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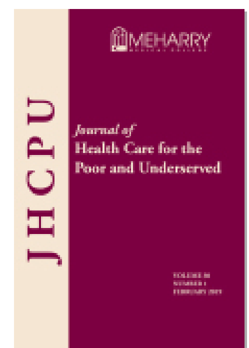

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Improving Medicaid Access in Times of Health Policy Change: Solutions from Focus Groups with Frontline Enrollment Workers

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Abstract: Enrollment navigators and government-employed Medicaid workers were an important element in the Affordable Care Act's (ACA) initial enrollment success. The Centers for Medicare and Medicaid Services eliminated 41% of funding for 2017 navigator programs and 90% of funding for outreach, arguing less investment was needed. Given that many remain uninsured, it is critical to identify effective enrollment practices. This study characterizes barriers and enrollment strategies from the perspective of California's Medicaid government and community-based enrollment workers (n=101 in eight focus groups). Participants identified a need for communication with policymakers, the state exchange, and each other regarding changing enrollment processes. Solutions include increased contact between enrollment workers to share strategies and policy updates regarding application processing, uniform policy interpretation, and details of ACA-related immigration law. Given efforts to weaken the ACA, it is critical to engage frontline workers in problem solving to streamline enrollment strategies, particularly for vulnerable populations.

Key words: Patient Protection and Affordable Care Act, Medicaid, health plan implementation, undocumented immigrants, enrollment.

Since the implementation of the Affordable Care Act (ACA) in 2014, the landscape of American health care has rapidly evolved. The ACA extended health insurance to at least 20 million people in the United States (U.S.), with 14.5 million enrolled in public insurance plans, including Medicaid and the State Child Health Insurance Pro-

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gram (SCHIP) since the first open enrollment period in 2014.[1] Despite these strides in enrollment, more than 28.9 million people (9% of the population) remain uninsured.[2] The country's remaining uninsured populations are disproportionately members of minority groups, particularly Latinos and immigrants without documentation.[3] Other remaining uninsured populations include those working class families and individuals between 100% and 133% of the federal poverty level who have not benefited as substantially from the ACA in the 17 states that have not expanded Medicaid.[4,5] This population is of particular interest as governors or state legislatures in some states (e.g., Idaho, Nebraska, and Utah) continue to debate Medicaid expansions after recent failed attempts to repeal or replace the ACA.[5,6]

Additionally, incentives for enrollment outside of employer-based coverage will decline beginning in 2019 with the repeal of the ACA's tax penalty for failing to enroll in health insurance (often referred to as the *individual mandate*). The Congressional Budget Office (CBO) projects that the repeal of the individual mandate, included in the 2017 Tax Cuts and Jobs Act, will result in four million Americans losing insurance by 2019.[7] This loss of coverage is related to the CBO's prediction of a 10% increase in premiums, "because healthier people would be less likely to obtain insurance and because, especially in the nongroup market, the resulting increases in premiums would cause more people to not purchase insurance."[7] By 2027, the CBO projects that the number of newly uninsured will grow to 13 million, with five million of those losing Medicaid coverage.[7]

The rollback of the individual mandate will not go into effect until 2019, but insurance coverage losses are already becoming evident. The Commonwealth Fund's Affordable Care Act Tracking Survey found that four million working age adults lost insurance coverage since 2016 and uninsurance rates among low-income adults increased from 20.9% in 2016 to 25.7% by March of 2018.[8] Given this erosion in health insurance rates nationally, and that recently proposed changes to the ACA are likely to disproportionately affect vulnerable populations (e.g., minorities, the poor, and immigrants), it is important to identify successful strategies to enroll persistently uninsured groups, populations who become newly eligible with future Medicaid expansions, and those who churn in and out of Medicaid programs.[9–11]

As the most populous state in the nation, California also had the largest population of the uninsured prior to the ACA, as well as the nation's largest immigrant and Latino populations, making it an ideal setting to study enrollment strategies for poor and underserved communities.[12,13] Although California has taken a particularly proactive approach to decreasing its uninsured population since the implementation of the ACA, an estimated three million Californians remain uninsured in 2017.[14,15] Thus, the state has faced and continues to face enrollment challenges related to clients with limited English proficiency, those living in mixed-immigration status households, and approximately 1.5 million undocumented immigrants who are projected to remain uninsured because of their exclusion from Medicaid and the health care exchanges under the ACA.[12,14] In California and across the country, Latinos remain the largest uninsured group with higher rates driven by documentation status and fear of deportation for some Latino immigrants.[3,13]

At the same time that federal health policy is in flux, the level of immigration enforce-

ment is also undergoing transformation.[16] At the time of this writing, the Deferred Action for Childhood Arrivals (DACA) program is at risk of being phased out, with executive branch attempts to cancel the program on hold, pending judicial resolution, thus jeopardizing employer-based health care and some state-funded Medicaid programs for this population.[17] In addition, health care workers and community-based organizations have reported that increasing fear among some immigrants and their families is limiting health care enrollment and utilization, even among those eligible for care (such as eligible legal immigrants and citizens living in mixed-status households).[18,19]

In the current policy climate, there are multiple factors that have great potential to result in confusion for customers about health insurance eligibility, including repeated efforts to modify or repeal the ACA, drastic reductions to health insurance enrollment and outreach budgets, and changes in immigration policy that have created what is widely perceived to be a hostile political environment. The Centers for Medicaid & Medicare Services (CMS) reduced funding for outreach efforts by 90% and funding for navigator programs by more than 40% for the shortened 2017 open enrollment period.[20,21] Given rapidly shifting health and immigration policies, reduced advertising and enrollment assistance, and the potential for customer confusion, it is critical to identify and implement effective enrollment and education strategies, particularly for populations that are historically marginalized and uninsured.

Background on California's frontline enrollment workers. It is within this context that this study assesses the lessons learned through a network of frontline enrollment workers who have been mobilized to help implement California's "No Wrong Door" policy for Medicaid enrollment. The "No Wrong Door" policy allows Californians to enroll in Medi-Cal (the state's Medicaid program) though any ACA health care exchange enrollment option, whether online, by telephone, or in person through enrollment workers. These frontline enrollment workers can be government employed Medi-Cal Enrollment Workers or community-based Certified Enrollment Counselors, a subset of whom are navigators funded through Covered California (California's Insurance Exchange program) grants.[22] The state's 22,000 government-employed Enrollment Workers (referred to as *government enrollment workers* here) are typically stationed at county offices or outreach sites. In addition, they may assist eligible Californians in enrolling in other entitlement programs, such as the Supplemental Nutrition Assistance Program, Temporary Assistance for Needy Families, and others. In contrast, the state's 5,000 community-based Certified Enrollment Counselors (referred to as *community-based enrollment workers* here) typically operate out of clinics and community-based organizations with a variety of missions, where they assist applicants with completing the state's health insurance application for Medi-Cal or private insurance on the state's health insurance exchange.

California's frontline workers have been integral to the state's ACA enrollment strategy. About 60% of new Medi-Cal enrollees required assistance to sign up for coverage during the first open enrollment period (October 1, 2013 to March 31, 2014), with 31% relying on a government enrollment worker and 8% relying on community-based enrollment workers.[23] These frontline workers are responsible for both facilitating enrollment, as well as identifying barriers to enrollment and helping overcome them as quickly as possible. To assist California's government and community frontline enrollment

workforce, the state developed a computerized system to provide immediate eligibility determination for Covered California and Medi-Cal insurance. As a result of these efforts, as of February 2018, California has successfully enrolled 4.4 million additional individuals in public health insurance (Medi-Cal and SCHIP) since September 2013, a 56% increase in enrollment.[24]

Frontline enrollment workers: Understudied influencers in the enrollment process. Given the success of California's enrollment strategies and the high level of client engagement with enrollment workers, it is critical to understand more fully the experiences of frontline enrollment workers, the barriers they encountered in the enrollment process, and the formal and informal solutions that they proposed to resolve these challenges. These lessons are critical in order to successfully reach populations who are persistently uninsured, to better respond to those who churn in and out of the public insurance system, and to prepare more fully for future policy changes. While prior research focused on enrollment challenges from the perspective of the client,[25–28] we are not aware of any studies in which enrollment barriers and successful enrollment strategies are explored from the perspective of frontline enrollment workers themselves. This study considers frontline workers as a key and understudied influencer in the policy implementation process.

Methods

This study was designed through an iterative process with an advisory board of 13 stakeholders from community-based organizations, health centers, a union representing frontline workers, and government agencies involved in health care enrollment, as well as 26 key informant interviews. Our advisory board and interviews (completed prior to the focus groups) provided contextual background, which guided the development of the focus group moderator's guide. These interviews were also critical in guiding our study recruitment strategies, formulating partnerships with county and union offices to facilitate coordination of the focus groups, and educating the research team about the Medicaid enrollment process, which varied somewhat across counties. While these interviews provided valuable background, the focus of the analyses presented here are the insights offered by the frontline enrollment workers.

Seven to 19 people participated in each of the eight focus groups (n=101). Focus groups were conducted between February and May of 2015 across four regions of California: the San Francisco Bay Area, the Central Valley, the Inland Empire, and Los Angeles County. These areas were chosen in order to involve a variety of urban and rural settings. Two focus groups were completed in each region, one with government enrollment workers and one with community-based enrollment workers. In addition, interviews with the local managers of frontline workers at each site were also conducted prior to each focus group. Interview questions included the logistics of enrollment in each county, the regional barriers to enrollment, the best practices identified as well as potential solutions to problems encountered. This information provided additional contextual background for the focus group moderators to understand more fully the enrollment process and specific jargon used at each site.

Government enrollment worker participants were recruited through county offices

with union assistance in some regions. Community-based enrollment workers were recruited via snowball sampling in regional clinic consortia with local managers, peers, and union representatives disseminating study recruitment materials through email and posted notices. Eligibility criteria for participation included being a community or government enrollment worker in one of the target regions, being over 18 years old, and being willing and able to participate in a focus group in English. Focus groups lasted approximately 90 minutes and were conducted by experienced moderators who obtained spoken informed consent from each participant on the day of the study. Focus groups were held during work hours in local office conference rooms identified by the county or clinic consortiums as convenient for the participants. A light meal was provided. When permitted by local management, participants were compensated for their time with a $30 Amazon gift card.

Participants completed a demographic questionnaire. Focus group topics included barriers to the Medi-Cal enrollment process, enrollment challenges for populations who are newly eligible or who historically have had poor access to health care, and possible solutions to the identified barriers. Focus group recordings were professionally transcribed and qualitative analyses were completed by two members of the research team, assisted by the program Atlas.ti (atlasti.com). Memos were used to derive and refine codes with a codebook used for final rounds of coding. Team members compared their coding and discussed discrepancies until common coding strategies were identified. Study findings were validated through iterative rounds of key informant interviews, engagement with the study's advisory board, and review by a panel of government enrollment worker union members from across the state. The University of California's Institutional Review Board approved this research protocol.

Results

Participants. Of the 101 focus group participants, 62 (61%) were government enrollment workers and 39 (39%) were community-based enrollment workers. Overall, 74% of participants identified as Latino. A majority of government enrollment workers (60%) and community-based enrollment workers (82%) reported speaking Spanish directly with applicants. Most community-based enrollment workers reported two years or less of experience with Medi-Cal enrollment, while most government enrollment workers reported more than three years of experience. Although most participants were working in urban areas, more community-based enrollment workers than government enrollment workers worked in rural regions (26% vs 5%). The majority of community-based enrollment workers in this study were hired by and co-located in health centers, while the majority of government enrollment workers were stationed at county welfare offices.

Barriers and solutions identified. Government enrollment workers and community-based enrollment workers both identified several systems-level barriers to the Medi-Cal enrollment process, including technical challenges with the enrollment computer system; a need for improved communication between Medi-Cal leadership, the state exchange, and front-line workers; and limited knowledge about tax law and immigration policy, and how they affect Medi-Cal enrollment. Overall, participants reported that the bar-

riers outlined below are representative of most cases that they see of Californians who are Medi-Cal eligible, but who remain uninsured. Barriers and proposed solutions are summarized in Box 1.

Technical challenges. Both government and community-based frontline workers consistently reported that the single largest barrier to enrollment arose from technical glitches in the state's electronic enrollment system. This system was designed to be the interface between the state's health insurance exchange and California's established county-based Medi-Cal enrollment systems. Key informants explained that—due to the tight development timeline for implementation of the ACA—the IT system was originally deployed with known limitations, and additional bugs were identified after deployment. Frontline workers reported that these unresolved issues, as well as the slow adaptation of the system to ongoing policy changes, increased their workload due to the time required to remove technical barriers and create informal data entry workarounds. These technical challenges also placed unnecessary burdens on applicants. One community-based enrollment worker explained, "Sometimes you're in the middle of enrolling, and the system crashes, and then you've got to tell [the client], 'You've got to come back.' And it's a burden . . . because this patient took half of the day off from work to come and do this application." Another government enrollment worker explained that while she appreciates the need for formal reporting of IT bugs, workers also feel compelled to create their own unsanctioned workarounds because, "we want to get the client the benefits. We're not going to sit there and wait for them to fix the error in five months when we can get a workaround and get them benefits today."

Focus group participants suggested increased transparency in the development of software fixes. To this end, government enrollment workers advocated for the development of a database available to all frontline workers that would include known bugs, sanctioned workarounds, and announcements about recent changes in the IT system. In addition, community-based enrollment workers suggested that the enrollment process could be facilitated if the state exchange provided them with read-only access to the state's Medi-Cal application system. This would allow community-based enrollment workers to facilitate enrollment by identifying missing documentation and giving them the opportunity to counsel applicants about reasons for application denials. One community-based enrollment worker explained, "If we had the capability to see the Medi-Cal system, and what's going on with the applications . . . that would be great, to have maybe even limited access. 'Okay, I see that you had a case that was denied. This is the reason why it was denied.'"

Frontline workers reported that, in light of a rapidly evolving IT system, they were inundated with email updates, which they did not have time to process. As an alternative to this barrage of emails, some supervisors summarized emails for frontline workers in writing or at staff meetings: "What I do is I read it all because that is my job, and then I do a summary and send it to them." Summaries in writing or at staff meetings allowed frontline workers to target their attention to critical IT updates, thus allowing them to focus on enrollment rather than processing email.

Need for increased communication about policy. Both government employed and community-based frontline workers reported a need for more consistent interpretation of Medi-Cal enrollment policies between the Medi-Cal program and Covered California,

Box 1.

SUCCESSFUL ENROLLMENT STRATEGIES AND PROPOSED CHANGES

Challenge Identified	Successful Example Strategies	Proposed Changes
Technical Challenges • Technical glitches in the enrollment software • Software not reflecting policy changes • Excessive emails regarding technical changes • Community-based enrollment workers cannot see Medicaid applications after submission	• Supervisors take responsibility for reviewing communications about technical updates and summarizing key takeaways for each work site. • Sharing software workarounds among frontline enrollment workers.	• Online database or "wiki" that includes known bugs, sanctioned workarounds, and announcements about recent changes in the IT system • Ongoing, timely, and relevant trainings about new IT fixes and sanctioned workarounds • Create a read-only access for community-based enrollment workers to identify missing paperwork and reasons for denials
Need for Increased Communication about Policy • Inconsistent interpretation of enrollment policies • Slow dissemination of policy changes to frontline workers • Policy updates are lost among other email communications	• State-employed Medicaid supervisors provide training for some community-based enrollment workers	• Case-based instruction on new policy implementation • Supervisors or regional policy experts can summarize policy changes and highlight changes that are most relevant at each work site • Web-based training on policy changes, particularly to reduce travel for rural frontline workers. • In urban settings in-person training was preferred • Centralized hotline or online Wiki with up-to-date policy interpretation
Specific Gaps in Knowledge • Tax policy related to national and state health insurance policy (e.g. ACA tax credits) • Eligibility for different immigrant populations	• Some sites had relationships with other community based organizations for client referrals (e.g. legal aid or immigrants or tax preparation)	• Case-based trainings (as noted above) • Training should include clarifications • Establish relationships with community-based organizations (e.g. immigration attorneys, tax preparers) for client referrals

as well as the need for rapid dissemination of policy changes to frontline workers (see Figures 1 and 2). Government enrollment workers and community-based enrollment workers reported witnessing different interpretations of the same policies on a wide range of topics, including determining household sizes, counseling clients about ACA related tax law, and Medi-Cal eligibility for some immigrants with temporary legal status (e.g., DACA), all of which are detailed further below. One government enrollment worker expressed frustration about inconsistent policy interpretation: "It's just we get different answers from everybody, depending on who you ask."

Frontline workers had several suggestions about how to improve dissemination of information about policy changes, as well as how to promote consistent policy interpretation between Medi-Cal and the state exchange. Some community-based enrollment workers received training on enrollment-related policy from Medi-Cal supervisors: "We actually have supervisors that will give a presentation for us, they will come for like two hours . . . and they're just such an excellent resource." Web-based trainings were another platform identified by participants for rapid and consistent dissemination of policy changes. Workers and supervisors in rural regions were particularly enthusiastic about web-based training, which lessens the burden of travel for frontline workers in remote regions. In areas where travel was less burdensome, workers reported that in-person training was more engaging. Finally, frontline workers also suggested having

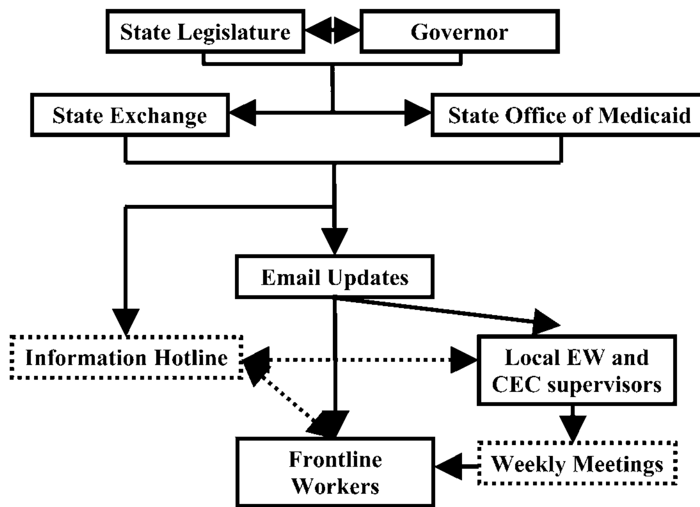

Figure 1. Current information flow for policy changes.[ab]
Notes
[a]Currently, policy changes are made by the state legislature and signed by the governor, then disseminated to the state's health care exchange and State Office of Medicaid. These agencies are responsible for further dissemination of policy changes to frontline enrollment workers. Enrollment Workers report that the most frequent way that they hear about policy changes is through an overwhelmingly large volume of email.
[b]Solid line: pathways currently functioning to promote policy implementation; Dotted line: resource or pathway for policy implementation may exist, but is reported by frontline workers to be difficult to access, not being utilized, not being available to all workers, or not functioning as planned.
EW = Medicaid Enrollment Worker
CEC = Certified Enrollment Counselor

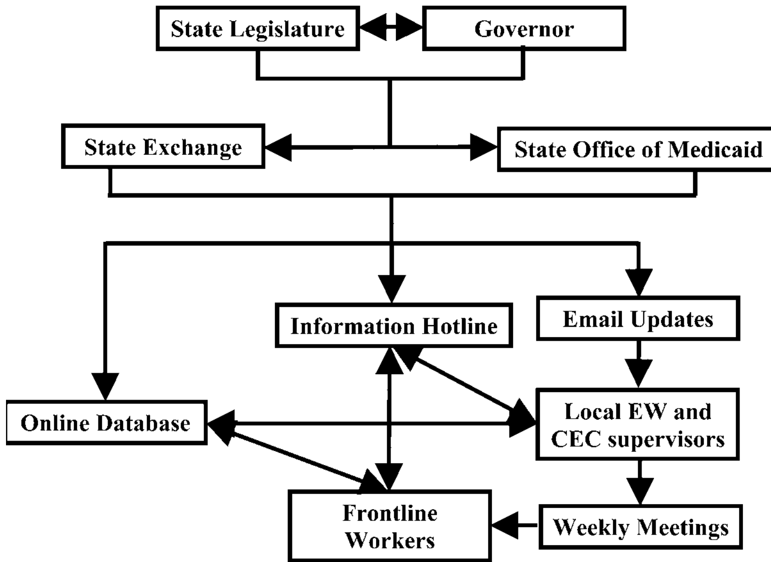

Figure 2. Proposed information flow for policy changes.[a]
Notes
[a]Study participants proposed using weekly meetings or training sessions with local supervisors as the primary means of disseminating information about enrollment policy changes with additional resources including an information hotline and online database with up-to-date policies for reference. They suggested that emails with policy changes be targeted at local supervisors who can help to screen and prioritize this information depending on the needs of each office.
EW = Medicaid Enrollment Worker
CEC = Certified Enrollment Counselor

a centralized hotline for policy questions, as well as an online reference or database with current eligibility guidelines that Medi-Cal Administrators could update regularly as enrollment policies change.

Gaps in knowledge. Government enrollment workers and community-based enrollment workers identified a few areas in which all frontline workers could benefit from additional training. Because of changes in Medi-Cal eligibility determination with the implementation of the ACA, focus group participants reported particular confusion over health policy and related tax issues. For example, frontline workers wanted additional training about the determination of household size when household composition is not adequately represented on tax documentation. In one case, a community-based enrollment worker noted that parents who are supporting children in Mexico are unable to claim them as dependents for U.S. income taxes.

Another common topic of confusion concerned recent shifts in California state policy about Medi-Cal eligibility for some immigrant populations, including those young people eligible for temporary reprieve from deportation through DACA. One government enrollment worker explained that although DACA recipients have been eligible to receive Medi-Cal since DACA began in 2012, a lack of dissemination of this policy has limited enrollment of this population. Some frontline workers reported first hearing

about DACA-recipients being eligible for Medi-Cal from their clients. "They're saying, 'Covered California told me that I am eligible because of DACA.' And then we got a newspaper article saying . . . they are eligible to sign up through Covered California, . . . and then we have to go back and redo [their applications]." These frontline workers reported frustration about incorrect denials of Medi-Cal to these eligible Californians. Other workers reported uncertainty about how to counsel applicants regarding the immigration consequences of applying for Medi-Cal, which was frequently cited as a barrier to enrollment. One worker recalled, "A lady came in to get insurance, and she had no pay stubs. Her husband refused to give her the information because he said, 'I'm not going to put myself in jeopardy with immigration so you can get insurance.'"

Frontline workers requested additional case-based training on these topics with concrete examples for determining household size and entering applications for young people with DACA who do not yet have a social security number. They also requested clarification about the limits of their roles and responsibilities in counseling clients about tax and immigration issues. "You're their enroller, not their lawyer," one community-based enrollment worker said. Frontline workers did express a desire to refer clients to more specialized resources when needed. Some reported partnerships with community-based tax or immigrant advocacy groups, while others expressed a desire to build alliances with such organizations.

Discussion

California has extended Medi-Cal and SCHIP enrollment to 4.4 million new people since the implementation of the ACA in 2014, accounting for about 28% percent of new enrollees on public insurance nationwide, greatly exceeding the state's 12% share of the U.S. population.[24,29] Frontline workers, including community-based enrollment workers and government enrollment workers, are responsible for the on-the-ground implementation of state and national health policy changes. The critical role of these frontline workers mirrors that of other professionals, such as police officers and teachers, who are at the vanguard of policy implementation in their fields, and have been dubbed "street-level bureaucrats."[30–34] Many of these voices had not been previously captured, nor their expertise acknowledged.

This study documents that frontline workers are a vital resource in identifying and problem-solving ongoing systems level barriers to health insurance enrollment, including the particularly challenging problem of standardizing policy implementation. This study's data, collected during the early phases of implementing new and complex federal policies in the country's largest and most diverse state, demonstrate that frontline workers can be assets in identifying specific barriers and solutions at a time of great flux. In particular, these data illustrate how enrollment practices related to both policy changes and technical challenges can be guided towards standardization over time, allowing consumers to receive consistent enrollment information and services, regardless of where they live or the pathway that they use to enroll.

The findings in this study are supported by prior research during the rollout of the State Child Health Insurance Program (SCHIP) in the late 1990s and early 2000s. Stud-

ies of SCHIP enrollment in New York City and the State of New York found particular barriers to enrollment for immigrants fearing deportation and those with limited English proficiency.[35] Systems-level barriers, such as ensuring adequately trained enrollment staff, timely communication of policy changes to frontline workers, dysfunctional IT systems, and the need for in-person or live phone support for application processing, were also noted in this more prescribed insurance program. Like the community-based enrollment workers in this study, caseworkers at local community-based organizations were helpful in the SCHIP enrollment process in many cases.[35] Attention to addressing enrollment barriers likely contributed to the high enrollment rates of uninsured children, particularly minorities, in the region.[36]

Frontline workers in this study identified many barriers to enrollment, with particular concern about their lack of knowledge regarding rapidly changing enrollment policies. Importantly, they also identified specific strategies for improving dissemination of policy changes to support their enrollment efforts, including frequent on-site training with supervisors to review policy changes, problem-solving challenging cases, and learning about how to document these changes in current IT systems. Frontline workers also reported that they could be supported in their roles with an up-to-date online database of current enrollment policies and regular communication among the state exchange, community-based enrollment workers, and government enrollment workers to facilitate completion of the enrollment process. Strategies—such as creating a portal for exchange workers to monitor Medicaid application progress and maintaining a hotline or online wiki of current enrollment policies and IT workarounds—are pragmatic interventions that require additional evaluation. All of these approaches could be useful to support enrollment workers in policy implementation as states work to maintain and maximize enrollment of populations that are churning on and off Medicaid, as well as those that may remain vulnerable as additional changes in federal and state health and immigration policy are implemented. Without such efforts, the existing system will continue to contribute to delayed health care coverage and frustration among both clients and frontline workers.

In addition, California's large Latino population and its relatively unusual policy of using state funds to provide Medicaid coverage for some undocumented immigrants, including immigrants with DACA and undocumented children, led enrollment workers in this study to express a particular desire to learn more about enrollment eligibility for different immigrant groups. This has become increasingly important as national immigration policy rapidly evolves and eligibility for public insurance programs for immigrant populations continues to shift in California and other states.[37] Preliminary research with health care workers, community-based organizations, immigrant parents, and some lay press accounts, all point towards a chilling effect of immigration policy changes on health care access.[18,19] With the continued growth of the Latino population nationwide and ongoing changes in insurance eligibility for immigrants, it is imperative to implement rapid policy dissemination strategies such as those suggested by our findings, in order to ensure that immigrants, who might hesitate to interact with enrollment officials, are not inadvertently turned away from enrollment opportunities for which they are eligible.[38–40] It will be important to continue studying the impact of immigration policy on health and health care access in immigrant communities,

as well as on the U.S.-born children of immigrants, as health care and immigration policies continue to change.[16–19]

In an effort to expand insurance coverage among vulnerable populations, some counties in California have expanded enrollment opportunities to include other points of contact with the social service system such as enrollment in the Supplemental Nutrition Assistance Program (food stamps), the Supplemental Nutrition Program for Women, Infants, and Children (WIC), and Temporary Assistance for Needy Families. Enrollment in these settings may be particularly valuable, as clients are likely to interact with these programs when their incomes are changing and they might become eligible for public insurance. Integration of Medicaid enrollment into applications for other entitlement programs is another testable intervention that could promote enrollment and requires further assessment.

Regardless of the specific health and immigration policy changes that are enacted in the coming years, states will continue to be able to tailor outreach and enrollment strategies to focus on diverse sectors of their populations that remain uninsured, such as minorities and members of mixed-immigration status families. Frontline enrollment workers are ideally positioned to shepherd clients through the enrollment process, having a unique vantage point on the needs in each region. While CMS argues that some navigator programs have not met their established enrollment goals and that other strategies, such as social media, can be effective for enrollment, budget cuts do not account for the other education and enrollment tasks that are falling to frontline workers in the face of policy changes.[20,41] These new tasks include spreading awareness about the markedly shortened open enrollment window in 2017, educating clients about the importance of health insurance coverage and changes in plan offerings occurring throughout the country, and ensuring that clients successfully complete the enrollment process.[42] Rather than reducing the role of frontline workers, the data presented here suggest that these workers can play a key role in strategic targeting of efforts to educate the public about how changes in open enrollment and plan availability affects their insurance eligibility and enrollment. The strategic messaging and outreach of frontline workers will be particularly important in light of CMS' reduced 2017 open enrollment period, as well as in the future with additional anticipated health insurance policy changes.[20,41]

As more national health policy proposals are under consideration, these research results may be a helpful case study of the barriers and potential solutions to promoting Medicaid enrollment during the implementation of future policy changes, particularly for vulnerable and immigrant populations. However, the data presented here come from a single state case study and therefore have several limitations. First, California is unique in many ways as a large minority-majority state, which is not only expanding Medicaid, but also implementing additional health care policies, such as extensive enrollment and outreach efforts and the utilization of state funds, to provide Medi-Cal to some immigrant populations not covered under the ACA. The unique policy environment of California may limit the generalizability of our findings. Second, California's unique county-based Medicaid enrollment system may also limit the generalizability of our findings. Third, while some of the enrollment barriers identified in this study may be common in other states, additional barriers are likely to exist in different regions and

among different populations. However, California's urban/rural mixture of counties captures many of the challenges faced by other regions of the country, and its diverse demographic characteristics prefigure the shifting racial and ethnic makeup of the country as a whole. Fourth, these data were collected in 2015 and do not specifically assess roll back of the individual mandate, reductions in the budget for ACA enrollment, attempts to repeal or replace the ACA, and threats to DACA and other temporary protected immigration programs. Finally, while participants reported that the barriers identified here are the primary factors that limit Medicaid enrollment for those who are eligible but uninsured in California, this study is qualitative and cannot access the magnitude of the impact of each of the identified barriers.

Evident throughout the focus groups and across different frontline enrollment workers in this study was a sincere commitment to the enrollment of vulnerable populations in need of health care and the desire to make "right" previous policies that may have served as barriers to their health insurance access. To maximize the success of these enrollment workers, states can promote communication about application processing between state and exchange frontline enrollment workers. States can also focus on rapid dissemination of IT and policy changes with ongoing trainings for these workers that target the most effective strategies for overcoming system and client problems as they emerge. These strategies will be particularly critical in regions and for populations where enrollment policies are evolving, including implementation of any new federal policies, and policy changes at the intersection of health policy and immigration policy. In addition, the solutions proposed by our participants are testable and require further evaluation to assess which will have the greatest impact on enrollment. To build on the early success of the ACA, as well as to continue expansion of health insurance coverage of uninsured populations, states must learn about the challenges, as well as the successes, of their frontline enrollment workers, not only at the time of initial enrollment, but also as clients' insurance status changes with shifts between public and private insurance eligibility and as insurers enter and exit the insurance exchanges.

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