Department of Health Care Services (DHCS), and other State partners will meet the obligations

Comments on Approach 1 – Quick Sort	
	for which they are responsible under the Affordable Care Act, other federal and state eligibility requirements. Of the 3 approaches provided to the HBEX approach 1, the "Quick Sort" will best achieve the assessment and referral principles. Approach 1 will require the call center staff to ask the minimum number of questions needed to provide the most accurate 'screen' to determine if a client is eligibile for Medi-Cal or Exchange-based insurance without duplication of work. To achieve principles 1, 2, 3 and 4 (as seamless, accurate and efficient process) the screen should include the fewest questions needed to accurately determine the type of coverage a client is likely eligible for. Approach 1 best achieves Principle 1 and 2 when compared to the other approaches (partial assessment and full assessment) because it will allow the Service Center to quickly assess clients for the appropriate programs and connect potential Medi-Cal clients to county eligibility workers the fastest. The "Quick Sort" approach ensures clients are assisted by workers with the highest level of training, skills and experience in Medi-Cal while maintaining a seamless assessment and enrollment process for Exchange-based products. Specifically, - Approach 1 achieves Principle 4 when compared to the other approaches (partial assessment and full assessment) because it minimizes the duplication of work between the service center and the county eligibility worker. - Approach 1 achieves Principle 3 when compared to the other approaches (partial assessment and full assessment) because it connect clients with workers that with the highest level of training, skills, language availability, cultural competency and experience in a particular program and client population. County eligibility workers already have the experience to enroll "mixed households" (containing both MAGI and non-MAGI eligible clients) which the call center

Comments on Approach 1 – Quick Sort	
	staff may not be able to determine under the partial assessment or full assessment options. - Approach 1 best achieves Principle 5 when compared to the other approaches (partial assessment and full assessment) by providing a clear delineation between Medi-Cal and Exchange programs, which will maximize the ability for DHCS, the HBEX and Counties to establish, measure, assess, and revise operations and protocols for the Service Center and County Medi-Cal programs. It is important to note that many of the counties are already preparing to expand in order to successfully execute warm hand offs and begin the process of Medi-Cal determination. - Approach 1 is also consistent with the federal rules established for state exchanges in the ACA for assessment and enrollment, and state law that requires county eligibility workers to do enrollment into Medi-Cal. Finally, Approach 1 also achieves the ACA's goal of the 'horizontal integration' and protects and strengthens the county-based social safety-net system that currently serves over 11 million Californians.
Behavioral Health & Recovery Services (BHRS) – San Mateo County	The Quick Sort option appears to allow for the fastest transfer from the Exchange's Call Center to the County for those pre-screened with a request for enrollment into MAGI-Medi-Cal / Medi-Cal and/or enrollment follow up questions. A quick transfer would be preferred for clients served by Behavioral Health & Recovery Services because due to the various challenges our client population faces a complicated method by which to connect with a real life person who is able to successfully answer the caller's request for assistance would result in a high number of dropped calls or conversations with inconclusive results. Please be also reminded that a lot of our clients may not call from their own land line, but either from a cell phone or by utilizing a Third Party extension in a non-private / public setting, especially if placed in transitional housing or homeless shelter, residential treatment facility or

Comments on Approach 1 – Quick Sort	
	Board and Care where they might only have a limited time available to place a call. It doesn't appear from the presentation slides that the SMART calculator is that much different from the CalHEERS data gathering process so I am not quite sure why there is a need for developing a new tool. It looks like the Quick Sort could be done by utilizing CalHEERS as the sorting tool, provided that entering initial data into the system doesn't require data input completion by the Exchange staff and that the CalHEERS screens, or data gathered by it, is made available to the counties that will pick up the call.
National Health Law Program & Western Center on Law and Poverty	**Option 1 (Simple Sort): Issues to Consider** • **Sorting questions should not be asked twice.** As we mentioned previously, information provided through the sort questions should be collected and available in real time to the counties that receive the warm hand off in order to avoid making the applicant answer questions twice. • **Warm hand-off and contingency plan.** This option does include the warm hand off essential in any bifurcated system. Also, the option lays out a contingency plan if a warm hand off is not possible.

Comments on Approach 2

Comments on Approach 2 – Partial Assessment	
Organization	**Comments**
100% Campaign & Partners (Pico California, California Coverage and Health Initiatives, United Ways of California)	• **Application started with initial questions in CalHEERs.** While this option does indicate that the information collected will be transmitted to the counties as required by the regulations, it still must be clarified that under this option an application will be started, thereby preserving the Medi-Cal application date, regardless of which entity makes the final Medi-Cal eligibility determination. • **ACA Compliance.** While this option appears to begin to capture more of the MAGI-based income information necessary to do an "assessment" of the applicant's potential eligibility for Medi-Cal, this option, like the "simple sort," warrants federal review and feedback before it is selected. • **Does include essential warm hand-off.** While the option, as presented, does indicate that there will an immediate "live transfer" to the county, it is not clear how long that will take or what contingencies will be made, if that assessment cannot be completed on the call at that time.
Asian Pacific American Legal Center	Weaknesses: • It is likely that hand-offs to the county would involve more than "one touch" and we know that multiple touches can potentially be discouraging for LEP consumers. • The lack of a full assessment could lead to program mis-assignments and ultimately more time spent following up with consumer for more information, which would be problematic for LEP consumers. • Transferring between a service center agent and a county eligibility worker could result in a

Comments on Approach 2 – Partial Assessment	
	loss of critical information, especially if the information intake is not housed in one system, such as CalHEERS. As we have noted, there are currently problems with receiving adequate customer services, including interpreter services, at some county eligibility offices and it might not be wise to rely on over-worked county agencies for effective customer services.
Health Access	• We note that among the advantages of Option 2 is that the information collected from the caller during the initial screening will transmitted to the county in a format that is consistent with Cal-HEERS. That clearly takes advantage of the standard Cal-HEERS structure, so there will not be problems with congruency of data on two systems or the re-asking and re-entering of the answers to the same questions. It also preserves the advantage of the protected filing date for the applicant in the typical circumstance where there will be re-contacts for missing information or proofs. However, there is a disadvantage that if the caller does not pursue the application that was initiated by the first call to the Exchange, it will have to be adjudicated by the rules of administrative finality. This generally consists of a letter telling the applicant that if they do not furnish information within a certain number of days, the partially completed application will no longer protect them and they will no longer have a right to any retroactivity.
Healthy Kids Mendocino	It's best to do a quick screening (option 2) and then have the family mail/fax/come in in person with the docs.
SEIU (Locals 221, 521, 721, & 1021)	Approaches 2 and 3 fall short in achieving the assessment and referral principles when compared to Approach 1. In contrast to Approach 1, both the partial assessment and full assessment will require more duplicate inquiry of potential clients that the quick sort approach. As a result, approach 2 and approach 3 necessarily require longer enrollment times than would be necessary to determine eligibility for Medi-Cal or Exchange Products. Approach 2 and 3 would also result in the duplication of work of service center staff and county Medi-Cal staff when handling Medi-Cal clients. More troubling is the fact that Approach 2 and Approach 3 will reduce the accuracy of the assessment

Comments on Approach 2 – Partial Assessment	
	because these approaches necessitate call center staff do more in-depth assessments of all clients without the necessary training and knowledge of the rules, policies and laws governing enrollment of non-MAGI eligible clients.
National Health Law Program & Western Center on Law and Poverty	**Option 2 (Partial Assessment): Issues to Consider** ● **Application started with initial questions in CalHEERs.** While this option does indicate that the information collected will be transmitted to the counties as required by the regulations, it still must be clarified that under this option an application will be started, thereby preserving the Medi-Cal application date, regardless of which entity makes the final Medi-Cal eligibility determination. ● **Does include essential warm hand off.** While the option, as presented, does indicate that there will an immediate "live transfer" to the county, it is not clear how long that will take or what contingencies will be made if that assessment cannot be completed on the call at that time.

Comments on Approach 3

Comments on Approach 3 – Full Assessment Completed	
Organization	**Comments**
100% Campaign & Partners (Pico California, California Coverage and Health Initiatives, United Ways of California)	• **ACA compliance.** While this option appears to ask numerous questions to determine that the applicant is "very likely Medi-Cal" eligible (the proposal indicates that over 50% of the application questions are needed), it is unclear if this "assessment" goes further than what the federal rules contemplated given there is no federal definition of "assessment" in the regulations. However, it is hard to see how this would be a more streamlined and less burdensome option, ***unless*** this approach envisions an application complete enough in order to assess "potentially Medicaid eligible" (or not) and either a presumptive or final Medicaid determination is made in real time. • **Full Medi-Cal assessment.** The description of this option indicates that the state service center representative would do a full assessment of Medi-Cal eligibility but then would transfer the information to the county/consortia. We are unclear whether this would mean the applicant would get an eligibility determination from the service center and would then choose a plan or whether eligibility determination and plan selection would be completed with the county. It appears that it is the latter, at least in cases where completion of this process indicates an applicant (or applicants) is very likely Medi-Cal eligible. The consumer should get a real time determination; otherwise this approach would not be streamlined. One modification could be to select plans with the original call center worker and then the caller is given a warm hand-off to finalize the Medi-Cal determination or given immediate coverage while the application is transferred to the county for a final Medi-Cal determination (see below). • **Needs to include warm hand-off or Accelerated Enrollment. If** a "warm hand-off" is not included under this option, we would expect that the applicant get either immediate coverage through a full Medi-Cal eligibility determination, or if that is not possible, then presumptive eligibility should be utilized, as federally allowed, to provide immediate coverage. As

Comments on Approach 3 – Full Assessment Completed	
	mentioned, we cannot support an option that does not preserve "real time" enrollment. • **Least disruption for LEP callers**. For Limited English Proficient callers, the wait time potentially doubles in a "two-touch" approach as these consumers will have to wait for interpretation services at the original call center and then a second time after they are transferred to a county agent. These longer call times will only exacerbate the challenges already faced by LEP populations in accessing affordable health insurance. It appears to create an additional undue burden to have an LEP person be expected to wait for an interpreter twice – especially in options 1 and 2 where the person is asked as few as five questions before they are transferred to another agent. A "simple sort" or "partial sort" option will not allow callers to establish even a tiny modicum of trust with the agent assisting them. This is especially important for LEP callers who face numerous barriers to enrollment. Option 3 will allow LEP individuals to establish trust with a bilingual application assister before they may have to be transferred to a county worker. This will also be important in LEP families with mixed cases where one applicant is Medi-Cal eligible but other family members are Exchange eligible to get the help they need without unnecessary delays.
Asian Pacific American Legal Center	We share the concerns expressed by Exchange Board members Paul Fearer, Kim Belshe, and Dr. Bob Ross expressed at the September HBEX meeting questioning the staff's recommendation for the "Quick Sort" (Option 1) rather than the "Full Assessment (Option 3). We agree with many of the reasons given by the board members to support Option 3. **The full assessment method (Option 3) is particularly critical for potential LEP consumers who:** • will require culturally and linguistically appropriate interpretation services and may be handed off multiple times by the county as currently occurs so we are concerned that there will not be a "one touch, warm hand-off" experience with Option 1 or 2;

Comments on Approach 3 – Full Assessment Completed	
	• could potentially become discouraged navigating a new system with more transfers and hand-offs, especially if they must repeat their situation over again to a new service center worker, and • ultimately might not purchase within the Exchange or get coverage through other public programs if it's too complicated or they do not understand their options. **Due to the reasons highlighted above, as well as the comparison below, APALC strongly recommends that the Exchange adopt Option 3, the "Full Assessment Completed" method.** **<u>Full Assessment Completed</u> – Recommended Approach** Given the marketing, outreach and education messaging that will be conducted to publicize the new health care insurance options, such as the concept of a "one-stop shop," consumers who make the effort to call the service center and inquire about health options will expect to provide all of the information required to make a determination of the appropriate programs for which they are qualified during the initial intake call. We have found consumers more than willing to provide a full assessment if they are assured that their personal information is safe and are provided with culturally and linguistically appropriate services. Strengths: • given the expected "churning" of enrollees between Medi-Cal and the Exchange, it would be much more efficient to obtain all of the necessary information at one time in order to make a proper determination in real time or soon thereafter; • it might not only limit the number of hand-offs or transfers, which is critical for limited English proficient (LEP) individuals navigating a new and potentially confusing system, but would obviate a need for any "hand-off" if the service center representative gathered all of the

Comments on Approach 3 – Full Assessment Completed	
	necessary information at one time; • it would also limit the delay times experienced while being transferred to another center which may need to obtain an interpreter if a bilingual staff person is not available; • it would also limit the "multiple touches" factor if there is an incomplete assessment at the beginning, not only for the LEP individuals where we have found that the initial contact is critical to retain the LEP caller on the telephone line, but also for any consumer who must be contacted again if all of the information is not obtained during the "Quick Sort" or "Partial Assessment"; • conducting a full assessment during the initial call, or obtaining as much information as possible, would enable the service center operator to easily input all of the information into CalHEERS so there would be one central storage place for all consumer data, making it more easily retrievable if and when necessary. **Information Technology**- With the large investment in the development of CalHEERS, APALC would recommend that the Exchange house all information from potential consumers who qualify for public programs like Medi-Cal/Healthy Families or the Exchange, in one system, CalHEERS. **Consumer Assistance**- We would also recommend that a consumer-friendly model like DMHC's utilization of the Health Consumer Alliance be used for consumer assistance. APALC and other consumer advocates frequently work with groups like HCA, which can provide culturally and linguistically appropriate services, and know this model works, in contrast to experiences with county public benefit offices. If county agencies were contracted with the Exchange, as we noted above, we would recommend careful selection of those agencies that have the capacity to provide culturally and linguistically appropriate assistance to LEP persons.

Comments on Approach 3 – Full Assessment Completed	
California Pan-Ethnic Health Network	**Strengths, weaknesses and opportunities of each of the approaches:** **Of the three options, Option 3 is the least disruptive for LEP callers:** For people who have no language barriers, the bifurcated option is already very likely to increase wait times. For Limited English Proficient callers, the wait time potentially doubles as these consumers will have to obtain interpretation services at the original call center and then a second time after they are transferred to a county agent. These longer call times will only exacerbate the challenges already faced by LEP populations in accessing quality services. We hear about these challenges from our local counterparts who are assisting LEP consumers daily to navigate through the maze of coverage options available to them pre-2014. We fail to see how an LEP person can be expected to wait for an interpreter twice – especially in Options 1 and 2 where the person is asked just 5-8 questions before they are transferred to another agent. Option 3 the "Full Assessment" is preferable as it will allow additional time for callers to establish trust with the agent assisting them. This is especially important for LEP callers who face numerous barriers to enrollment including a lack of translated information about the requirements of the ACA. A full assessment is also especially important in mixed family cases where one applicant is Medi-Cal eligible but other family members are Exchange eligible as mentioned above. Thank you again for the opportunity to provide input on this critical plan. We look forward to continuing to work with the Exchange Board and staff to realize its vision of improving the health of all Californians.
California Rural Legal Assistance Foundation	CRLAF would like to ensure that the barriers to enrollment that might keep eligible consumers from applying to the Exchange are removed. We would like to see the maximization of enrollment for farm worker, rural populations, and low-income individuals. Given the aforementioned, we believe that "Approach 3: Full Assessment Completed" will be beneficial for the clients that we serve who face cumulative health impacts. We are also open to seeing a hybrid of the options that continues to factor consumers that are geographically isolated such as those who live in Disadvantaged

Comments on Approach 3 – Full Assessment Completed	
	Unincorporated Communities (DUCs), those who may be Limited English Proficient (LEP), the individuals that live in rural communities, etc. Our main goal is to ensure that the Service Center assists vulnerable groups in a manner that is consumer centered.
Clinica Sierra Vista	I like the dashboard's presented in scenario 3 for sorting Exchange from Medi-Cal applicants. However, it looks like we are back to the same, cumbersome and inefficient channeling of Medi-Cal applications whether MAGI or non-MAGI appropriate, to the county offices for final action. This expensive and unnecessary step should only be needed when applicants do not have assistors or navigators available to help them.
Health Access	• While quick and efficient processing ("one touch and done") is certainly desirable, the accuracy of the information conveyed and the choices the consumer makes as a result, are equally or more important. Consumers appreciate fast service, but place a premium on the accuracy and reliability of the information given. The Health Access "mystery shopper" survey released in May 2012 of the current customer service performance provided by four CA health agencies concluded that the agencies who were knowledgeable and "were on the consumer's side" got the highest marks for customer service, as opposed to those who gave even faster, but less complete or knowledgeable answers to consumers. • We believe the HBEX should consider the relative cost/advantage calculation proposition of Option 3. It entails obtaining the answers to more questions from the potential applicant to provide more assurance regarding the likelihood of eligibility, but would guarantee a transfer to the county for the completion of the full application and adjudication. It would also require a fairly lengthy screening which while not 100% predictive of entitlement, would of necessity elongate the screening process without appreciatively increasing the accuracy of entitlement.
SEIU (Locals 221, 521, 721, & 1021)	Approaches 2 and 3 fall short in achieving the assessment and referral principles when compared to Approach 1. In contrast to Approach 1, both the partial assessment and full assessment will require

Comments on Approach 3 – Full Assessment Completed	
	more duplicate inquiry of potential clients that the quick sort approach. As a result, approach 2 and approach 3 necessarily require longer enrollment times than would be necessary to determine eligibility for Medi-Cal or Exchange Products. Approach 2 and 3 would also result in the duplication of work of service center staff and county Medi-Cal staff when handling Medi-Cal clients. More troubling is the fact that Approach 2 and Approach 3 will reduce the accuracy of the assessment because these approaches necessitate call center staff do more in-depth assessments of all clients without the necessary training and knowledge of the rules, policies and laws governing enrollment of non-MAGI eligible clients.
National Health Law Program & Western Center on Law and Poverty	**Option 3 (Full Medicaid assessment): Issues to Consider** **Full Medi-Cal determination.** The description of this option suggests that the state service center representative would do a full assessment of Medi-Cal eligibility but then would transfer the information to the county/consortia. The later conflicts with the approach adopted by the Administration which is to have Medi-Cal determinations made by the counties. It should also be clarified where plan choice would take place. **Needs to include warm hand off or immediate coverage.** We are concerned that a "warm handoff" is not included under this option. Applicants should get either immediate coverage through a full Medi-Cal eligibility determination, or presumptive eligibility should be utilized, as federally allowed, to provide immediate coverage.