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POLICY NOTE

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# Successful Strategies for Increasing Enrollment in California's Low Income Health Program (LIHP)

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# Executive Summary

More than 400,000 Californians had ever enrolled in California's Low Income Health Program (LIHP) as of March 2012. These LIHP enrollees, who would otherwise be underinsured or uninsured, now have access to services through their county's safety net facilities and contracted providers. This policy note highlights innovative and successful strategies for outreach, enrollment, and redetermination and retention, as well as the challenges faced by LIHPs.

## Innovative Outreach Strategies

- Partnering with service providers, county-based organizations, and advocacy groups.
  - Service providers are the most commonly used channel for in-reach and outreach, as reported by 14 LIHPs.
  - Advocacy groups play a key role in reaching the targeted population due to their established relationships with users who might not otherwise be exposed to the program, as reported by 7 LIHPs.
- Utilizing information technology (IT) systems to train workers for outreach and to help identify eligible individuals in other public programs.

## Effective Enrollment Strategies

- LIHPs take applications and process enrollment at an array of sites; however, the most commonly used type of site was health and social service agencies. Another effective method was to streamline screening and enrollment processes: for instance, facilitating data entry of applicants' information using kiosk systems.
- Placing outreach and eligibility workers in high-volume service provider locations.
- Verifying documentation using available information systems.

## Successful Retention and Redetermination Methods

- Mailing of notifications and prepopulated applications to redetermine and renew enrollees.
- Web-based renewal options that allow clients to renew via the Internet.

This policy note documents how LIHPs have identified and implemented innovative strategies to mitigate the challenges they have encountered. LIHPs have developed customized approaches to dealing with problems reported by clinics, public agencies, and enrollees, with the goal of improving the enrollment and redetermination processes. While LIHPs continue to face challenges, efforts to improve outreach, enrollment, and retention and redetermination continue. The efforts made by LIHPs can better prepare counties for the full implementation of the Affordable Care Act (ACA) in 2014.

# Background

California's Low Income Health Program (LIHP), known as California's "Bridge to Reform" §1115 Medicaid Waiver, is an optional program established at the local level that offers health care coverage to low-income adults. LIHPs receive 50 percent federal financial participation (FFP) funds due to the waiver administered by California's Department of Health Care Services (DHCS). To be eligible for LIHP, individuals must be U.S. citizens or have satisfactory immigration status, be between the ages of 19 and 64, have incomes less than 200% of the federal poverty level (FPL), and not be eligible for Medicaid programs. LIHP includes two components, distinguished by family income eligibility levels: Medicaid Coverage Expansion (MCE) for those living at or below 133% FPL, and Health Care Coverage Initiative (HCCI) for those living above 133% through 200% FPL. LIHP builds upon the previous Health Care Coverage Initiative demonstration waiver program operated by the 10 legacy counties to provide a statewide expansion of health care coverage in the counties that opt to participate.

Counties and other governmental entities are implementing LIHP through a staggered process that began in the 10 legacy counties in July 2011. "Governmental entities" refers to the County Medical Services Program (CMSP), which is a consortium of 35 counties. In addition, health authorities like the California Rural Indian Health Board are eligible to create a program. In January 2012, CMSP and three counties began operating LIHPs, and seven additional counties plan to launch during 2012 and 2013. Two counties' launch dates are currently pending. The program will end on December 31, 2013, at which time enrollees will be transitioned into the Medi-Cal program (MCE enrollees) or the California Health Benefit Exchange (HCCI enrollees), which will launch on January 1, 2014.

# Definitions

**CMSP:** The County Medical Services Program (CMSP) is a consortium of 35 rural counties: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Kings, Lake, Lassen, Madera, Marin, Mariposa, Mendocino, Modoc, Mono, Napa, Nevada, Plumas, San Benito, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Tuolumne, Yolo (joined on July 1, 2012), and Yuba.

**Legacy County:** Counties that participated in the previous Health Care Coverage Initiative demonstration waiver program (2007-2010): Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura.

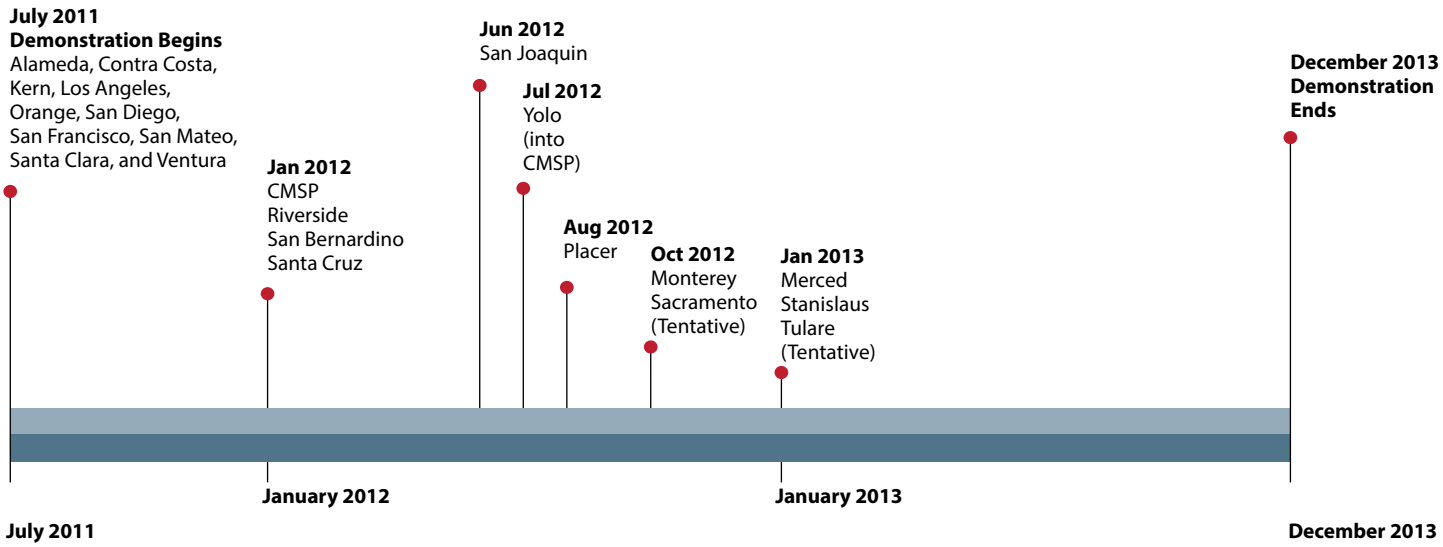
**New LIHPs:** For the purposes of this policy note, the newly implemented programs discussed are the CMSP consortium, Riverside, San Bernardino, and Santa Cruz counties.

**MCE:** Medicaid Coverage Expansion is the component of LIHP that covers adults ages 19-64 with family incomes at or below 133% of FPL.

**HCCI:** Health Care Coverage Initiative is the component of LIHP that covers adults ages 19-64 with family incomes above 133% through 200% FPL.

## Exhibit 1.

LIHP Implementation Timeline by County or Consortium




Notes: (1) CMSP refers to the County Medical Services Program, which is a consortium of 35 counties. Yolo joined CMSP on July 1, 2012.
(2) Implementation dates are current as of August 2012, yet are subject to change for pending counties. One governmental entity and one county (California Rural Indian Health Board and Santa Barbara) are planning to participate in the program but have not determined launch dates.

Source: Low Income Health Program contracts with Department of Health Care Services.

Due to the time of survey administration, data on outreach, enrollment, retention, and redetermination efforts were collected among the 14 LIHPs that were operating as of March 31, 2012 (Exhibit 1). This survey was administered during February 2012, and follow-up questions or calls with key informants were administered if needed.

### Moving Individuals from Eligible to Enrolled

Exhibit 2 displays the processes that lead eligible populations to LIHP enrollment. There are two overall methods: in-reach and outreach. In-reach refers to activities administered by the county to identify, engage, and enroll an eligible individual within its existing system. Outreach refers to those same activities but is aimed at individuals outside the county's system. Each LIHP first identifies its eligible population and then formulates an in-reach or outreach strategy. The LIHP receives applications from a portion of those who were contacted through in-reach/outreach, as well as from individuals who have learned of the program through other avenues. The application process culminates in eligibility determination. For those who are determined to be eligible, an enrollment period of up to 12 months is granted (with the exception of CMSP and Contra Costa County, which only grant an enrollment period of up to six

## Exhibit 2.

Outreach, Enrollment, and Redetermination Process for LIHPs


Source: Data from UCLA's survey of LIHPs on outreach, enrollment, retention, and redetermination.

**Exhibit 3.**

Total Monthly Unduplicated Enrollment in LIHPs, July 1, 2011, to March 31, 2012


Note: Project enrollment (512,000) is the total projected enrollment target as submitted to CMS in the DHCS waiver concept paper.

Source: Individual-level enrollment data submitted to UCLA Center for Health Policy Research by operating LIHPs as of March 31, 2012.

months). Several months before each enrollee's enrollment term ends, the LIHPs notify and assist the enrollee with redetermination of eligibility, as required by program rules for renewal.

## Number of Individuals Enrolled Has Nearly Doubled Since Program Began

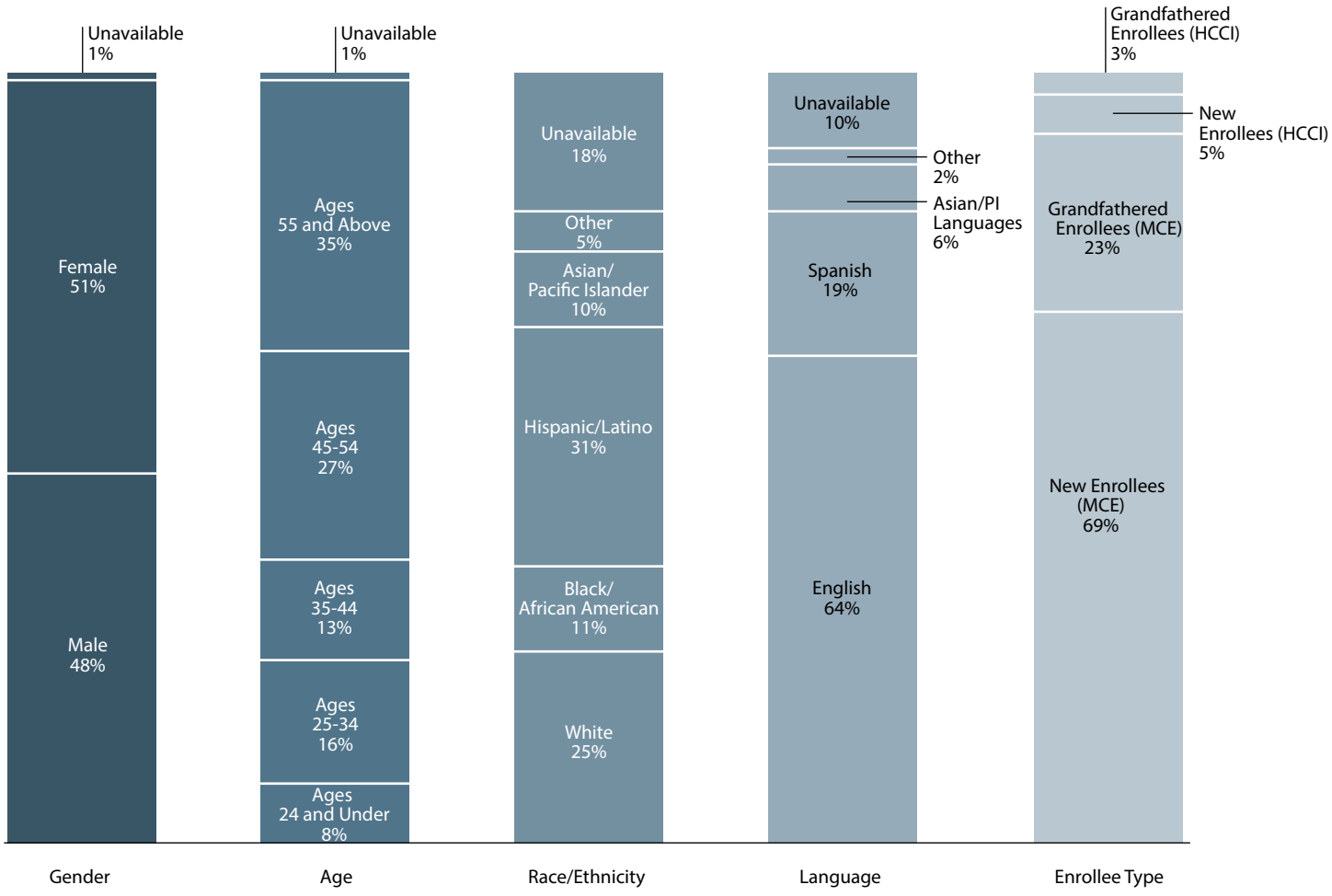
The data show that enrollment has increased steadily since the beginning of the program. As of March 31, 2012, a total number of 413,295 adults were ever enrolled, which includes all individuals who remained or who disenrolled from the program during the nine-month program operation period (Exhibit 3). This is an increase of 54.4 percent statewide since the first month of the program. During the first six months of operation, enrollment grew by an average of 8 percent. In January 2012, enrollment grew by 21 percent, due mainly to the new LIHPs launched on January 1, 2012. Overall, LIHPs reached 80.7 percent of the program's target enrollment number of 512,000 enrollees (Exhibit 3). While this goal is the projected target for December 2013, LIHPs were close to reaching it after just nine months of program implementation.

Though the data demonstrate growth in enrollment, approximately 11.9 percent of LIHP enrollees have disenrolled at some point in the program. Eleven LIHPs provided data on disenrollment reasons, with enrollees found to have left the program for one of the following reasons: they were determined eligible for another public program or private coverage; they became ineligible for the program due to either increased income or relocation; or they failed to respond to redetermination requests or to submit a renewal during redetermination.[1] The last reason is a challenge that many counties face.

1 Disenrollment data are unavailable for Alameda County, CMSP, and Los Angeles County. Disenrollment data represent roughly 6 percent of all individuals ever served in the program, for any break in coverage, whether or not they reenrolled in LIHP.

## Exhibit 4.

Demographics of LIHP Enrollees




Total Cumulative Unduplicated Enrollees: 413,295

Note: Numbers may not add up due to rounding.

Source: Individual-level enrollment data submitted to UCLA Center for Health Policy Research by operating LIHPs as of March 31, 2012.

### Sociodemographic Status of LIHP Enrollees

Given that California's demographics are rich in variety, it is no surprise that the demographics of LIHP enrollees mirror that diversity. Gender is evenly distributed, with a little more than half of enrollees being female (51 percent). LIHP enrollees are predominantly older adults, with three in five of all enrolled adults over the age of 45. Almost one-third (31 percent) are Latino, while 25 percent are White, 11 percent are African American, and 10 percent are Asian/Pacific Islander. About 27 percent of LIHP enrollees are non-English speakers. Close to three-fourths (74 percent) are new enrollees. Of the total LIHP population, 92 percent have incomes at or below 133% FPL (Exhibit 4).

## LIHP Enrollment Demonstrates Progress Toward Enrolling the Estimated ACA-Eligible Population

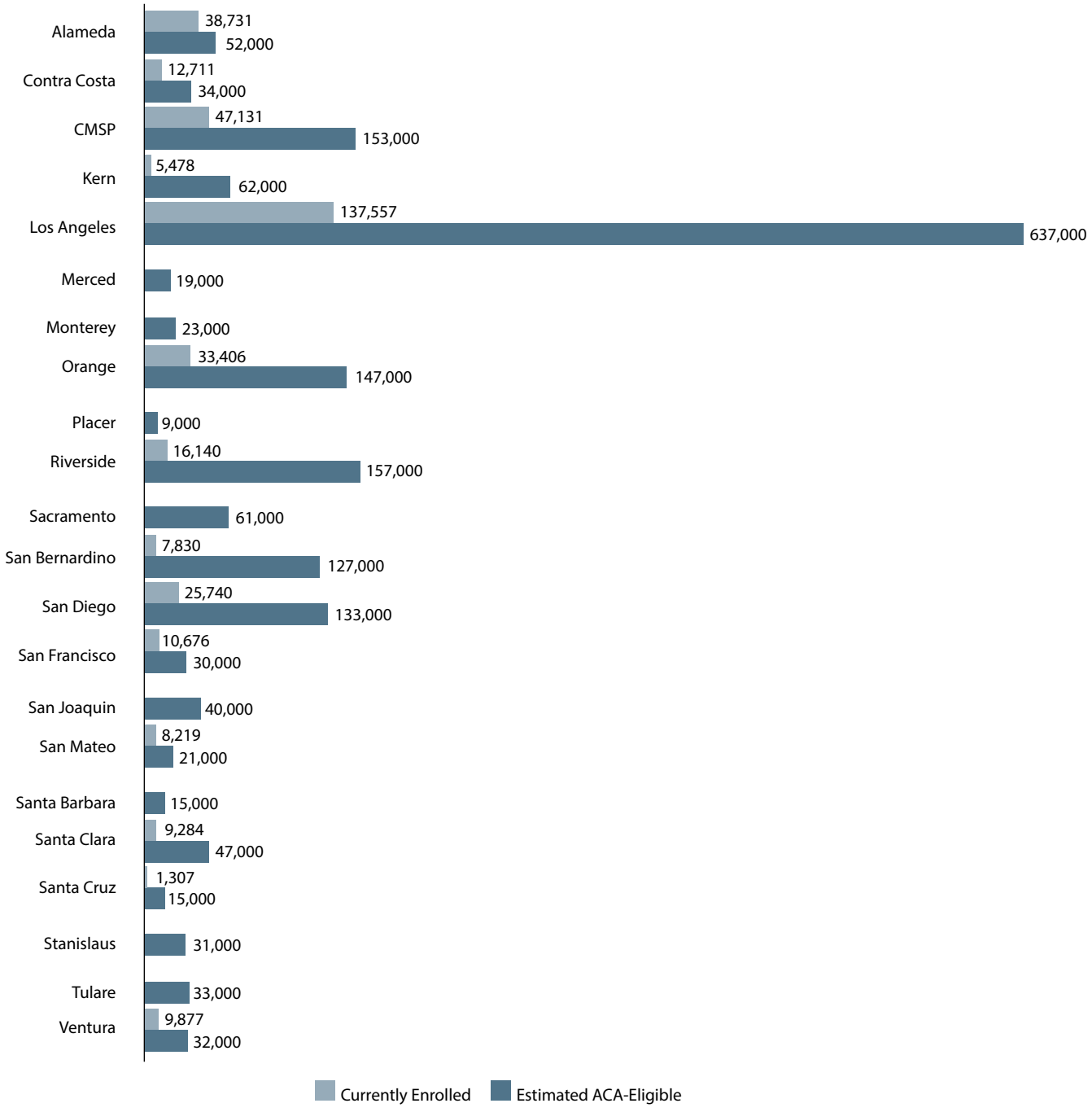
LIHP is jointly funded by local and federal dollars, and each program can therefore limit enrollment by establishing a lower income level for eligibility. Of the 22 LIHPs, only 4 will expand enrollment to the maximum allowable level of 200% FPL. The remaining 18 programs will operate only the MCE component of LIHP, with restricted eligibility of 133% FPL or less. A list of the various FPLs across the LIHPs can be found in Appendix 1: Local LIHP Federal Poverty Levels, Enrollment as of March 31, 2012, and Estimated ACA-Eligible Population.

To assess the impact of the LIHPs providing coverage to uninsured Californians, we estimated the number of uninsured who meet legal residency and citizenship requirements and do not exceed the maximum income threshold approved by CMS for LIHP enrollees (200% FPL) in each county (Exhibit 5). Specifically, estimates of the potentially eligible population include adults ages 19-64 whose income is less than or equal to 200% FPL, who are U.S. citizens or have satisfactory immigration status, are currently uninsured, are residents of the county/region, are not currently eligible for Medi-Cal, and are not currently pregnant. Estimates do not account for potential uptake by currently insured individuals who may use LIHP-MCE as secondary coverage if they meet other program eligibility requirements. This population is also the group that will be eligible for coverage once ACA is implemented in 2014, when they could go into either the Medi-Cal Expansion (the Expansion) or the Health Benefits Exchange (the Exchange).

Exhibit 5 not only demonstrates the number of adults enrolled in the various LIHPs across the state, but it also shows the progress the program has made toward absorbing the estimated number of ACA eligibles. The majority of LIHPs, whether they are legacy counties or new LIHPs, have enrolled at least one-fourth and as many as almost half of UCLA's estimated eligible populations, if their income thresholds for eligibility were set at the maximum allowable FPL of 200% (Exhibit 5). Having lower local income thresholds to determine eligibility effectively reduces the eligible population pool and those who would seamlessly transition from LIHP to ACA, increasing the need for ACA take-up for those not enrolled in LIHP. This policy note, however, highlights best practices for outreach and enrollment that are currently in place across the LIHPs, which can be applied to outreach ACA-eligible individuals who are not LIHP enrollees.

## Exhibit 5.

LIHP Enrollment as of March 31, 2012, and Estimated ACA-Eligible Population




Sources: The estimated number of eligible ACA individuals is based on small area estimation using 2007 and 2009 California Health Interview Survey (CHIS) data, with the exception of CMSP, which used the CHIS 2009 direct estimate. The methodology for these estimates can be found in Data Sources and Methods. Current enrollment estimates are based on enrollment data submitted to UCLA by operating LIHPs as of March 31, 2012. Please see Appendix 1: Local LIHP Federal Poverty Levels, Enrollment as of March 31, 2012, and Estimated ACA-Eligible Population for more information on the various FPLs across the LIHPs and 95% confidence intervals of the estimates.

# In-reach and Outreach Strategies

In developing in-reach and outreach strategies, certain LIHPs began by first targeting specific populations to enroll in their program. Ten of the fourteen implemented LIHPs have strategic outreach and in-reach plans targeting existing low-income populations that already use services in the county system. Seven LIHPs reported outreach to potentially eligible "nonusers," who may be unaware of available programs, are healthy and not proactively seeking care, or have experienced barriers to accessing care. Several LIHPs also reported targeted outreach to special populations, such as the general release population (individuals released from jail or prison), those who are chronically ill, high utilizers of health services (e.g., frequent emergency room visitors), and college/university students.

## Challenges for Outreach

The central challenge reported for outreach was the small number of staff dedicated solely to LIHP enrollment activities. Counties may have staff either perform outreach activities or process enrollment for any of their public programs, depending on what the demand might be. Eligibility staff are at times pulled from the office to conduct outreach and vice versa. This leads to delays or limited outreach activities. In any case, LIHPs found ways to overcome these obstacles to continue ramping up enrollment.

## Partnerships: Pivotal in Reaching Eligible Populations

LIHPs often partnered with community-based organizations, network providers, and county staff of health and social service agencies for in-reach and outreach efforts to reach their target populations. Training clinical staff was effective in reaching and enrolling frequent emergency room users or other medical service users. Capitalizing on the resources of partnering organizations alleviated the burden of outreach activities for county eligibility workers.

### *Service Providers*

Service providers are the most commonly used channel for in-reach and outreach (Exhibit 6). Thirteen LIHPs reported that collaborating with their own network providers was the most successful mechanism for reaching eligible adults. San Francisco and San Mateo counties noted that outreach to potential applicants through their existing network providers was successful due to the high level of interest among individuals while seeking care. Roughly an equal number of LIHPs reached eligible populations at hospitals or emergency departments (ED) by utilizing financial counselors at EDs or training frontline staff to educate and enroll LIHP eligible adults (Contra Costa, Kern, Santa Cruz, and Ventura counties). Training clinical staff was also identified as an effective strategy. San Bernardino County trained staff at all licensed emergency hospitals through quarterly meetings about program eligibility requirements and the emergency reimbursement process.

*Advocacy Groups*

Advocacy groups played a key role in reaching the targeted population due to their established relationships with users who might not otherwise be exposed to the program, as reported by seven LIHPs. These advocacy groups represent patients, foster youth, low-income populations, laborers' rights, housing, and Latino health, as well as homeless service agencies, legal aid, and faith-based groups. Santa Clara County partnered with a local consortium of community health clinics to hold educational sessions informing eligible adults about LIHP and assisting them with the application process. Kern County partnered with its local initiative health plan to develop an aggressive outreach strategy targeting the county's eligible population. Lastly, the Santa Cruz County Health Department partnered with local nonprofit community health clinics, the County Organized Health System, local hospitals, and the County Social Services Department to facilitate LIHP implementation, including outreach, training, and enrollment activities.

## Exhibit 6.

Outreach Methods by LIHP

| Outreach Methods | Alameda | CMSP | Contra Costa | Kern | Los Angeles | Orange | Riverside | San Bernardino | San Diego | San Francisco | San Mateo | Santa Clara | Santa Cruz | Ventura | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Community-Based** | | | | | | | | | | | | | | | |
| Advocacy Groups | – | – | – | ✓ | ✓ | ✓ | ✓ | ✓ | – | – | – | ✓ | ✓ | ✓ | 8 |
| Community Events | – | – | ✓ | ✓ | ✓ | – | – | ✓ | ✓ | ✓ | – | – | – | ✓ | 7 |
| Health Fairs | – | – | ✓ | ✓ | ✓ | ✓ | – | ✓ | – | – | – | ✓ | – | ✓ | 7 |
| **Service Providers** | | | | | | | | | | | | | | | |
| Clinics/FQHCs | ✓ | – | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 13 |
| Emergency Rooms | ✓ | – | ✓ | ✓ | ✓ | – | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 12 |
| Hospitals | ✓ | – | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 13 |
| **Media** | | | | | | | | | | | | | | | |
| Brochures/Flyers | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | – | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 13 |
| Mail | – | – | ✓ | ✓ | ✓ | – | ✓ | ✓ | – | – | – | – | ✓ | ✓ | 7 |
| Media/Ads | – | – | – | – | ✓ | – | – | ✓ | – | – | – | – | ✓ | ✓ | 4 |
| County Website | ✓ | ✓ | – | – | ✓ | – | ✓ | – | ✓ | ✓ | ✓ | ✓ | – | ✓ | 9 |
| Other | – | ✓ | – | – | – | – | – | – | – | ✓ | ✓ | ✓ | – | ✓ | 5 |

"✓" = Yes "–" = No

Notes: (1) CMSP refers to the County Medical Services Program, which is a consortium of 35 counties. Yolo joined CMSP on July 1, 2012. (2) "Other" includes school-based health centers, information hotlines, human services agency offices, a network of Certified Application Assistants who are trained to do outreach, and training webinars for network providers on program rules and eligibility.

Source: Data from UCLA's survey of LIHPs on outreach, enrollment, retention, and redetermination.

### Information Technology: Facilitating Distribution of Information and Identifying Eligible Populations

One innovative approach is to use information technology (IT) to train workers for outreach and to help identify eligible populations. When working with a large, dispersed workforce, webinars are an effective and low-cost tool for training hospital and clinic staff, county eligibility workers, and behavioral health personnel in LIHP eligibility criteria and enrollment processes. CMSP held a series of 16 training webinars two months prior to launching LIHP. Another innovative approach is to convert enrollees of the existing medically indigent program or other charity care venue to LIHP using existing data sources (Alameda County and CMSP).

## Enrollment Strategies

LIHPs take applications and process enrollment at an array of sites; however, the most commonly used type of site was health and social service agencies. All LIHPs surveyed reported collecting applications where individuals seek care, including community health centers, county hospitals, emergency rooms, and privately contracted facilities (Exhibit 7). Applications were also commonly collected at partnering county departments, such as mental health departments and social service agency offices. At all locations, public and community health workers such as certified county workers, Certified Application Assistants (CAAs), county social workers, and staff from the Department of Public Social Services and the Department of Mental Health were available to screen, fill out applications, and assist applicants in various languages. Spanish-speaking workers or materials in Spanish were available at all LIHPs. Six LIHPs also reported having workers who could assist in Vietnamese, Chinese, Armenian, Korean, Tongan, and Tagalog languages, and three LIHPs utilized translation services that covered multiple languages remotely.

The type of enrollment site with the highest number of completed applications was partnering county departments (Exhibit 7). Under this umbrella, four LIHPs reported that social service agencies collected the most completed applications, while three LIHPs reported that county hospitals received the most completed applications. These sites also engaged in significant outreach efforts, with LIHPs reporting these sites as their most utilized outreach venues.

The reasons for certain facilities having higher completed numbers of applications varied. Access to a higher number of uninsured patients and having trained clinical or onsite enrollment staff to educate uninsured patients about the program and assist them with their applications were reported as major reasons. Another key factor affecting application completion was having the capability to process applications, determine eligibility, and enroll individuals onsite, which led to the handling of large volumes of applications.

## Exhibit 7.

Enrollment Sites by LIHP

| LIHP Enrollment Sites | Alameda | CMSP | Contra Costa | Kern | Los Angeles | Orange | Riverside | San Bernardino | San Diego | San Francisco | San Mateo | Santa Clara | Santa Cruz | Ventura | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Service Providers** | | | | | | | | | | | | | | | |
| Community Health Centers | ✓ | ✓ | ✓ | – | ✓ | ✓ | – | ✓ | – | – | ✓ | ✓ | ✓ | ✓ | 10 |
| County-Based Clinics/Doctor's Office | ✓ | ✓ | ✓ | – | ✓ | – | ✓ | ✓ | – | ✓ | ✓ | ✓ | ✓ | ✓ | 11 |
| Privately Funded Clinics | – | ✓ | ✓ | – | – | ✓ | – | – | – | – | – | – | – | – | 3 |
| Private Hospitals | – | ✓ | ✓ | – | – | ✓ | – | ✓ | ✓ | – | ✓ | – | ✓ | – | 7 |
| County Hospitals | ✓ | – | ✓ | ✓ | ✓ | – | ✓ | ✓ | – | ✓ | ✓ | ✓ | – | ✓ | 10 |
| Emergency Room | ✓ | – | ✓ | ✓ | ✓ | – | – | ✓ | – | – | ✓ | ✓ | ✓ | ✓ | 9 |
| **Community-Based Locations** | | | | | | | | | | | | | | | |
| Family Resource Center | – | – | – | – | – | – | – | – | – | – | ✓ | – | – | – | 1 |
| Community-Based Organizations or School Districts | – | – | – | – | – | ✓ | – | – | – | – | ✓ | – | – | ✓ | 3 |
| School Clinics | – | – | ✓ | – | – | – | – | – | – | – | – | – | – | – | 1 |
| **Partnering County Departments** | | | | | | | | | | | | | | | |
| Medically Indigent Services | ✓ | – | ✓ | – | – | – | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 10 |
| Mental Health Department | ✓ | – | ✓ | – | ✓ | – | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 11 |
| Social Service Agency | – | ✓ | ✓ | – | – | – | – | ✓ | ✓ | ✓ | ✓ | – | – | ✓ | 7 |
| **Remote-Access Systems** | | | | | | | | | | | | | | | |
| Website | – | ✓ | – | – | – | ✓ | – | ✓ | ✓ | – | – | – | – | – | 4 |
| Centralized Phone Unit | – | – | ✓ | – | – | – | – | ✓ | ✓ | – | – | – | – | – | 3 |
| Electronic Self-Service Kiosks | – | – | – | – | – | – | – | ✓ | – | – | – | – | – | – | 1 |

"✓" = Yes "–" = No

Notes: (1) Light-blue shaded areas denote sites that had the highest number of completed applications. (2) CMSP refers to the County Medical Services Program, which is a consortium of 35 counties. Yolo joined CMSP on July 1, 2012. (3) CMSP could not determine which facility had the highest number of completed applications due the large number of counties in the consortium.

Source: Data from UCLA's survey of LIHPs on outreach, enrollment, retention, and redetermination.

## Challenges in Enrolling Eligible Adults

LIHPs faced various challenges specific to enrollment, which they noted as being a complex process for the applicant. A few LIHPs noted that personnel could not attend to the high volume of work involved in processing applications due to limited staffing. Several counties reported that applicants struggled to navigate the application process, including collecting all required documentation. Obtaining required documentation, such as birth certificates, was the most difficult part of the citizenship and verification process. Verifying identity can be problematic as well, especially for the homeless, those born outside California, and individuals coming out of the criminal justice system. In some cases, financial hardship for applicants was also a barrier to obtaining the necessary documentation.

## Revamping Enrollment Systems to Streamline Processes

A unique solution for lifting some of the enrollment burden was to collect application data via a kiosk system. San Bernardino County has self-service kiosks placed at the county's regional medical center (one in the lobby of outpatient specialty care, the other in the insurance verification office) to collect demographic and other eligibility information for applicants interested in public coverage. The kiosk first screens for eligibility and then creates an electronic application for the program that the applicant is eligible for. These kiosks enable enrollees to fill out an electronic application, which eliminates the need to use an eligibility worker's time to enter an applicant's information from a paper application. Verification to determine eligibility is still administered in person, where the eligibility worker reviews and verifies an applicant's eligibility. In the future, the kiosks will have a scanning capability for eligibility documentation, with the exception of documents to verify identity and citizenship, as required by the Deficit Reduction Act (DRA). Original documentation to verify identity and citizenship would still need to be reviewed by an eligibility worker to verify authenticity of the document and then to verify eligibility.

Another effective method was to streamline screening and enrollment processes. LIHPs reported placing outreach and eligibility workers, including financial counselors, in high-volume service provider locations to enroll eligible adults (Contra Costa and San Bernardino counties). To reduce long wait times, Los Angeles County established a "fast track" option for applicants who were dropping off documentation and did not require the full services of a certified application assistant (CAA). Applicants were given a voucher that instructed them to report to a specific window to avoid long wait times when returning to submit required documentation. In addition, utilizing available information systems to verify documentation was reported as an easy method of validating an applicant's eligibility. Examples of information systems include the California Birth Record Database, Experian credit reports, and Social Service Information Technology systems, such as the Statewide Automated Welfare System (SAWS).

### *Decreased Time in Determining Eligibility*

A few LIHPs reported a decrease in the amount of time it took to determine eligibility since they were launched. Eligibility determination is measured from the time the LIHP receives a complete application to the time when an enrollee receives a coverage card or is granted access to receive medical services. Alameda County decreased its eligibility determination time from six or seven weeks in July 2011 to one or two weeks by March 2012. Since launching its LIHP in July 2011, Los Angeles County decreased its determination time from two or three weeks to one to three days. Riverside and San Francisco counties have similar systems, with an applicant able to walk in to submit an application and be determined eligible within the same day. Similarly, Santa Cruz County can determine eligibility in 30 to 45 minutes, and an enrollee can walk out with a notice of action letter and seek medical services the same day. San Mateo County had reduced eligibility determination from 45 days to 2 days since launching its LIHP. By observing these decreases in the reported time needed to determine eligibility, we can infer that the counties' efforts in streamlining the enrollment process were effective.

Reasons for a decrease in the time to determine eligibility varied. Los Angeles County can determine eligibility in an hour or less if an enrollee submits a complete application with all required documentation to a Department of Health Services (DHS) eligibility worker; however, it still takes about one to three days for an applicant to receive a benefits card. Riverside County is able to determine eligibility quickly due to extensive outreach to educate potential enrollees and prepare them for the application process. Stationing staff at various point-of-service facilities assists with this process. Lastly, a "fast track" for those who come in only to submit documentation decongests the primary office. San Francisco County can determine eligibility within 30-45 minutes if an applicant provides all the necessary paperwork and an eligibility worker can easily determine eligibility, similar to Los Angeles County. Use of an application assistor and One e-App facilitate this process. Access to the Medi-Cal Eligibility Data System (MEDS) for linking data assists Santa Cruz County in determining eligibility in such a short time span.

# Retention and Redetermination Strategies

LIHPs not only focused on how to recruit and enroll potential LIHP enrollees, but they also developed comprehensive approaches for retention and redetermination. The most frequent retention strategy was mailing notifications to enrollees whose enrollment period was due to expire (Exhibit 8). Timing of notification in counties ranged from 30 to 90 days prior to the end of the enrollment period, and some counties used multiple reminders. Another common method, used by seven LIHPs, was reenrollment during a medical appointment. While this may be the simplest method of reenrollment for some counties, it is not the most effective for enrollees who do not seek care within their allowable redetermination time.

**Exhibit 8.**

Retention and Redetermination Strategies by LIHP

| Retention Strategy | Alameda | CMSP | Contra Costa | Kern | Los Angeles | Orange | Riverside | San Bernardino | San Diego | San Francisco | San Mateo | Santa Clara | Santa Cruz | Ventura | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Community-Based** | | | | | | | | | | | | | | | |
| Calling Members | – | – | – | – | ✓ | – | – | – | – | ✓ | – | ✓ | – | ✓ | 4 |
| Mailing Notifications | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 14 |
| Prefill Application for Members | – | – | – | – | – | – | – | – | – | ✓ | ✓ | – | – | ✓ | 3 |
| Renew During Medical Appointment | ✓ | – | ✓ | ✓ | ✓ | – | – | – | – | ✓ | ✓ | – | ✓ | – | 7 |
| Other | – | – | – | – | – | – | – | ✓ | – | ✓ | ✓ | – | – | – | 3 |
| Total | 2 | 1 | 2 | 2 | 3 | 1 | 1 | 2 | 1 | 5 | 4 | 2 | 2 | 3 | – |

"✓" = Yes "–" = No

Note: CMSP refers to the County Medical Services Program, which is a consortium of 35 counties. Yolo joined CMSP on July 1, 2012.

Source: Data from UCLA's survey of LIHPs on outreach, enrollment, retention, and redetermination.

## Challenges in Retention and Redetermination

LIHPs reported that efforts to retain enrollees are not always successful. Enrollees' frequent eligibility changes caused them to leave the program. The redetermination process was complex and potentially daunting for some enrollees, particularly those without immediate health care needs who may not have been incentivized to reenroll. Some LIHPs encountered difficulties in contacting enrollees, who did not always notify the LIHP of new contact information. In all of these instances, LIHPs expressed interest in developing more refined processes to retain enrollees, but most have limited capacities for uniformly implementing successful strategies.

## Effective Approaches to Retaining and Redetermining LIHP Enrollees

LIHPs developed effective approaches for simplifying the redetermination process and preventing disruption of coverage for enrollees. Notifying and reminding enrollees of redetermination deadlines by mail was an effective practice. San Francisco County included automated telephone calls, with enrollees contacted 45 days prior to termination in addition to being notified by mail. The county then followed up with a live telephone call in the enrollee's preferred language within 15 to 30 days prior to the enrollment end date.

Prefilled renewal forms are another effective approach to simplifying redetermination. Populating known information on behalf of renewal applicants was seen as an essential tool for recertification and retention. A few counties sent enrollees prefilled renewal forms, with a postage-paid envelope for returning the completed form and documentation. San Mateo also implemented this method in April 2012, and the county received back approximately 10 percent of the 1,000 prefilled applications within one week.

LIHPs have also employed other strategies for retention and redetermination. San Bernardino County has planned to regularly release a report to clinic staff listing enrollees whose enrollment term is near expiration. San Mateo County has deployed a Web-based renewal option that allows clients to renew their coverage via the Internet. In addition, the county reviews the data of enrollees who fail to reenroll in order to identify characteristics or factors that can contribute to discontinuity in enrollment. The data can inform targeted retention efforts for these populations.

### *Patient-Centered Care*

Another approach to retention is to invest in medical care that is more patient-centered. Identifying what matters most to patients can enrich their experience and increase retention. Dr. Mitchell Katz, director of the Los Angeles County Department of Health Services, noted in a webinar that changing the culture in a medical office can have a big impact on retaining enrollees.[2] Treating employees well, building pride in their work, encouraging staff to seek care at their own centers, and creating unit-based management teams can have positive effects on the morale of staff, which is then evident in their services to enrollees. Offering services in the patient's native language can help the individual feel comfortable with the provider. Extending hours for individuals to see their doctors after work hours can help retain enrollees. Even offering amenities such as ample parking, decreasing or eliminating long wait lines, and maintaining a clean facility can increase patient satisfaction.

2 UCLA Center for Health Policy Research. 2012. Engaging enrollees in the redetermination process: Innovative strategies for retention. Video webcast. Retrieved from *https://connectpro72759986.adobeconnect.com/_a782517175/p57jxv3gz13/?launcher=false&fcsContent=true&pbMode=normal*.

# Conclusions: Looking Forward to 2014

Despite the various challenges, LIHPs have successfully enrolled more than 400,000 individuals during the first nine months of operation. Moreover, LIHPs have identified and implemented innovative strategies to mitigate the challenges they have encountered. LIHPs have developed customized approaches to dealing with problems reported by clinics, public agencies, and enrollees, with the goal of improving the enrollment and redetermination processes. While LIHPs continue to face challenges, efforts to improve outreach, enrollment, and retention and redetermination continue.

The efforts made by LIHPs can better prepare counties for the full implementation of the Affordable Care Act (ACA) in 2014. Given that the Medi-Cal Expansion will absorb eligible individuals beyond those currently enrolled in LIHP, these existing outreach and enrollment systems act as a training ground for enrolling eligible low-income individuals into Medi-Cal. Counties will be able to use their existing resources and apply new methods from learned lessons and experiences. Though counties are independently undertaking these enrollment efforts, they still face multiple burdens. Lack of human and/or financial resources and difficulties in obtaining documentation to verify eligibility continue to be issues that counties face. Providing additional funding for IT systems or creating a more simplified, yet comprehensive, enrollment/redetermination process could assist counties in improving the efficiency of their outreach and enrollment efforts, and thus increase enrollment to the maximum allowable number of individuals.

## Data Source and Methods

The information in this policy note is based on responses to a UCLA qualitative survey of LIHPs on outreach, enrollment, retention, and redetermination that was administered to the 14 operating LIHPs in February 2012; on LIHP enrollment data submitted to UCLA as of April 30, 2012; and on current deferral poverty levels, extracted from LIHP contracts with the California Department of Health Care Services. Estimates for the number of adults potentially eligible for the program at the maximum allowable income level (200% FPL) in each area are based on small area estimates (SAEs) using the 2007 and 2009 California Health Interview Survey (CHIS) and the American Community Survey (ACS). Small area estimates were not generated for CMSP, given that the direct estimate using CHIS 2009 was stable when combining counties into one group.

The method of producing small area estimates (SAEs) was developed by the Center for Health Policy Research and has been used over the past 10 years. It can be characterized as a design-oriented and model-based synthetic estimation. The method uses CHIS survey data with ACS[3] data to build models predicting estimates for the "finite" population in larger geographic areas, with patterns of associations used to derive estimates for smaller geographic areas. Predicted values for the outcomes of interest in the population data are calculated and then aggregated to derive the final SAEs for the desired area level. For the SAEs in this policy note, the model was built on CHIS 2007 and 2009 data, accounting for year-to-year differences. The model parameter estimates were then applied to decennial U.S. Census population data from ACS, representing the population from which CHIS 2009 survey data were drawn.

Rigorous attention was given to assessing the accuracy of SAEs. The variances were derived through bootstrapping, a computer-intensive statistical method. The final SAEs were checked for consistency with survey direct estimates. Confidence intervals and coefficients of variation of the final estimates were calculated and presented. As a final review, experts within the Center were asked to examine the results based on their expertise and then compare them to external data sources, when available, to assess their validity.

3 For more information on the ACS and CHIS small area estimate methods, please visit *http://www.census.gov/acs/www/methodology/methodology_main/* and *http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/C/PDF%20ChronicConditionsCHIS2007.pdf*.

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## Appendix 1.

Local LIHP Federal Poverty Levels, Enrollment as of March 31, 2012, and Estimated ACA-Eligible Population

| LIHP | Local LIHP's Federal Poverty Level | Currently Enrolled (as of March 31, 2012) | Estimated ACA-Eligible Population (95% Confidence Interval) |
|---|---|---|---|
| Alameda | 200% | 38,731 | 52,000 (26,000 – 77,000) |
| Contra Costa | 200% | 12,711 | 34,000 (16,000 – 51,000) |
| County Medical Services Program (CMSP) | 100% | 47,131 | 153,000 (142,000 – 177,000) |
| Kern | 100% | 5,478 | 62,000 (35,000 – 90,000) |
| Los Angeles | 133% | 137,557 | 637,000 (490,000 – 783,000) |
| Merced | 100% | NA | 19,000 (10,000 – 28,000) |
| Monterey | 100% | NA | 23,000 (12,000 - 33,000) |
| Orange | 200% | 33,406 | 147,000 (78,000 - 216,000) |
| Placer | 100% | NA | 9,000 (4,000 – 14,000) |
| Riverside | 133% | 16,140 | 157,000 (88,000 – 225,000) |
| Sacramento | 67% | NA | 61,000 (28,000 – 94,000) |
| San Bernardino | 100% | 7,830 | 127,000 (70,000 – 184,000) |
| San Diego | 133% | 25,740 | 133,000 (101,000 – 166,000) |
| San Francisco | 25% | 10,676 | 30,000 (15,000 – 45,000) |
| San Joaquin | 80% | NA | 40,000 (21,000 – 58,000) |
| San Mateo | 133% | 8,219 | 21,000 (10,000 – 32,000) |
| Santa Barbara | 100% | NA | 15,000 (7,000 – 22,000) |
| Santa Clara | 75% | 9,284 | 47,000 (23,000 – 71,000) |
| Santa Cruz | 100% | 1,307 | 15,000 (8,000 – 23,000) |
| Stanislaus | 50% | NA | 31,000 (17,000 – 45,000) |
| Tulare | 100% | NA | 33,000 (18,000 – 47,000) |
| Ventura | 200% | 9,877 | 32,000 (16,000 – 48,000) |

Sources: The estimated number of ACA-eligible individuals is based on small area estimation using the 2007 and 2009 California Health Interview Survey (CHIS) data, with the exception of CMSP, which used the CHIS 2009 direct estimate. The methodology for these estimates can be found in Data Sources and Methods. Current enrollment estimates are based on enrollment data submitted to UCLA by operating LIHPs as of March 31, 2012.