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Measuring Effectiveness of Obamacare's Medicaid: A Case Study of Early Implementation in Santa Clara County

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ABSTRACT

One of the mandates of Obamacare is the expansion of Medicaid to enhance access to affordable health care. However, the success or failure of implementation hinges not only on the soundness of the policy, but also on how effectively the states and local agencies will implement the policy. One of the purposes of this study is to measure the effectiveness of local implementation through its impact on Medicaid participation rate. The study examines the New Public Management (NPM) techniques adopted by the County of Santa Clara's Social Services Agency (SSA) to implement Obamacare's Medicaid expansion. Although this researcher is currently an employee of SSA, this study was not sanctioned by the agency, but was independently undertaken as an academic requirement for Golden Gate University's Executive Master of Public Administration program.

The findings in this study show that Medicaid participation rate for non-elderly adults with no children—a class of previously ineligible beneficiaries targeted by the Medicaid expansion—nearly doubled in the first year of Obamacare implementation. The study establishes a positive correlation between the local implementation of NPM techniques and policy outcome in connection with the Medicaid expansion. While challenges remain for local welfare agencies as Obamacare implementation is relatively at infancy, this study finds that the SSA's adoption of NPM techniques to implement the Medicaid expansion effectively reduced the number of uninsured residents in Santa Clara County in the first year of policy implementation.

Chapter 1: INRODUCTION

The Patient Protection and Affordable Care Act (ACA), more commonly known as "Obamacare," exposed the extreme political partisanship among lawmakers in fiscal year 2013, where the health care law was a pivotal point in congressional budgetary discussions that eventually resulted in a temporary shutdown of the federal government at the start of fiscal year 2014. With the federal government back to business as usual, news reports have it that critics of the law and those who support it are adamant to see Obamacare fail or succeed even as implementation of the law is relatively at infancy since January 1, 2014.

The signature achievement that Obamacare seeks to accomplish is its "near-universal guarantee of access to affordable health insurance" by expanding Medicaid eligibility and offering premium subsidies for the purchase of private health insurance through state health insurance exchanges (Sommers et al., 2011, p. 228). Prior to the ACA implementation, Medicaid eligibility required that applicants have linkage to the program, which was usually established through a deprived child; deprivation of a child was established through the absence, death, incapacity or unemployment/underemployment of at least one parent in the child's family (DHCS, 2014). As part of the ACA implementation, the California Legislature eliminated the deprivation requirement, thus allowing childless adults to become potentially eligible for the program (DHCS, 2014).

However, even before Obamacare took effect in January 2014, it was already marred by issues and controversies. Not only did Obamacare become the subject of bargaining of budgetary discussions in Congress as mentioned above, but the open enrollment for health insurance at the exchanges, which began in the last quarter of 2013 in preparation for the

implementation rollout, also encountered website technology glitches based on news reports. In addition, a study conducted prior to the ACA implementation projected that churning between health exchange premium subsidy and Medicaid eligibilities would potentially disrupt health coverage for millions of beneficiaries nationwide as both programs are income-sensitive. Sommers et al. (2011) explain that, while Obamacare will expand Medicaid eligibility to all nonelderly citizens and eligible legal residents whose family income does not exceed 133 percent of the federal poverty level or FPL [This FPL limit does not include a 5-percent income disregard formula, which effectively sets the income limit to 138-percent of the FPL.], those who are ineligible for Medicaid with incomes of up to 400 percent of the FPL can receive premium subsidies through tax credits for health plans under the exchanges. "Using national survey data, we estimate that within six months, more than 35 percent of all adults with family incomes below 200 percent of the federal poverty level will experience a shift in eligibility from Medicaid to an insurance exchange, or the reverse; within a year, 50 percent, or 28 million, will. To minimize the effect on continuity and quality of care, states and the federal government should adopt strategies to reduce the frequency of coverage transitions and to mitigate the disruptions caused by those transitions (Sommers et al., 2011, p. 228)."

Notwithstanding the issues and controversies that have hounded Obamacare thus far, its success or failure as far as the Medicaid component is concerned hinges not only on the soundness of expanded eligibility policy, but also on how effectively the states—and its instrumentalities—would implement it. The California Healthcare Foundation (2013) estimates that California's Medicaid program, also known as Medi-Cal and said to be nation's largest Medicaid program in terms of people served, would benefit an additional one million participants

in 2014 due to expanded eligibility under Obamacare. Amid an anticipated surge in Medi-Cal participation, this study looks into the specific policy implementation techniques that were utilized by the County of Santa Clara's Social Services Agency (SSA), particularly the agency's Department of Employment and Benefit Services (DEBS), to cope with the demand. Although there has been no clear-cut definition of New Public Management (NPM), various literatures suggest that it pertains to an informal set of practices characterized by deviation from traditional bureaucratic practices, flexibility in management, openness to organizational changes, customer orientation, and focus on performance, outputs, efficiency and effectiveness in policy implementation. Thus, the study examines the NPM techniques that were implemented by the SSA, together with statistical data regarding Medi-Cal participation rates before and after the implementation of Obamacare's expanded Medicaid policy. Unlike the study conducted by Sommers et al. (2011), whose article entitled "Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth between Medicaid and Insurance Exchanges" focused partly in analyzing policy provisions of Obamacare, this study is limited to measuring the effectiveness of local implementation for the Medicaid component of the controversial health care law. If SSA effectively implements an expanded Medi-Cal policy by increasing program participation rate using NPM techniques, the correlation between NPM and effective implementation can serve as a model for similar agencies in other counties. At the same time, the results of the study can become a baseline for gauging the success or failure of Obamacare, at least in Santa Clara County, in reducing the number of uninsured Americans partly through Medicaid expansion.

Purpose of the Study

The purpose of this study is to establish a correlation, if any, between NPM techniques that were adopted by the SSA's DEBS in implementing Obamacare's expanded Medicaid mandate and Medi-Cal participation rate in Santa Clara County before and after such NPM techniques were implemented. Specifically, the study seeks to identify NPM techniques that were adopted by DEBS in response to the challenge of implementing the expanded Medicaid policy that establishes a new class of potential program beneficiaries, i.e., citizens and legal residents between 19 to 64 years old with no children and whose household income is at or below 138% of the federal poverty limit. The study also seeks to measure the effectiveness of local policy implementation by examining statistical data regarding Medi-Cal participation rates for non-elderly adults in Santa Clara County before and after the implementation of Obamacare. Corollary to these objectives, the study tests whether or not the local implementation of NPM techniques would result in organizational effectiveness in connection with Obamacare's Medicaid expansion.

Main Research Question and Subquestions

Research Question

Has the County of Santa Clara's Social Services Agency's (SSA) adoption of New Public Management (NPM) techniques to implement Obamacare's Medicaid expansion effectively reduced the number of uninsured Americans in the county?

Subquestions

1. What changes to Medi-Cal program implementation, if any, did the SSA adopt to increase Medi-Cal participation rate in Santa Clara County in connection with implementing Obamacare?

2. What is the impact of the SSA's policy implementation changes, if any, to Medi-Cal participation rate in Santa Clara County?

3. How satisfied are front-line workers in the SSA's policy implementation changes, if any, in connection with implementing Obamacare's Medicaid expansion?

Research Hypothesis

If the County of Santa Clara's Social Services Agency adopts New Public Management techniques, the agency will effectively implement the Medicaid expansion mandate of Obamacare by increasing program participation rate.

Research Assumptions

This research assumes that an increase in Medi-Cal participation rate equates to reducing the number of uninsured, notwithstanding the possible actual difference between uninsured populations before and after the implementation of Obamacare. Additionally, such assumption also disregards other factors potentially affecting uninsured populations, such as health coverage

through other programs such as California's health insurance exchange, more popularly known as Covered California.

Scope and Limitations of the Study

This research seeks to identify policy implementation changes consistent with NPM, which the SSA adopted to implement the Medicaid expansion mandate of Obamacare. The study also analyzes Medi-Cal participation rates pre- and post-Obamacare and examines the correlation, if any, between participation rate changes and the local implementation of NPM techniques. However, Medi-Cal participation rate data for collection would be limited to those of calendar years 2013 and 2014 to delineate pre- and post-Obamacare data sets.

Chapter 2: LITERATURE REVIEW

Overview

This literature review explores the New Public Management (NPM) practices characterized by deviation from traditional public administration, flexibility in management, performance measurement, and adaptability to change. The NPM school of thought did not arise from a formal body of theory; hence, the extensive discussion of NPM in this literature review seeks to provide a deeper understanding of public agency practices that are consistent with NPM.

This section also cites literature related to pre-ACA Medicaid expansion that may have implications on the implementation of Obamacare's Medicaid expansion mandate. While pre-ACA studies are indeed promising as to the projected impact of Obamacare in expanding access to healthcare among uninsured populations, other studies also underscore the importance of implementation effectiveness. As part of this literature review, one of the case studies presented here tests the relationship between NPM implementation and service delivery by local government employees—which is exactly one of the purposes of this research. That is, to test the relationship between the local implementation of NPM techniques and organizational effectiveness in connection with Obamacare's Medicaid expansion.

New Public Management vs. Traditional Public Management

A review of various literature suggests that the NPM concept is one that is not carved in stone. In an article entitled "The New Public Management and its Critics," Mathiasen (1999) notes that NPM was not borne out of a formal body of theory. "It is possible to view the New Public Management as nothing more than the public management equivalent of a cake recipe,

that is, a set of practices that can be readily transferred from one culture and one political system to another. If such is the case, then discussions of principles and paradigms are academic; it is only necessary to identify best practices (Mathiasen, 1999, p. 91)." Mathiasen (1999), however, also cites characteristics of NPM based on the definition of the Organisation for Economic Co-operation and Development, a collaboration of various countries claiming to promote policies that improve the social and economic well-being of people around the world, which include decentralized management, the flexibility to explore alternatives to direct public services, and a closer focus on results in terms of efficiency, effectiveness and quality of service, among other characteristics.

Mathiasen (1999) also explains the need to deviate from traditional controls in line with NPM's client-centric focus. "Identification and measurement of customer requirements is widely accepted as an important feature of New Public Management, and can easily be identified with current efforts at developing better performance measures. Of course, the public manager may be constrained in responding to these requirements because the manager lacks the authority or the budget to do so, or because doing so would create equity or ethical problems (Mathiasen, 1999, p. 103)." Hence devolving responsibility at lower levels within public service organizations becomes necessary. "There is no reason why the New Public Management could not incorporate the use of cross-functional teams (Mathiasen, 1999, p. 103)."

In an article entitled "Traditional Public Administration versus The New Public Management: Accountability versus Efficiency," Pfiffner (2004) explains the concept of NPM by distinguishing it from traditional public administration in terms of measurements of government activity. Pfiffner (2004) states that the two approaches to public management

present a tug-of-war between the values of accountability and efficiency, with the NPM approach putting emphasis on performance, while the traditional approach focuses on resources used. "Thus, the new public management favors decentralized administration, delegation of discretion, contracting for goods and services, and the use of the market mechanisms of competition and customer service to improve performance (Pfiffner, 2004, p. 4)." Pfiffner (2004) further explains that, under the NPM approach, performance measures replace the traditional management's tight control mechanism designed to measure inputs or resources used for accountability. "Granting more discretion to managers to manage is necessary; if they are to be held accountable for their performance, they must have the flexibility to use their judgment (Pfiffner, 2004, p. 4)."

Pfiffner (2004) points out, though, that the NPM's focus on performance measurement has its pitfall. "The difficulty lies in choosing the correct indicators that will validly measure what the governmental program is really intended to accomplish (Pfiffner, 2004, p. 8)." While the NPM approach works best when government programs or activities closely resemble private goods and activities, he asserts that performance can be difficult to measure when it comes to certain services, such as analytical or social services. In these instances, measuring performance may require more expertise to monitor the quality of service and can be costly (Pfiffner, 2004, p. 8). On the other hand, proponents of traditional public management underscore the importance of accountability of resources as its greatest strength (Pfiffner, 2004). "A hallmark of the traditional model is its rhetorical stress on efficiency. But efficiency is very difficult to measure…. Thus one of the most common measures of government production is that of resources used, that is, inputs (Pfiffner, 2004, p. 7)."

Brodkin (2006) examines efforts to implement NPM strategies in the provision of public welfare and also discusses the concepts of performance and accountability. He contends that, while NPM techniques such as performance measurement may be used as a strategy to manage discretion in welfare agencies, the need for accountability constitutes a difficult challenge. "Certain types of performance quotas…are easy to measure and enforce, but they… may even create incentives that undermine quality (Brodkin, 2006, p.13)."

Performance Management

Osborne et al. (2009) offer ways to measure performance of public agencies by identifying five components of performance measurement—inputs, processes, outputs, program outcomes and policy outcomes—which all work together much like a production line. Performance can be measured by efficiency, the cost per unit of process or output; effectiveness, a measure of how successful inputs and processes are at producing desired outputs; and cost-effectiveness, the ratio of inputs to outcomes (Osborne et al., 2009). They assert that "effectiveness is the most important thing you can measure," since policy outcome as a performance indicator measures the "impact [the policy] is having (Osborne et al., 2009, pp. 252-253)." Meanwhile, Immordino (2014) defines effectiveness as "the degree to which a government agency meets the perceived need for services at an acceptable level of service quality (p.4)."

Bromberg (2009) discusses how performance measurement can be a tool for increasing managerial discretion, while ensuring accountability to stakeholders. A renewed emphasis on performance measurement, he states, came about with the reinventing government movement

and NPM. "The common mantra was let managers manage. The idea was to provide managers with broad goals, or outcomes, and hold managers responsible for those outcomes (Bromberg, 2009, p.215)." Bromberg (2009) also highlights the importance of having a clear purpose for which a performance measurement system is designed to be used. Citing studies, he states that "utilizing outcome measures and developing performance measurement systems in an inclusive manner will add to the effectiveness of performance measurement (Bromberg, 2009, p. 220)."

Flexibility in Management

While various literatures related to NPM emphasize the concept of performance measurement, one cannot overlook the important role of administrators and front-line managers in policy implementation. In an article entitled "Administration, Governance and Policy Tools in Welfare Policy Implementation," Ewalt et al. (2004) cite the important role of administrators or managers in policy implementation, as their influence are heightened by the NPM concept of devolution. "Thus, we expect implementation to be a function of the commitments of administrators in following through on policy intent. Implementation will be more successful depending on the extent to which leaders in welfare agencies emphasize goals and strategies…. (Ewalt et al., 2004, p. 453)." Their study, however, focused on means-tested, cash-based welfare assistance, particularly the Temporary Assistance for Needy Families (TANF), and not Medicaid. In part, their study found that, "consistent with several generations of implementation research, that administrative commitments, reflected in attitudes and orientations, can provide an important link between policy goals and policy outcomes. In other words, when administrators believe in the policy and model that belief, it makes a difference (Ewalt et al., 2004, p. 458)."

In the same vein, Riccucci et al. (2004) emphasize the significant role of managers in aligning front-line practices in welfare reform implementation. Although creating a commitment to policy decisions on the part of front-line workers is a common challenge for public agencies, as they continue to believe that traditional eligibility concerns are their most important goal, management practices play a significant role in enhancing organizational performance. "To the extent that public managers want to redirect local staff to focus their attention on the new goals associated with welfare reform, they can create the conditions under which staff have clear signals about what is expected and could provide them with the resources and incentives to realign their priorities (Riccucci et al., 2004, p.438)." These management factors include performance monitoring and training, among others. "Performance monitoring has been suggested by many observers as a particularly important management strategy for influencing front-line workers' perceptions of goal priorities. These findings lend support to the conclusion that managers can help to realign workers' priorities by linking performance with desired policy objectives (Riccucci et al., 2004, p. 445)."

Andrews et al. (2011) also underscore the role of managers in aligning implementation with strategy to improve organizational performance. In an article entitled "Strategy Implementation and Public Service Performance," they discuss about how strategy implementation may affect organizational performance. "Our findings indicate that when considering implementation style, there is 'no best way' to do it…. Second, our study demonstrates that the concept of fit or organizational alignment is important in understanding implementation (Andrews et al., 2011, p. 663)." Andrews et al. (2011) concede that no implementation style by itself will likely enhance organizational performance, but assert that the

most important implication of their research is that "managers should seek to ensure that the implementation style of their organization is matched to its strategic orientation (Andrews et al., 2011, p. 663)."

Middle managers also play a significant role as change agents in the success of policy change implementation. This was the finding of Birken et al. (2013) in a study about health center implementation of health care innovation. In an article entitled "Improving the Effectiveness of Health Care Innovation: Middle Managers as Change Agents," Birken et al. (2013) found that middle managers influenced implementation effectiveness when they engaged in extra-role behaviors, such as developing linkages with community resources. "Our findings suggest that health care executives may promote implementation effectiveness by predisposing middle managers to proactivity. Executives may encourage proactivity among middle managers by creating climates in which proactivity is rewarded, supported, and expected (Birken et al., 2013, p. 41)."

Embracing Change

Meanwhile, a reexamination of how government does business is forcing government agencies to change their cultures and overall orientations. McNabb (2009) points out that organizational culture can significantly limit change and transformation of public agencies into high-performing organizations, calling it as a "strong force within the organization (McNabb, pp. 151-152)." Recognizing the importance of organizational culture in transformational change, McNabb (2009) attempts to explain what organizational culture is all about and how to overcome the challenges posed by a culture that resists change, stating that organizational culture is simply

the way people in the organization think and act (pp. 47-49). To overcome the challenges related to changing organizational culture, he proposes the development of an organizational strategy "to bring everyone's attitudes to a point where change will be accepted (McNabb, 2009, p. 47)."

An organizational culture of learning is consistent with NPM values, as Reschenthaler et al. (1998) point out that NPM allows governments "to become more effective learning organizations, and thus, more effective in adapting to change (p. 96)." They cite that governments must "borrow from the 'learning' of the private sector" if they were to provide services more efficiently and effectively (Reschenthaler, 1998, p. 98). "It is no longer accepted that large bureaucracy and hierarchy are desirable, much less necessary for efficiency and effectiveness. The same forces that have driven private organizations to think in terms of concentrating on core competencies can be leveraged (Reschenthaler, 1998, p. 96)." They state that a learning organization approach complements NPM in helping government agencies in devising and implementing public policy. "The New Public Management's basic theme is stated conspicuously in the National Performance Review when it calls for delegating authority, replacing rules and regulations with incentives, developing budgets based upon results, exposing government operations to competition, searching for market rather than administrative solutions, and whenever possible, measuring the success of government in terms of consumer satisfaction (Reschenthaler, 1998, p. 97)."

McNabb (2009) explains that NPM involves the shifting "from traditional bureaucratic maintenance model of governance to a business-centered, customer-driven system that delivers public services in an increasingly efficient and effective manner (p. 7)." Thus, embracing change, such as increased use of technology, is consistent with NPM practices. Meanwhile,

Cohen et al. (2003) discuss how technological changes have been changing the way governments do business. They note that clients who seek public services are no longer required to physically request those services at local government offices, as the Internet provides them with convenient access at little to no cost. Cohen et al. (2003) state that technology can be used as a management tool not only for providing direct services to the public, but also for changing the way governments perform their daily tasks. "While the concept of e-government had often focused on the external or service delivery function, we noted a great deal of discussion of internal uses of the web for everything from performance measurement to procurement (Cohen et al., 2003, p. 3)."

At the local level, the experience of the Erie County of New York is an empirical lesson about flexibility in management and adapting to change. In a study, Armstrong et al. (2012) detail how the Erie County Departments of Social Services, Probation and Mental Health developed a shared plan of action in reforming a system of care for children when the county government was facing a fiscal crisis. They conclude that one of the challenges in sustaining any system reform is the capacity to think outside the box and deviate from traditional government operations. They also underscore the significant impact of inter-departmental collaboration and monitoring of performance indicators in implementing system change.

The Promise of Obamacare

Even before the implementation of Obamacare's Medicaid expansion—which was set to begin on January 1, 2014—some scholars already predicted the potentially substantial impact of the new policy. In an article entitled "Medicaid 'Welcome-Mat' Effect of Affordable Care Act

Implementation Could be Substantial," Sonier et al. (2013) use data from the Massachusetts health reforms in 2006 to predict a substantial rise in Medicaid participation in various states. They note some factors that affect people's behavior in response to policy changes, including the intensity of public outreach, suggesting that the degree of change in Medicaid participation rates are partly impacted by the intensity level of outreach. They also point out that a streamlined application process and less burdensome information requirements from applicants would likely increase Medicaid participation.

A separate study using data on ACA-related Medicaid expansion initiated by some states—including California—before January 1, 2014 also predict a continuing rise in Medicaid enrollment. Sommers et al. (2014) base their findings on administrative records in California, Washington, D.C., Minnesota and Connecticut—state governments that exercised their option to introduce Medicaid expansion initiatives before 2014. While they found that the ramp-up of Medicaid enrollment was "gradual and linear over time," they also note that the intensity of public outreach accompanying the national expansion could potentially result in accelerating Medicaid participation rates in various states.

In California, the pre-ACA Medicaid expansion known as the "Low Income Health Program (LIHP)", expanded health coverage to nonelderly adults from 19 to 64 years old individuals with incomes of up to 200-percent of the federal poverty limit. Notably, the same category of individuals are also targeted for Medicaid expansion under Obamacare. In a study, Meng et al. (2012) report that the LIHP program enrolled a total of 413,295 individuals within nine months of implementation that began in July 2011. Meng et al. (2012) suggest that the LIHP experience can better prepare counties in implementing Obamacare's Medicaid expansion

mandate. The LIHP experience provides lessons about outreach and community partnerships, streamlining enrollment processes, and implementing participant retention strategies. At the same time, the LIHP implementation also exposed multiple burdens facing county agencies providing Medicaid and related services, including the lack of human resources, difficulties in obtaining documentation to verify eligibility, and lack of financial resources to improve information technology systems.

The Role of Effective Implementation

The impact of the ACA in expanding health coverage to uninsured populations depends on its implementation. Kowalski (2014) makes this case in her research about the impact of ACA across states during the first six months of implementation. In her research, Kowalski (2014) found that states that took a larger role in ACA implementation had better participation rates than "direct-enforcement" states—those that left implementation up to the federal government. The study, however, focused on the health insurance market that includes plans purchased through state exchanges and directly from insurers—not Medicaid. In that market, Kowalski (2014) found that the ACA resulted in some 13.2 million people having health coverage within six months of Obamacare's implementation.

How local governments implement service delivery is expected to translate to achieving the intended policy outcome. That is, in the case of Obamacare, for uninsured populations to have access to health coverage through their employers, Medicaid and health insurance exchanges. In Australia, Brunetto et al. (2008) examine the relationship between NPM implementation and service delivery by local government employees, noting that NPM-related

changes to organizational processes were expected to enhance the flow of information among employees and, ultimately, to improve employee productivity that translates to improved organizational output. Brunetto et al. (2008) test this relationship using the social capital theory, which values social relationships within an organization for employees to undertake work tasks and meet customers's needs effectively. The study assesses the quality of information-sharing among managers, supervisors and front-line employees. It concludes that local government employees' level of satisfaction with communications processes "significantly affected their role clarity which in turn did affect their ability to undertake work tasks effectively and therefore, this probably affected their level of job productivity (p. 52)." However, Brunetto et al. (2008) note that, "while the implementation of NPM was supposed to improve the quality of organisational [sic] processes embedded within, the findings suggest a different outcome (p. 52)." That study, therefore, provides a baseline for future research to test the correlation between NPM and organizational performance in local policy implementation, which is also one of the purposes of this research.

Chapter 3: RESEARCH METHODS

Research Design

The purpose of this study is three-pronged: first, to establish a correlation, if any, between New Public Management (NPM) techniques that were adopted by the Social Security Administration (SSA) in implementing Obamacare's Medicaid expansion and Medi-Cal participation rates in Santa Clara County; second, to measure the effectiveness of local implementation of the Medicaid expansion policy; and third, to test whether or not the local implementation of NPM techniques has a correlation with organizational effectiveness.

Thus, this research is a case study about the above-mentioned correlations and provides a mixed-method approach with an embedded design requiring qualitative and quantitative data for triangulation. Qualitative data gathering techniques include observation, interviews with SSA and/or Department of Employment and Benefits Services (DEBS) executives and managers, and survey among front-line employees. Quantitative data for analysis include actual Medi-Cal enrollment statistics from DEBS, as well as secondary data based on a 2014 survey conducted by the California Health Interview Survey.

Qualitative Data

While this researcher already identified certain changes to organizational processes at the DEBS' Benefit Service Center (BSC) by way of observation, interview questionnaires for DEBS executives and/or managers were designed to identify other NPM-related changes that they perceive to be critical to the local implementation of Obamacare's Medicaid expansion.

A survey was also designed and used to measure the level of satisfaction of front-line employees about communication processes related to NPM organizational changes and the local implementation of Medicaid expansion. The survey measured the level of satisfaction of front-line employees through a Likert scale. Purposive sampling method was adopted for the survey in selecting the 288 eligibility workers of BSC and the DEBS' Application Assistance Center (AAC) as target population. Since the two service centers played a huge part in the SSA's implementation of the Medicaid expansion, the eligibility workers of these service centers were selected for the survey as they are the front-line employees who directly interact with Medicaid clients and process Medicaid caseloads. Initially, the survey questionnaire was prepared via the Internet survey service Survey Money (www.surveymonkey.com) and was planned for electronic deployment via the service centers' electronic mail address book. However, due to restrictions in the use of the agency's electronic address book, 200 paper copies of the survey questionnaire were printed and prepared for manual, random distribution at the two service centers' offices and at the respective breakrooms from December 1 to 8, 2015.

Quantitative Data

This research measured Santa Clara County's Medi-Cal participation rate for nonelderly persons without children and whose household income is at or below 138% of the federal poverty limit (FPL). Participation rate measures "the fraction of people who are eligible for a program who choose to enroll (Sommers et al., 2012, p.1)." Thus, participation rate was measured by the number of Medi-Cal enrollees in comparison to the total number of persons who are potentially eligible for the program. The actual number of Medi-Cal enrollees in 2013

and 2014, particularly for non-elderly adults with no children, was obtained directly from DEBS. This research also incorporated secondary data from a 2014 survey conducted by the California Health Interview Survey (CHIS) at the UCLA Center for Health Policy Research to obtain an estimated number of Medicaid-expansion-eligible residents in Santa Clara County.

Research Question

Has the County of Santa Clara's Social Services Agency's (SSA) adoption of New Public Management (NPM) techniques to implement Obamacare's Medicaid expansion reduced the number of uninsured Americans in the county?

The research question was framed in that manner to measure the effectiveness of Obamacare in terms of policy outcome, particularly as to how it has impacted the uninsured population in Santa Clara County. While previous studies suggest that the implementation of public policy has a correlation with achieving the intended policy outcome, the above-mentioned research question guided this study by examining how the SSA implemented Obamacare's Medicaid expansion in Santa Clara County and measuring implementation effectiveness through program participation rate for non-elderly adults in the policy's first year of implementation. However, since an increase in Medicaid participation rate is expected due to a newly eligible class of participants, the research question also made it imperative to adopt another metric to measure implementation effectiveness—the level of satisfaction of front-line employees in the quality of service provided to clients in connection with Medicaid expansion implementation.

Research Hypothesis:

If the County of Santa Clara's Social Services Agency adopts New Public Management techniques, the agency will effectively implement the Medicaid expansion mandate of Obamacare by increasing program participation rate among non-elderly adults.

The research hypothesis guided the study by identifying New Public Management techniques adopted by the county's Social Services Agency in implementing Obamacare's Medicaid expansion. This hypothesis also guided this study by paving the need to measure implementation effectiveness through metrics such as program participation rate.

Dependent and Independent Variables:

The dependent variable for this study is: the agency will effectively implement the Medicaid expansion mandate of Obamacare by increasing program participation rate. The independent variable for this study is: if the County of Santa Clara's Social Services Agency uses New Public Management techniques.

While this case study does not imply a causal relationship between these variables, it seeks to establish a correlation between them. The correlation establishes predictability of effective implementation of Obamacare's Medicaid expansion mandate (dependent variable) if the independent variable is met.

Operational Definitions

Obamacare pertains to the federal legislation known as the "Patient Protection and Affordable Care Act."

New Public Management (NPM) pertains to a set of practices in public administration characterized by deviation from traditional public sector management, performance measurement, flexibility in management and openness to change.

Medicaid pertains to the federal-state health insurance program that helps pay for medical costs of low-income individuals and/or families. **Medi-Cal** pertains to California's Medicaid program. For the purposes of this study, ***"expanded Medicaid mandate of Obamacare"*** pertains to changes in California's Medicaid program that modified program requirements allowing previously ineligible, non-elderly persons below 65 years old, whose household income is at or below 138% of the federal poverty limit, to participate in the program.

Federal poverty limit (FPL) pertains to the set minimum amount of gross income that a family needs to support its basic necessities such as food, shelter and clothing, as set by the U.S. Department of Health and Human Services. For purposes of this study, ***"138% of the FPL"*** pertains to the income limit for non-elderly adults to become potentially eligible under Obamacare's Medicaid expansion.

Program participation rate pertains to the percentage of Medicaid enrollees who qualified under Obamacare's Medicaid expansion in comparison to the estimated number of

Medicaid-expansion-eligible, nonelderly persons based on a 2014 survey conducted by the California Health Interview Survey at the UCLA Center for Health Policy Research.

Effectiveness can be defined as "the degree to which a government agency meets the perceived need for services at an acceptable level of service quality (Immordino, 2014, p. 4). For the purposes of this study, effectiveness would be measured in two ways: firstly, by comparing Medicaid participation rates for calendar years 2013 (pre-Obamacare implementation) and 2014 (Obamacare implementation kickoff) and secondly, by determining the level of satisfaction of front-line employees through a Likert-scale survey, particularly as to how organizational changes consistent with NPM contributed to the quality of information-sharing and role clarity among the employees. For the purposes of this study, ***"effectively implement"*** means that the County of Santa Clara's Social Services Agency's implementation of Obamacare's Medicaid expansion resulted in increased program participation rate and that the level of satisfaction of front-line employees as to their role clarity in the program implementation—and the quality of service to clients—is acceptable or satisfactory.

Data Collection Process Overview

Primary Data

Primary data were collected from the County of Santa Clara's Social Services Agency (SSA), particularly from the agency's Department of Employment and Benefits Services (DEBS). Data collection methods included in-person interviews, using structured questionnaires, with the following SSA executives and managers: DEBS Director Denise Boland (who spoke on

behalf of SSA Acting Director Robert Menicocci); Mr. Robert Sacasa and Ms. Angelica Diaz, Program Manager III and Program Manager I, respectively, at BSC; and Ms. Nellie Jorge, Program Manager III at the DEBS' Application Assistance Center (AAC). The interview questionnaires are shown in **Appendices A to C**. An unstructured interview was also conducted with Ms. Margareta Hodzic, DEBS Program Bureau Manager, who was also the Program Manager I overseeing the Health Care Reform (HCR) unit under the BSC at the time Obamacare's Medicaid expansion was initially implemented.

Additional primary data were collected using a survey of front-line employees at the BSC and the AAC. A copy of the survey questionnaire is shown in **Appendix D**. Relatedly, an unstructured interview was conducted with Ms. Raquel Vallejo, an eligibility worker at BSC and the chief steward of the labor union representing eligibility workers in Santa Clara County, to get an explanation of her responses to the survey questionnaire.

Secondary Data

Statistical data related to the actual number of Medicaid enrollees under Obamacare's Medicaid expansion were obtained from the SSA, while statistical data pertaining to the county's estimated number of nonelderly adults who potentially qualify for Obamacare's Medicaid expansion—including uninsured persons—were obtained from the 2014 California Health Interview Survey, which is retrievable through an Internet database at www.ask.chis.ucla.edu.

Controlling for Internal and External Validity

One limit to internal validity is that an increase in Medicaid participation rate could result from factors other than effective local implementation, such as the change in program eligibility requirements brought on by the legislation itself. Since Obamacare's Medicaid expansion pushed up the income limit to 138% of the federal poverty limit for program eligibility, it was anticipated that more individuals would enroll in the Medicaid program. However, this is not an experimental study that seeks to establish a causal relationship between the SSA's implementation of Medicaid expansion and program participation rate, but is a case study that attempts to establish a correlation between these variables.

This research should have external validity for county welfare agencies implementing Obamacare's Medicaid expansion.

Limitations:

The measurement of policy implementation effectiveness in this research does not take into consideration the level of satisfaction of SSA's Medicaid clients regarding services received. Instead, it measures the level of satisfaction of SSA's front-line employees who serve Medicaid clients. This researcher assumes that, if front-line employees level of satisfaction as to how organizational changes translated to information-sharing and role clarity is acceptable, the employees serve Medicaid customers at an acceptable level of quality. This researcher also assumes that an increase in Medi-Cal participation rate equates to reducing the number of uninsured, notwithstanding the possible difference between uninsured populations before and after the implementation of Obamacare. Additionally, this research assumes that the estimated

number of potentially eligible non-elderly persons, whose household income is at or below 138% of the federal poverty limit, is the same or negligible for the calendar years 2013 and 2014 for the purpose of calculating program participation rates.

Chapter 4: RESULTS AND FINDINGS

Objectives

This chapter seeks to answer the research question: has the County of Santa Clara's Social Services Agency's (SSA) adoption of New Public Management (NPM) techniques to implement Obamacare's Medicaid expansion effectively reduced the number of uninsured Americans in the county?

To answer the research question, this chapter explores the following sub-questions:

1. What changes to Medi-Cal program implementation, if any, did the SSA adopt to increase Medi-Cal participation rate in Santa Clara County in connection with implementing Obamacare?

2. What is the impact of the SSA's policy implementation changes, if any, to Medi-Cal participation rate in Santa Clara County?

3. How satisfied are front-line workers in the SSA's policy implementation changes, if any, in connection with implementing Obamacare's Medicaid expansion?

Interview with Ms. Denise Boland, DEBS Director

A structured interview was conducted with Ms. Denise Boland, Director of the SSA's Department of Employment and Benefits Services (DEBS), who spoke on behalf of SSA Acting Director Robert Menicocci. The interview questions and recapitulations of the interview responses are detailed below:

Question No. 1: Considering that the implementation of Obamacare's Medicaid expansion is relatively new, what strategies or techniques did your agency implement to enhance public outreach and encourage program participation among Santa Clara County residents?

The SSA capitalized on its partnerships with nonprofit community groups to enhance public awareness about health care reform, including Medicaid expansion. One of the key external partners was Working Partnerships USA, a community organization composed of non-profit organizations and faith-based groups and engaged in grassroots organizing. At the same time, the SSA tapped into its existing networking infrastructure, such as partnerships with the Second Harvest Food Bank and Sacred Heart Community Service, non-profit groups that have been partners of the SSA's Calfresh (also known as "Food Stamps") program. The SSA also provided training for representatives of community partners so that the latter can assist their respective clients in applying for Medicaid through the SSA's online application system, www.mybenefitscalwin.org. Ms. Boland intimated that forming partnerships with community groups was very effective as a public outreach strategy by saying: "At least for Santa Clara County, we didn't have to tell people about it [Medicaid expansion]. We have had trouble [in] just keeping up with the volume of applications." Ms. Boland added that total Medi-Cal caseloads have grown by 72-percent since the implementation of Obamacare's Medicaid expansion.

Question No. 2: What major factors in your agency's implementation of Obamacare's Medicaid expansion (MAGI Medi-Cal) contributed to an increase in Medi-Cal enrollees in 2014 compared to 2013?

Among the factors that contributed to an increase in Medi-Cal enrollees in 2014 is the SSA's inter-program collaboration. To illustrate, Ms. Boland cited the automatic Medi-Cal enrollment of persons receiving assistance from the General Assistance, a separate SSA program that provides monthly cash assistance to low-income residents who do not qualify for any other similar federal or state programs. In addition, she mentioned Medi-Cal enrollment assistance directly at the hospital site, particularly at the County of Santa Clara's Valley Medical Center. Ms. Boland also attributed the increase in the number of Medi-Cal enrollees to the change in legislation itself, explaining: "The fact that those 19- to 64-year-old [persons] weren't eligible before and desperately needed it [health coverage] shows the need." State legislation such as Assembly Bill 720, which further expanded Obamacare in California by assisting formerly incarcerated persons in Medi-Cal enrollment prior to being released, is also a contributory factor to the increase in Medicaid participation rate.

Question No. 3: How did your management approach/strategy contribute to this achievement?

The SSA's partnerships with community groups and collaboration among various programs within the agency contributed to the increase in Medicaid enrollees. Ms. Boland stated: "You cannot solve poverty by yourself, but [by] working together, we're stronger." The SSA also established workgroups involving its managers and union representatives. This was documented in the Santa Clara County Health Care Reform Implementation Strategy, which was retrieved by this researcher from the SSA Intranet for reference. At least a year before the implementation of Obamacare's Medicaid expansion, the SSA already documented an implementation strategy that created various workgroups and committees composed of its

executives, managers, employees and union representatives. Ms. Boland stated that the SSA was "geared up and ready" in anticipation of Obamacare implementation.

Question No. 4: How did the Social Services Agency's implementation of MAGI Medi-Cal contribute to achieving Obamacare's goal of reducing the number of uninsured?

The increase in Medicaid enrollees contributed to achieving Obamacare's goal of reducing the number of uninsured. Ms. Boland also cited the SSA's implementation of other programs, such as premium subsidy at Covered California as a contributory factor in reducing the number of uninsured. The SSA does not have its own estimate of the number of uninsured in Santa Clara County. "Certainly, there are still uninsured people that are out there," Ms. Boland stated, adding that another growth area to anticipate is undocumented children, who will be able to qualify for full-scope Medi-Cal benefits beginning May 2016 due to another state legislation.

Question No. 5: What major challenges, if any, do you anticipate in the future as far as your agency's implementation of MAGI Medi-Cal is concerned?

One of the major challenges is dealing with the technology glitches in Covered California, also known as the California Healthcare Enrollment, Eligibility and Retention System (CalHEERS), which can result in churning off and on Medicaid. "There is still challenge with the computer system. As you know, the CalHEERS system doesn't work well," stated Ms. Boland. CalHEERS is the information system where determination of eligibility for Medicaid or premium subsidy for private health insurance is made. The technology issues impact not only program eligibility retention, but also client communication with respect to the tax forms that

they need to receive in connection with Obamacare's mandate for individuals to have health coverage. Ms. Boland anticipates that the SSA will be flooded with phone calls and in-person visits from clients if the tax forms are not received timely for the tax filing season.

Interview with Mr. Robert Sacasa and Ms. Angelica Diaz, Program Managers at the Benefits Service Center (BSC)

A structured interview was conducted with Mr. Robert Sacasa, Social Services Program Manager (SSPM) III at the BSC. Mr. Sacasa also invited Ms. Angelica Diaz, SSPM I at BSC, to assist him in responding to the interview questions. The interview questions and recapitulations of the interview responses are detailed below:

Question No. 1. What is the role of the BSC in implementing Obamacare's Medicaid expansion, also known as Modified Adjusted Gross Income (MAGI) Medi-Cal?

The BSC, formerly known as the Medi-Cal Service Center, was the premiere office within SSA that was responsible for implementing Obamacare's Medicaid expansion in Santa Clara County. The BSC was involved in the design and build committees that mapped out workflow processes on how to implement Medi-Cal expansion. The BSC created the Health Care Reform (HCR) Unit, a team initially composed of 50 eligibility workers, 6 supervisors and 6 clerical workers, to spearhead the implementation of Obamacare.

Question No. 2: What are the major challenges in BSC's implementation of MAGI Medi-Cal? How did BSC address these challenges?

Among the major challenges in the beginning of implementation was proper interpretation of the law and identifying training needs for existing and incoming staff to manage new and existing caseloads. Other challenges were how to use the existing technology (CalHEERS) provided by the state and meeting the state's mandate for a one-stop call center capable of answering phone calls from Covered California clients and processing telephonic applications.

BSC addressed these challenges by providing training among workers regarding new Medicaid regulations and phone handling, in collaboration with the SSA's Staff Development and Information Systems offices. BSC also cross-trained eligibility workers to register applications into its computer systems, which earlier was completed as a clerical function. The cross-training paved the way for a change in business process such that calls being routed from the state's Covered California customer hotline for potential Medi-Cal eligibility were picked up by the HCR eligibility workers, who then registered applications into CalHEERS by themselves without clerical assistance. Due to limited capabilities of the CalHEERS system during the early implementation of Obamacare, particularly in electronically verifying client information through federal databases, BSC also implemented a "workaround" process by utilizing a scanning system that will receive documentary verifications from clients so that applications could be processed and eligibility determinations could be made.

Question No. 3: What organizational changes that are critical to MAGI Medi-Cal implementation, if any, did the BSC adopt?

Besides the change in business process, the BSC also "focused heavily on sharing of information among all levels of the organization." Mr. Sacasa also stated that the design-and-build committees involved various stakeholders, including supervisors, eligibility workers, clerical workers, Information System staff and Program Bureau staff, among others. Mr. Sacasa also pointed out that all committees involved in drafting the Santa Clara County Health Care Reform Implementation Strategy included representatives from the labor unions. In addition, the BSC also coordinated with other counties for information sharing regarding Obamacare implementation.

Question No. 4: What is the impact of the organizational changes, if any, on the implementation of ACA's Medicaid expansion in terms of processing Medi-Cal caseloads?

Mr. Sacasa stated that Medi-Cal caseloads increased significantly by approximately 250 percent due to the implementation of the Medicaid expansion. He intimated that eligibility workers were overloaded with high caseload volumes, saying: "Staffing-wise, we have struggled to maintain staffing that we needed." Although the BSC conducted batches of mass hiring over 100 eligibility workers, Mr. Sacasa noted that the eligibility worker basic training module—which includes classroom training about eligibility regulations and hands-on training on CalHEERS and the county's eligibility software system CalWIN—takes six months to complete before these workers can actually work on live Medi-Cal cases. He added: "We're just now feeling that we've gotten to a point where we're healthy when it comes to staffing." Mr. Sacasa also stated that there is an ongoing assessment of staffing need not only due to Obamacare implementation but also due to other factors such as retirement, promotion and attrition.

Question No. 5: What communication techniques, if any, did the BSC use to ensure that front-line employees (eligibility workers) have a clear understanding about the organizational changes and their role in implementing MAGI Medi-Cal?

With the creation of the HCR Unit, eligibility workers in that unit were eventually regarded as "in-house experts" in Obamacare's Medicaid because of their early exposure to the CalHEERS system along with possessing experience in processing those cases. The BSC utilized this expertise by allowing other eligibility workers to "shadow" with the HCR workers. In collaboration with the Program Bureau, the BSC also developed workflow documents and disseminated policy updates and interpretations through the Intranet and shared folders that are accessible to the workers.

Question No. 6: Considering that the implementation of MAGI Medi-Cal is relatively new, what management technique, if any, did the BSC implement to enhance public outreach and awareness about the program?

The BSC collaborated with community organizations to enhance public outreach and awareness about Obamacare's Medicaid expansion. As part of this effort, the BSC also targeted community organizations involving cultural minorities and low-income populations. It also partnered with the county-operated hospital, the Valley Medical Center, to boost public outreach among patients who needed Medi-Cal. In addition, the BSC participated in community events, where it set up informational booths, distributed flyers and stationed representatives to answer questions about Obamacare's Medicaid expansion.

Question No. 7: What major challenges for BSC, if any, do you anticipate in the future as far as implementing MAGI Medi-Cal is concerned?

An ongoing challenge for the BSC is how to get the technology for Obamacare-related eligibility determinations fixed. Mr. Sacasa said that the intermittent interface between the CalHEERS and CalWIN technology systems has resulted in confusion among eligibility workers and has made the eligibility determination process a challenge. Mr. Sacasa stated that the BSC is part of an 18-county consortium that is exerting pressure on the state government so that the latter can address the information technology issue.

Interview with Ms. Margareta Hodzic, former HCR Program Manager at BSC

An unstructured interview was also conducted with Ms. Margareta Hodzic, former BSC SSPM I who had direct oversight of the HCR Unit during the initial implementation of Obamacare. The interview asked about her HCR experience, including the challenges and how the HCR Unit addressed those challenges. A recapitulation of Ms. Hodzic's statement is detailed below.

One of the challenges during the early implementation of Obamacare was the high volume of calls and the high turnout of clients visiting the BSC offices to apply for Medi-Cal. While the HCR Unit expected that the CalHEERS system would be fully functional, the technology's electronic verification system was not working at all. The CalHEERS system absolutely failed to interface with the county's CalWIN system initially. To address these challenges, the HCR Unit created a business process where client information is put on paper forms first before the said information was transposed into the computer systems. An electronic

inbox was also created to accept paper verification from clients so that their Medi-Cal applications could be processed. To meet the demand resulting from high volume of calls and high client turnout at the offices, the HCR also initiated a change in business process whereby eligibility workers took the computer application registration function from the clerical units; additionally, the HCR adopted a rolling schedule among its workers for an extended daily phone coverage from 8am to 8pm, instead of the usual business hours of 8am to 5pm, to accommodate more telephonic applications. To date, the technology challenge remains as the interface between the CalHEERS and CalWIN systems are not at optimal level, with frequent glitches and interruptions.

Interview with Ms. Nellie Jorge, SSPM III at the Application and Assistance Center (AAC)

A structured interview was conducted with Ms. Nellie Jorge, SSPM III at the AAC (Intake/New Applications office). The interview questions and recapitulations of the interview responses are detailed below:

Question No. 1: What is the role of the Application Assistance Center (AAC) in implementing Obamacare's Medicaid expansion, also known as Modified Adjusted Gross Income (MAGI) Medi-Cal?

Although the AAC was not initially principally involved in the implementation of Obamacare's Medicaid expansion, it assisted the HCR Unit under BSC in processing Medi-Cal caseloads. The AAC—the SSA's office principally tasked to accept new applications for various programs such as Calfresh and Calworks (cash aid)—also accepted and processed Medicaid

cases in multi-program applications. Recently, however, the HCR Unit was transferred to the AAC Unit to accept new applications pertaining to Obamacare's Medicaid expansion.

Question No. 2: What are the major challenges in AAC's implementation of MAGI Medi-Cal?

Processing a high volume of Medi-cal caseloads in a timely manner was a major challenge for AAC during the initial implementation of Obamacare. Ms. Jorge recalled: "They (clients) were applying online, but they were also coming here because we couldn't process fast enough." Consequently, clients flocked the lobby for in-person assistance regarding their applications and to seek general information regarding Obamacare. The CalHEERS system also posed a challenge in the timely processing of Medi-Cal caseloads, partly because the information technology system allowed multiple applications from the same clients, resulting in technical issues that delayed proper eligibility determination.

Question No. 3: How did AAC address these challenges?

The AAC changed its lobby process to address the crowding of clients requesting for in-person assistance. The AAC also implemented "workarounds" to process Medi-Cal caseloads despite the limited capabilities of CalHEERS, in collaboration with the SSA's Program Bureau and Information Systems offices. In addition, the AAC conducted training and distributed training materials among its staff regarding Obamacare's Medicaid expansion. It intensified communication efforts among employees by way of staff meetings several times a week. To address the public's confusion about the Medicaid application process, the AAC participated in the Emergency Assistance Network, which Ms. Jorge described as a collaboration of agencies

and community organizations, for information sharing and enhancement of public outreach efforts regarding Obamacare.

Question No. 4: What organizational changes that are critical to implementing MAGI Medi-Cal, if any, did the AAC adopt?

In addition to her preceding responses, Ms. Jorge mentioned the consolidation of clerical staff at AAC and BSC into one single clerical unit to allow cross-training of functions. Since the HCR Unit also has an "intake" function, the unit was recently transferred to AAC. Prior to the transfer of HCR Unit to the AAC, Ms. Jorge stated that inter-program, inter-office collaboration was critical to implementing Obamacare's Medicaid expansion.

Question No. 5: What is the impact of the organizational changes, if any, on the implementation of ACA's Medicaid expansion in terms of processing Medi-Cal caseloads?

Inter-program, inter-office collaboration within the SSA helped spread the high volume of Medi-Cal caseloads that would have been cumbersome for the HCR Unit alone to process, with Ms. Jorge saying: "It's been a transition time frame, but now, [there is] less crowding at the lobby and people are already active for Medi-Cal." Over time, eligibility workers have become more familiar with CalHEERS and the regulations and processes related to implementing Obamacare's Medicaid expansion. The organizational changes also contributed to a more stable structure in place to implement the Medicaid expansion, with the creation of the HCR Unit.

Question No. 6: What communication techniques, if any, did the AAC use to ensure that front-line employees (eligibility workers) have a clear understanding about the organizational changes and their role in implementing MAGI Medi-Cal?

As mentioned in the preceding responses, training was conducted among front-line workers regarding new regulations and processes related to the Medicaid expansion. The AAC also conducted team meetings as often as "several times a week" to ensure that front-line workers are kept abreast about the organizational changes and their respective roles.

Question No. 7: Considering that the implementation of MAGI Medi-Cal is relatively new, what management technique, if any, did the AAC adopt to enhance public outreach and awareness about the program?

The AAC collaborated with various departments within SSA and community organizations outside the agency to enhance public outreach and awareness about Obamacare's Medicaid expansion. Ms. Jorge reiterated the AAC's participation in the Emergency Assistance Network, which includes community organizations that have existing partnerships with the SSA, such as Second Harvest Food Bank and Inn Vision Shelter Network.

Question 8: What major challenges for AAC, if any, do you anticipate in the future as far as implementing MAGI Medi-Cal is concerned?

The major challenge in implementing Obamacare's Medical expansion in the future remains to be the technology system, particularly CalHEERS. Ms. Jorge stated that the system is still not stable to date and needs to be fixed. One suggested fix to the CalHEERS system is the

capability to prevent multiple applications by the same client if there is already an existing application.

Interview with Ms. Raquel Vallejo, SEIU Local 521 chief steward for eligibility workers

A paper copy of the survey questionnaire was given to Ms. Vallejo, chief steward for eligibility workers at the Service Employees International Union (SEIU) Local 521, the labor union representing service workers in the County of Santa Clara. Ms. Vallejo completed the survey questionnaire based on her capacity as chief steward, citing her frequent dealings with eligibility workers regarding work-related issues. Ms Vallejo was then asked to explain each response to the survey questionnaire. The survey responses and recapitulations of Ms. Vallejo's explanations are detailed below.

Survey Statement No. 1: I have a clear understanding of the changes to eligibility determination related to MAGI Medi-Cal.
a. ___ Strongly Agree
b. ___ Agree
c. _X_ Somewhat Agree
d. ___ Disagree
e. ___ Strongly Disagree

Ms. Vallejo qualified her response by saying that an important factor to an acceptable level of understanding of the changes to Medi-Cal eligibility determination is the supervisors, many of whom provide technical assistance and knowledge sharing among eligibility workers.

Survey Statement No 2: I have a clear understanding of my role in MAGI Medi-Cal public outreach (example: phone support).
a. ___ Strongly Agree
b. ___ Agree
c. ___ Somewhat Agree

d. _X_ Disagree
e. ___ Strongly Disagree

Ms. Vallejo stated that confusion sometimes arises as to whether client calls will be answered or referred to Covered California. Ms. Vallejo partly attributed this confusion to technology glitches in CalHEERS. Since eligibility determination in CalHEERS is sometimes erratic, confusion arises as to how to provide client information.

Survey Statement No. 3: Communication about policies and procedures related to MAGI Medi-Cal within my organization is clear and timely.
a. ___ Strongly Agree
b. ___ Agree
c. ___ Somewhat Agree
d. ___ Disagree
e. _X_ Strongly Disagree

Ms. Vallejo stated that policies and procedures are not clear and timely. By way of example, Ms. Vallejo said that when there was an instruction from the state government to prevent a negative action on existing Medi-Cal cases, procedural guidance as to how negative action could be prevented in the computer systems is lacking. By the time the instruction is received by the front-line worker, Ms. Vallejo said that some Medi-Cal cases were already discontinued in the information systems.

Survey Statement No 4: When I am confused with my MAGI Medi-Cal cases, I can always approach my supervisor for clarification.
a. ___ Strongly Agree
b. ___ Agree
c. _X_ Somewhat Agree
d. ___ Disagree
e. ___ Strongly Disagree

Ms. Vallejo qualified that, while some supervisors are knowledgeable and helpful, others need more training.

Survey Statement No. 5: My organization's training for MAGI Medi-Cal eligibility determination is adequate.
a. ___ Strongly Agree
b. ___ Agree
c. ___ Somewhat Agree
d. _X Disagree
e. ___ Strongly Disagree

Ms. Vallejo stated that the training provided is not very "solid." Refresher courses are needed so that front-line workers can have a solid understanding of Medi-Cal eligibility determination.

Survey Statement No. 6: My level of understanding of MAGI Medi-Cal affects the quality of service that I provide my clients.
a. _X Strongly Agree
b. ___ Agree
c. ___ Somewhat Agree
d. ___ Disagree
e. ___ Strongly Disagree

Ms. Vallejo stated that front-line workers' level of understanding of new Medi-Cal rules not only affects the quality of service to clients, but also negatively impacts on employee morale.

Survey Statement No. 7: The quality of service that I provide my clients based on my understanding of MAGI Medi-Cal is:
a. ___ Excellent
b. ___ Good
c. ___ Satisfactory
d. _X_ Poor

e. ___ Very Poor

Ms. Vallejo qualified her response by saying: "Even if we can explain the process, because of the technology and the difficulty that we're having, we cannot confidently say [to clients] that you can go to the doctor today."

Researcher's Observation

This researcher has been an eligibility worker at BSC since the early implementation of Obamacare's Medicaid expansion. For the first few months in 2014, processing of Medicaid expansion cases were put on hold, while awaiting guidance from the Program Bureau as to how those Medi-Cal caseloads should be processed. Basic training about eligibility regulations about the Medicaid expansion were provided through classroom-type sessions through the SSA's Staff Development office. The training also consisted of hands-on training using the county's CalWIN system, but there was no training platform for the CalHEERS system regarding eligibility determination.

The BSC also receives program updates from the SSA's Program Bureau for regulatory changes and procedural guidance, with step-by-step instructions and CalWIN screenshots regarding Obamacare Medi-Cal processing. However, as technical updates were made to the CalWIN system, some of the program updates that were earlier disseminated turned out to be deficient to properly adjudicate Medi-Cal caseloads. This resulted in delayed processing of high-volume Medi-Cal caseloads that were spread out from the HCR Unit to the entire BSC and all other DEBS welfare program and satellite offices. The pressure of heavy caseload work prompted front-line workers to initially resist the changes. The caseload issue nearly resulted in a

bargaining deadlock between the county and the SEIU Local 521 in mid-2015; a labor strike was imminent, but the strike was averted following extended negotiations.

In this researcher's experience, a pragmatic approach and the support of the supervisor were helpful in processing Medi-Cal caseloads, as the supervisor gave him the flexibility to perform workarounds and experiment on the computer systems, as long as the results were in compliance with the substantive provisions of Medi-Cal regulations, thus allowing familiarity with the computer systems' functionalities and limitations. This researcher's supervisor also openly authorized system overrides so that proper Medi-Cal eligibility could be timely activated in the state's Medi-Cal Eligibility Data System (MEDS), which is the controlling information system that healthcare providers access when Medi-Cal clients visit their clinics for health services.

Performance measurement was also put in place at BSC such that eligibility workers were given daily quotas for caseload completion. Performance reports were being given to supervisors on a daily basis for them to discuss performance issues that need to be addressed, if any. While some workers consistently met performance quotas, others had issues in catching up and attributed the difficulty to the technology glitches in the CalHEERS system.

Secondary Statistical Data

The California Health Interview Survey (CHIS) is an annual random-dial telephone survey of more than 20,000 Californians covering the state's 58 counties (UCLA, 2015). It is funded by a consortium of public and private entities, including the California Department of Health Care Services and the California Department of Public Health.

The 2014 CHIS estimates that there are 433,000 individuals whose income is at or below 138% of the federal poverty limit in Santa Clara County (AskCHIS, 2015). Of this total, the 2014 CHIS data estimate that 38,000 are currently uninsured, 257,000 currently have Medi-Cal, while 138,000 have health coverage other than Medi-Cal. Thus, for purposes of calculating Medi-Cal participation rate under Obamacare's Medicaid expansion, this research assumes that 433,000 Santa Clara County residents are potentially eligible for Medi-Cal, regardless of coverage status.

Actual figures released by DEBS show that the number of adults with no minor children who were eligible for Medi-Cal in 2013 was 80,511; as shown in Figure 1, the total nearly doubled to 154,816 in 2014, one year after the implementation of Obamacare's Medicaid expansion (DEBS, 2015).

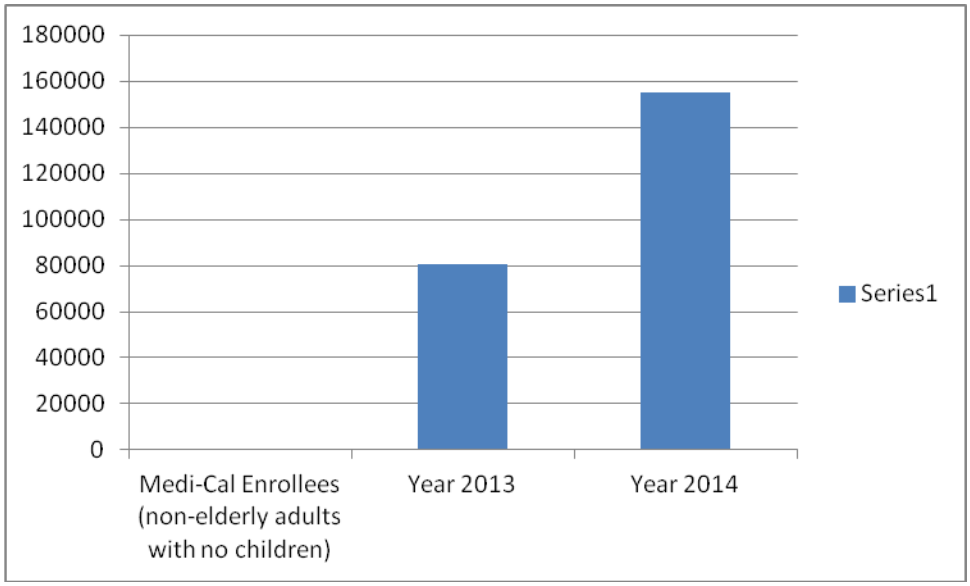

Figure 1: Number of Medi-Cal Enrollees (non-elderly adults with no children)

For purposes of calculating participation rate in this study, the equation can be expressed mathematically as shown in Figure 2:

MPR = (x/y) x 100%

Where MPR pertains to Medi-Cal Participation Rate among adults with no minor children;

X pertains to the number of Medi-Cal enrollees; and

Y is the estimated number of individuals who are potentially eligible for Medi-Cal

Figure 2: Mathematical formula for calculating Medi-Cal participation rate

Thus, for purposes of this study, Santa Clara County's Medi-Cal participation rate for non-elderly adults with no minor children in 2013 is 18.59%, while that of 2014 is 35.75%.

Survey Questionnaire

There are 288 eligibility workers at the BSC and AAC offices. Exactly 200 paper copies of the survey questionnaire were printed and prepared for distribution from December 1 to 8, 2015 at the BSC and AAC offices and at the respective breakrooms. Out of 200 questionnaires, 133 were completed and returned to this researcher. The results of the survey responses are detailed in this section.

Statement 1: I have a clear understanding of the changes to eligibility determination related to MAGI Medi-Cal.					
Strongly Agree	Agree	Somewhat Agree	Disagree	Strongly Disagree	TOTAL
36	52	32	10	3	133
27%	39%	24%	8%	2%	100%

Table 1: Tally of Responses to Survey Statement No. 1 (N = 133 responses)

A majority of survey respondents—or 66 percent—indicated that they have a clear understanding of the changes to eligibility determination related to MAGI Medi-Cal, also known as Modified Adjusted Gross Income Medi-Cal—the Medicaid program created under Obamacare. In contrast, only 10% of the survey respondents indicated that they do not have a clear understanding of the new Medicaid program (Table 1).

Statement 2: I have a clear understanding of my role in MAGI Medi-Cal public outreach (example: phone support).					
Strongly Agree	Agree	Somewhat Agree	Disagree	Strongly Disagree	TOTAL
38	54	29	10	2	133
28%	41%	22%	8%	1%	100%

Table 2: Tally of Responses to Survey Statement No. 2 (N=133 responses)

As shown in Table 2, a majority of the survey respondents—or 69 percent—indicated that they have a clear understanding of their role in MAGI Medi-Cal public outreach. Only 9% disagreed.

Statement 3: Communication about policies and procedures related to MAGI Medi-Cal within my organization is clear and timely.					
Strongly Agree	Agree	Somewhat Agree	Disagree	Strongly Disagree	TOTAL
9	32	47	34	11	133
7%	24%	35%	26%	8%	100%

Table 3: Tally of Responses to Survey Statement No. 3 (N=133 responses)

A total of 34% of the survey respondents disagreed or strongly disagreed with the statement that internal communication about policies and procedures related to the new Medicaid program are clear and timely. As shown in Table 3, only 31 percent of the respondents favorably rated the timeliness and clarity of internal communication, while 35 percent indicated that they "somewhat agree."

Statement 4: When I am confused with my MAGI Medi-Cal cases, I can always approach my supervisor for clarification.					
Strongly Agree	Agree	Somewhat Agree	Disagree	Strongly Disagree	TOTAL
38	55	28	11	1	133
29%	41%	21%	8%	1%	100%

Table 4: Tally of Responses to Survey Statement No. 4 (N=133 responses)

A majority of survey respondents—or 70 percent—agree or strongly agree that eligibility workers can always approach their respective supervisors for clarification when they are confused about their Obamacare Medicaid caseloads. An additional 21 percent of the respondents indicated that they "somewhat agree." Only 9% of the respondents are in disagreement, as shown in Table 4.

Statement 5: My organization's training for MAGI Medi-Cal eligibility determination is adequate.					
Strongly Agree	Agree	Somewhat Agree	Disagree	Strongly Disagree	TOTAL
9	32	38	44	10	133
7%	24%	28%	33%	8%	100%

Table 5: Tally of Responses to Survey Statement No. 5 (N=133 responses)

Approximately 41 percent of the survey respondents believe that the organization's training related to the Obamacare Medicaid expansion is not adequate. Table 5 shows that an additional 28 percent responded that they "somewhat agree," indicating that the organization's training may not be unexceptionally solid. By comparison, only 31 percent of the respondents believe that the organization's training about Obamacare's Medicaid expansion is adequate.

Statement 6: My level of understanding of MAGI Medi-Cal affects the quality of service that I provide my clients.					
Strongly Agree	Agree	Somewhat Agree	Disagree	Strongly Disagree	TOTAL
61	51	16	5	0	133
46%	38%	12%	4%	0%	100%

Table 6: Tally of Responses to Survey Statement No. 6 (N=133 responses)

Some 84 percent of the respondents agree with the survey statement, which establishes a correlation between the level of understanding of front-line employees and the quality of service that they provide. An additional 16 percent "somewhat agree." Table 5 shows that only 4 percent disagreed with the statement that their level of understanding of Obamacare Medicaid affects the quality of service that they provide clients.

Question 7: The quality of service that I provide my clients based on my understanding of MAGI-Medi-Cal is:					
Excellent	Good	Satisfactory	Poor	Very Poor	TOTAL
36	64	29	3	1	133
27%	48%	22%	2%	1%	100%

Table 7: Tally of Responses to Survey Statement No. 7 (N=133 responses)

Only 3 percent of the respondents rated the quality of client service poorly. A clear majority—or 97 percent of the respondents—believe that they have been providing service of satisfactory to excellent levels of quality based on their understanding of Obamacare's Medicaid expansion.

Analysis:

The SSA's implementation of Obamacare's Medicaid expansion consisted of partnerships with community groups to enhance public outreach and awareness about the program. It was also characterized by collaboration among its various offices and programs. At the forefront of the implementation was the creation of a special unit, the HCR Unit, dedicated to implementing Obamacare, while various offices and programs within the agency pooled resources to provide support by way of spreading out a high volume of caseloads, conducting training and technical support, and changing business processes to streamline the processing of high-volume Medi-Cal caseloads despite an unstable state-provided technology platform in CalHEERS. All those management approaches are consistent with NPM practices characterized by deviation from traditional public administration, flexibility in management, adaptability to

change and performance management. Qualitative data in this research identified the above-mentioned implementation changes adopted by the SSA to increase Medi-Cal participation rate, thus satisfying the first research subquestion: "What changes to Medi-Cal program implementation, if any, did the SSA adopt to increase Medi-Cal participation rate in Santa Clara County in connection with implementing Obamacare?"

Medi-Cal participation rate among non-elderly adults certainly increased with Obamacare's Medicaid expansion. However, the SSA attributes this change not only to how it implemented the health care reform law, but also to the inherent changes brought on by the legislation, which made previously ineligible adults potentially eligible for Medicaid. State legislation also enabled certain populations, such as former inmates, to benefit from Obamacare's Medicaid expansion. Nevertheless, the data appear to be sufficient to establish the correlation—not causation—between the implementation of NPM techniques by the SSA and the increase in Medi-Cal participation rate among previously ineligible, non-elderly adults with no minor children. Secondary statistical data show that Medicaid participation rate among non-elderly adults with no children nearly doubled in the first year of Obamacare's implementation compared to the previous year, which answers the second research subquestion: "What is the impact of the SSA's policy implementation changes, if any, to Medi-Cal participation rate in Santa Clara County?"

Meanwhile, while the implementation of NPM techniques is expected to enhance the flow of information that would strengthen front-line workers' understanding of Medicaid expansion and the processes associated with it, the survey data show mixed results. Majority of the eligibility workers surveyed claimed to have a clear understanding of changes to eligibility

determination and their role in public outreach in connection with Obamacare's Medicaid expansion, even as 41 percent of the survey respondents claim that the organization's training related to the program is inadequate. Notably, a substantial 34 percent of the survey respondents also disagreed that communication about policies and procedures related to the Medicaid expansion is clear and timely, while 35 percent indicated that the timeliness and clarity of communication are unexceptionally passable. However, the qualitative data show that the SSA has implemented communication techniques, such as the use of the Intranet and dissemination of policy and procedural updates related to Medicaid expansion. Additionally, the active role of supervisors in providing technical assistance and knowledge sharing among eligibility workers, as claimed by the chief steward of front-line workers, support the workers' declaration that they have a clear understanding of eligibility determination changes and their role in public outreach related to the Medicaid expansion. Further, the survey data also corroborate the statement of the chief steward in that majority of the survey respondents agreed or strongly agreed that they can always approach their respective supervisors for clarification when they are confused about their Medicaid caseloads.

Survey data also show that a clear majority of the respondents—or 84 percent—is in agreement that the level of understanding of the Medicaid expansion program affects the quality of service provided to clients. Including those who responded that they "somewhat agree," 96 percent of the respondents affirmed the correlation between the workers' level of understanding of the program and the quality of service to program clients. This correlation suggests that, if the workers' level of understanding of the program is good, the quality of service that they provide program clients can also be good. Consistently, 75 percent of the survey respondents rate the

quality of service to Medicaid expansion clients from good to excellent; 22 percent said it is satisfactory, while only 3 percent rated the quality of service from "poor" to "very poor." While this researcher recognizes the possibility of bias when the survey respondents were asked to evaluate themselves in terms of the quality of service they provide, there is reason to believe that the responses were credible as survey and qualitative data support the finding that workers have a clear understanding about the Medicaid expansion program. This finding satisfies the third research sub-question: "How satisfied are front-line workers in the SSA's policy implementation changes, if any, in connection with implementing Obamacare's Medicaid expansion?" Notably, however, survey data suggest that training and communication related to policy implementation changes need to be strengthened.

From the discussion above, this study attempts to answer the research question: Has the County of Santa Clara's Social Services Agency's (SSA) adoption of NPM techniques to implement Obamacare's Medicaid expansion effectively reduced the number of uninsured Americans in the county? To the extent that a correlation between the implementation of NPM techniques and Medicaid participation rate has been established and that program participation rate nearly doubled in the first year of Obamacare's implementation compared to the preceding year, the SSA's adoption of NPM techniques to implement Obamacare's Medicaid expansion has effectively reduced the number of uninsured Americans in Santa Clara County. To the extent that front-line workers are able to provide good to excellent quality of service to Medicaid expansion clients, the SSA has effectively implemented the Medicaid expansion in the county.

Summary of Findings and Analysis

The County of Santa Clara's Social Services Agency (SSA) implementation of Obamacare's Medicaid expansion was characterized by partnerships with community groups to enhance public outreach and awareness about Medicaid expansion. The SSA's implementation of the Medicaid expansion was also characterized by inter-program and inter-departmental collaboration within the agency, as well as changes to business processes to meet the anticipated demand brought on by the new law. The data show that Medi-Cal participation rate among non-elderly Santa Clara County residents, whose household income is at or below 138-percent of the federal poverty limit (FPL), nearly doubled during the first year of Obamacare's implementation compared to the previous year. The SSA attributes this partly due to its implementation techniques consistent with NPM. It also attributes the increase in participation rate due to the policy change itself, which made previously ineligible, non-elderly adults with no minor children potentially eligible for Medicaid. Survey data also show that front-line workers—particularly the eligibility workers who directly interact with Medicaid clients and process eligibility determination of Medicaid caseloads—have a high level of satisfaction on the quality of service provided to clients, notwithstanding the inadequacy of worker training and the unexceptionally effective organizational communication related to the Medicaid expansion. Despite the shortcomings of the Covered California information system, the increase in program participation rate and the high level of satisfaction among front-line workers who believe that they have provided Medicaid clients with good to excellent service support the finding that the County of Santa Clara's implementation of Obamacare's Medicaid expansion in the first year was effective in reducing the number of uninsured residents in the county.

Chapter 5: CONCLUSIONS AND RECOMMENDATIONS

Conclusions

I. There is a positive correlation between the local implementation of New Public Management (NPM) techniques and achieving policy outcome in connection with Obamacare's Medicaid expansion.

The results and findings in this study suggest that there is a correlation between the local implementation of New Public Management (NPM) techniques and achieving policy outcome. Specifically, the implementation of NPM techniques by the county's Social Services Agency (SSA), among other factors, reduced the number of uninsured residents in Santa Clara County by increasing Medicaid participation rate under Obamacare's Medicaid expansion. Notably, the SSA also attributes the increase in Medicaid participation rate to the inherent changes in the health care reform law, which made formerly program-ineligible residents potentially eligible for the Medicaid program.

One of the key NPM strategies and techniques was an extensive collaboration with private and community groups to enhance public outreach and awareness about Medicaid expansion. Internally, the SSA also tapped into various stakeholders from all levels within the organization to adopt an implementation strategy in anticipation of the Obamacare implementation rollout. Additionally, the agency initiated structural changes to create a Health Care Reform (HCR) Unit dedicated to implementing Obamacare's Medicaid expansion and fostering inter-departmental and inter-program collaboration to spread out the high volume of Medicaid caseloads among various offices.

II. There is a positive correlation between the adoption of NPM techniques and organizational effectiveness in the local implementation of Obamacare's Medicaid expansion.

Survey data show that a total of 84 percent of the respondents agree or strongly agree with the statement that their level of understanding of Obamacare's Medicaid expansion affects the quality of service provided to Medicaid clients. This establishes a correlation between the level of understanding of front-line workers and the quality of service provided to clients. However, while workers assess their level of understanding of the Medicaid expansion as good to excellent, their grasp of the program and related rules and procedures could not have emanated from adequate training. Rather, qualitative data in this research point to other factors that contributed to that level of understanding. The SSA has implemented communication techniques, such as the use of the Intranet and dissemination of policy and procedural updates through collaboration between the Program Bureau and the service centers. The implementation of workarounds and changes in business processes despite the shortcomings of the California Healthcare Enrollment, Eligibility and Retention System (CalHEERS) technology system were contributory factors. In addition, the creation of the HCR Unit dedicated to implementing the Medicaid expansion, along with the active role of supervisors, facilitated knowledge sharing among eligibility workers. These factors are all part of the NPM practices adopted by the SSA to implement Obamacare's Medicaid expansion. Thus, research data support the finding that there is a correlation between the adoption of NPM practices and the quality of service provided by front-line workers to clients.

III. The SSA's adoption of NPM techniques to implement Obamacare's Medicaid expansion has effectively reduced the number of uninsured Americans in Santa Clara County.

Medicaid participation rate among nonelderly residents nearly doubled during the first year of Obamacare's implementation. The SSA attributes this growth to the adoption of NPM techniques, along with the inherent program changes brought on by the health care reform law. Part of this success was due to the agency's strategic partnerships with community groups to enhance public outreach and awareness about the Medicaid expansion. Inasmuch as the adoption of NPM techniques resulted in a significant increase in Medicaid participation rate, it has effectively reduced the number of uninsured Santa Clara County residents during Obamacare's first year of implementation. Research data also support the finding that the adoption of NPM techniques enabled the agency's front-line workers to provide service to clients effectively based on a clear understanding of the Medicaid expansion.

Recommendations

I. The SSA's Program Bureau must lead the creation of a "CalHEERS workaround" committee beginning January 2016 to extensively identify and document information system issues and "workaround" solutions.

The SSA must constantly fill in the gap resulting from the frequent glitches to the technology system to ensure that Medicaid eligibility determinations are timely processed and Medicaid benefits remain uninterrupted for those who are eligible. The technology issue with the

CalHEERS system was unanimously identified by the SSA's leadership, middle managers and front-line workers as a major challenge to implementing Obamacare's Medicaid expansion. In the short-term, regularly documenting known issues and temporary "workaround" solutions will mitigate the shortcomings of the technology system, while a long-term technological fix at the state level is ongoing. This can be achieved through collaboration with the Program Bureau, the service centers, Staff Development, and Information System offices within the agency. The creation of a "CalHEERS workaround" committee from the stakeholder offices within the agency can better identify technology issues and document issue-specific "workaround" solutions. The SSA can also leverage on the contributions of the committee when it elevates the magnitude and severity of the technology issues before a multi-county consortium. Currently, the County of Santa Clara is actively engaged in this multi-county consortium that is exerting pressure on the state government to address the technology issues in CalHEERS (R. Sacasa and A. Diaz, interview, November 24, 2015).

II. The SSA's Staff Development Office must tap into the expertise of the HCR Unit in redeveloping training modules related to Obamacare's Medicaid expansion no later than February 2016.

The SSA must adopt a training strategy in connection with the implementation of Obamacare and related program changes. Such strategy can include the development of a more robust training module by tapping into the "in-house experts" at the HCR Unit, who have had extensive experience in applying the Medicaid regulatory concepts into the CalHEERS platform.

At the same time, the SSA must capitalize on the value of knowledge sharing provided by

eligibility work supervisors among front-line workers. Supervisors are the "go-to" persons of eligibility workers whenever the latter are confused about their Medicaid cases. The training strategy must include the training of supervisors so they can enhance their knowledge sharing capabilities to support front-line workers.

III. The SSA's Research and Evaluation office should design and administer quarterly customer satisfaction surveys at the service centers beginning January 2016.

The SSA should strengthen its customer feedback mechanism not only to gauge customer satisfaction on the agency's quality of service, but also to identify areas of concern for improvement. While customers can generally elevate complaints to service centers' supervisors of the day if they choose to, a strong focus on customer feedback will enable the agency to identify strengths and weaknesses to improve customer experience. This can be implemented at the service centers, where clients go to regarding their Medicaid cases.

Area for Future Research

I. Case study of Medicaid participation rate among elderly Americans in Santa Clara County

While Obamacare expanded Medicaid for non-elderly Americans whose income is at or below 138-percent of the federal poverty limit (FPL), one area for future study is a case study that will examine Medicaid participation rate among elderly populations. Elderly persons are a vulnerable sector of society. Unlike non-elderly adults, who benefitted from Medi-Cal expansion when program changes increased income limit to 138% of the FPL and eliminated property

limits for eligibility, non-elderly populations remain subject to asset tests and lower income limit at 100% of the FPL for regular Medi-Cal eligibility. A case study will provide data-driven findings that will identify whether or not there is a need to expand health care reform to this vulnerable sector of society.

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Appendix A

Interview Questionnaire for Mr. Robert Menicocci, Acting SSA Director

1. Considering that the implementation of Obamacare's Medicaid expansion is relatively new, what strategies or techniques did your agency implement to enhance public outreach and encourage program participation among Santa Clara County residents?

2. What major factors in your agency's implementation of Obamacare's Medicaid expansion (MAGI Medi-Cal) contributed to an increase in Medi-Cal enrollees in 2014 compared to 2013?

3. How did your management approach/strategy contribute to this achievement?

4. How did the Social Services Agency's implementation of MAGI Medi-Cal contribute to achieving Obamacare's goal of reducing the number of uninsured?

5. What major challenges, if any, do you anticipate in the future as far as your agency's implementation of MAGI Medi-Cal is concerned?

Appendix B

Interview Questionnaire for Mr. Robert Sacasa, BSC Program Manager

1. What is the role of the Benefit Service Center (BSC) in implementing Obamacare's Medicaid expansion, also known as Modified Adjusted Gross Income (MAGI) Medi-Cal?

2. What are the major challenges in BSC's implementation of MAGI Medi-Cal? How did BSC address these challenges?

3. What organizational changes that are critical to MAGI Medi-Cal implementation, if any, did the BSC adopt?

4. What is the impact of the organizational changes, if any, on the implementation of ACA's Medicaid expansion in terms of processing Medi-Cal caseloads?

5. What communication techniques, if any, did the BSC use to ensure that front-line employees (eligibility workers) have a clear understanding about the organizational changes and their role in implementing MAGI Medi-Cal?

6. Considering that the implementation of MAGI Medi-Cal is relatively new, what management technique, if any, did the BSC implement to enhance public outreach and awareness about the program?

7. What major challenges for BSC, if any, do you anticipate in the future as far as implementing MAGI Medi-Cal is concerned?

Appendix C

Interview Questionnaire for Ms. Nellie Jorge, AAC Program Manager

1. What is the role of the Application Assistance Center (AAC) in implementing Obamacare's Medicaid expansion, also known as Modified Adjusted Gross Income (MAGI) Medi-Cal?
2. What are the major challenges in AAC's implementation of MAGI Medi-Cal?
3. How did AAC address these challenges?
4. What organizational changes that are critical to implementing MAGI Medi-Cal, if any, did the AAC adopt?
5. What is the impact of the organizational changes, if any, on the implementation of ACA's Medicaid expansion in terms of processing Medi-Cal caseloads?
6. What communication techniques, if any, did the AAC use to ensure that front-line employees (eligibility workers and customer service technicians) have a clear understanding about the organizational changes and their respective roles in implementing MAGI Medi-Cal?
7. Considering that the implementation of MAGI Medi-Cal is relatively new, what management technique, if any, did the AAC adopt to enhance public outreach and awareness about the program?
8. What major challenges for AAC, if any, do you anticipate in the future as far as implementing MAGI Medi-Cal is concerned?

Appendix D

Survey Questionnaire

1. I have a clear understanding of the changes to eligibility determination related to MAGI Medi-Cal.
a. ___ Strongly Agree
b. ___ Agree
c. ___ Somewhat Agree
d. ___ Disagree
e. ___ Strongly Disagree

2. I have a clear understanding of my role in MAGI Medi-Cal public outreach (example: phone support).
a. ___ Strongly Agree
b. ___ Agree
c. ___ Somewhat Agree
d. ___ Disagree
e. ___ Strongly Disagree

3. Communication about policies and procedures related to MAGI Medi-Cal within my organization is clear and timely.
a. ___ Strongly Agree
b. ___ Agree
c. ___ Somewhat Agree
d. ___ Disagree
e. ___ Strongly Disagree

4. When I am confused with my MAGI Medi-Cal cases, I can always approach my supervisor for clarification.
a. ___ Strongly Agree
b. ___ Agree
c. ___ Somewhat Agree
d. ___ Disagree
e. ___ Strongly Disagree

5. My organization's training for MAGI Medi-Cal eligibility determination is adequate.
a. ___ Strongly Agree
b. ___ Agree
c. ___ Somewhat Agree
d. ___ Disagree
e. ___ Strongly Disagree

6. My level of understanding of MAGI Medi-Cal affects the quality of service that I provide my clients.
a. ___ Strongly Agree
b. ___ Agree
c. ___ Somewhat Agree
d. ___ Disagree
e. ___ Strongly Disagree

7. The quality of service that I provide my clients based on my understanding of MAGI Medi-Cal is:
a. ___ Excellent
b. ___ Good
c. ___ Satisfactory
d. ___ Poor
e. ___ Very Poor