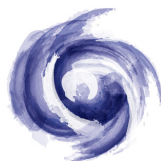


# The State of Enrollment in California

August 2026



SIERRA HEALTH  
FOUNDATION



Dear Colleagues,

We are excited to share this timely report on the current state of health coverage outreach and enrollment in California — The State of Enrollment in California. The aim is to reestablish a comprehensive baseline of the landscape and history of enrollment in health coverage programs such as Covered California and Medi-Cal (Medicaid). We also uncover insights into the current policy environment and recommend interventions to strengthen coverage moving forward.

Over its 40 years, Sierra Health Foundation has committed to enrollment and expanded health care access in the state. In 1988, Sierra Health Foundation was one of the first organizations to fund care for AIDS patients, expanding access and seeding the creation of the Center for AIDS Research, Education and Services. In 1989, the Foundation expanded prenatal care for low-income women in rural Northern California through its Prenatal Care Access Initiative. In 2007, as the new president and CEO, I worked with the Board of Directors to set a new direction prioritizing health equity and promoting the social determinants of health as drivers for addressing health disparities, at the heart of all future work. In 2011, we launched the Sacramento Regional Health Care Partnership to advance regional health care reform preparedness and expand safety net services, with a special focus on building infrastructure for federally qualified health center (FQHC) expansion in the region. From 2020 to 2022, The Center at Sierra Health Foundation, our nonprofit sister organization, awarded sub-grants to a cohort of community-based organizations in rural parts of the state to help facilitate Medi-Cal enrollment and retention. This work took place in four rural northern California counties through the state's Medi-Cal Health Enrollment Navigators Project, as highlighted in this report. These efforts have continually confirmed the importance of equitable access to health coverage in achieving positive health outcomes and reducing health disparities.

Health coverage programs like Medi-Cal are only viable as long as people remain enrolled. As the health care landscape changes over time, documenting the enrollment process is key to understanding the impacts of these changes and how they influence the coverage landscape. California continues to be a leader and innovator in closing coverage gaps, even prior to the passage of the Patient Protection and Affordable Care Act (ACA). As the coverage landscape shifts, the enrollment system must also adapt to keep people enrolled to access coverage and care, including the workforce that retains knowledge in coverage and access such as Navigators and health access assisters, as well as a responsive enrollment platform.

With significant state and federal policy changes coming to Medi-Cal over the next few years by way of H.R. 1 enactment, this report provides a critical baseline of who is enrolled in coverage today. That foundation will help policymakers, providers and community organizations make informed decisions and develop effective strategies to protect and expand coverage. We believe everyone in the health care ecosystem has a role to play, and looking ahead, we make strategic recommendations aimed at building resiliency and maintaining and expanding coverage gains. Without it, we run the risk of individuals and families losing coverage and becoming uninsured and foregoing critical, even lifesaving care.

In keeping with our mission, Sierra Health Foundation remains committed to building stronger, healthier communities. We hope this report provides a blueprint communities can use to understand key enrollment steps, map new systems to upcoming policy changes and keep health coverage strong in California.

Sincerely,

Chet P. Hewitt  
President and Chief Executive Officer  
Sierra Health Foundation

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## ***Where California Stands on Enrollment:***

**Medi-Cal:** 14.1 million<sup>1</sup> or 1 in 3 Californians

**Covered California:** 1.9 million<sup>2</sup>

**Uninsured rate:** 5.9%<sup>3</sup>

## **Introduction**

In California, more than 14 million people — or one in three people living in the state — are enrolled in Medi-Cal,<sup>4</sup> California’s Medicaid program for low-income individuals and families. Even prior to the passage of the Affordable Care Act (ACA) in 2010, California prioritized health coverage and was successful in expanding Medi-Cal and other forms of health coverage over the years. While enrollment numbers do not remain static, on average, the uninsured rate in the state fell from 17.8% in 2008 to 5.9% in 2024.<sup>5</sup>

**Outreach and enrollment continue to remain the critical first steps to accessing coverage and care, especially in light of upcoming federal changes that will make it more difficult for individuals to remain enrolled in Medi-Cal or to enroll in the first place. In this issue brief, we shine a spotlight on the state of enrollment in California for Medi-Cal and Covered California** (the state’s health insurance exchange), including eligibility and enrollment systems, the workforce of eligibility workers and assisters, the outreach and messaging that drives communications to individuals and families enrolled in health coverage programs, and the history of enrollment in the state.

We share recommendations and opportunities to enhance the systems, workforce and communications that drive enrollment in communities for beneficiaries, especially in consideration of imminent Medi-Cal eligibility and enrollment changes as the result of federal legislation and state budget cuts. These changes, such as work requirements, six-month renewals and immigrant eligibility changes, will create more barriers for people trying to enroll in Medi-Cal that go against California values around healthcare access and generally make it harder for people to access care and stay healthy. All healthcare stakeholders — the state, counties, Medi-Cal managed care plans (MCPs), providers, funders and others — can work together to address and mitigate these obstacles.

## **Why Enrollment Matters**

Efficient eligibility determination processes and user-centered enrollment applications are essential to ensure timely, accurate and streamlined access to Medi-Cal. Although the ACA sought to further California’s “No Wrong Door” approach and simplify enrollment processes,<sup>6</sup> administrative burdens may still deter eligible individuals when they try to enroll in Medi-Cal.

Individuals who lack health coverage often forego important, timely medical care, which makes eventual treatment more expensive or requires emergency room care.<sup>7</sup> Moreover, one in 10 Medicaid enroll-

### **Navigators as Trusted Messengers to Support Enrollment**

Navigators usually work for community-based organizations (CBOs) with deep ties to the communities where they work. These organizations may be focused on helping people enroll in public benefits, like Medi-Cal, or they may have expertise with a specific population. Because of the organizations’ knowledge, expertise and cultural competence, they are trusted by families and individuals in the communities they serve.

Navigators receive grant funding from Covered California to help enroll individuals in coverage during open enrollment or throughout the year.

ees experience churn,<sup>8</sup> in which enrollees are disenrolled and then must re-enroll into coverage over a short period of time, often due to either administrative burden at renewals or fluctuating incomes. Churn leads to disruptions in care and is costly to the state due to increased administrative expense.<sup>9</sup>

**Understanding and making sense of Medi-Cal’s complex eligibility rules, enrollment processes and documentation requirements is often too difficult for individuals to navigate on their own.<sup>10</sup>**

Community-based, in-person assistance, in the form of navigators and enrollment assisters who work for community-based nonprofit organizations, is trusted and valued by both consumers and community members. Navigators and assisters work in the enrollees’ local neighborhoods, communicate in culturally and linguistically appropriate ways, and act as “trusted messengers” for those who need help navigating coverage options.

For individuals living in rural areas, where internet access may be lacking or transportation to social service offices is hard to access, navigators can play an important role. And in an era of misinformation and distrust of public institutions, trusted messengers are even more critical.

## California’s Current Enrollment Landscape: How It Works Today

Continuing the approach of “No Wrong Door,” there are multiple ways for someone interested in participating in Medi-Cal to apply and enroll:

- Online through the statewide enrollment system at CoveredCA.com
- Online at the county level through BenefitsCal.com
- In person or by phone at county eligibility offices
- In person with the support of a navigator, enrollment counselor or broker
- By mail with a traditional paper application

Interested individuals must provide household information, proof of income, citizenship/immigration status, proof of residency, etc. Some groups may have additional requirements, such as an asset test for older adults. The figure on the next page depicts the process for initial enrollment, which may take up to 45 to 90 days.<sup>11</sup>

### Outlier Cases for Temporary Coverage

Pregnant individuals and children can often get temporary coverage from participating clinics. Individuals in acute distress showing up in participating hospitals can also enroll and receive immediate, temporary benefits for up to two months through the Presumptive Eligibility Program.

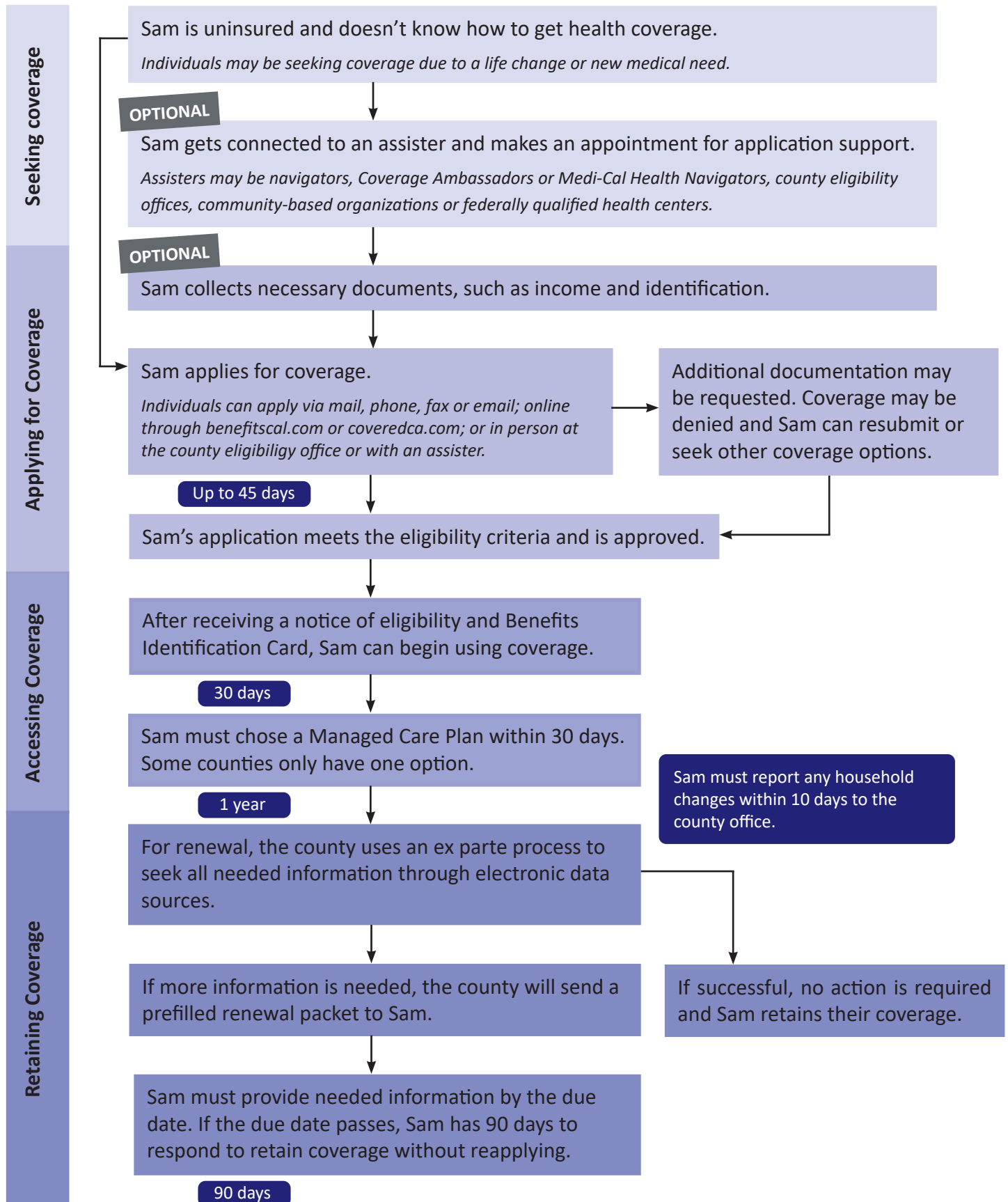
Medi-Cal applications are routed to the county of residence, where a county eligibility worker reviews the application, requests additional information or documentation from the individual if anything is missing or unclear, and makes a determination of whether the individual meets the criteria for Medi-Cal.

If so, the county eligibility worker authorizes eligibility in the system, which then assigns an Aid Code identifying the specific eligibility group or groups the applicant qualifies for, as well as the associated scope of benefits and costs and level of federal funding that the state receives for the type of individual.<sup>12</sup>

The applicant is notified by mail and/or online of the eligibility determination, and if they are approved, the state sends the applicant two items:

1. A benefits identification card (BIC).
2. A package of materials so that the individual can select a Medi-Cal managed care plan.

# Client Enrollment Journey



The California Department of Health Care Services (DHCS) contracts with Maximus, a private company that serves as an enrollment broker, to provide support to the applicant to select a Medi-Cal plan if there is more than one plan in the county and if the applicant needs help.<sup>13</sup> If the applicant does not make a choice, they will be automatically enrolled into a plan.

Medicaid managed care is mandatory for the majority of Medi-Cal enrollees, except for a few exceptions.<sup>14</sup> Maximus notifies the selected plan, which sends the applicant a welcome package. Once fully enrolled in Medi-Cal or the Presumptive Eligibility Program,<sup>15</sup> individuals begin receiving coverage.

| Barriers to Enrollment                                             | Solutions                                                                                                                                                                                   |
|--------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Lack of transportation to county eligibility offices or navigators | Online options for applying                                                                                                                                                                 |
| Limited internet connection                                        | Option to apply by phone or use in-person assistance                                                                                                                                        |
| Complexity of what documents are necessary for applying            | Assistance from navigator, assister or county eligibility workers                                                                                                                           |
| Navigating application portals                                     | Assistance from Covered California call center representatives or navigators/assisters                                                                                                      |
| Being unhoused without a place to receive Medi-Cal notices by mail | Receive mail through social service agencies or community organizations, or general delivery through the postal service <sup>16</sup>                                                       |
| 45-day window for county determining eligibility                   | Retroactive eligibility for getting coverage, <sup>17</sup> with assistance from legal services if the state does not determine eligibility within the window or the individual gets denied |
| Plan selection complexity                                          | Navigator/assister assistance or Health Care Options (Maximus)                                                                                                                              |

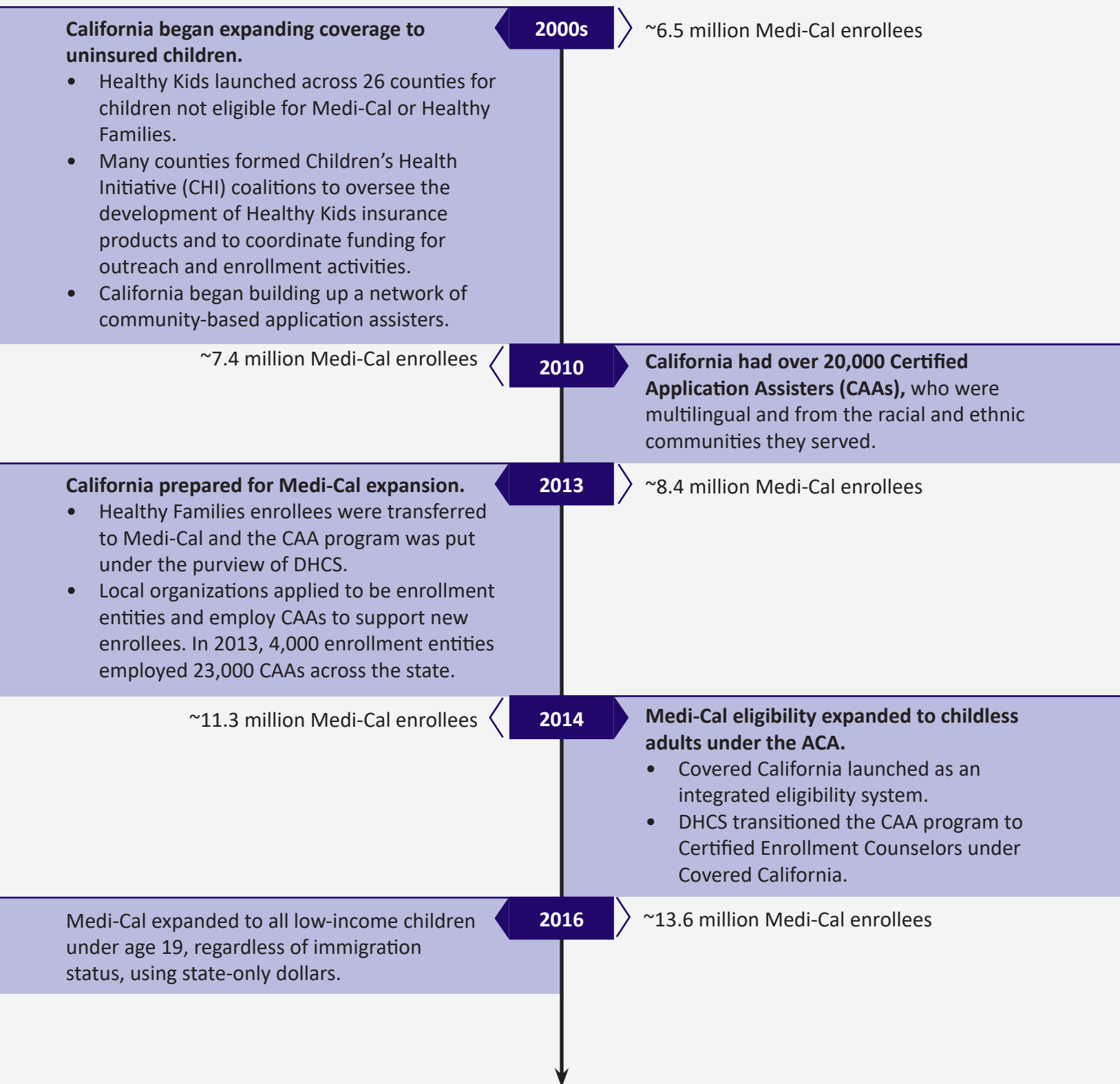
## Timeline of Enrollment in California

**2000s:** California began expanding coverage to uninsured children. For those who were not eligible for Medi-Cal or Healthy Families (the state's Children's Health Insurance Program, or CHIP), 26 counties organized a third program called Healthy Kids for non-citizens or those in families with higher incomes, which was financed by public and private sources but with no state or federal participation.<sup>18</sup> To increase coverage of low- and moderate-income children, many California counties organized Children's Health Initiatives, coalitions that were formed to oversee the development of the Healthy Kids insurance products and coordinate state and private funding for outreach and enrollment activities.<sup>19</sup> Effective strategies for increasing enrollment of children included online applications, school-based enrollment, use of media campaigns, provider in-reach and community health workers (CHWs).<sup>20</sup>

**2010:** Many states used a system or network of community-based application assisters to support enrollment assistance for eligible families, including California. As of 2010, California had over 20,000 Certified Application Assistants (CAAs), who were multilingual and from the racial and ethnic communities they served. Applications submitted with the help of CAAs were found to be more complete than those submitted without CAA help.<sup>21</sup>

**2013:** In preparation for Medi-Cal expansion, Healthy Families enrollees were transferred to Medi-Cal and the CAA program was put under the purview of DHCS. CBOs, healthcare providers and local government agencies applied to be enrollment entities and employ CAAs to support new enrollees. As of 2013, there were 4,000 enrollment entities across the state and 23,000 CAAs. However, the CAA program had no dedicated funding. The entities relied on regional and local foundations and a variety of funding sources to sustain their outreach and enrollment activities.<sup>22</sup>

## A Snapshot of the California Enrollment Timeline<sup>23, 24</sup>



## A Snapshot of the California Enrollment Timeline, continued

**The California legislature acted to increase coverage.**

- A new state law authorized Covered California to automatically enroll individuals losing coverage in Medi-Cal.
- The legislature funded the Medi-Cal Health Enrollment Navigator Project to reach hard-to-enroll populations.

**2019**

~12.8 million Medi-Cal enrollees

~13 million Medi-Cal enrollees

**2020**

Full-scope Medi-Cal expanded to all low-income young adults (ages 19 to 25), regardless of immigration status, using state-only dollars.

Full-scope Medi-Cal expanded to older adults (ages 50+), regardless of immigration status, using state-only dollars.

**2022**

~15 million Medi-Cal enrollees

2023: ~15.6 million Medi-Cal enrollees  
2025: ~14.7 million Medi-Cal enrollees

**2023-25**

**California worked to keep eligible individuals enrolled in Medi-Cal after COVID-19 continuous coverage ended.**

- California streamlined eligibility systems and cut overall disenrollments in half.
- The state launched the DHCS Coverage Ambassador program for trusted messengers and community organizations to reach Medi-Cal members.

Full-scope Medi-Cal expanded to all adults (ages 26 to 49), regardless of immigration status, using state-only dollars.

**2024**

~14.9 million Medi-Cal enrollees

**2025**

Congress passed H.R. 1, which included significant changes to Medicaid eligibility and financing.



**2013 (continued):** Much of the money dedicated to enrolling individuals into coverage during the ACA transition was focused on marketplace coverage. Due to stipulations in the law, Covered California and other state-based marketplaces could only use their funding to support marketplace consumer enrollment, not Medicaid enrollment.<sup>25</sup> To support Medi-Cal enrollment assistance, philanthropic organizations contributed significant grant funding to the state, which was matched by federal funds.<sup>26</sup> Additionally, the federal Health Resources and Services Administration (HRSA) provided support to health centers across the country, including in California, for Medicaid outreach and enrollment.<sup>27</sup>

**2014:** The passage of the ACA led to an expansion of Medicaid eligibility, as well as enrollment simplification, including a single streamlined application, the use of electronic data matching to verify applicant information, and coordination between state Medicaid agencies and health insurance marketplaces (which is Covered California in California). This led to a system that supports the rules for determining both advance premium tax credits (APTCs) and modified adjusted gross income (MAGI) Medi-Cal at the state level, managed through DHCS and Covered California. Over the next decade, California also consolidated its county-based eligibility systems, moving from three different eligibility systems to one.<sup>28</sup>

In mid-2014, with Medi-Cal expanded, DHCS closed the CAA program and encouraged all CAAs to become Certified Enrollment Counselors under Covered California.<sup>29</sup> Enrollment entities that did not work for or receive funding from health plans were eligible for Covered California's Enrollment Assistance Program.<sup>30</sup>

**2016:** Full-scope Medi-Cal expanded to all low-income children under age 19, regardless of immigration status, using state-only dollars.

**2019:** A new state law authorized Covered California to automatically enroll those losing Covered California coverage into Medi-Cal. This initiative launched in 2023 and facilitated enrollment for 112,000 people within the first year.<sup>31</sup> Additionally, the Medi-Cal Health Enrollment Navigator Project was funded by the legislature to reach hard-to-enroll populations.<sup>32</sup>

**2020:** Full-scope Medi-Cal expanded to all low-income young adults ages 19 to 25, regardless of immigration status, using state-only dollars.

**2020-2023:** During the COVID-19 public health emergency, Congress enacted a continuous coverage provision for Medicaid in exchange for enhanced federal funding for states to keep people enrolled in health coverage. This provision ended in March 2023, and states began the process of unwinding the continuous coverage requirement by resuming redeterminations.

**2022:** Full-scope Medi-Cal expanded to older adults ages 50+, regardless of immigration status, using state-only dollars.

**2023-2025:** The state implemented numerous strategies to keep eligible individuals enrolled in Medi-Cal as renewals resumed from June 2023-2024 at the end of the COVID-19 era continuous coverage requirement. The federal government provided states with system flexibilities to reduce procedural terminations and increase ex parte (i.e., automated) renewals.

California adopted most of these system flexibilities, and in working with the United States Digital Service to improve data use and streamline eligibility systems, increased ex parte rates from 34% to 66% and saw overall disenrollments drop in half from 19-21% to 9%. The state conducted significant outreach and launched the DHCS Coverage Ambassador program for trusted messengers and community organizations to reach Medi-Cal members. This multilingual outreach campaign used targeted text and email and paid media to reach members, as well as distributing a statewide toolkit of outreach resources for partners.<sup>33, 34</sup>

**2024:** Full-scope Medi-Cal expanded to all adults ages 26 to 49, regardless of immigration status, using state-only dollars.

**2025:** Congress passed H.R. 1, which included significant changes to Medicaid eligibility and financing, such as work requirements and six-month redeterminations for expansion adults, as well as new restrictions on provider taxes to finance the program.

## California Enrollment System Landscape

### Current eligibility and enrollment system

In California, Medi-Cal enrollment is administered at the county level, while the state oversees the program, creating policies for counties to implement.

County eligibility staff use an integrated eligibility system, the California Statewide Automated Welfare System (CalSAWS), to enter applicant and recipient information, evaluate eligibility and authorize benefits across public benefit programs. CalSAWS is integrated with the BenefitsCal.com application portal and supports the determinations by performing benefits calculations, issuing benefits based on worker approvals and managing case information.<sup>35</sup>

There are five ways to apply for Medi-Cal: online, by mail, in person at a county office, by phone with county staff or by fax. The online integrated benefits portal, BenefitsCal.com, is used across counties for Medi-Cal applications, as well as other benefits programs such as CalFresh and CalWORKs.

Applicants can also apply through CoveredCA.com, the state health insurance marketplace, which also has an integrated streamlined online application for APTC or Medi-Cal coverage. In 2026, DHCS made revisions to the paper application for health coverage to align with both online portals for further streamlined enrollment.

### Enrollment assister workforce

Multiple types of assisters work across the state to support Medi-Cal outreach, enrollment and retention efforts, including those directly integrated or linked with Medi-Cal, as well as independent entities. While assisters cannot directly enroll a consumer into coverage or retain health coverage for others, they can help individuals with filling out applications or renewal documents or field questions about these processes.

Initiatives to support enrollment efforts by the state include volunteer-driven Coverage Ambassadors, the grant-funded Medi-Cal Health Navigators, and Covered California Navigators.



#### Coverage Ambassadors

DHCS created the Coverage Ambassadors campaign in response to the end of the COVID-19 era continuous coverage requirement to help prevent coverage losses for Medi-Cal beneficiaries during resumed redeterminations.

Today, more than 7,000 Coverage Ambassadors continue to support outreach and enrollment efforts at a diverse set of entities that serve as trusted messengers at the local level, such as providers, MCPs, advocates, CBOs, healthcare facilities, clinics and DHCS employees, among others. While some of these groups may have already been doing Medi-Cal outreach and enrollment efforts, bringing them together as Coverage Ambassadors helps create messaging consistency across many partners statewide.<sup>36</sup>

## Medi-Cal Health Enrollment Navigator Project

Another state initiative in recent years, the Medi-Cal Health Enrollment Navigator Project, was legislatively mandated to enroll harder-to-reach, vulnerable populations in Medi-Cal.<sup>37</sup> With money appropriated through the legislature, counties and CBOs worked on this project from 2019 to 2022. Later, the California Primary Care Association (CPCA) continued the Navigator project with DHCS to provide \$20 million in funds to community health centers (CHCs) to assist with Medi-Cal outreach, enrollment, renewal and utilization from 2023 to 2025.

The initiative reached 98 CHCs, enrolling and retaining coverage for 124,000 people. The project had 12 target populations of focus, such as people with disabilities, substance use disorders or limited English proficiency; people experiencing homelessness; immigrants; and justice-involved individuals.<sup>38</sup>

## Covered California Navigators

Those seeking health coverage may not know the exact program they qualify for, emphasizing the importance of “no wrong door” approaches. While primarily providing support for enrollment into plans on Covered California, Covered California Navigators do support with Medi-Cal enrollments when individuals are found eligible.

For the 2024-27 Navigator program grant cycle, 51 organizations were awarded funding.<sup>39</sup> As a part of a pilot, the Covered California Navigator Program also provided Supplemental Outreach Grants in FY 2024-25 to CBOs and CHWs to support outreach efforts to diverse and underserved communities by providing referrals to enrollment counselors,<sup>40</sup> allocating \$500,000 to six lead awardees.<sup>41</sup>

## Payers and Providers



Payers and providers also play a role in the Medi-Cal outreach and enrollment landscape. MCPs can provide outreach about Medi-Cal generally or support members with renewals, both without choice counseling. Any marketing materials for Medi-Cal must be approved first by DHCS.<sup>42</sup>

MCPs are not required in their contracts with DHCS to provide outreach and enrollment assistance,<sup>43</sup> but some plans provide their own additional enrollment support initiatives, such as through text message reminders or providing individual support.

For example, LA Care and Blue Shield have a community resource center, including enrollment support staff to help with Medi-Cal applications and renewals.<sup>44</sup> Most recently, Santa Clara Family Health Plan started partnering with CBOs to support enrollment and retention ahead of eligibility changes due to immigration status in 2026.<sup>45</sup>

## Hospitals

Hospitals primarily provide support through presumptive eligibility, which provides immediate, temporary Medi-Cal benefits for up to 60 days for those who qualify. Across the state, there are 400 approved providers that can grant presumptive eligibility.<sup>46</sup>

At a hospital, registered staff, separate enrollment assisters, contractors or assigned eligibility staff can follow up to support with completing applications for ongoing Medi-Cal after presumptive eligibility.<sup>47</sup> Some hospital systems like Providence and Dignity have financial counselors that can support with enrollment into Medi-Cal as a part of their role in navigating medical bill payments. Physicians, nurses and office staff are permitted to discuss plan membership with their patients.<sup>48</sup>

## CHWs

CHWs play an important role in retaining coverage in Medi-Cal. They can be employed by providers, community organizations, hospitals, or directly with MCPs.

While covered services are limited to those already enrolled in Medi-Cal, CHWs can provide health navigation services,<sup>49</sup> such as retaining coverage in Medi-Cal. CHW providers can additionally employ Certified Enrollment Counselors if they are Certified Enrollment Entities to assist individuals with both Covered California and Medi-Cal applications.

### Effective Enrollment Assistance Is Culturally Competent

Of all Medi-Cal and CHIP recipients, 1 in 4 has limited English proficiency.<sup>50</sup> Enrollment assistance must be culturally competent and linguistically appropriate to effectively support those seeking coverage.

The enrollment assister workforce adheres to this approach in the following ways:

- Covered California Navigators have defined responsibilities to provide assistance to the populations they work with in culturally and linguistically appropriate ways.
- CHWs have lived experiences in common with the communities they serve.
- Coverage Ambassadors represent diverse organizations and disseminate materials in up to 19 languages.

Federal law also requires the following language assistance:

- Notice of available language assistance services is required on all Medicaid applications, notices and other communications.<sup>51</sup>
- States are required to identify prevalent non-English languages, and then the state and contracted MCPs must make oral interpretation and written materials, including notices, available in those languages.<sup>52</sup>

## Policy Changes Require a Renewed Focus on Enrollment

Health insurance and public programs are already complex, and individuals often need assistance with enrolling or retaining their coverage. With major upcoming changes to Medi-Cal eligibility and financing policy, enrollment-focused work will be even more critical. Supporting individuals in maintaining health coverage may be as important as initial enrollment for California to maintain the coverage gains they have invested in for decades.

Due to budget constraints the state faced in 2025, **the legislature enacted some changes to Medi-Cal to balance the budget, including:**

- Reinstating the asset test for certain older adults and people with disabilities in Medi-Cal.
- Cuts affecting the unsatisfactory immigration status (UIS) adult population, including freezing new enrollment in full-scope Medi-Cal,<sup>53</sup> instituting \$30 monthly premiums and eliminating dental benefits.

While these cuts were delayed until July 2027 in the 2026-27 budget agreement between Governor Newsom and the California Legislature,<sup>54</sup> California will still have to make major changes to Medicaid due to Congress enacting H.R. 1 in July 2025. **These Medicaid changes means that:**

- Medi-Cal enrollees and applicants in the adult expansion population will have to meet work requirements, also called community engagement requirements (January 2027).



- Medi-Cal enrollees in the adult expansion population will have more frequent redeterminations, every six months instead of every year (January 2027).

These additional reporting requirements are estimated to cause up to 2 million Californians to lose coverage,<sup>55</sup> even if still otherwise eligible for the program. Prior to the ACA and expansions of full-scope Medi-Cal to undocumented populations, California counties operated robust indigent care programs (i.e., county-financed programs for low-income residents ineligible for other forms of coverage). Under California law, counties are legally obligated to provide basic, medically necessary healthcare for uninsured residents.<sup>56</sup> With reductions in the uninsured over the years, these programs have not been needed, but many counties are now preparing to restore them.<sup>57</sup> The 2026-27 California budget did not include any funding to support county indigent care, with anticipated costs for counties at \$2 billion to \$5.5 billion a year and anticipated enrollment at 417,000 to 1.3 million.<sup>58</sup>

Additionally, because of further changes in H.R. 1, California will have to make major adjustments to the managed care organization (MCO) tax the state uses to finance much of its share of Medi-Cal and draw federal matching funds.<sup>59</sup> California stands to lose billions of dollars from these changes and new restrictions on provider taxes. The state will have to significantly increase spending to make up for these Medi-Cal financing restrictions.<sup>60</sup>

## Recommendations for Stakeholders to Help Californians Enroll in and Retain Coverage

As California looks ahead to enact Medi-Cal changes as a result of the 2024-25 state budget agreement and H.R. 1, all stakeholders — funders, Medi-Cal MCPs, providers, counties and state agencies — have a role to play in helping ensure Medi-Cal enrollees retain coverage and potentially eligible individuals can enroll.

In this section, we use the following icons to show which health care stakeholders can contribute to or participate in each recommendation:

**State**



**Counties**



**MCPs**



**Providers**



**Funders**



**Advocates**



**CBOs**



### 1. Streamlining Enrollment Systems and Leveraging Technology

DHCS' eligibility and enrollment H.R. 1 implementation plan focuses, in part, on simplifying the renewal process with clearer forms and easier steps for the six-month renewals.<sup>61</sup> In addition, DHCS can:



**Continue investments to increase ex parte (i.e., automated) renewal rates.**

The state made major strides during unwinding in increasing ex parte rates, or rates of automatically renewing coverage using existing data sources. The state took up waiver flexibilities that supported ex parte rate increases during that time, and some of those strategies remain available through CMS.<sup>62, 63</sup>

The upcoming additional redeterminations and verifications for community engagement requirements will create additional hurdles for ex parte renewals. While DHCS plans to leverage data sources from other systems for work requirement eligibility verification,<sup>64</sup> they can also contribute to maintaining ex parte rates by ensuring counties have access to additional data sources, establishing consistent data hierarchies for those sources and using data sources for both exclusions and verifications to community engagement.

 **Leverage artificial intelligence (AI) and automation to support eligibility work, with clear guardrails to prevent harm.**

Automation and AI can increase efficiency on the systems side, such as managing documentation and leveraging electronic data sources for enrollee information, which frees up staff to focus on direct care.<sup>65, 66</sup>

## 2. Boosting Enrollment Workforce

While states are leveraging AI for chatbots to answer basic questions, it is unlikely that AI will ever replace the need for a human workforce. Medi-Cal enrollment is complicated, health insurance literacy is generally low,<sup>67</sup> and individuals need higher-touch assistance from a more culturally and linguistically diverse workforce to navigate the enrollment process and select a health plan. Recommendations include:

   **Increase investments for current enrollment assister programs.**

The state, funders and MCPs can provide funding for assister programs across the state. Funding can enhance assister activities in areas that lack resources or with populations that are particularly hard to reach, such as rural populations, those without transportation or individuals with limited English proficiency.

DHCS can claim federal match of 50% for outreach and enrollment-related activities for Medicaid and CHIP.<sup>68</sup> Similar to philanthropic investments during the ACA, stakeholders could invest in enrollment activities matchable by federal funding. MCPs and funders could also directly fund CBOs that focus on enrollment.

State, regional and local investments in assister programs may become even more critical in the future for organizations that rely on grants. The federal government has issued a proposed rule that could make federal funding more difficult for some organizations to attain in the future.<sup>69</sup>

 **Providers can support with work reporting requirement exclusions.**

Providers will newly need to play a pivotal role in supporting with Medi-Cal enrollment and redetermination efforts. The June 2026 interim final rule from CMS ties medical frailty exclusion to the inability to work, making automatic verification through data sources very challenging and documentation from providers even more critical to demonstrate compliance.<sup>70</sup>

For patients who meet the definition of medically frail and are excluded from work reporting requirements, providers, especially those who specialize in certain conditions that meet the medical exclusions, can share diagnosis and treatment documentation with patients to help meet any reporting requirements. Providers can also support in demonstrating short-term hardship exceptions, such as those in an inpatient hospital setting or nursing facility and those who have to travel for an extended period to seek medical care, by providing relevant documentation.<sup>71</sup>



 **Providers can amplify messages about renewals.**

Providers are often trusted information sources and have close relationships with patients, making them impactful messengers for Medi-Cal renewals. Providers can communicate generally to individuals about watching for

renewal packets or other information from Medi-Cal in the mail, pointing them toward assisters in the community that could support them with their packets. Additionally, providers could share specific reminders to patients about their upcoming renewals, but this comes with two caveats:

1. MCPs would need to make renewal dates accessible through provider portals or the monthly transfer of member information files (MIFs).
2. Many renewals are expected to be done on an ex parte basis, and informing enrollees about renewal dates may cause them to worry if they don't receive renewal packets in the mail, leading them to reach out to county eligibility offices unnecessarily and, ultimately, overwhelming county eligibility workers.

### **Embed additional assisters or CHWs in clinics and practices.**

For individuals already on Medi-Cal, CHWs can provide health navigation services, which include helping the member enroll or maintain enrollment in government or other assistance programs, provided that the services are related to improving the member's health and are provided pursuant to a CHW plan of care or treatment plan.<sup>72</sup> DHCS plans to partner with CHWs in Medi-Cal outreach and enrollment efforts to educate members amid upcoming policy changes.<sup>73</sup>

### **Ensure county eligibility workers are adequately staffed, trained and funded.**

Ongoing investments in staffing and training are needed to communicate to everyone helping individuals and families about the changes around eligibility and new community engagement requirements, as well as other policy updates. Adequate funding will support sufficient staffing levels to manage workload increases, staff time to participate in training and development, and maintenance of policy materials and technical assistance.

There is concern that the increased administrative burden on counties will interfere with otherwise routine activities, like resolving application denials or terminations, or fixing incorrect share of cost assessments. Counties estimate they will need 2,000 more eligibility workers statewide to accommodate their additional workload due to these new requirements. This amounts to \$270 million for the county-level Medi-Cal workforce in 2026-27 and \$344 million in 2027-28.<sup>74</sup>

Training resources provided to all those assisting consumers ensure that everyone is working from the same script and giving out accurate information.<sup>75</sup> DHCS is already conducting monthly webinars and plans to work with counties on funding needs and technical assistance.<sup>76</sup> They may consider earlier or more proactive communication with county staff.

### **Assisters can work non-traditional hours to serve consumers.**

Counties can partner with MCPs, local providers and CBOs to be available during weekends and evenings to support enrollment efforts when individuals are off work and can attend appointments with an assister. For example, one Southern California health plan is helping to fund a county's effort to place eligibility workers at weekend outreach events.

### **Build assister capacity to support immigration issues related to coverage and enrollment.**

As a result of H.R. 1 and state budget cuts, many coverage and eligibility changes for immigrant populations are coming into effect. In addition, with the federal government escalating immigration policies, implementing the

new public charge rule and sharing Medicaid data with ICE, many immigrants are more fearful to go to doctor's offices to access care or seek coverage — regardless of immigration status or program eligibility. Assister organizations can work with CBOs with deep ties to immigrant communities to help resolve emerging issues and monitor policy changes and impacts.

#### **Issue guidance to allow read-only access to CalSAWS for non-social service department entities.**

To better facilitate application completion, DHCS could issue guidance to county social service departments on giving CalSAWS read-only access to sister county departments (e.g., public health), CBOs or any organization that signs a memorandum of understanding (MOU) with a county. While some counties already do this, there is inconsistency across the state, and guidance could be helpful in reminding or informing counties about this opportunity. Organizations or departments with read-only access would be able to help applicants or enrollees understand what documents or information might be missing from their application or renewal and save them from having to make more than one additional phone call or trip to the county eligibility office. County eligibility workers would still be fully responsible for determining eligibility for Medi-Cal.

### 3. Increasing Collaboration and Strategizing Communications

DHCS plans to leverage its Coverage Ambassadors — a network of more than 6,000 partners statewide, including counties, MCPs, advocates, providers, schools and community organizations — to distribute resources and messaging at the local level. Additionally, California stakeholders can:

#### **Provide community engagement resources to enrollees.**

To meet the new work requirements for Medicaid in H.R. 1, 8% of Medicaid enrollees in California will need to find work or volunteer opportunities.<sup>77</sup> (Most enrollees already work, attend school or have an illness, disability or caregiver responsibilities that would exclude them.) Some healthcare stakeholders, like MCPs with strong local and community ties, could be valuable resources to help their members who are subject to work requirements find volunteer opportunities or job resources.

At the state level, DHCS could partner with the Employment Development Department to create resources for these individuals, and DHCS proposes including employment supports in its 1115 waiver renewal application.<sup>78</sup>

#### **Establish regularly convening community collaboratives on outreach and enrollment.**

While there are stakeholder advisory groups with DHCS, advocates and other stakeholders that engage at the state-level, such as the Coverage Ambassador network, this does not exist in all counties. Existing county groups could be repurposed to bring stakeholders together on outreach and enrollment issues in the future.

For example, the state has funded Providing Access and Transforming Health (PATH) Collaborative Planning and Implementation (CPI) collaboratives as part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative since 2022, bringing together county governments, medical providers, health systems and CBOs. When CalAIM funding ends at the end of 2026, these collaboratives could shift to focus on enrollment.



### **Develop a story bank and share stories within communities.**

To continue building a culture of coverage, community coalitions can collect and document stories from the field to demonstrate the work being done to successfully support enrollment of individuals and families in health coverage — or support people in maintaining coverage through meeting community engagement reporting requirements or eligibility redeterminations — and the positive impact for those receiving coverage.

### **Develop and amplify outreach campaigns.**

Crafting a multi-stage outreach campaign will be important to successfully reach populations affected by upcoming policy changes. DHCS has also shared plans to keep providers informed of changes and is considering providing printed materials for clinics, as well as placing navigators in clinics to provide enrollment assistance at point of care.<sup>79</sup> Culturally and linguistically appropriate messaging will need to be tested for specific audiences to determine what resonates, keeping in mind that different populations will be affected by different changes.

Components of a comprehensive statewide campaign could include printable flyers; messaging toolkits with social media examples; paid advertising on billboards, TV and radio; YouTube videos; and frequently asked questions. For example, as part of DHCS' outreach campaign plans for upcoming H.R. 1 changes, the state will provide culturally relevant materials in plain language across all 19 threshold languages, or languages identified as the primary language for 5% or 3,000 members of the Medi-Cal population.<sup>80</sup> To help DHCS maximize state matching funds for outreach, funding could come from other sectors such as philanthropy, MCPs and hospital systems.

### **Expand MCP member messaging.**

MCPs could play a vital role in helping to communicate with their members around upcoming renewal dates or community engagement reporting requirements. Because of the key role that MCPs play in Medi-Cal, individuals may be more familiar with their MCP than DHCS, and thus, more responsive to MCP outreach. DHCS plans to engage MCPs as communication partners during upcoming Medi-Cal changes and is exploring ways MCPs can support work requirement verifications or exclusions.<sup>81</sup> MCPs could also help to distribute outreach materials to their contracted network providers to disseminate to enrollees at the point of care.

### **Rapid evaluation and monitoring.**

Ongoing rapid evaluation of outreach efforts, enrollment and retention is critical so that the state and those working on the ground can determine if current strategies are successful or if pivots are necessary. So far, DHCS has identified metrics to evaluate, such as number of individuals subject to work reporting requirements, number in compliance and number of procedural disenrollments.<sup>82</sup> DHCS could consider additional metrics such as number of members subject to community engagement by type of qualifying activity and by type of exclusion, and how many are identified by ex parte. Close monitoring of call center wait times and application processing times will also be important to examine the impact on member experience due to increased verifications.



Adequate funding through the state and/or philanthropies should be allocated to support these activities. Convening outreach and enrollment collaboratives on the local level, as suggested in an earlier recommendation, could be a way to both surface problems and communicate information to address challenges on the ground.

## Conclusion

Building a robust enrollment system with focused improvements in enrollment technology, workforce and communication strategies will be critical to mitigate uncertainty in healthcare coverage enrollment due to legislative and policy changes now and in the future. All stakeholders play a pivotal role in helping to ensure individuals and families remain covered and enrolled, with access to quality, affordable healthcare.

## Acknowledgments

This paper was commissioned by Sierra Health Foundation and written by Transform Health, LLC.

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The authors are grateful to the individuals and organizations who reviewed this paper, including:

- Chet P. Hewitt, Kaying Hang, Matt Cervantes and Madeline Sabatoni at Sierra Health Foundation
- Christiana Smith, Eric Nielson and Roshena Duree at California Welfare Directors Association
- Tiffany Huyenh-Cho at Justice in Aging
- Yingjia Huang at California Department of Health Care Services
- Staff at Covered California
- Staff and Board Members of California Coverage & Health Initiatives

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