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Modernizing California's Health Insurance Counseling & Advocacy Program (HICAP): Strategy Recommendations

Brianna Ensslin Janoski

ATI ADVISORY
IDEAS TO ACTION IN HEALTHCARE & AGING

EXECUTIVE SUMMARY

State Health Insurance Assistance Programs (SHIPs) provide valuable counseling services to Medicare beneficiaries across the country. Each state program varies in its design and operations. This report was developed to provide the California Department of Aging (CDA) with information to review and consider to modernize its SHIP, referred to as the Health Insurance Counseling & Advocacy Program (HICAP) in California. The information and recommendations included in this report were gathered via key informant interviews, a public survey of California stakeholders, a survey of Area Agencies on Aging (AAAs)/HICAPs, as well as a literature review and online analysis. The recommendations outlined for CDA to evaluate for further exploration and potential implementation include:

1. Develop a strategic roadmap for HICAP to include modernizing the organizational culture, mission, and tactics to achieve CDA's equity and accessibility goals for the organization.
2. Support the development of a HICAP Technical Assistance Center (TA Center) to provide more robust learning and training opportunities.
3. Evaluate rebranding HICAP.
4. Implement two annual statewide CDA-driven marketing campaigns and evaluate opportunities for other statewide marketing supports.
5. Redesign the CDA HICAP website.
6. Make improvements to the SHARP data system.
7. Explore opportunities to increase monitoring and oversight of AAAs and subcontractors.
8. Develop a strategic roadmap of how HICAPs will support dually eligible individuals moving forward, including counseling on D-SNP, PACE, and overall, integrated care.
9. Strengthen relationships, referrals, and feedback loops with related agencies and organizations.
10. Reevaluate the current formula used to distribute funds to HICAPs.

These recommendations are meant to provide a menu of options to advance the state's HICAP modernization efforts. It is anticipated that these considerations will be the basis for further analysis and stakeholder engagement.

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ACKNOWLEDGMENTS

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Interviews were conducted with the following California stakeholders:

- **California Department of Aging (CDA):** Michelle Davis, Denise Crandall, and Gilbert Sauceda
- **California Health Advocates (CHA):** Bonnie Burns, Tatiana Fassieux, and Christina Kahn
- **Covered California:** Karen Avakian, Katie Ravel, and Andrea Zvonicek
- **Department of Health Care Services (DHCS):** Anastasia Dodson
- **Department of Managed Health Care (DMHC):** Christin Hemann and Amanda Levy
- **Justice in Aging:** Amber Christ

Interviews were conducted with the following national experts and stakeholders:

- **Center for Health Care Strategies:** Alex Kruse (former Florida SHIP Director)
- **Idaho SHIP Director:** Shannon Hohl
- **Ohio SHIP Director:** Christina Reeg
- **SHIP TA Center Staff:** Ginny Paulson, Angela Burk, Dennis Smith, Sue Choplin, and Sarah Fleming
- **Washington SHIP:** Tim Smolen (Washington SHIP Director) and Judith Bendersky (former Alaska SHIP Director)
- **Wisconsin SHIP Director:** Michelle Grochocinski
- **United Healthcare:** Jesse Eller, CEO of UnitedHealthcare Massachusetts.

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PURPOSE

The State of California, in its Master Plan on Aging, has encouraged extending the reach and services of the Health Insurance Counseling & Advocacy Program (HICAP). Through the HICAP, California provides Medicare and related health insurance counseling and education to eligible seniors and individuals with disabilities. With almost one-quarter of the State's population expected to be an older adult by 2030, the State has acknowledged now is an opportune time to consider the strength of a program that can provide critical advice and connection to the most appropriate resources available to these individuals. Further, almost 30% of older Californians are reported to be low-income or near low-income, illustrating that the connection between Medicare and Medicaid, as well as other available supports (e.g., Meals on Wheels) is critical for a large portion of the State's population. As a part of the California Master Plan for Aging, one of the initiatives under Strategy B: Health Care as We Age is to "Modernize Medicare counseling services (HICAP) to serve more beneficiaries, continually improving cultural competency and language access, within existing resources."

With support from The SCAN Foundation, this project sought to analyze the current infrastructure and design of the HICAP, scope out promising approaches to operating State Health Insurance Assistance Programs (SHIPs) in other states and make recommendations for consideration by the California Department of Aging (CDA) as it looks to modernize HICAP. The information and recommendations included were gathered by stakeholder engagement that occurred between May and August 2021, including key informant interviews with 18 individuals, a public survey that received 374 responses, a survey of Area Agencies on Aging (AAAs)/HICAPs that received 32 responses, as well as a literature review and online analysis.

SHIP LANDSCAPE REVIEW

History

States nationwide operate SHIPs, to provide counseling and assistance to Medicare beneficiaries and their families. HICAP, the California-based SHIP, was established in 1984 under Assembly Bill 2419. By 1985, HICAP had expanded into 11 county- based pilot programs. By 1989, there were 24 HICAPs serving all 58 counties across California. HICAP was further established in California legislation in 1996 under the Mello-Grandlund Older Californians Act (OCA) and retains State authorization under the OCA. In 1990, the United States Congress established the federal SHIP and looked to HICAP as a model.

National Landscape

Nationally, SHIPs provide their services via counselors – whether paid, volunteer, or provided via in-kind support. SHIP counseling is provided free and confidentially for state residents who are Medicare beneficiaries or their representatives, or who will soon be eligible for Medicare.

States have flexibility to implement SHIPs through an aging agency or department of insurance. These programs may operate with more or less centralization, with the more centralized programs operated by a single state agency, whereas more decentralized programs contract out the operational role to local entities. In some decentralized models, such as California's, these local entities may subcontract with other community-based organizations to serve beneficiaries. A national SHIP Technical Assistance Center evaluation found that there are positives and negatives to the various structures.[i] For example, programs administered by an aging agency excelled at partnership development and use of a broad network to reach targeted populations, while programs administered by insurance agencies seem to excel in areas related to oversight of managed care and inappropriate broker practices.

Key statistics from that evaluation include:

- About two-thirds of SHIPs are administered by state agencies serving seniors and individuals with disabilities while the other one-third of SHIPs are administered by state insurance agencies.[ii]
- Twenty-four (24) SHIP programs self-report as operating under a centralized model (including, Guam, Puerto Rico, and Virgin Islands).
- Thirty (30) SHIP programs self-report as operating under a decentralized model.[iii]
  - Among these, twenty-two (22) SHIP programs self-report that they subcontract to AAAs.

California Landscape

HICAP is administered by the CDA, which contracts with 26 AAAs to provide HICAP services throughout the State. AAAs may provide services directly or by contract with a local nonprofit organization. HICAPs, whether administered by the AAA or local nonprofit organization, are responsible for providing direct assistance to beneficiaries to help them understand how to use their Medicare benefits including Prescription Drug Plan coverage, Medicare Advantage plans, Medicare supplemental policies, Medicare Savings Programs, and long-term care insurance.

The HICAPs in San Mateo, Santa Clara, Orange, Riverside, San Bernardino and San Diego Counties and the City and County of Los Angeles assist dually eligible individuals selected for passive enrollment into California's Financial Alignment Demonstration Program, Cal MediConnect. HICAPs provide counseling to these beneficiaries on their health coverage options under the demonstration program.

California HICAP Technology

Access to HICAP services is facilitated by phone- and internet-based technologies. The primary access point to the 26 local HICAPs is the statewide HICAP toll-free telephone number at 1-800-434-0222. Beneficiaries call in and leave their information on an answering machine for local program staff to triage to determine if the caller needs to make a phone or in-person counseling appointment with a registered HICAP counselor. Program staff may also refer callers to community education events or local counseling sites for more information. If services outside the scope of HICAP are required, the caller is referred to the local AAA. Beneficiaries may find more information on HICAP through the CDA website, including local HICAP sites and services available.[iv]

Reporting and case management is handled through an internet-based system. CDA commissioned PeerPlace Networks to develop the Statewide HICAP Automated Reporting Program (SHARP) as a reporting and case management internet-based system leveraged by the HICAPs, AAAs, and CDA. SHARP has served as the core system for these entities to share data since 2009.

California Funding

HICAP receives funding from three key sources: (1) fees assessed on Medicare Health Care Service Plans deposited in the HICAP Special Fund; (2) reimbursements from the Insurance Fund; and (3) federal SHIP grant funding provided by the Administration for Community Living (ACL). Nationally, California receives more federal SHIP funding than any other state. From April 1, 2019 – March 30, 2020, California received $4,269,535 in federal SHIP dollars while the state with the next highest funding allotment, Florida, received $2,729,528.[v] The basic formula used to determine distribution of funds across HICAP sites is to afford a base amount to all HICAPs and then allocate the remainder of funds based on the number of Medicare beneficiaries in the service area.

Unique Funding Strategy Spotlight: Washington is considering implementing a Limited English Proficiency (LEP) funding determination for counties that have an LEP population of 5% or more (as designated by the Office of Financial Management [OFM]). The calculation is based on the percent each county has of the state's overall LEP population, not the percent of each population that is considered LEP. The proposed allocations under consideration are: 5%-14.99% receive $5,000 annually; 15%-34.99% receive $10,000 annually; and 35% or greater receive $15,000 annually.

STUDY FINDINGS

Support for Medicaid and Dually Eligible Individuals

HICAPs operating in a county with the Cal MediConnect program engage directly with the Managed Care Organizations (MCOs) and more heavily overall on issues related to dually eligible individuals. Of the AAA/HICAP survey respondents conducted as part of this research, 16 collaborate with their local Medi-Cal MCOs and 16 collaborate with Medicare Advantage plans. HICAPs report varying levels of engagement with MCOs ranging from sitting on advisory committees and having quarterly touch bases to simply working with MCOs to resolve specific beneficiary issues.

HICAPs report employing different strategies to support dually eligible individuals. Of the AAA/HICAP survey respondents:

23 provide counseling on D-SNPs[1]

22 provide counseling related to Medi-Cal benefits for dually eligible beneficiaries

8 provide counseling on Cal MediConnect MCOs

25 train counselors how to respond to Medi-Cal questions

25 provide counseling related to Medi-Cal eligibility for dually eligible beneficiaries

Examples of supports offered include: referring clients to key programs and conducting three-way calls with these programs and HICAP counselors on the line; educating clients who are aging in to Medicare with Medi-Cal on how the programs work together; screening and application assistance; providing access to the county Medi-Cal database for status on eligibility and collaboration with Medi-Cal offices or referral of complicated cases to the program's legal department; receiving referrals from Social Services; establishing an internal referral system to share information; developing a working relationship with the local Medi-Cal office; reviewing Medi-Cal topics and watching webinars on dually eligible individuals with counselors during monthly meetings; and sharing building/office space with Medi-Cal staff/offices.

Equity and Accessibility for People with Limited English Proficiency (LEP) and with Disabilities

Stakeholder survey results indicate opportunities to improve HICAP services for individuals with LEP or disability to ensure the program offers these beneficiaries consistent and high quality services. HICAPs reported various approaches to providing accessibility for beneficiaries with LEP. Most HICAPs report leveraging bilingual

1 D-SNPs are Dual Eligible Special Needs Plans, a type of Medicare Advantage plan designed specifically for dually eligible individuals.

counselors to the extent possible but acknowledged bilingual staff are difficult to recruit and retain without competitive salaries. Interpreter lines (such as www.certifiedlanguages.com), county interpreters, handheld translators, and translation services (for American Sign Language) are reportedly used by some programs. Spanish-language materials from the Centers for Medicare & Medicaid Services' (CMS) Medicare materials may be distributed at local resource centers in areas with high numbers of Spanish speaking individuals. Other programs tailor resources to the different local languages and partner with local community agencies serving individuals of various backgrounds (e.g., postcards in Spanish, Chinese, and Korean distributed at food distribution sites serving these populations). One HICAP reportedly has a telephone system with several language voicemail boxes for callers to choose from, and another partners with its local Medi-Cal and Social Security Administration offices and has found it to be an excellent resource to inform and refer consumers to HICAP.

The reported efforts to ensure accessibility for individuals with disabilities was similarly varied across survey respondents. Strategies some HICAPs leverage include: offering phone or video appointments and in some instances, in-home visits; counseling in and setting up HICAP offices in Americans with Disabilities Act (ADA) compliant sites; partnering with local Disability Rights Centers, Braille Institute, Independent Living Centers, and GLAAD (an LGBTQ acceptance organization) to engage clients and staff; offering materials in different sizes, colors, or modes (e.g., braille); offering ADA and 508 compliant websites; offering No Wrong Door approaches or otherwise working to connect individuals with disabilities with appropriate programs and services such as transportation, if needed; and the use of the TTY/Federal Relay Service[2] for individuals who are deaf or deaf/blind to use text-based telecommunications to communicate.

Marketing and Outreach

Nationally, SHIPs take different approaches to ensuring Medicare beneficiaries and other individuals are aware of and can access SHIP services, including renaming the SHIP program and active outreach. SHIP names vary from state-to-state. While many have elected to retain the name SHIP, there are several creative alternatives leveraged as outlined in **Table 1**.[vi] In Alaska, the SHIP changed its name to the Medicare Information Office and found that this approach was helpful to Medicare beneficiaries in understanding the role of the office. The former SHIP Director in Alaska reported that this helped the program be highlighted in Google searches and helped beneficiaries identify what the office did just by looking at the program name in the phone book. A contest among volunteers was used to rename the program.

Table 1. Alternative State SHIP Names

Name	State(s)
Connecticut's Program for Health Insurance Assistance, Outreach, Information and Referral, Counseling, Eligibility Screening (CHOICES)	Connecticut
Community Leaders Assisting the Insured of Missouri (CLAIM)	Missouri
Health Insurance Counseling & Advocacy Program (HICAP) Health Insurance Information Counseling and Assistance Program (HIICAP)	California, Texas New York
Insurance Counseling Assistance and Referrals for Elders (I-CARE)	South Carolina
Medicare Information Office Medicare Assistance Bureau (MAB) Medicare Assistance Program (MAP) Medicare/Medicaid Assistance Program (MAPP)	Alaska Delaware Guam, Oklahoma Michigan
Pennsylvania Medicare Education and Decision Insight (PA MEDI) *	Pennsylvania

Name	State(s)
Senior Health Insurance Benefit Advisors (SHIBA) Senior Health Insurance Benefits Assistance (SHIBA) Statewide Health Insurance Benefits Advisors (SHIBA)	Idaho Oregon Washington
Senior Health Insurance Counseling for Kansas (SHICK) State Health Insurance Counseling (SHIC)	Kansas North Dakota
Serving Health Insurance Needs of Elders (SHINE) Serving Health Insurance Needs of Everyone (SHINE) State Health Information & Insurance Education (SHIINE)	Florida Massachusetts South Dakota
Virginia Insurance Counseling and Assistance Program (VICAP)	Virginia
Virgin Islands State Health Insurance Assistance Program (VISHIP) Vermont State Health Insurance Assistance Program	U.S. Virgin Islands Vermont

**Note that this was recently changed in July 2021 from the prior name – APRISE.*

SHIPs also take a varied approach to marketing and outreach. For instance, while Florida has a decentralized model similar to California that contracts with AAAs to operate its SHIP at the local level, the Florida State Unit on Aging retains a centralized approach to marketing and outreach. To do this, the office dedicates a small portion of funding to support state staff to execute these efforts statewide.

The former SHIP Director of Alaska deployed a hands-on approach to outreach and engagement, including writing an article each year in advance of Medicare open enrollment about the Medicare program and how individuals could contact the SHIP to understand their options. She also worked with organizations such as the Alaska Pharmacists Association to print an article in their newsletter, and offered continuing education to pharmacists and pharmacy techs to refer beneficiaries to SHIP counseling.

HICAP Metrics

Data from this project demonstrate that HICAP is generally well-received. However, other data also suggest the program reaches only a small number of Medicare beneficiaries.

HICAP reached a maximum of 1.08% of Medicare beneficiaries in 2016-17 and a low of 0.85% of Medicare beneficiaries in 2020-21.[vii] When compared with SHIPs in other states, for the 2017 SHIP grant year (April 2017 – March 2018), California was placed in the "fair" category for grantees with penetration rates between 2.81%-3.66%. For context, there were 16 states in the fair or low categories, with 38 states ranking higher in the average, good, or excellent categories.[viii]

In June 2021, this research project distributed a public survey soliciting feedback from California beneficiaries and interested stakeholders related to their experiences with HICAP. Key findings from the resulting data are summarized on the following page. The subsequent page presents **Exhibit 1**, which visualizes how respondents rated their HICAP experiences on a scale of 1 through 5 (with 5 being the most favorable experience rating).

1 | Beneficiary Ratings of their Experience with HICAP (see Exhibit 1)

53% ★★★★★
ranked their experience with HICAP as a 5 out of 5

12% ★★★★★
ranked their experience with HICAP as a 4 out of 5

18% ★★★★★
ranked their experience with HICAP a 3 or lower

2 | Service Delivery Modes

45%
received services in person

45%
received services via telephone[2]

8%
received services via video communication

12%
accessed online resources

3 | Connections to Social Determinants of Health Resources

18% received connections from HICAP to services for themselves or their loved one to benefits or services such as housing, food, or transportation services

4 | Satisfaction with Disability and Language Accommodations

26% were not satisfied with the accommodations they received for a disability or language needs

5 | Beneficiaries Access Points to HICAP

11%
received a referral from their service provider

17%
received a referral from a friend or family member

12%
heard about HICAP from an event

11%
learned about HICAP from an online search

6 | Branding and Name Recognition

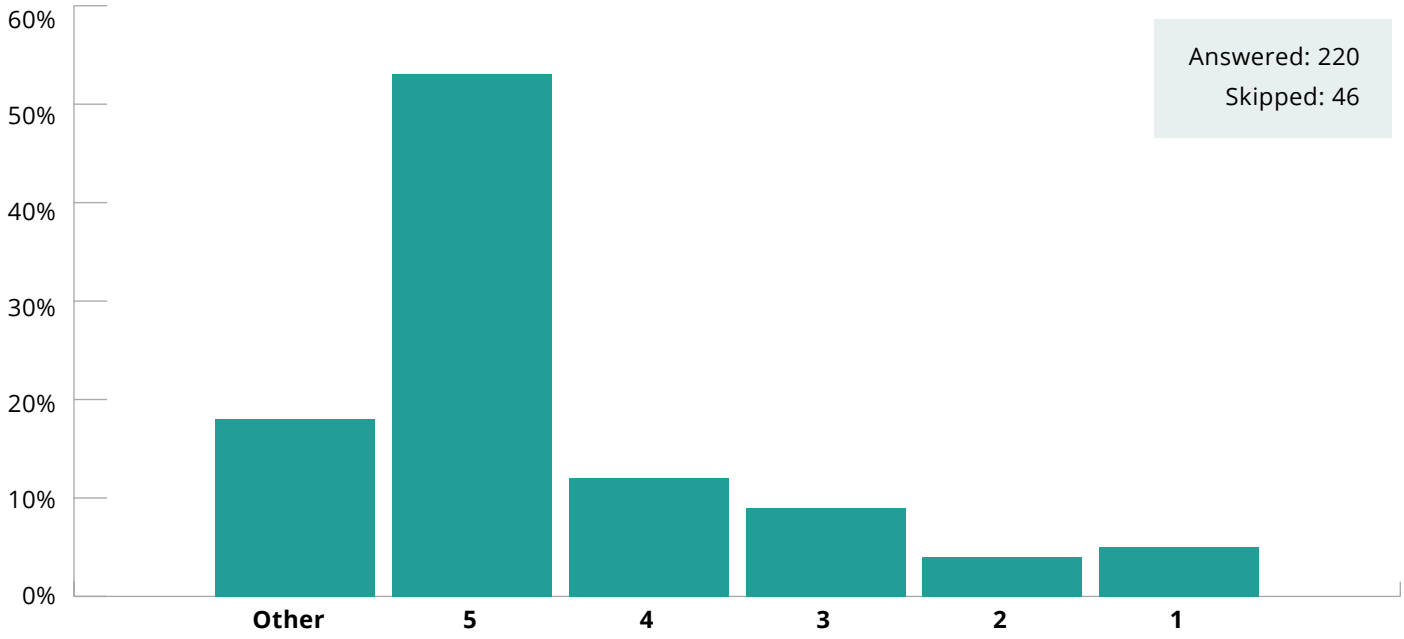
35%
do not feel the HICAP name is recognizable

34%
believe the HICAP name is "somewhat" recognizable

15%
believe the HICAP name is recognizable

2 Service delivery mode response results are not mutually exclusive. Some respondents selected multiple answers such as telephone and in-person.

EXHIBIT 1: BENEFICIARY RATINGS OF THEIR EXPERIENCE WITH HICAP



IDENTIFYING HICAP'S STRENGTHS, WEAKNESSES, OPPORTUNITIES, AND THREATS

This study illuminates strengths, weaknesses, opportunities, and threats (SWOT) present in the existing HICAP. Our findings demonstrate the program has high consumer satisfaction, but there are inconsistencies and reduced impact in a number of areas assessed. Our insights in this SWOT analysis concern both the structure and operation of the current HICAP, and our research sources included all aspects of this project: surveys, literature reviews, and key informant interviews. The analysis covers the full range of perspectives about the program that were reviewed as a part of this research project.

SWOT Analysis

Strengths	Weaknesses
▪ Most of the engaged beneficiaries rank HICAP services received highly. ▪ Delivery of HICAP via local, trusted resources is highly valued. ▪ HICAPs that serve clients via hybrid approaches report that it allows them to better meet the needs of clients. ▪ Cal MediConnect county based HICAPs have some best practices on partnering with integrated health plans and educating individuals on integrated care options. ▪ HICAPs that operate directly from the AAA report close coordination with other AAA services. ▪ HICAPs with stronger volunteer technical support programs report improved retention rates. ▪ Flexibility for HICAPs to tailor their programs to meet the needs of each unique community. ▪ HICAP volunteers are an incredibly valuable element of the program across the state. ▪ Offering direct face-to-face services, in client's languages, to engage hard-to-reach communities is successful. ▪ CDA offered a series of Equity in Aging webinars in 2021 that were well-received and appreciated. ▪ California Health Advocates resources are reportedly very useful for all parties including beneficiaries, stakeholders, and AAAs/HICAPs. ▪ Many HICAP program websites offer beneficiary friendly resources.	▪ The SHARP database needs improvements to make sure data are reported timely to all appropriate parties to ensure oversight and quality improvement. Improvements should include implementation of new measures to improve monitoring and quality improvement, and to streamline the reporting system for HICAPs. ▪ Funding currently does not allow for competitive salaries in many high cost of living locations which leads to high HICAP staff turnover. ▪ Additional funding for another staff member at HICAPs would help improve outreach efforts. ▪ No unified or statewide HICAP marketing strategy currently exists. ▪ Improvements needed on the CDA HICAP website. ▪ Drastic variation across each HICAP website in terms of resources offered and accessibility. ▪ CDA should ensure appropriate lead time is given to programs for the implementation of new requirements and that ample efforts are made to entertain flexibilities for HICAPs to implement new requirements in a way that works best for their program. ▪ Improvements needed in the support offered to HICAPs for technology needs (data) from CDA. ▪ More transparency requested between AAAs/HICAPs and the CDA HICAP team about what they are working on and changes affecting the HICAP operations and staff members. ▪ Reports of inconsistent and not always timely communication between CDA and HICAP program managers including on an ongoing basis and for annual materials (e.g., timely distribution of Counselor Handbooks each year). ▪ Inconsistent training for counselors and supports for clients around Long-Term Care, Long-Term Care Insurance, and LTSS. ▪ Inconsistent access to a hot line manned by live individuals with HICAP training and limited to no access afterhours.

Opportunities	Threats
▪ Support a HICAP-specific technical assistance resource center to support best practice sharing, offer standard training for Program Managers to leverage both for themselves and for their volunteers, serve as a central repository for statewide materials, support continued quality improvement across HICAPs, and increase touch points and relationships between HICAP peers. A mentorship program among Program Managers could be included in this effort. ▪ Strengthen communication and engagement between CDA and HICAPs to support collaborative relationships and earlier resolution of issues. ▪ Strengthen relationships, referrals, and feedback loops with related agencies and organizations. ▪ Have CDA support facilitated introductions between HICAPs and local, state, and federal government agencies that serve mutual clientele. ▪ Build strengths of HICAP counselors to help beneficiaries get the most out of their Medicare Advantage value-added benefits. ▪ Explore rebranding the HICAP name to demonstrate more clearly what the program offers. ▪ Pilot implementation of HICAP workplans with financial incentives to achieve equity goals. ▪ Explore how the 1-800-Medicare contractor and local eligibility workers in the County could network directly to HICAP counselors to eliminate the need for several phone calls. ▪ Evaluate mechanisms to create an intersection between various related phone lines to HICAP, including the Friendship Line and California Aging and Adult Information line. ▪ Recommend expanding accessibility of counseling online and through a "chat" feature or email. For this to happen HICAPs would need financing and technical support for a more secure online portal and software, similar to how CDA provides supports via PeerPlace. ▪ Multiple HICAPs would like to permanently adopt a hybrid service delivery model that includes phone, video, and in-person appointment options. ▪ CDA could advocate with CMS/ACL to allow HICAP access to Part D information on Medicare.gov and figure out how to get AEP MA/PDP data that auto populate printable comparison charts. ▪ Explore connections with providers/hospitals, AmeriCorps VISTA, and UC schools for volunteer capacity building.	▪ Operations vary significantly across HICAP locations. ▪ CDA has minimal control, oversight, and monitoring of HICAP contractors/ subcontractors including minimal authority to implement corrective actions. ▪ Data system, SHARP, is inefficient, and not supportive of modernization efforts. ▪ Lack of public awareness of the HICAP program and what it offers. ▪ Concerns around large portions of HICAP funding going to AAA overhead despite 10% cap. Survey responses on this issue from the AAAs/HICAPs ranged with 11 responses that AAAs retained 10%, one retains 7%, one retains 20%, and one currently retains 2% but is reducing that to 0% next year. ▪ Recruitment, training, development, and retention of paid staff and volunteers poses a significant challenge across HICAPs. Recruiting and retaining staff with specialized skills, including bi-lingual staff poses an additional challenge. ▪ Serving more than one PSA can complicate the HICAP's administrative and financial work, because the AAAs operate so differently from one another. ▪ HICAPs serving multiple counties/PSAs report challenges with distribution of materials and office spaces, coordinating marketing campaigns, time consuming travel times to remote areas, and overall diversity of demographics served and implications of this for needing a diverse set of volunteers, outreach needs, volunteer recruitment and training supports. ▪ Inconsistent training/education for counselors on the range of integrated care options for dually eligible individuals including PACE. ▪ Reports by some individuals of long waits to receive assistance and long waits to receive call backs. ▪ Inadequate continuing education/collaboration supports for HICAP program managers. ▪ Funding streams for HICAPs are on different timelines.

RECOMMENDATIONS TO MODERNIZE HICAP

Modernizing the HICAP will require an ambitious range of efforts to reach more beneficiaries, prioritize addressing equity, and ensure the provision of consistent and culturally appropriate quality services. Recommendations for CDA's consideration are outlined below. These recommendations reflect a wide range of ideas identified through interviews, literature reviews, and the survey results. The ideas presented below are meant to serve as a menu to spur additional conversations among the CDA team to prioritize the areas of greatest importance to HICAP modernization and the recommendations with the greatest viability of implementation. It is important to note that some recommendations below may need statutory authority to implement but were included to provide a full picture of the concepts collected throughout this research.

1 Develop a strategic roadmap for HICAP to include modernizing the organizational culture, mission, and tactics to achieve CDA's equity and accessibility goals for the organization.

This framework should be developed with key stakeholder input and incorporate a cultural shift to have CDA viewed as a partner to offer support to HICAPs to expand beyond the Department's role as a regulator. Another central theme should be to develop a focus as an organization on ensuring diversity in its organizational makeup and equity in the delivery of services.

- To fully realize the goal of promoting a more equitable system and improving accessibility of HICAPs to individuals with disabilities and LEP, CDA should develop a strategy that lays out the various steps required to achieve the most important equity and accessibility goals for the program.
- CDA could require that each HICAP work towards certain performance standards to advance equity and accessibility of their respective marketing campaigns, outreach efforts, and services. This could be implemented via a contract requirement or an optional pilot program that CDA could develop to incentivize HICAPs to make certain key improvements.
- CDA could help HICAPs set standards for each team to strive towards for the diversity of staff and volunteers and consider opportunities to support these goals across the state.
- CDA could offer a statewide language line for all HICAPs to leverage. Currently, HICAPs are required to provide appropriate language services, but there is no specific mandate that a language line be offered and made easily accessible. Providing a centralized resource could ensure equitable access to appropriate language services across the state.
- CDA could consider implementation of performance incentives or withholds to HICAPs for steps to improve upon metrics related to issues identified in Article XX, "Bilingual and Linguistic Program Services Needs Assessments," per Exhibit D-Special Terms and Conditions of the model HICAP contract with CDA. The needs assessment could inform selection of performance goals on which each HICAP must report progress towards achievement.

2 Support the development of a HICAP Technical Assistance Center (TA Center) to provide more robust learning and training opportunities.

A HICAP TA Center would provide new resources that local HICAP sites could leverage to increase capacity and serve more beneficiaries each year. This new resource could be used to develop and offer a California-specific standardized volunteer training that HICAPs may elect to leverage and adapt as needed for use with their volunteers. It could also offer robust HICAP Program Manager and volunteer continuing education and

engagement activities to build on what the CDA team already offers. This change could promote additional consistency across programs, share best practices including on use of technology and outreach to LEP populations, and support ongoing quality improvement activities. This could include development of training and materials for use across HICAPs specifically tailored to serving diverse cultures, individuals with LEP, individuals with disabilities, and individuals in long-term care. Consideration should also be given to potentially supporting the TA Center to serve as a resource for counselors to make referrals for help with specialty issues and challenging cases. There are several potential avenues for consideration to support continuing education, training opportunities, and sharing of best practices across HICAPs.

One HICAP found that most independent living facilities for individuals 55 and older did not have Wi-Fi or their own computer devices.

- The TA Center could convene HICAPs on an, at minimum, quarterly basis to bring Program Managers together in learning collaborative settings. Best practices and creative strategies across many domains should be shared via the learning collaborative structure including volunteer recruitment, retention, and training; relationship building strategies with community partners; marketing and outreach strategies; strategies to address equity; and approaches to serving individuals with LEP and disabilities.
- CDA could also consider additional staffing on the CDA team to promote continuous quality improvement activities. Incremental steps could be implemented within the current CDA team structure to promote these activities, or this function could be delegated as a responsibility of a new TA Center. For instance, a low-lift step to increase shared learning would be to repurpose a portion of every quarterly HICAP Program Manager Forum Call to include an opportunity for 1-2 HICAP Program Managers to share a success or a challenge that the group could learn from.
- The TA Center could offer each HICAP access to models, formats, and resources to leverage to ensure that all HICAP counselors have access to ample continuous education and peer learning opportunities such as monthly webinars and case sharing opportunities. For instance, a structure could be shared to help HICAPs implement approaches for volunteers to talk through different scenarios to support peer learning on how to approach various issues.
- The TA Center might also invest in a learning management system so there is a plan and system to train HICAP counselors that does not exclusively rely on in-person trainings.
- While CDA currently collects work plans from each HICAP, the focus of these work plans is more day-to-day operations and is quite high-level. The TA Center could develop an optional work plan structure that HICAPs would be encouraged to engage in that would be accompanied by additional targeted guidance and support to help each HICAP reach its desired goals as laid out in the work plan. Eventually, this new, more innovation-driven structure could be evaluated to be a mandatory part of the program pending the success of early implementers.
- The TA Center could share best practices to overcome equity issues related to technology. For instance, during the pandemic, one HICAP found that most independent living facilities for individuals 55 and older did not have Wi-Fi or their own computer devices. Without appropriate space or technology to support a group presentation, the HICAP had to support them to do virtual individual counseling sessions.
- The TA Center could share tailored trainings and resources for HICAPs to support the provision of customized counseling to individuals with certain issues, such as best practices in helping individuals

of different cultural or ethnic backgrounds, or individuals with mental health conditions. This is likely happening today to varying degrees across HICAPs, but it would be good to provide a base level for all programs through the TA Center. The HICAP of San Mateo for instance engages National Alliance on Mental Illness (NAMI), and mental health office staff to help develop tailored information for individuals with mental health issues. CDA used to have a mental health specialist on staff and has engaged with NAMI as well.

- CDA could add a recommendation in its program manual that each HICAP implement a mentoring program among volunteer counselors that could help with volunteer retention and continuing education. Such peer learning models could also be supported by sharing of best practices from the TA Center.

3 Evaluate rebranding HICAP.

Conduct a targeted stakeholder outreach to confirm the decision to rebrand the HICAP name, consider systemic costs to rebranding, and determine next steps to roll out a rebranding initiative. Of the stakeholder survey respondents, 35% do not feel the HICAP name is recognizable, 34% believe the HICAP name is "somewhat" recognizable, and only 15% believe that the HICAP name is recognizable. The anecdotal feedback during interviews provided a mixed perspective on changing the HICAP name but leaned more towards exploring a change.

- Consider engaging the volunteers to help explore new name options to promote their buy-in.
- Note that the former SHIP Director in Alaska claimed significant benefits to changing the state's SHIP name to the Medicare Information Office. The Alaska state office determined the new brand via a naming competition among its volunteers. Other research conducted as a part of this project indicates that many states have elected to take on names that better reflect the specifics of what the program offers.

4 Implement two annual statewide CDA-driven marketing campaigns and evaluate opportunities for other statewide marketing supports.

Engage HICAP Program Managers, Medicare beneficiaries, and other key stakeholders such as DHCS, Justice in Aging, and CHA, to inform development of a statewide marketing campaign to increase the number of volunteers and then a subsequent campaign to increase the number of beneficiaries accessing HICAP.

- The first portion of this marketing campaign should focus on building capacity through encouraging volunteers to engage and support their local HICAPs as counselors. The second portion of this campaign should roll out a few months afterwards and strive to build awareness and education about HICAP offerings. Within this campaign, there should be a specific focus on recruiting volunteers that meet that diversity needs of beneficiaries and reaching a diverse group of beneficiaries including those with LEP and individuals with disabilities. Direct mail postcards to LEP and low-income households, and Spanish radio talk show advertisements have shown success in engaging hard-to locate populations in other state programs. Campaigns should highlight the core selling points that HICAPs are local, trusted, experienced, and unbiased. AAAs could potentially pool money to support a statewide effort while retaining a portion of their overall marketing allotment for local campaigns.
- Consider contracting with an entity, perhaps through the TA Center, to help the HICAPs train staff to improve their social media usage to reach hard-to-locate populations and otherwise expand outreach to potential volunteers and beneficiaries. This should include leveraging social media to celebrate and provide recognition to volunteers and staff to support retention. While such support has been offered intermittently, a steadier stream of support for HICAPs is recommended. This could be done in a few ways such as a

mentorship program across Program Managers with strong capabilities in this area, or via the TA Center.

- Produce CDA-developed YouTube videos for all HICAPs to leverage, if desired, to assist in volunteer recruitment and general understanding of what HICAPs can offer beneficiaries. Currently, there are a few HICAPs that appear to leverage YouTube (e.g., Council on Aging Southern California has several videos) but this practice is not widespread, and a generic California model could help all programs offer a quick video on their websites for an easy, accessible overview of the program.
- Train HICAP Program Managers to leverage informal Medicare Liaison partners. The TA Center could help facilitate the sharing of this best practice for HICAP program managers to consider building in their local regions. These positions would be volunteer opportunities for individuals who want to help people but do not want to become certified counselors. These Liaisons could be instrumental in helping connect and refer beneficiaries to HICAP. Ohio and Alaska each employ this model. In Alaska, the former SHIP Director reported that she would check in with these Medicare liaisons quarterly and supply them with magnets, business cards, and materials for them to distribute to community members to help spread the word about SHIP. In this instance, she had Liaisons in tribal communities, and engaged a range of individuals including pilots, tax attorneys, village health aides, and gas station attendants. Relationship building with the village health aides ensured they would display a SHIP magnet[3] on their filing cabinet behind the desk when they met with clients, and always mention SHIP whenever Medicare was raised in conversations with beneficiaries.
- CDA could offer minimal additional funding to select HICAPs to pilot new approaches to outreach and engagement with hard-to-reach populations. The program could be modeled after the National Council on Aging's efforts to expand the reach of Benefits Enrollment Centers in which it supports programs to build their capacity and then synthesize and share learnings as tips for other similar programs.
- Provide additional supports to HICAP Program Managers to learn from one another regarding their outreach efforts to low-income beneficiaries through creative community-based organization partnerships. CDA, or its HICAP Technical Assistance Center, could conduct a scan of how various outreach programs engage hard-to-locate beneficiaries and share those practices across programs. Multiple SHIPs for instance have stated they have experienced great success with partnerships with food banks to have them include SHIP and Low Income Subsidy (LIS) materials, often in various languages depending on the community, in each food box they distribute. Ensuring this is a widespread practice across California HICAPs would help expand outreach into vulnerable communities.

Multiple SHIPs have stated they have experienced great success with partnerships with food banks to have them include SHIP and LIS materials.

5 Redesign the CDA HICAP website.

An extensive rework of the CDA HICAP site should be informed by national best practices, other state models, learnings from Covered California, as well as California stakeholder and HICAP Program Manager input. Consideration should be given to a realistic timeline for when CDA will complete a potential rebranding exercise and what improvements could be made to the CDA HICAP website in the meantime to improve accessibility

3 Funding for items such as the SHIP magnet used by the Alaska SHIP program would have to come from local HICAP dollars per rules in California on expenditures.

- Revamp the CDA HICAP website and connections to other programs and related sites. A more detailed assessment of how the CDA HICAP website compares to five other state SHIP programs' websites can be found in Appendix A. Included in the CDA HICAP website rework should be the addition of:
    i. An overview of how HICAP is funded, its mission, and impact to level-set users on what HICAP does and why it operates neutrally and at no cost to the client.
    ii. An online access point to request assistance should be explored (see Tennessee's example).
    iii. A section that clearly outlines volunteer opportunities, how to get involved, features a story of a volunteer, and provides easy links to get engaged.
    iv. A video that features HICAP volunteers and clearly outlines the services of HICAP. (See Washington's example). Key tutorials should be included in these videos such as an overview of how individuals can set up their MyMedicare account online to facilitate more individuals doing so on their own. Culturally tailored training and videos could also be developed to be leveraged across HICAPs. Note that Council on Aging Southern California has a few good YouTube videos that could be leveraged/are great examples in CA (click here).
    v. A comprehensive and easy to navigate list of resources to complementary and related supports, such as myCaremyChoice and BenefitsCheckUp.
- As a part of the process to consider how the website should be reworked, recommendations should be made to the CDA Information Technology team around key metrics that it should begin collecting and reporting to the CDA HICAP team such as reporting monthly how many visitors they get to the HICAP site and engagement with various resources. This data should be tracked over time and used to help evaluate any new CDA marketing campaigns it might implement for the HICAP program statewide.

6 Make improvements to the SHARP data system.

Engage HICAP Program Managers in a series of forums to solicit their input on key features needed to improve the SHARP data system and additional metrics to use to better oversee the program and encourage performance improvement. Improved data capabilities will be critical to measuring achievement of CDA's equity and broader HICAP Modernization goals. Additional data insights could also be leveraged to inform advanced marketing and outreach strategies. After a strategic plan is developed to outline the data system and metric changes required, CDA would need to engage external IT support to implement enhancements to the SHARP data system. The strategic plan should outline improvements for three purposes: i) Improve internal access and utilization features for simple oversight and internal reporting; ii) Improve data fields and expand measures; and iii) Expand access to sister agencies to enable a closed loop referral system.

- Exploration of an opportunity to implement a robust customer relationship management (CRM) system that incorporates scheduling systems, better analytics, and seamless reporting tools would be helpful as well.
- Expand assessment questions to include capturing any referrals made to other departments or programs. To make this addition within the current SHARP data system, funding would be required to make the technological additions and roll out training to staff. There are mandatory fields and leading questions to assist counselors in conducting their sessions with beneficiaries, but the form utilized by HICAP counselors is largely driven the requirements set by ACL.

7 Explore opportunities to increase monitoring and oversight of AAAs and subcontractors.

Improving CDA's monitoring and oversight of AAAs and their subcontractors will be largely contingent on refinements to the SHARP data system. However, there are certain avenues that CDA might explore to otherwise increase monitoring and oversight.

- Develop and implement additional contract requirements to promote consistency, equity, oversight, and impact of HICAPs statewide.
  i. Request contracted entities share copies of subcontracts, memorandums/letters of understanding with CDA for CDA to do a thorough review and analysis of necessary changes to require across subcontracted agreements. (Allowed per Exhibit A. "Scope of Work" Contract section Article V. SUBCONTRACTs, E).
  ii. Build out Exhibit A. "Scope of Work" Contract section Article II, T regarding subcontracted services. This section should be reviewed by a HICAP Key Stakeholder Advisory committee to inform strengthening oversight and operations of subcontracted HICAPs.
  iii. Require HICAP entities to include certain key HICAP resources and information on their websites.
    - Subcontracted entities should feature HICAP as a key service on the landing page of their websites. Each entity should offer a certain baseline of accessible resources and materials on their site. There is currently drastic variation across sites, from easy to read and digest Medicare Advantage and Dual Eligible Special Needs Plan (D-SNP) comparisons accessible on Kern County Aging and Adult Services' website, to very minimal resources on Merced County AAA's site regarding Understanding your Medicare Benefits and COVID-19.
    - Each website should include multiple avenues to contact and engage with HICAP, either to receive services or learn more and sign up to volunteer.
    - For instance, Self-Help for the Elderly is a widely recognized organization administering HICAP. However, if you scroll down on their homepage, of the six core services highlighted, HICAP is not one of them. Users must navigate to a separate menu at the top of the page to identify HICAP as a program. Note that there is no context given next to the name, so unless an individual knows what HICAP is, they will not know to click to learn more about Medicare counseling.
  iv. Require HICAPs to report to CDA on specifics of marketing campaigns to provide greater insight into current practices and to identify opportunities for sharing of best practices across programs. Currently, CDA only receives high-level information on events but does not have visibility into the specifics of each HICAPs' marketing budget, marketing plans, or what is executed upon.
  v. Require HICAPs to provide a direct feedback loop to CDA during emergencies regarding what issues they are hearing from beneficiaries to inform potential response efforts or planning efforts for better future responses.
- Implement a new oversight policy to increase CDA's insight into AAA and HICAP expenditures and timelines for subcontract execution.

CDA currently has no visibility into when contracts are executed with direct service providers to ensure timeliness.

Currently, there is limited oversight except for a monitoring exercise CDA conducts once every four years to cite and document compliance issues. For AAAs that subcontract, CDA only has access to a high-level budget and cannot currently analyze actual costs and expenditures. Some PSAs struggle with executing subcontracts timely for various reasons and CDA currently has no visibility into when contracts are executed with direct service providers to ensure timeliness. There are risks with both the minimal current oversight of AAAs and of the subcontracted entities operating HICAPs that should be addressed to improve consistency and reduce unequitable variations in program structures and resulting community impact. For instance, there was an anecdotal report that one AAA retains 40% of the funding for its HICAP, despite the 10% cap on overhead expenses.[4] One survey response also indicated that a AAA retains 20% of funds for administrative expenses. This is at the same time as another county's AAA can manage to give 100% of funding directly to its subcontractor to operate the HICAP.

- Implement a form of monitoring at least quarterly and include measures to gauge quality and equity improvements that provides HICAPs with constructive feedback to make measurable changes. Currently, CDA prepares semi-annual progress reports to ACL that captures what the HICAPs are doing with the contract funding to meet expectations of the federal grant. Limited other monitoring occurs throughout the year such as checking-in on hours and requirements regarding staff meeting and volunteer registrations. A full monitoring review is currently conducted by CDA for each HICAP once every four years.
- A thorough national scan and targeted stakeholder engagement could be solicited to determine appropriate evaluation metrics that go beyond simply measuring performance data and begin to collect outcomes data.

8 Develop a strategic roadmap of how HICAPs will support dually eligible individuals moving forward, including counseling on D-SNPs, PACE, and overall, integrated care.

HICAPs can engage with DHCS around Medicaid Managed Long Term Services and Supports (MLTSS), D-SNPs, Cal MediConnect, and overall integrated care programs for dually eligible beneficiaries in a variety of ways. Some roles HICAPs may play include: i) Counseling beneficiaries on new enrollment options; ii) Understanding MLTSS/D-SNP enrollment processes and potential for alignment; and iii) Offering feedback on enrollment materials. There are a variety of steps that could be taken to support next steps for HICAP modernization as it relates to serving individuals who are dually eligible for Medicare and Medicaid.

- Development of a roadmap for how HICAP should approach serving dually eligible individuals, it would best be done in collaboration with DHCS, including Office of Medicare Innovation and Integration (OMMI), and CDA's HICAP team with some stakeholder input. This position should include a clear outline of the exact expectations for counselors in relationship to provision of education to dually eligible individuals. Use this philosophy to inform targeted trainings to HICAP counselors regarding the considerations for counseling dually eligible beneficiaries on integrated care model options. Ensure training and education of counselors helps them understand that for dually eligible individuals, counseling needs to not just help beneficiaries compare their monthly premiums, costs, network providers, and extra benefits; but also learn to identify and educate individuals on the opportunity to receive care coordination and care management support for those with extra needs that could benefit significantly from D-SNPs' model of care and aligned enrollment in a single Medi-Cal MCO/D-SNP.

4 Note that this information came from an interview and could not be verified. While CDA conducts bi-annual audits that should capture this information, the audits have not indicated that AAAs are retaining more than the 10% for overhead.

- Further develop the relationship between CDA's HICAP team and DHCS.
  i. While the two teams have recently begun bi-weekly touch points, ensuring those meetings continue and that CDA actively engages in DHCS' California Advancing and Innovating Medi-Cal (CalAIM) workgroup meetings will enhance CDA's advocacy in issues related to dually eligible individuals and bi-directional information sharing. A formal workstream should be created to ensure information flows from DHCS, to CDA and down to the HICAPs and volunteers of upcoming Medicaid policy changes. As DHCS builds out its Office of Medicare Innovation and Integration, it will also present additional opportunities for DHCS to collaborate with CDA and learn from its teams' expertise on Medicare Advantage, D-SNPs, and Medicare.
  ii. Work with DHCS to: a) Consider the value of naming the D-SNP/aligned MLTSS program to provide a unified "sales pitch" on what members get from being in any aligned plan within the "program"; and b) explore implementing certain requirements in D-SNP state Medicaid agency contracts that mandates D-SNPs: i) educate their staff about HICAP services at a minimum; ii) promote HICAPs as a trusted resource; and iii) offer a dedicated telephone line for HICAPs to use to connect with the plan. Could explore the viability of requiring that D-SNPs offer training or certain materials to support HICAPs engage around D-SNPs.
  iii. CDA has begun this effort and should continue to strategically explore opportunities to maximize collaboration and coordination between DHCS' Medi-Medi Navigator program and HICAPs. A brief review should be conducted to: i) Identify any overlap between nonprofits/CBOs operating both programs; ii) Solicit best practices from Medi-Medi Navigator programs in outreach and engagement of beneficiaries to share with HICAPs; and iii) Identify opportunities for referrals or cross-marketing and outreach.
- Build relationships with Medi-Cal Health Plans and D-SNPs. CDA's HICAP team and the various HICAP programs could benefit from building relationships with both Medi-Cal MCOs and D-SNPs. Building these relationships will help facilitate shared learning, identify opportunities for HICAP programs to leverage MCO resources and for MCOs to support HICAP efforts, and create better linkages for problem resolution. San Mateo HICAP has built a strong relationship with their County Organized Health System (COHS), Health Plan of San Mateo (HPSM), through inclusion of HPSM on the HICAP's advisory committee it has been leading with community stakeholders since 2009. The relationship led to HPSM offering to help San Mateo HICAP fill a need by writing the HICAP into HPSM's translation services through a Memorandum of Understanding agreement to share access to this critical resource line. The HICAP program manager sits on the CCI – CareAdvantage Cal MediConnect (CMC) Advisory Committee that provides updates and changes about the plan to their committee members. The Advisory Committee meets quarterly and has allowed the HICAP Program Manager to provide input and feedback about the plan, Medicare and HICAP updates and complaints from duals.
- Consider establishing a regular meeting between CDA's HICAP team, DHCS, D-SNP staff, and appropriate other entities related to CalAIM (e.g., for the CMC program, this is currently the Health Consumer Alliance; Medi-Medi Navigator program staff may be engaged as well). These meetings should begin well before CalAIM launches and continue throughout launch and ongoing operations of CalAIM to work through potential issues collaboratively and promote identification and spread of best practices and innovations. The Ohio SHIP established monthly meetings with its LTC Ombudsman and each MyCare Ohio plan (duals demonstration) that has been successful in mitigating concerns and coming up with solutions collectively throughout the course of the duals demonstration.
- Consider implementation of a risk mitigation strategy with the launch of CalAIM either through the addition of a specialty resource team at CDA or via the TA Center. This should include a baseline training for all counselors on CalAIM, dually eligible individuals, Medicaid, D-SNPs, default enrollment, and the benefits of aligned Medicare and Medicaid enrollment for dually eligible individuals. This risk mitigation strategy should also include a process for escalating higher-level questions.

- Coordinated Care Initiative (CCI) counties have been receiving financial alignment grants that have proven helpful in allowing participating HICAPs to rise to the challenge of supporting dually eligible individuals with additional counseling needed around the Cal MediConnect (CMC) demonstration. As the CMC comes to an end, a similar grant structure should be evaluated and implemented to support HICAPs to take on the additional capacity building and workload necessary to support the transition from the CMC program to the D-SNP/aligned MLTSS plan structure.
- Design tailored trainings/supports to enhance HICAP counselors' abilities to counsel dually eligible individuals on how to get the most out of their supplemental benefits. Dually eligible individuals require additional support and education when they enroll in a new D-SNP to understand how to maximize the value that the plan can offer to them. HICAP counselors can play a key role in helping individuals understand what these plans can offer and how to access the full scope of available benefits.

Covered California Help Center had a total of 5,317 unique calls and emails related to Medicare between January 1, 2019 and June 25, 2021.

- The mycaremychoice.org tool is a website meant to help Californians with Medicare and Medi-Cal understand their coverage options and make the best choice based on their unique needs. CDA should ensure all HICAP counselors are trained on how to use and have easy access to the website to help dually eligible individuals navigate and understand their care options.[ix]

9 Strengthen relationships, referrals, and feedback loops with related agencies and organizations.

CDA should do a systematic review of key aligned organizations, entities, and departments to set up formal touch points with on a regular basis. Key organizations and departments to focus on include the Social Security Administration, DHCS, California Department of Insurance (CDI), Office of the Patient Advocate, Department of Managed Health Care (DMHC), Department of Public Health, and Covered California. There should be an initial kick off meeting with each of these entities to establish relationships and expectations, and to ensure referral and collaboration opportunities are being maximized.

- Set up regular touch points between CDA's HICAP team and key state agencies/departments. At the kickoff for each conversation, an exploration of how each agency can better collaborate to support Medicare and Long-Term Care beneficiaries should be reviewed. Currently, except for recently established bi-weekly meetings with the DHCS team, CDA's primary points of contact with CDI and DMHC include invitations to the two agencies to present at HICAP trainings. A touch point between CDA and CDI could help ensure HICAPs receive access to critical technical information.
    i. There is an opportunity for CDA and its partner agencies to review how various touch points with beneficiaries can be tracked and potentially better coordinated. For instance, DMHC's Help Center had a total of 5,317 unique calls and emails related to Medicare between January 1, 2019 and June 25, 2021. Of these, 2,110 were referred to CMS; 1,810 were referred to HICAP; and 1,401 were referred to other entities. The extent to which other Department's call centers refer to HICAPs should be further explored. Opportunities to improve warm handoffs and ensure whole-person services are being delivered would be ideal.

ii. Currently, Covered California sends notices to beneficiaries they have touch points with who may qualify for Medicare. Both versions of these notices refer individuals to contact HICAP and were made in collaboration with the CDA HICAP team.

- Engage the Public Health Department to explore opportunities for HICAPs and the State Department of Public Health and/or local public health departments to collaborate to better identify and outreach to hard-to-locate beneficiaries.
- Make connections with the Ryan White HIV/AIDS program. The Iowa SHIP works with the Ryan White HIV/AIDS program to assist patients understand the best Part D coverage options for their unique needs. In Iowa, staff at five Ryan White HIV/AIDS program locations were trained as SHIP counselors to facilitate engagement with this population.[x]
- While this already occurs to a certain extent, the TA Center or CDA team could expand on existing efforts to offer additional guidelines, recommendations, or model resources (e.g., handouts or slide decks) for HICAPs to leverage to support volunteers' efforts to connect beneficiaries to the bevy of potential resources that are available to help them manage diverse social and health-related needs (e.g., SNAP, Benefits Enrollment Centers, Benefits Check Up).
- While certain HICAPs already engage with the Health Consumer Alliance, a strategic effort either through CDA or the TA Center should be considered to encourage more HICAPs statewide to create bi-directional referrals between Health Consumer Alliance and HICAP. The Health Consumer Alliance is dedicated to helping Californian's access health care and while their focus is more on Medi-Cal and Covered California, there is no mention or referral to HICAP on their website if individuals might be eligible for Medicare.[xi]

10 Reevaluate the current formula used to distribute funds to HICAPs.

The CDA is actively engaged in conversations today to explore opportunities to modernize the current parameters used to distribute HICAP funds. Building on the existing work being done, there are a few opportunities CDA could explore to supports its overall HICAP modernization goals.

- While ensuring a base rate goes to all HICAP locations and considering the likely volume of beneficiaries served are two important considerations that CDA should continue to consider when distributing dollars, other factors could be evaluated as well. This is important for a variety of reasons including accounting for higher cost of living in certain locations and implications for recruiting and retaining staff. It could also be important to evaluate how funds could be better distributed to support core outreach and equity-related initiatives in areas with higher distribution of individuals with LEP or other special needs.
- CDA could evaluate the development and piloting of an upside-only performance-based incentive or other alternative funding structure. It could leverage a small portion of existing funds or potentially a small portion of one-time funding to support this effort. The model should be carefully developed with stakeholder input to ensure equitable accessibility to HICAPs with varied existing resources that might impact their ability to participate. While implementing a total revamp of the funding structure to HICAPs based on performance is not immediately recommended, CDA may consider incorporating performance-based incentives into the funding structure to encourage HICAPs to make strides in certain areas (e.g., equity goals). For instance, Washington's SHIBA program is implementing a new, workplan-based funding structure and writing in various diversity requirements to promote efforts to create a more representative workforce and volunteer base.
- Access to technology to support secure counseling in the field is critical. Considerations should be given to ensure HICAP funding is sufficient to support access to secure technology for counselors. This includes subscriptions for HICAPs to leverage technology such as Zoom and Canva.

APPENDIX A. WEBSITE MARKETING ASSESSMENT OF NAVIGATION & STRUCTURE

	Website Marketing Assessment of Navigation & Structure	Organizational Structure[xii]
California HICAP	**Strengths** ▪ Both a strength and a weakness is that when searching for HICAP services in a particular county, the user is linked to a page that helps them consider other services available (e.g., meals). While this is important to help connect individuals to broader support services, it misses the intent of the search for Medicare Counseling. **Opportunities** *Searching for HICAP* ▪ The first three resources found after Googling for "HICAP" leads you to California Health Advocates. The fourth option brings you to the HICAP page on CDA's website. ▪ The hicap.org website is owned by the HICAP of San Francisco. *CDA HICAP Page* ▪ The "How to Find Services in My Area" section's link to learn more about Medicare brings you to a "Healthcare" page with additional links that is not easy to navigate or help individuals find what they need. ▪ The "How to Find Services in My Area" section's link to "Find Services in My County page" brings the searcher to a map which is easy to navigate, but then when you click on your location, it brings you to a full listing of services, in which the user has to navigate around the page to find HICAP. If the user does know to scroll down to find HICAP specific services, the links to the various local HICAPs are sometimes broken (e.g., psa2 is broken), don't mention HICAP as a service offered (e.g., San Mateo County AAA) or the local site's page doesn't clearly articulate HICAP services or use the HICAP name (e.g., Center for Health Care Rights in LA County). ▪ As a referral only line, the HICAP number provided on the CDA website provides no opportunity for direct contact to a live person with potential for great loss to follow up. At a minimum, a note alerting individuals that this is a line to receive a call back only should be added to the site. ▪ The home page on CDA's website for HICAP does not clarify that family members or caregivers can receive counseling under "Who Can Get These Services". ▪ Could direct readers to 211 to help support connections to housing, food, and other supports.	▪ Aging Agency ▪ 155 paid staff; 14-in-kind.[5] ▪ Decentralized model ▪ Subcontract with AAAs

5 Note: Staffing levels are from a NASUAD 2013 resource but provided for reference as it relates to how CA compares to the other states' in terms of size and scope.

	Website Marketing Assessment of Navigation & Structure	Organizational Structure[xii]
	CDA Home Page ▪ Users must scroll down half of the page to find anything about "Individuals and Families". There is no main tab at the top that speaks directly to Individuals and Families. Ideally, there would be an – "I'm seeking services" tab or button front and center on the landing page at the top. Recommendation: Add a consumer tab that then links to all of the "How Do I?" features and other pertinent sections for consumers. ▪ If you click on "Helpful Tools & Tips" and then "Healthcare", it lists out four bullets. The Medicare link brings you directly to CMS' Medicare homepage, it should bring you to HICAP, or perhaps have an option to allow individuals to choose their path to learning more.	
Idaho **SHIBA**	**Strengths** ▪ There are easy to navigate "New to Medicare?" pages that include basics on premiums and risks of not signing up for Part B and D when an individual first becomes eligible. ▪ Provides quick links to find and compare up-to-date Medigap standard rates across the state by category (smoker/age range). ▪ There is a central location off the homepage for individuals to sign up to be a volunteer and learn more.	▪ Insurance Agency ▪ Staff unknown ▪ Centralized model ▪ 10 full time staff
Florida **SHINE**	**Strengths** ▪ There is a standalone website dedicated to the SHIP. ▪ There is an easy to access, up-to-date calendar of upcoming "Virtual Medicare Classes" front and center on home page which is very easy to find and access. ▪ Links are provided to SHINE's Facebook page. ▪ Steps to become a volunteer and benefits to becoming a volunteer are centrally featured on the homepage. ▪ Volunteer celebration/recognition are featured centrally. ▪ Links from the homepage easily navigate the user to pages with links to all counties across the state to find up-to-date listings of upcoming events and contact information for local counseling site options. ▪ The resources link off the homepage clearly navigates you to up-to-date links learn more about: Medicare, Prescription Drug Assistance, Financial Assistance Programs, Long-Term Care Resources, Senior Medicare Patrol (SMP) Resources, Disability, Social Security, Military, and Federal and State Agencies. ▪ A link from the homepage easily navigates you to a page dedicated to Volunteers. Links you to volunteer benefits, volunteer of the year awards, how to get started, featured volunteer, and an application to become a volunteer. Subsequent links give you access to different job descriptions and greater detail readily available to help you evaluate and understand the opportunity to volunteer.	▪ Aging Agency ▪ 11 full time staff, 5 part-time ▪ Decentralized model ▪ Subcontracts with AAAs

	Website Marketing Assessment of Navigation & Structure	Organizational Structure[xii]
Ohio **OSHIIP**	**Strengths** ▪ OSHIIP homepage, located within the Department of Insurance website, provides four drop down menus to learn more about: OSHIIP History; Free Services; Speakers Bureau; OSHIIP Volunteer Information; and Medicare Information and Publications. ▪ While there is not extensive information provided (no tailored information for those wanting to learn more on their own), the information is clear and concise and easy to navigate to know where to go to find more information.	▪ Insurance Agency ▪ Staff unknown ▪ Centralized model
Washington **SHIBA**	**Strengths** ▪ Very simple, direct website structure and explanations of supports offered. ▪ Includes a video featuring SHIBA volunteers that helps promote volunteering and the program itself. ▪ Under the "Become a SHIBA Volunteer" page, there is a very clear, easy to follow outline of why someone might want to volunteer and how SHIBA volunteers help the community. There are also three specific links to videos with transcripts of interviews with volunteers.	▪ Department of Insurance ▪ Decentralized model ▪ Subcontract with AAAs ▪ 14 full time state staff ▪ Each of the 20 entities has a FT volunteer coordinator. Subgrantees are expected to provide in kind services.
Wisconsin **SHIP**	**Strengths** ▪ Provides a two page overview on the impact of the SHIP in Wisconsin which is helpful for researchers, policy makers, and community partners, but could also be helpful to demonstrate to potential beneficiaries the scope of involvement of the program in their communities. ▪ Because of the nature of how Wisconsin's program is designed, it is operated primarily by staff who are specialists in their respective areas, so from a positive perspective, this can improve immediate access to specialized services. This model however, may be challenging for some to navigate or know where to start.	▪ Aging Agency ▪ 144 full time staff, 30-50 part time ▪ Decentralized model ▪ Subcontract with AAAs

ENDNOTES

i As reported by the SHIP TA Center staff during an interview conducted on 6.29.21.

ii NASUAD. State Health Insurance Programs. February 2013. Available at: http://www.advancingstates.org/documentation/Surveys/SHIP%20Staffing%20and%20Volunteer%20Levels.pdf

iii SHIP TA Center Portal. SHIP Profiles and Practices. Accessed 7.21.21.

iv CDA HICAP website. Available at: https://aging.ca.gov/Programs_and_Services/Medicare_Counseling/

v https://acl.gov/sites/default/files/programs/2019-06/SHIP%20Funding%20revised.pdf

vi SHIP Program Contact Information. Available at: https://www.tn.gov/content/dam/tn/aging/documents/SHIP_National_Contact_Info.pdf

vii Budget Change Proposal Cover. DF-46 (Rev 02/20). Budget Request Name 4170-033-BCP-2021-A1. Health Insurance Counseling and Advocacy Program Modernization.

viii ACL. State Health Insurance Assistance Program (SHIP) Report to Congress GY 2017. Available at: https://acl.gov/sites/default/files/programs/2021-03/38BState%20Health%20Insurance%20Assistance%20Program%20%28SHIP%29.pdf

ix myCaremyChoice. Available at: https://www.mycaremychoice.org/en

x ACL. State Health Insurance Assistance Program (SHIP) Report to Congress GY 2017. Available at: https://acl.gov/sites/default/files/programs/2021-03/38BState%20Health%20Insurance%20Assistance%20Program%20%28SHIP%29.pdf

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ATI ADVISORY
IDEAS TO ACTION IN HEALTHCARE & AGING

ATI Advisory (ATI) is a research and advisory services firm changing how businesses, communities, and public programs serve frail older adults. We provide insight backed up by original research, delivering practical solutions for our clients and the families they serve. Our founder, Anne Tumlinson is an influential voice among healthcare leaders working to transform how care is delivered and financed in this country.