



**U.S. Department of Health and Human Services  
Assistant Secretary for Planning and Evaluation  
Office of Disability, Aging and Long-Term Care Policy**

# **COUNTY EXPERIENCES WITH MEDICAID EXPANSION IMPLEMENTATION: CASE STUDY REPORT**

**March 2016**

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This report was prepared under contract #HHSP23320095651WC between HHS's ASPE/DALTCP and the Research Triangle Institute. For additional information about this subject, you can visit the DALTCP home page at <https://aspe.hhs.gov/office-disability-aging-and-long-term-care-policy-daltcp> or contact the ASPE Project Officers, Emily Rosenoff and Jhamirah Howard, at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201; [Emily.Rosenoff@hhs.gov](mailto:Emily.Rosenoff@hhs.gov), [Jhamirah.Howard@hhs.gov](mailto:Jhamirah.Howard@hhs.gov).

# **COUNTY EXPERIENCES WITH MEDICAID EXPANSION IMPLEMENTATION: Case Study Report**

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# TABLE OF CONTENTS

**ACKNOWLEDGMENTS** ..... iii

**ACRONYMS** ..... iv

**EXECUTIVE SUMMARY** ..... vi

**INTRODUCTION** ..... 1

**METHODS** ..... 4

    Site Selection Criteria ..... 4

    Site Visit Approach ..... 4

    Identification of Key Themes ..... 5

    Key Similarities and Differences Across Counties ..... 5

**FINDINGS** ..... 7

    State Integration ..... 7

    Partnerships ..... 8

    Eligibility Determination and Enrollment ..... 11

    Outreach Strategies ..... 13

    Health Care Literacy and Access ..... 15

    Provider Issues ..... 18

    Funding and Staffing ..... 21

**CONCLUSIONS AND LOOKING FORWARD** ..... 24

**APPENDICES**

    APPENDIX A. Description of County Programs ..... A-1

        Alameda County, California: "Bridge to Reform" ..... A-1

        Cook County, Illinois: "CountyCare" ..... A-7

        Cuyahoga County, Ohio: "MetroHealth Care Plus" ..... A-16

        King County, Washington: "Transitional Bridge" Demonstration ..... A-21

    APPENDIX B. Key Characteristics of County Programs ..... A-29

## **LIST OF TABLES**

TABLE B-1. Key Characteristics of County Programs..... A-29

## **ACKNOWLEDGMENTS**

RTI would like to express its gratitude to each of the stakeholders we interviewed in Alameda County, California; Cook County, Illinois; Cuyahoga County, Ohio; and King County, Washington that generously gave of their expertise and time during our site visits to their county. And in doing so, helped us to develop and on-the-ground understanding of the issues, challenges, and strategies in implementing a Medicaid expansion at the county-level.

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## ACRONYMS

The following acronyms are mentioned in this report and/or appendices.

ABE	Application for Benefits Eligibility
ACA	Affordable Care Act
ACHCSA	Alameda County Health Care Services Agency
ACO	Accountable Care Organization
AIDS	Acquired Immune Deficiency Syndrome
ASPE	HHS Office of the Assistant Secretary for Planning and Evaluation
BHP	Basic Health Plan
CalHEERS	California Healthcare Eligibility Enrollment, and Retention System
CCHHS	Cook County Health and Hospitals System
CMS	HHS Centers for Medicare and Medicaid Services
DSH	Disproportionate Share Hospital
DSHS	Washington Department of Social and Health Services
DSS	California Department of Social Services
EHR	Electronic Health Record
EMR	Electronic Medical Record
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
HCA	Health Care Authority
HHS	U.S. Department of Health and Human Services
HIV	Human Immunodeficiency Virus
LIHP	Low Income Health Program
MAA	Medicaid Administrative Activities
PCMH	Patient-Centered Medical Home
RV	Recreational Vehicle

SSN

Social Security Number

TASC

Treatment Alternatives for Safe Communities

TPA

Third Party Administrator

## EXECUTIVE SUMMARY

Counties face many decisions and challenges in implementing the Medicaid expansion at the local level, including operational and financing changes for county offices that process Medicaid eligibility, and for county-supported health service providers. Yet, very little research has been done to look at the impact of the Medicaid expansion at the county level. The purpose of this project, entitled “County Experiences with Medicaid Expansion Implementation” is to gain an understanding of these efforts, identify and synthesize lessons from early Medicaid expansion efforts to help inform states and counties, and provide tailored technical assistance to select counties in the ongoing implementation of their work. This project was funded by the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

The first step in this work was a series of discussions with representatives from national organizations, experts in Medicaid expansion, and county leaders in counties in which section 1115 Medicaid demonstration authority was used to implement a Medicaid coverage expansion prior to January 2014. The second step in the process was to conduct a literature review and environmental scan, guided by the issues identified by national and county stakeholders. The third step was a series of site visits to four counties in which a Medicaid coverage expansion had been implemented prior to 2014 with the goal of developing a comprehensive understanding of the Medicaid coverage expansion implementation on the ground.

### Site Visit Counties

The site visits occurred in Alameda County, California; Cook County, Illinois; Cuyahoga County, Ohio; and King County, Washington. At the time of the visits, Medicaid coverage expansion had been implemented by the four counties for varying amounts of time, ranging from 1½-4 years. In addition to the criteria of having adopted Medicaid coverage expansion prior to 2014, other factors were considered in the county selection process. These included the health delivery system and resources; expertise in engaging key sub-populations among the newly Medicaid-eligible; the adequacy of the primary care and behavioral health provider networks; and the potential generalizability of the county’s experiences to other counties. The following provides a short synopsis of key factors considered in selecting each of the counties.

Alameda County’s Medicaid expansion occurred on November 11, 2010, under the Low Income Health Program component of a state Section 1115 demonstration and a modification to the county’s existing Health Care Coverage Initiative benefit. Alameda County’s expansion work focused on getting coverage for newly-eligible and vulnerable

populations, along with special initiatives for integrating behavioral health with primary care.

Cook County's Medicaid coverage expansion began on February 1, 2013, and was through a Section 1115 demonstration. Eligible individuals were enrolled in CountyCare, a new Medicaid managed care entity established by Cook County Health and Hospitals System (CCHHS). This enabled Medicaid payments to cover care for the expansion population that had previously been delivered through the John H. Stroger, Jr. Hospital (formerly known as Cook County Hospital) and CCHHS clinics largely as uncompensated care. CountyCare expanded its provider network to include other community hospitals and federally qualified health centers that were also serving the eligible population within Cook County. CountyCare aimed to enroll eligible, but uninsured consumers in Cook County, particularly those who were patients within their provider network. Additionally, Cook County focused on getting coverage for the Cook County jail population that would take effect upon their release and provide continuity of care following individuals' release from incarceration.

The State of Ohio expanded Medicaid to eligible individuals in Cuyahoga County on February 5, 2013, under a Section 1115 demonstration. Beneficiaries enrolled in the demonstration were patients of the MetroHealth System who previously had been receiving uncompensated care. Cuyahoga's expansion emphasized the enrollment of frequent emergency department users, persons with behavioral health needs, and persons with chronic diseases. It included a particular focus on the use of care coordination to try to improve the integration of services and care provided to these populations.

Washington's Section 1115 demonstration expanded Medicaid coverage on January 1, 2011, to individuals in a state-funded managed care program, known as the Basic Health Plan as well as individuals enrolled in two additional state-only funded medical care programs. With approximately 29 percent of Washington residents living in King County and an extensive system of health care service provision and of targeted Medicaid outreach and enrollment, King County was also included. King County focused on all uninsured, with added attention on ethnic minorities and other vulnerable populations, such as those experiencing homelessness, and people with serious mental illness and other disabilities.

## Findings

In many ways, the findings of the site visits echoed findings from the national stakeholder meeting, local stakeholder discussions, and literature review, but they also identified unique issues based on each county's specific experiences. Discussions with stakeholders and with site visit interviewees covered multiple areas related to the Medicaid expansion and counties' experiences in planning and implementing the expansion. The case study incorporates these topic areas, including state integration;

key partnerships; eligibility determination and enrollment; outreach strategies; health care literacy and access; provider issues; and funding and staffing.

**Integration with the state.** Integration with the state was a key issue identified by stakeholders. Successful strategies for productive integration with the state included support at the state-level; the establishment of inter-agency coalitions assembled to guide the Medicaid expansion effort among agencies; as well as the need for clear, definitive direction from the state regarding data systems and documentation standards for eligibility verification.

**Partnerships.** Partnerships with public agencies and community based organizations were critical to expansion implementation efforts. Key strategies to creating successful partnerships to facilitate the Medicaid expansion included frequent and open communication and leveraging existing relationships, creating a shared understanding about what can be gained from coverage expansion and involving partners in the planning stages.

**Enrollment.** Since many of these coverage expansions took place prior to the implementation of new streamlined eligibility and enrollment processes, stakeholders reported a number of operational issues. The issues related to eligibility determinations and enrollment include the documentation requirements, Medicaid application processes, difficulties in sharing data across agencies to facilitate enrollment, and eligibility systems issues that were sometimes stretched by the transition to a statewide eligibility system under the ACA, and a backlog of enrollments and renewals at the state level. Successful strategies and lessons learned focused on the importance of regular communication to resolve system issues and working with key safety net providers and justice agencies to facilitate enrollment. Presumptive eligibility and streamlined enrollment and renewal processes using acceptable alternatives to various forms of eligibility documentation were also emphasized. If implementing coverage expansions today the streamlined eligibility and enrollment processes should mitigate many of these issues.

**Outreach.** Counties worked to enroll hard to reach individuals during their outreach. Some of the issues they encountered included a lack of trust in government institutions particularly among immigrants, justice-involved persons, and low-income persons who had previous negative experiences with government programs. Successful strategies and lessons learned in overcoming outreach and enrollment challenges, included proactively identifying and contacting prospective enrollees; leveraging partnerships with providers and community and organizations who have established trust within these communities; working with locally administered health and human services programs to create presumptive eligibility and one-stop enrollment processes

**Health care literacy.** The issues of health care literacy and access to health care are intertwined in the eyes of many stakeholders involved in county-level administration of Medicaid expansion. Stakeholders expressed concern that low-health care literacy would affect this population's ability to make health care appointments, and to

understand which types of providers to see for which needs. Strategies and lessons learned in addressing these issues included making specific efforts around cultural competency in communication with very diverse populations. In some counties, the use of care coordinators to help newly-enrolled individuals find appropriate resources to meet their health care needs was particularly successful in improving health care literacy and access to services.

**Services.** One issue included how to address the increased demand for services, particularly among patients who need specialty care and substance abuse or mental health services. A second issue is how providers are adapting to new health care payment models, either in response directly to the types of patients that have become Medicaid-eligible under expansion, or to respond indirectly to trends in the Medicaid or the health care financing environment that happen to coincide with Medicaid expansion. Most counties utilized options to optimize service delivery within their existing provider networks, emphasizing the use of physician assistants and nurse practitioners who could deliver primary care services at the upper end of their licensed scopes of practice. All counties tried hiring new providers to meet the increased demand of seeing newly-eligible patients. Innovative strategies were used to accommodate the new payment model, such as moving primary care clinics towards a patient-centered medical home model, implementing a comprehensive care coordination program for enrollees, and funding training for primary care providers to learn how to integrate behavioral health with primary care, among others.

**Resources.** Counties also faced funding and staffing challenges. Interviewees noted the need to staff customer service representatives to handle questions about enrollment and use of benefits to support the new population. Strategies counties used and lessons learned included combining funding from multiple sources to fund the expansion activities. For staffing shortages, case workers and contracted workers were used to process enrollment as a way to quickly get staff onboard. Call centers were staffed up to meet the needs of the newly-eligible population and drop-in centers where individuals could ask questions were also made available.

## Conclusions

The findings from this case study offer a variety of strategies and lessons learned that counties implementing a Medicaid expansion may want to consider when they encounter challenges. In addition to identifying successful strategies, we also note remaining challenges that counties continue to address in health system operations, access to services, outreach and enrollment, and county administration that counties seek ways to resolve. These concerns include the financing of safety net hospitals, connecting especially vulnerable populations coverage; addressing low health literacy among newly eligible populations; effectively integrating behavioral and physical health, and improving infrastructure and communication among all agencies involved in the ongoing implementation of the Medicaid expansion.

Many of the issues encountered occurred before some of the changes resulting from the ACA were in effect (e.g. streamlined eligibility processes) or were implemented alongside other major changes in health care. Therefore, the experiences in these counties implementing early coverage expansions may not be representative of issues that would be encountered today. County programs continue to evolve, working through the myriad of challenges that present themselves with the expansion. We have shared these experiences so that other counties can find common ground and use information that can help them in thinking of avenues for addressing their needs.

## INTRODUCTION

As of March 2016, 31 states, including the District of Columbia, had expanded Medicaid coverage under the Affordable Care Act (ACA) to individuals up to age 65, with incomes up to 138 percent of the Federal Poverty Level (FPL), who meet residency and lawful citizenship requirements.<sup>1</sup> The impact of implementing the ACA on local and county governments has been lacking in research, yet depending on the state, the effect of the expansion on these governments may be profound. More than half of states require counties to fund a portion of the state's share of Medicaid by either covering the costs of specific services for Medicaid recipients (e.g., long-term care or mental health), or by funding Medicaid administrative costs through intergovernmental transfers. Counties are often responsible for the provision of numerous social and health services to low-income and uninsured individuals. Counties may do so through county health departments or county-owned hospitals or in partnership with other local, regional, state, or public or private health care providers, often underwriting a significant amount of the care (National Association of Counties, 2013). Enrollment and coverage through the Medicaid expansion for the portion of eligible, low-income individuals who were previously in some county-based programs would leverage federal funding, helping to offset county costs.

Additionally, increased Medicaid coverage provides many people with access to mental health and behavioral services, as well as other community health care, and counties have the task of ensuring adequate providers are available for the newly-covered population. Access also requires continuity of care, which requires effective linkages among county agencies and organizations. The availability of Medicaid coverage provides an incentive to leverage those opportunities in which the county is the provider, whether through jails, county safety net providers, mental and substance abuse providers, or Medicaid. Providing outreach to ensure that eligible individuals are enrolled and retain their Medicaid coverage as long as they remain eligible also often falls to counties.

As such, counties face many decisions and challenges in implementing the Medicaid expansion at the local level including operational and financing changes for county offices that process Medicaid eligibility and for county-supported health service providers. Understanding these efforts is central to the threefold focus the U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Planning and Evaluation's (ASPE's) *County Experiences with Medicaid Expansion Implementation* project:

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<sup>1</sup> Louisiana's Governor signed an Executive Order on January 12, 2016, to adopt the Medicaid expansion, but coverage under the expansion is not yet in effect, so Louisiana is not included in the 31 states that expanded coverage as of March 2016.

- Gathering information on Medicaid expansion administration, outreach, and enrollment at the county and local level.
- Identifying and synthesizing lessons from early Medicaid expansion efforts to help inform states about the key county and local preparations necessary for implementing a Medicaid expansion.
- Providing tailored technical assistance requested by select counties in the ongoing implementing of their Medicaid expansion work.

The first step in this process was a series of discussions with two groups of stakeholders: national organization representatives and experts in Medicaid expansion implementation; and county and local leaders in counties in which section 1115 Medicaid demonstration authority was used to implement a Medicaid coverage expansion prior to January 2014. The discussions considered topics such as integrating state and county-level Medicaid expansion activities, coordinating with critical partners, the impact of the expansion on the county health system, provider adequacy, program management, outreach and enrollment, coordination with ACA enrollment, and health care utilization. Discussions within each of these topic areas focused on key challenges and issues, successful strategies and lessons learned, and areas for potential technical assistance for counties.

The second step in this process was a literature review and environmental scan. Guided by the discussions of issues identified by national experts and county stakeholders, this review focused on providing further understanding of these issues and identifying key lessons for counties to inform their efforts in implementing Medicaid coverage expansions.

The third step was a series of site visits to four counties in which a Medicaid coverage expansion had been implemented prior to January 2014 with the goal of developing a direct, comprehensive understanding of the Medicaid coverage expansion's implementation in the county. The outgrowth of these visits is this case study report, which looks in-depth at the counties visited and incorporates findings from the discussions with stakeholders and the literature review and environmental scan. This report discusses key characteristics of these counties, identifies key similarities and differences across programs, challenges and issues in implementation and in ongoing programs, and strategies that were successful in addressing them. Appendix A offers a description of the specific county programs. Appendix B provides a table with the key characteristics of the county programs. Given the differences among counties across the country in administrative structure, population size, proximity to urban centers, state-county relationships, and a myriad of other factors, there is no one way to implement a Medicaid expansion that will be relevant for all counties. In addition, many of the issues encountered occurred before some of the changes implemented as part of the ACA (e.g. streamlined eligibility processes) or were implemented alongside other major changes in health care. Therefore, the experiences in these counties implementing early coverage expansions may not be representative of issues that

would be encountered today. Nonetheless, counties can glean lessons from stakeholders, the literature, and other counties implementation experiences to help inform some of the decisions that they make as they move forward with their own programs. This is the intent of this case study and it is our hope that counties will find it informative and useful.

## METHODS

### Site Selection Criteria

Counties were considered for a site visit if a Medicaid coverage expansion had been implemented in their county prior to ACA implementation on January 1, 2014, either through a county-level or statewide Section 1115 demonstration or state plan amendment and the expansion was locally driven or the county serves as a provider of health services and is strongly involved with outreach and enrollment efforts. In addition to this basic criterion, other factors considered were:

- Health delivery system and resources available (e.g., county jail, community health centers, public health services, hospitals, behavioral or substance abuse treatment centers) and whether partnerships have been developed among them.
- Expertise in engaging key sub-populations among the newly Medicaid-eligible, including individuals experiencing homelessness, those with chronic diseases, those with behavioral health needs, and those involved with the justice system.
- Adequacy of primary care and behavioral health provider networks (with the aim of including localities with more and less robust networks).
- Potential generalizability of the county's experiences to other counties.

Based on the criteria, discussions with ASPE, and the receptiveness of counties to participating, four counties were selected: Alameda County, California; Cook County, Illinois; King County, Washington; and Cuyahoga County, Ohio.

### Site Visit Approach

Site visits occurred from June 2014 through October 2014. The timing of site visits was set to accommodate the availability schedules of county stakeholders. At the time of the visits, Medicaid coverage expansions had been implemented by the four counties for varying amounts of time, ranging from 3.5 years in Alameda County, 2.75 years in King County, 1.75 years in Cook County, and 1.67 years in Cuyahoga County. A stakeholder who was central to the expansion enrollment effort was identified at each site to serve as a primary contact for site visits, follow-up phone interviews, and subsequent technical assistance. One member of our project team served as the primary RTI contact for each site, to give site staff a consistent "face" for this project. Based on discussions with the primary stakeholder, individuals who were important to the Medicaid expansion work were selected for interviews, representing a range of agencies and organizations and roles. People interviewed included staff at community-

based organizations, municipal or county government staff (including Medicaid agency staff and Department of Human Services' staff), health plan administrators, medical providers, systems navigators, and members of key local commissions, policy committees, or advisory groups involved in Medicaid expansion.

RTI developed a discussion guide that could be tailored to local policy context and the respondent's role in the Medicaid coverage expansion. Three-person teams visited the four counties over a period of three days, providing time for detailed interviews with stakeholders from a wide variety of agencies. When key stakeholders were unavailable during the site visit, telephone interviews were conducted after completion of the site visit to ensure a comprehensive understanding of the county's experiences. One team member took near-verbatim notes on a Pointsec-protected laptop for each interview. Immediately afterwards, notes were reviewed for accuracy and completeness.

## **Identification of Key Themes**

Discussions with stakeholders covered multiple areas related to the Medicaid expansion and the stakeholder's practical experiences in planning and implementing the expansion. Guided by topic areas that emerged during the stakeholder discussion, interviews focused on the following areas:

- State Integration;
- Key Partnerships;
- Eligibility Determination and Enrollment;
- Outreach Strategies;
- Health Care Literacy and Access;
- Provider Issues; and
- Funding and Staffing.

Notes taken during interviews were synthesized and major themes that emerged within each topic area were identified and summarized. These themes are discussed in depth in this case study, both within the description of each county visited and in the overall findings.

## **Key Similarities and Differences Across Counties**

A key factor in determining similarities and differences was whether the coverage expansion was led at the county or state and if at the county-level, the agency or organization driving its implementation. Cook, Illinois and Cuyahoga County, Ohio were county-led expansions, in which the Medicaid expansion occurred only in the specific county prior to 2014 and did not occur statewide. These expansions were driven by the county public hospital and initially converted their existing uninsured population base who were served by providers within the system, although they later expanded their provider networks to include other community hospitals and federally qualified health

centers (FQHCs). Cook County also expanded its focus to getting coverage for individuals exiting Cook County jail. Alameda County, California's efforts were county-led, driven by the Alameda County Health Care Services Agency (ACHCSA), with a more expansive focus from the outset on getting newly-eligible people in the community enrolled. King County, Washington was a state Medicaid expansion, but a large portion of the expansion population resided in the county and extensive outreach of newly-eligible and the provision of services was through the county.

While counties visited varied in their approaches in designing and implementing the Medicaid expansion, there were strong similarities across counties. Having a County or Public Hospital Administrator who served as a "champion" along with both a vision and commitment by leadership at both the county and the state level was an important first step that these counties shared. Additionally, close working relationships with the state (that often existed prior to the expansion) were critical through the development and implementation of the expansion. This did not mean that there were no challenges or tensions between the two governments. Examples were provided by interviewees in all counties of times when it seemed that state requirements were designed without county input or an understanding of county-level processes, but overall, counties were pleased with the collaborative relationships that grew out of their hard work and praised state counterparts.

All counties successfully developed partnerships with other organizations that supported their Medicaid expansion implementation. They each reached out to other safety net providers (i.e., FQHCs), the criminal justice system, and community and faith-based organizations to help lead the charge on outreach and enrollment of new beneficiaries. The three counties that had their own eligibility and enrollment systems also facilitated enrollment by using administrative data to lessen the eligibility documentation burden on applicants. When the statewide Medicaid expansion was implemented in 2014, people enrolled in the early expansion in each of these counties were manually processed into the new statewide system.

Each county interviewed spoke of focusing on enrollment in their first year of implementation and how with the success they experienced in enrolling so many of the newly insured, they realized that they needed to now focus on ensuring access, coordination of care, and provider adequacy and were working in this direction. To address rising demand for services, providers were hiring additional clinical and administrative staff and were adapting to new payment models. Counties were also recognizing a lack of health care literacy in many of the newly insured and its potential impact on their ability to use their coverage and struggling with finding adequate resources to address it.

## FINDINGS

While each of the counties that were visited had their own unique circumstances, it was also clear that the counties shared some commonalities. In many cases, these issues were echoed by findings from the discussions with national experts and local stakeholders as well as the literature review conducted before the site visits. This section describes strategies for addressing implementation issues, integrating findings from the national and local stakeholder discussions, the literature review, and the site visits across the following topics:

- State Integration;
- Key Partnerships;
- Eligibility Determination and Enrollment;
- Outreach Strategies;
- Health Care Literacy and Access;
- Provider Issues; and
- Funding and Staffing.

### State Integration

#### *Operational Issues*

A number of issues related to state integration were identified throughout the project and were echoed during the site visits. In particular:

**“Silos” among agencies.** While not the case in every county, interviewees at both the state and county-level identified that “silos” such as those between state Medicaid and state behavioral health agencies or those between county departments of human services and county hospitals created challenges in coordinating implementation of Medicaid expansion efforts.

**Systems issues and/or state and county-level resources.** Systems issues and/or staff capacity to handle the processing of applications was a challenge echoed across all counties. New system development and resource issues arose during application and enrollment processing. The challenges occurred both at the state level and county level.

**Workforce issues.** In some cases, counties identified the requirement to have state employees determine eligibility for Medicaid as a challenge.

## ***Successful Strategies to Overcome Operational Issues***

**Coalition-building.** During the national stakeholder meeting, local stakeholder interviews, and site visits, it was clear that inter-agency coalitions assembled to guide the Medicaid expansion effort have been invaluable in strengthening the coordination among agencies and in many communities. Coalition-building efforts at state and county levels were strengthened by frequent meetings, early involvement of all stakeholders in the planning process, an emphasis on potential shared cost savings, and an emphasis on better and more efficiently serving a shared population. Many counties emphasized the value of frequent meetings and calls between the county health care agency and the state Medicaid agency to address state-county communication gaps as critical to their success. For example, Alameda County participated in weekly webinars with the state Medicaid agency throughout the implementation process to identify and resolve any issues encountered by the county which led to quick resolution of many issues.

**Support from the state-level.** Several counties noted that the implementation of their Medicaid expansion could not have been successful without the state's involvement in negotiating the terms of the Section 1115 demonstration with both the HHS Centers for Medicare and Medicaid Services (CMS) as well as with elected officials.

**Clear guidance.** Local stakeholder interviews and county site visits highlighted the need for clear, definitive direction from the state regarding data systems and documentation standards for eligibility verification. Several interviewees in state-level agencies also identified that at times their inability to provide this type of guidance is driven by a lack of clear federal guidance and suggested the need for further communication with CMS on issues, such as requirements to have state employees determine Medicaid eligibility.

## **Partnerships**

### ***Operational Issues***

Site visit interviews, along with national stakeholder meeting and literature review findings, show that expansion leaders are faced with a host of challenges in creating partnerships that are critical to expansion work.

**Lack of shared language among stakeholders.** Effective partnerships often include public agencies, community-based organizations, health providers, and organizations with expertise in dealing with specific populations. Many of these organizations have divergent goals and define their targeted population in different terms. Getting these stakeholders on the same page about the goals of Medicaid expansion requires commitment and finding intersecting areas of common concern.

**Extensive time and resources required from lead agencies.** Effective partnerships require a significant time a staff resource commitment, which is difficult for agencies that are oftentimes understaffed and already overextended.

### ***Successful Strategies to Overcome Operational Issues***

Counties employed the following promising practices to build successful partnerships:

**Create a shared understanding about what can be gained from coverage expansion and involve partners in the planning stages.** Across the site visit counties, successful partnerships were based on a foundation of shared understanding regarding the implications of coverage expansion for all partners' constituents. Partners were effectively motivated to participate and contribute by a desire to realize the potential benefits of Medicaid expansion for the populations they serve. For example, the ACHCSA convened a collaboration involving various key county-level entities by appealing to these agencies' commitment to public health and social justice, ensuring that all partners were deeply invested in the mission of expanding coverage. Additionally, county leaders developed buy-in by including partner organizations in the planning stages of their expansion efforts, allowing partners to actively shape these efforts and the goals they sought to address. Cook County representatives included charitable foundations in early workgroups, established to identify obstacles to enrolling hard-to-reach populations, strategies for overcoming these obstacles, and potential outcomes associated with expanded access for these populations. Specifically, Cook County relied on a workgroup, established prior to the Medicaid expansion, consisting of a variety of community stakeholders co-chaired by a county judge to conduct its jail-based enrollment drive.

**Maintain regular communication and create opportunities for partner feedback.** Providing ample opportunity for communication and feedback with partner organizations represented another key feature of effective partnerships. The nature of this communication varied by stakeholder type and county context, but it consistently benefited both expansion leaders and their partners. In Alameda County, ACHCSA coordinated regular contact and meetings with their partners as they worked through implementation issues. Public Health--Seattle and King County used its First Friday Forum to allow stakeholders to share information about progress in expansion implementation and to deal with problems that arose. Partner organizations appreciated this opportunity to stay abreast of developments and have their concerns heard.

**Work with community organizations that already serve low-income populations to facilitate outreach and enrollment of hard-to-reach populations.** Our literature review suggested that organizations serving low-income populations are natural partners in outreach and enrollment work, and site visit interviews echoed this finding. Site visit counties partnered with a variety of entities in their community who had established relationships with the intended target population of the Medicaid expansion. Cook County leaders worked with predominantly African American churches to reach

low-income, uninsured Cook County residents. To reach justice-involved populations, counties worked with a variety of public agencies and non-profit organizations. For instance, in Cook County, Treatment Alternatives for Safe Communities (TASC), a community-based organization that regularly works with justice-involved populations, played an integral role in orchestrating the county's successful jail-based enrollment drive. King County had success in reaching its homeless populations by training case managers to become application assistors.

**Work with provider organizations and draw on existing relationships with provider organizations when possible.** Literature review findings suggested that provider organizations and health centers are natural outreach and enrollment partners because of their existing relationships with health care consumers, along with their vested interest in the success of Medicaid expansion due to the potential for increased reimbursement for services provided to previously uninsured patients. Indeed, provider organizations proved to be crucial partners in all site visit counties. Across counties, FQHCs proved to be valuable partners in reaching uninsured residents, as they regularly engaged uninsured individuals with medical needs and were in some cases able to invest their own resources in outreach and enrollment. In Cook County, relationships between Cook County Health and Hospitals System (CCHHS) and provider organizations were in many cases formalized through the creation of CountyCare, which created a contractual relationship that for care delivery, outreach, and enrollment. Similarly, MetroHealth in Cuyahoga County drew on existing relationships it had with provider organizations that delivered specialty care to the expansion population. In King County, provider organizations took a high degree of initiative in coordinating their own outreach and enrollment work. Hospitals, with support and guidance from the Washington State Hospital Association, designed and conducted outreach and enrollment plans. Behavioral health providers met regularly to discuss their effective strategies for outreach and enrollment.

**Use partnerships to streamline the enrollment process.** Particularly valuable partnerships were those that served to make the enrollment process more efficient and to garner support in the form of enrollment resources. Cook County provides an example of a partnership that streamlined the enrollment process by creating an effective way of addressing documentation requirement; applicants often lacked copies of their birth certificates, but a relationship with the Cook County Clerk's Office made it possible for applicants to apply without having birth certificate. In addition to their reliance on state agencies for enrollment funding support, county leaders worked with state agencies to ensure that the enrollment process went smoothly. For example, in King County, the county worked with the state to deal with problems that came up in application processing and to address any ambiguity in eligibility rules.

## Eligibility Determination and Enrollment

### *Operational Issues*

The communities that we examined implemented coverage expansions prior to many of the streamlined eligibility and enrollment processes now in place. Therefore, many of the issues that these counties encountered may be mitigated with new streamlined processes.

Site visit counties discussed numerous challenges related to the documentation requirements, the difficulties in sharing data across agencies to facilitate enrollment and eligibility systems issues that were sometimes exacerbated by the transition to a statewide eligibility system under the ACA. Although most interviewees agreed that the early expansion had positioned them well relative to counties and localities without early expansion efforts, the transition was often fraught with challenges. Most often, these challenges took the form of data systems compatibility issues (i.e., difficulties migrating cases from old to new Medicaid data systems). Specifically, issues identified and discussed included:

**Eligibility documentation.** Members of key target populations, including justice-involved persons, homeless persons, and those with no income, were unlikely to have traditional forms of eligibility verification documentation (including photo identification, birth certificates, tax forms, pay stubs, and proof of address).

**Multi-stage coverage application process.** The multi-stage Medicaid application process is perceived as very difficult for low-income, vulnerable populations to complete.

**Legal and regulatory barriers.** Data-sharing problems impeded the development of many partnerships that were aimed at identifying and enrolling eligible persons and coordinating their care. There are legal and regulatory barriers to sharing data among agencies, including regulations associated with the Health Information Portability and Accountability Act and additional constraints specific to behavioral health information.

**Differences in access to information technology.** Variation in access to information technology at the local level impedes multi-sector coordination. For example, staff in some local agencies lacked ready access to email or the Internet.

**Glitches in electronic enrollment platforms.** County agencies reported many problems with application platforms freezing or presenting glitches that were time-consuming for staff to resolve. Such systems challenges often greatly impacted the time required of partner agency staff to input applications, limiting the volume of enrollments that could be facilitated using existing staff.

**Backlog of enrollments at the state level.** In all counties visited, there were challenges with processing enrollments that had been submitted by the county to the state, at least initially. Such challenges often led to a substantial backlog.

**Transition from county-based to statewide eligibility systems.** Stakeholders in the three county-driven early expansion systems shared a variety of logistical challenges associated with the transition to an expanded statewide Medicaid program. Some noted that periods of uncertainty about pending state-level expansion decisions had impeded the transition planning process. They also noted that data systems differences presented immense challenges in transitioning people from local programs to the state Medicaid system. In one county, the selected system for Medicaid enrollment post-ACA implementation was acquired from a state with a centralized Medicaid eligibility system. This created specific challenges for their ability to use the system in a county-based Medicaid system that used the application to determine eligibility for multiple programs (some of which were county-based). This resulted in workers having to move to completing two eligibility applications, one for county-based programs and services and the other for Medicaid when previously, there had only been one application.

**Concern about system backlog at renewal resulting in people losing coverage.** Stakeholders and counties were very concerned that enrollment backlogs and systems issues would result in the newly-covered losing Medicaid coverage at the time of renewal. Alameda was particularly concerned that the state had declined accepting an extension for renewals that had been offered by CMS.

### ***Successful Strategies to Overcome Operational Issues***

**Regular communication to resolve system issues.** National and county stakeholders as well as site visits interviewees emphasized the importance of regular, recurring phone calls and in-person meetings with major partners. County stakeholders recommended focusing particular effort on ties with key safety net providers (including behavioral health, hospitals, and community clinics) and justice agencies. A strong individual relationship between the county health director and the county social services director was seen to be crucial for optimizing enrollment and renewal processes. To address state system issues that impacted their ability to enroll new individuals, several counties had recurring phone calls with the state. This relationship with the state was key to being able to identify and resolve challenges as they came up during implementation.

**Presumptive eligibility and streamlined enrollment processes.** Several counties worked with their state Medicaid offices on acceptable alternatives to various forms of eligibility documentation. For example, Cook County worked with its state partners to obtain formal guidance authorizing the use of self-attestation of income and of residence, as well as the use of jail fingerprints to substantiate identity for incarcerated persons. Counties also identified (and in the case of Alameda, even paid to access) existing administrative sources of eligibility verification data, such as county

birth and death records, jail fingerprint records, and income records, to document eligibility. Cuyahoga County used an auto-enrollment protocol which considered anyone served by their disproportionate share hospital (DSH) program within the last 90 days to be eligible, and drew on the county administrative lists to establish United States citizenship rather than requiring this documentation from applicants. For more detail on specific strategies, see Appendix.

**Streamlining renewal processes.** Finally, stakeholders and county interviewees emphasized the need to automate and simplify renewal/redetermination systems as much as possible in order to ensure retention and facilitate continuity of care. Cuyahoga County negotiated with the state to have renewals done on a staggered basis so that not all enrollees would need to be renewed at the same time. The hope was that the staffing resources would be better able to address renewals.

## Outreach Strategies

### *Operational Issues*

Numerous issues related to reaching newly-eligible persons through outreach were discussed in the literature review, by national and county-level experts at the national stakeholder meeting, and by stakeholders on site visits.

**Trust.** A lack of trust in government institutions presented a barrier to engaging some eligible populations, such as immigrants, justice-involved persons, and low-income persons who had previous negative experiences with government programs.

**Knowledge and cultural competence of enrollment personnel.** National stakeholders reported a lack of cultural competence and gaps in knowledge of Medicaid eligibility criteria and application processes among health insurance Navigators. They also reported that communities had difficulty securing Navigator participation and follow-through for community-sponsored outreach and enrollment events.

**Enrollment resources.** Many outreach and enrollment strategies are resource-intensive, and counties' ability to sustain them over time is uncertain.

**Differential effectiveness of outreach efforts with different populations.** All four sites reported challenges with reaching some communities in their outreach and enrollment efforts. These often included rural communities, immigrants (particularly people in mixed-documentation-status families and members of small, non-Latino immigrant communities with limited English proficiency), people with mental illness, and those experiencing homelessness. In addition, some sites faced challenges obtaining the enrollment statistics they needed to be able to determine how well their enrollment efforts were working in different communities and where to target more resources or reconsider their approach.

## ***Successful Strategies to Overcome Operational Issues***

Stakeholder discussions and site visit interviews yielded a variety of strategies that counties have found helpful in overcoming these outreach and enrollment issues, including:

**Proactively identifying prospective enrollees and initiating contact with them.** Several counties used data on patients from county hospitals and community clinics to automatically target uninsured persons for Medicaid enrollment. They supported targeted patients in completing the application process, including drawing on existing electronic records from other government programs or even purchasing birth records from other states for administrative matching purposes (Alameda County). Cuyahoga County enrolled all individuals from its charity care program who met certain criteria into the newly expanded Medicaid program.

**Leveraging partnerships with providers, community and faith-based organizations.** Counties worked with other locally administered health and human services programs to create presumptive eligibility and one-stop enrollment processes. For example, Alameda County added a checkbox to required paperwork for county General Assistance recipients and behavioral health services clients to indicate if they wanted automatic health coverage enrollment. Several hospital systems presumptively enrolled uninsured emergency department patients. Typically, the hospital was responsible for actively following up to obtain required documentation from these patients, but would still be reimbursed for their care during the presumptive eligibility period, even if the documentation could not be obtained or they were found to be ineligible for Medicaid.

County interviewees and national stakeholders agreed that engaging partners effectively was crucial to overcoming outreach challenges. All counties and national stakeholders stressed the importance of working through trusted channels to reach members of marginalized groups. For example, King County developed a comprehensive list of important sub-populations of newly-eligible persons in the county. Some, such as neighborhood zip codes containing large numbers of eligible persons, were identified based on sheer numbers, while others (such as the Samoan immigrant community) were small in numbers but deemed important for health equity reasons. The county then identified liaisons and partners in each of the targeted communities to guide and facilitate their outreach and enrollment materials and activities.

Key outreach and enrollment partners across the four site visit counties included providers serving low-income patients, community-based and faith-based organizations in low-income neighborhoods, and other county government agencies (e.g., justice). Stakeholders noted that many faith-based organizations and community groups were willing to volunteer resources toward getting the constituencies they cared about enrolled. Various county site visit interviewees reported success from building partnerships with county justice agencies, and Alameda County strongly recommended helping staff in these and other partner agencies to identify (and obtain state

certification of) match-eligible Medicaid Administrative Activities (MAA) to help them draw down federal match to afford their involvement. Alameda County also recommended saving staff labor by linking the jail booking and Medicaid application processes, so that eligibility-relevant data elements from the jail intake could be pulled into a pre-populated Medicaid application.

**Conducting large-scale community outreach events.** Counties leveraged their partnerships to implement a number of large-scale community outreach efforts, often reaching large numbers of eligible persons without large marketing budgets. For example, the leader of the Cook County health system reported traveling to a different “mega-church” every Sunday and delivering a pastor-endorsed pitch for health coverage enrollment, accompanied by a supporting team of application assisters. Alameda County leveraged a wide, diverse county-contracted community clinic network to educate patients about coverage and help them enroll. County leaders felt that this strategy was particularly effective for bringing members of urban, low-income communities of color into coverage in large numbers. Other mass community outreach efforts included mobile outreach and enrollment units (such as Alameda County’s “Enrollment on Wheels” RV), outreach at rural libraries and community centers (in King County), and widespread event-based outreach at events such as farmer’s markets and community fairs.

## Health Care Literacy and Access

### *Operational Issues*

The issues of health literacy and access to health care are intertwined in the eyes of many stakeholders involved in county-level administration of Medicaid expansion.

**Causes of low-health care literacy are multi-faceted.** In the site visits, stakeholders perceived that many factors contribute to low-health literacy among the Medicaid expansion population, factors such as: long-term, historical exclusion from traditional health insurance (public or private) prior to Medicaid expansion; multiple physical, mental, and behavioral health co-morbidities; and extenuating life circumstances such as homelessness. This means that there is no one approach to effectively address this issue.

**Low-health care literacy impacts the utilization of health services.** Stakeholders expressed concern that low-health literacy would affect this population’s ability to make health care appointments, and to understand which types of providers to see for which needs. County officials and health plans administering benefits to the Medicaid expansion population raised questions as to how to address the implications for both quality of care (such as care coordination) and cost of care. As one stakeholder pointed out, use of the Emergency Department for non-emergent conditions may be less an issue of health literacy and more a sign that health care system changes are needed to draw people towards primary care instead. Similarly, for high-

need populations such as people with homelessness and co-morbidities, coordinating care across multiple services would be difficult for even the savviest health care consumer. For example, in conversations with national stakeholders, organizations partnering with counties to promote Medicaid expansion reported that even their front-line staff sometimes find county health services systems difficult to navigate.

**Cultural competence.** Lack of cultural competence among local providers and in health education materials impact the ability for different populations to understand the new benefits for which they are eligible and how to access these benefits.

Some counties highlighted barriers to health care access regardless of individuals' health literacy. These include:

**Disruption in continuity of care.** When enrollment in coverage through the Medicaid expansion results in auto-assigning an enrollee to a primary care provider other than the provider they usually see, this has the possibility of disrupting care. This applies to populations with special needs, such as individuals who are HIV positive or living with AIDS and covered under HIV-specific or Ryan White programs, as well as people who were receiving free primary care from providers who may or may not participate in Medicaid or an expansion-specific county health plan.

**Criminal justice transition.** Transitioning the health care of justice-involved persons from prisons and jails to the community upon release present distinct difficulties in terms of release planning and reestablishing connection with health care in a home community. Persons incarcerated in prisons are often housed far from their home communities, and have experienced a long period of disconnection from those communities and their local service providers. However, their release dates are fairly reliable. Those in county jail may be better able to stay connected to their home community, but have highly variable release dates, which can hinder having processes to ensure they are enrolled in Medicaid when they leave.

### ***Successful Strategies to Overcome Operational Issues***

We found a number of tested and suggested strategies to overcoming issues related to low-health literacy, disruption in continuity of care, transitions of justice-involved people to their communities, and lack of cultural competence. These strategies came from site visit counties, national stakeholders, and recent published literature.

**Use of care coordination.** One strategy that was used to address health literacy was the use of care coordinators to help newly-enrolled individuals to find appropriate resources to meet their health care needs (Cuyahoga County) or placing a care coordinator in a hospital Emergency Department to refer patients back to their medical home, schedule follow-up appointments, and provide education about availability of the

medical home.<sup>2</sup> In Cuyahoga County, care coordination includes giving patients access to online provider systems, like a Personal Health Record, to help patients make appointments online. Contracting with homelessness and supportive housing organizations to serve as care coordinators for clients with housing needs along with medical, dental, and behavioral health needs was another strategy that was recommended by the national stakeholder group.

**Direct and indirect communication with enrollees.** Clinic-based advertising (e.g., simple flyer with images) describing services that are available with Medicaid coverage were also effective for communicating with enrollees about available services. This effort helps promote the use of preventive services and connects people to a health care provider so that they are more likely to renew and continue coverage upon their renewal date. Additional marketing from county, clinics, health plans, or Medicaid to urge people to not throw away important Medicaid enrollment material, but rather direct people to places that can help them understand their coverage. A number of counties and stakeholders cited the establishment of call centers or in person drop-in centers as central to addressing the concerns of the newly-eligible population and improving enrollees' health care literacy. Some counties sent letters to every newly-enrolled person that specified their primary care provider assignment, and then made a follow-up call to determine whether the enrollee had been able to make an appointment with that provider. One particularly interesting approach described in the literature but not identified during the site visits was the idea of using text messaging about health care coverage to support health literacy.<sup>3</sup>

**Transitions from criminal justice to community health care.** Transitions from the criminal justice system into care creates unique challenges. To address these challenges, some counties trained probation officers about benefits of health care and health coverage, and include health care in re-entry plans where appropriate, and follow-up to see if they accessed needed services. King County trained release planners to serve as in-person application assisters. Other counties also contracted with a behavioral health assessment provider designated to serve the probation population, and stationing this worker at a local probation office. In addition to probation providing an opportunity to intervene, national stakeholders suggested using a nurse discharge planner under contract to the sheriff's department to coordinate pre-release planning that included appointments with community-based providers and prescriptions for post-release medications. Employing a social worker at the health plan level to assist those returning from prison in accessing medical and behavioral health services should also be considered.

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<sup>2</sup> N. Pourat, A.C. Davis, E. Salce, D. Hilberman, D.H. Roby, & G.F. Kominski (2012). In ten California counties, notable progress in system integration within the safety net, although challenges remain. *Health Affairs*, 31(8), 1717-1727.

<sup>3</sup> A. Gates, J. Stephens, & S. Artiga (2014). *Profiles of Medicaid Outreach and Enrollment Strategies: Using Text Messaging to Reach and Enroll Uninsured Individuals into Medicaid and CHIP*. Kaiser Commission on Medicaid and the Uninsured.

**Cultural competence.** Several counties were reaching out to very diverse populations. To address issues of cultural competence, most counties translated materials by providing English language and second language in their program materials--this leverages the materials about Medicaid and health insurance as teaching tools as well. In King County which had a very diverse population, they found it effective to conduct focus groups with key communities to understand messages that will work as well as including images of people that reflect the ethnicity of the population that is receiving the materials. King County also used a Promotora model which includes the use of lay Hispanic/Latino community members who receive specialized training to provide basic health education in the Hispanic/Latino community to increase health literacy.

## Provider Issues

### *Operational Issues*

Two major themes related to health care providers in early Medicaid expansion emerged across sites, interviewees, and the literature. The first theme is the increased demand for services, usually among patients who need specialty care and substance abuse or mental health services. The second theme is how providers are adapting to new health care payment models, either to respond directly to the types of patients that have become Medicaid-eligible under expansion, or to respond indirectly to trends in the Medicaid or health care financing environment that happen to coincide with Medicaid expansion.

**Increased demand for services.** In part due to the increased demand from Medicaid expansion, county leaders, hospitals, and primary care providers often report frustration with having inadequate capacity for serving specialty and behavioral health needs. In some places, the influx of enrollees also stretched existing primary care, dental, and pharmacy capacity. In counties that faced primary care shortages, interviewees noted that was an ongoing concern prior to the Medicaid expansion.

**Adapting to new health care payment models.** All types of providers are adapting to new payment models that are emerging because of, or concurrent with Medicaid expansion. In some cases, new payment models and the needs of the expansion population are providing sufficient pressure on health care providers to drive changes in care delivery. However, even where providers recognize the need to change care delivery models, they are facing barriers in making those changes. Examples of challenges to achieving desired care delivery models identified across counties include:

- The development of patient-centered medical homes (PCMHs) in primary care, especially to bridge medical and social service needs, requires change in physician culture towards team-based care, and practices often lack resources to adopt all medical home features.

- Safety net providers, such as county hospitals and clinics have experience caring for the Medicaid expansion population, but now that their patients have Medicaid, they may choose to seek care elsewhere. These county hospitals are facing both a decrease in Medicaid DSH payments and the potential loss of a client base that could generate revenue for the hospital now that they have Medicaid coverage. They need to develop a different set of strategies to become the provider of choice.
- Greater coordination across primary care and behavioral health care would best manage the health of individuals with physical and mental co-morbidities, but barriers to doing so include shortages in mental health providers; federal regulations governing the disclosure of substance abuse treatment information; and state laws governing the disclosure of mental health treatment information.
- Providers of behavioral health services and services to the homeless population may be ideally suited to continue their care of current clients now eligible for Medicaid services, but in order to bill Medicaid for services, these providers must meet Medicaid requirements. Behavioral health service providers may not meet the degree or certification requirements (i.e., peer counselors) even though they have effective methods for addressing clients' health needs. Other funding streams need to be utilized and coordinated to continue funding these services. Providers of services to the homeless still need non-Medicaid funding sources for housing.
- In some cases, interviewees identified there is a lack of physical space to bring in new providers so they can staff up their services with the influx of newly-eligible.
- Electronic health records (EHRs) could be useful tools for quality improvement and coordination across providers, but the implementation of EHRs is often difficult and time-consuming.
- In counties that developed a new managed care plan for the expansion population, new benefits managers may be inexperienced in contracting with behavioral health providers that have been serving the Medicaid population, or designing benefit packages that allow patients to be served most efficiently.

### ***Successful Strategies to Overcome Operational Issues***

Counties are addressing provider-related issues in a number of ways, according to what they can do given their state's Medicaid policies and the capacity of local health care and social services.

**Optimizing service delivery using existing resources.** Most counties utilized options to optimize service delivery within their existing provider networks, emphasizing the use of Physician Assistants and Nurse Practitioners who could deliver primary care

services at the upper end of their licensed scopes of practice. In Cook County, access was increased through expanded provider hours, such as evenings and Saturdays. In Alameda County, the health plan offered block grants to providers who could increase access through same-day visits. The Alameda County Health plan also recruited independent physicians of color whose practices were already embedded in low-income communities into their network.

**Using new resources.** All counties tried hiring new providers to meet the increased demand of seeing newly-eligible patients. Both Alameda and Cook Counties expanded their health plan networks to include more providers in areas where a long-term rise in demand was expected among the newly-covered population, such as primary care and behavioral health. Networks included existing community mental health agencies and FQHCs, however, this was often not enough to meet the increased demand. In some cases, there was insufficient space, so building new facilities to accommodate additional staff was necessary. King County contracted with a non-profit that offers dental care in vans (mobile sites) to meet the increased demand for dental services.

**Adapting services to the new payment model.** Innovative strategies to accommodate the new payment model were introduced in the counties we visited and were discussed during the national stakeholder meeting and on county stakeholder calls. These included:

- Moving primary care clinics towards PCMH model, as one way to try to shift the county health system's approach away from costly emergent care only towards more cost-effective preventive care. (Cook County)
- Implementing a comprehensive care coordination program for enrollees to ensure that they were accessing appropriate services. (Cuyahoga County)
- Conducting a paramedic medicine pilot (paramedics doing home visits after hospital discharge) to reduce readmissions. (Alameda County)
- Funding training for primary care providers to learn how to integrate behavioral health with primary care. (Alameda County)
- Providing assistance to behavioral health providers to get their providers certified for Medicaid billing, and providing additional training for behavioral health providers on using Medicaid billing codes for their services. (Alameda County)
- Hiring administrative billing staff at behavioral health clinics, especially to process Medicaid billing. (King County)
- Expanding referral networks from county clinic sites to community health centers, when county primary care clinics are at capacity. (King County)

- Changing behavioral health care benefits managers when it was evident that the initial benefits manager did not have sufficient experience contracting with local providers who were well-suited to provide services to expansion population. (Cook County)
- New York Medicaid is allowing housing providers who are certified Medicaid providers to become designated as a Medicaid health home. (National Alliance to End Homelessness).
- Moving towards value-based payment models for Medicaid; for example, Hennepin County established a county-based accountable care organization (ACO) to contract with Medicaid. This ACO shares financial risk among its component parts, including a medical center, health plan, social services organization, and FQHC.
- Braiding funding to cover services that meet the needs of individuals who qualify for multiple programs. This strategy was recommended by national stakeholders, but was not evident in any of the county site visits or interviews we did.
- Building data systems to track quality of care metrics by patient population rather than by funding source. This strategy was recommended by national stakeholders, and was not evident in any of the county site visits or interviews we did.

## Funding and Staffing

### *Operational Issues*

Both national and county-level stakeholders reported that counties faced issues related to funding and staffing.

**Adopting new business and delivery models.** County health systems and homeless service agencies adapted their business models and internal processes to compete for patients and change the way they collected and reported health care delivery and quality data. Many county safety net providers lacked experience in marketing their services and competing for clients. CCHHS created a new managed care plan CountyCare within the CCHHS. In this way, Cook County took on the role of both the primary provider of services to the population as well as being the insurer for those individuals. Under state changes in Medicaid, nearly all Cook County residents will be in Medicaid managed care plans by 2015. This will provide the population CountyCare served during the early expansion with the opportunity to choose coverage through over 15 different managed care plans. County health systems and other safety net providers also faced challenges with updating their business models to focus more on billing and meet new requirements for quality and safety reporting.

**Lack of new staff resources.** At the state level, additional staff were not hired to work on Medicaid expansion and Marketplace roll-out. Instead, work was reallocated among existing staff. Counties also faced eligibility worker staffing issues, and many lacked the necessary funding or approval to hire new staff to process applications in a timely manner.

**Delays in hiring and difficulty retaining staff.** Cook and Cuyahoga counties experienced delays in hiring staff (case workers and health plan staff) due to bureaucratic and/or administrative delays. Most counties found it difficult to retain adequate staff to process applications and/or work with state workers who processed applications.

**Increase in demand for customer service.** Counties experienced an increase in demand for customer service representatives to answer questions and help the public understand the Medicaid expansion. Increased customer service representatives were needed to handle questions about enrollment and the use of benefits to support the new population. The new population often has limited experience with health insurance and several counties staffed call centers to address their questions about benefits.

**Data integration.** Cuyahoga County and King County both reported that data integration issues with the state impacted staff workload and capacity.

### ***Successful Strategies to Overcome Operational Issues***

We found a number of successful strategies to overcoming issues related to funding and staffing to support the Medicaid coverage expansion including:

**Using local funding resources.** In order to overcome funding challenges, counties combined funding from multiple sources. For example, Cuyahoga County was able to use allocated county taxes to fund the non-federal share of Medicaid financing and Alameda County combined funding from a local tax, Medicaid dollars, and MAA funding to fund the expansion.

**Staffing case workers to process enrollment.** Hiring delays combined with the increase in demand for processing enrollments had the potential to overwhelm the system. In Cook County, contract employees were used to overcome challenges with hiring delays related to bringing new case workers onboard. Alameda County also contracted out approximately 70 percent of services to other providers, including community health centers where staff were already integrated in the community. In Cuyahoga County, overtime was provided to existing staff when hiring was delayed due to administrative issues. Additionally, data integration issues with the state caused further strain to case worker staff capacity for Cuyahoga and Cook counties. To overcome these challenges, counties developed work-arounds for system errors and provided overtime for staff.

**Staffing customer service representatives.** County interviewees also stressed the importance of accounting for the customer service needs of the population in addition to the service delivery needs. While each county approached this differently, their successful strategies included staffing a large call center that was staffed up to meet the needs of the newly-eligible population, staffing drop-in centers where potential and new enrollees could ask questions, and training staff (especially at FQHCs) to address questions or connect enrollees with resources to address their concerns.

**Involving safety net providers.** County stakeholders and county site visit interviewees reported that many safety net providers had invested in enrolling their clients in Medicaid, developing billing-compatible data systems, and hiring staff for billing work. Some had transitioned to serving as medical homes, a business model which many believed would be financially strong. This was particularly true in the FQHCs in each county that appeared to take on a significant role in enrollment and saw the financial benefits of being able to bill for services that they had traditionally provided on sliding scale or without payment.

## CONCLUSIONS AND LOOKING FORWARD

The findings from this case study offer a variety of different strategies that other counties implementing Medicaid expansion efforts may want to consider when they encounter challenges. However, in addition to identifying successful strategies for overcoming operational issues, challenges still remain to be addressed even within the counties included in the site visits. During site visits, stakeholders were asked to identify those areas where issues remained. The areas identified across all counties fall into four main categories: health systems operations, access to services, outreach and enrollment, and county administration.

**Health system operations.** This category garnered a lot of interest, especially among health plans, provider organizations, and clinicians. One main concern centers on implementing managed care for Medicaid enrollees in a network of providers that involves the county health system and others. Another main concern, expressed mainly by the hospital systems in Cuyahoga, Cook, and Alameda counties, is how to keep Medicaid expansion patients at the safety net hospital once they have the ability to choose their own plan, for continuity of care as well as reimbursement reasons. This concern is related to more specific financing concerns identified in some counties by health centers.

**Access to services.** Two of the most frequently mentioned topics across all counties were how to connect the justice-involved population to health care services at crucial points, such as during the re-entry process, and how to educate Medicaid expansion beneficiaries generally about how to navigate the health care system, especially where there are concerns that low-health literacy is a hindrance to understanding how to use health insurance benefits. Additionally, several counties expressed concern with how to provide optimal access to beneficiaries who needed behavioral health care services in addition to physical health care. Another common area of interest was in evaluating the county's efforts to improve access to health care services.

**Outreach and enrollment.** Common concerns expressed across counties were how to outreach to people in specific populations about enrollment, and how to ensure that eligible people renew their enrollment and retain coverage. Outreach messaging was especially a concern in communities with a high proportion of individuals who had been in the United States less than five years, and renewal was a concern particularly among transient populations, such as the homeless. A couple of counties specifically wanted more information on how to efficiently target outreach efforts.

**County administration.** Several counties talked about the need to improve infrastructure and communication with the state and among agencies involved in the ongoing implementation of the Medicaid expansion.

Even with the differences among counties, we identified common themes in Medicaid coverage expansions. County programs will continue to evolve, working through the myriad of issues that present themselves. We have shared these experiences and innovative approaches so that other counties can use this information to help address their specific program needs.

## **APPENDIX A. DESCRIPTION OF COUNTY PROGRAMS**

This section of the case study provides a description of each of the four county programs that had site visits: Alameda County, California; Cook County, Illinois; Cuyahoga County, Ohio; and King County, Washington. It looks at key characteristics of the county within each of the topic areas, considering the issues and challenges faced in these areas and the ways in which counties addressed them. A brief listing of each county's characteristics is provided in Table B-1 in Appendix B.

### **Alameda County, California: "Bridge to Reform"**

#### ***Expansion Date, Mechanism, Population Covered, and Special Population Focus***

Alameda County expanded its Medicaid program to non-pregnant adults ages 19-64 with income at or below 133 percent of the FPL on November 11, 2010, under the Low Income Health Program (LIHP) component of a state Section 1115 demonstration. The county's existing Health Care Coverage Initiative benefit was then modified to include non-pregnant adults from 133 percent up to 200 percent of the FPL who were otherwise ineligible for Medicaid.

Alameda County's expansion work has focused on getting coverage for newly-eligible persons and in engaging several vulnerable populations, including justice-involved persons (jail and probation populations), persons with chronic diseases, and persons with behavioral health needs. It includes special initiatives for integrating behavioral health with primary care and for improving the comprehensive management of chronic diseases.

#### ***Integration with the State***

Alameda County Health Care Services Agency (ACHCSA), the lead agency for the county's Medicaid expansion, initiated contact with the state Medicaid office to pursue the Medicaid expansion opportunity and was actively involved throughout the waiver design and approval process, building close working relationships with the state in the process.

Overall, county representatives were extremely pleased with the collaborative relationships that grew out of this hard work. They attributed this success to several strategies, including:

- Maintaining frequent, open communication between ACHCSA leadership and state contacts.

- Working with state professional associations that would advocate for county needs in state-level policy decisions.
- Raising questions and issues at weekly webinars hosted by the state Health Insurance Marketplace.

Although generally a positive process, there were some challenges in coordinating the county's work with the state. Efforts by county agencies to work collaboratively and address county-level challenges were sometimes hindered by state policies and procedures. Examples of state policy decisions that county stakeholders found challenging to implement included:

- The state's decision not to delay Medicaid renewals by six months to accommodate early enrollment system difficulties. With the backlog in enrollments, the county was concerned that beneficiaries would lose coverage when the time came for renewal.
- A state requirement that county agencies pay health care providers for services within 15 days. To issue payment, the county system requires a contract signed by both parties, a payment mechanism created, and approval from the agency board, a process that cannot be accomplished rapidly enough to issue a check in 15 days.
- A state mandate that required that all people with mild to moderate mental illness receive behavioral health services from primary care providers and all people with severe mental illness receive those services from the county Behavioral Health Care Services Agency. Although this principle was generally followed in assigning individuals to care, turning it into a requirement reportedly disrupted care for those consumers with severe mental illness who were stable and being effectively served by a primary care provider, and for those with mild to moderate mental illness who were being well served by the county Behavioral Health Care Services Agency.

### ***Key Partnerships***

ACHCSA serves as the "hub" organization for an active network of county-level entities involved in enrolling and serving the expanded Medicaid population. Core partners in this work include the county Medicaid managed care plan, the county public hospital system, a network of contracted community medical and behavioral health care providers (including FQHCs) serving the county's low-income residents, and the county Department of Social Services (DSS). Other partners include the county jails, county probation, and the state's contracted Health Insurance Marketplace organization, Covered California.

In general, partner organizations considered the Medicaid expansion implementation effort as well-coordinated across involved organizations, and partners were in frequent communication with ACHCSA. When asked how ACHCSA had cultivated these healthy partnerships, a county stakeholder explained:

*We're a payer but we also have to elevate this to a mission. We have to talk about it as a moral and ethical failure of society that medical debt has led to people's ruin. We have to connect this to work in public health and social justice to make this a movement, not just a revenue opportunity. But we also have to leverage purchasing power [as a major purchaser of contracted health care services]. There's also the stick that says, "We're the local health authority, be on our side or we'll make it tough on you." It's the stick of regulatory power, the carrot of new financing, and the art of "This is a unique moment in time, do something special." When I look back, we did all three well.*

Various interviewees noted that ACHCSA had been able to build on strong, existing relationships with most of these partner entities that predated the early Medicaid expansion implementation effort. These existing relationships had resulted from county's longstanding reliance on a large, widely dispersed contracted network of culturally competent medical providers to serve its low-income residents. In addition to these existing partnerships, county stakeholders noted that cultivating relationships with other non-provider community partners such as churches, childcare organizations, and other community-based non-profit organizations had been key to its successful outreach and awareness-raising efforts. Interviewees noted that if these existing relationships had not been in place, it would have been a challenge to both create the relationships and implement such an ambitious program at the same time.

### ***Eligibility Determination and Enrollment***

Prior to January 1, 2014, ACHCSA had an agreement with the state Medicaid and social services departments to operate its own system for Medicaid eligibility and enrollment with Alameda County residents enrolled under the expansion waiver. According to county stakeholders, this system enabled them to overcome traditional enrollment barriers and bring 85,000 new enrollees into the Medicaid early expansion program and the county-funded health benefit program. (The county imposes a sales tax explicitly designated to fund health care for low-income county residents, which raised annual revenues of approximately \$100 million.) Undocumented immigrants were also enrolled in the county-funded program, which offers benefits equivalent to Medicaid.

Interviewees credited the success of this enrollment system to two factors. First, they noted that it encouraged residents to complete the enrollment process onsite at various county medical providers that serve Alameda's low-income communities, such as the public hospital and various FQHCs located in low-income communities. Individuals in the newly-enrolled population appear to be more comfortable at the offices of community-based (and culturally competent) health care providers than at the county DSS office. This approach also leveraged the existing trust between individual patients

and providers as well as the organizational trust that these provider entities had built over many decades of work in their communities. Second, the ACHCSA worked to minimize the up-front effort involved in completing an enrollment application by using administrative data (such as purchasing large birth and death record datasets from other states) to lessen the eligibility documentation burden on applicants.

When California implemented statewide Medicaid expansion in 2014, those individuals who had been enrolled in the county-specific LIHP Medicaid expansion program were processed into the new statewide Medicaid system by the Alameda County DSS. Because the enrollment process used by Alameda County during the demonstration was not the same as the enrollment process using the statewide Medicaid system used by the Alameda County DSS, it was initially anticipated that all individuals enrolled during the waiver would have to be manually moved into the new system. However, Alameda County was able to work with Alameda County DSS to use a batch loading process to bring patients enrolled in the demonstration into the state system.

Enrollments experienced a dramatic slowdown in application processing rates compared to the ACHCSA system. This was partly due to new eligibility requirements in processing enrollments (including the need to send each case through the MAGI algorithm and also up to the federal data hub for administrative data matching) and partly due to the fact that applications had to be processed by DSS employees who could not significantly increase their workload without additional staff. There were also initial problems with the state processing and certifying enrollment counselors. During LIHP, the county was able to operate nimbly with hiring temporary employees and making overtime available to process applications, if needed. With the Medicaid expansion under the ACA, there was an extensive application backlog, with the county estimating that there were approximately 46,000 applications that had yet to be processed by DSS. Interviewees were very concerned about what would happen when the time came for people to renew, with the possibility that they will lose coverage with the enrollment delays.

Additionally, providers that still accepted new Medicaid applications on behalf of DSS found the new application data system (CalHEERS) to be much less user-friendly for their staff and for applicants than the former streamlined, multi-benefit application system (One-e-App).

However, county agencies continue to investigate ways to streamline this process. At the time of the RTI site visit in summer 2014, plans were underway for the county jail to use its intake database to auto-populate Medicaid applications. These plans were on hold due to a massive general application backlog at the time of the site visit, but were regarded as very promising by stakeholders.

## ***Outreach Strategies***

Alameda County considers its success in outreach and getting people enrolled during their early expansion to be the result of having their own web-based eligibility system, their long-standing investment in indigent care, and doing in-reach with uninsured enrollees at community clinics and the public hospital. Partnerships allowed outreach to meet people where they are and respond to their needs. The county considers its partnerships with Community Health Centers and safety net providers as one of the secrets to their success. These providers are trusted resources within the communities they serve, often have long-standing relationships with the indigent, and are invested in cultural competency. When these providers went through their records and then contacted uninsured members who might be eligible, a significant percentage of people responded and came into the facility, met with an enrollment counselor, and completed an application.

Alameda County found the most difficult populations to reach were those with limited English proficiency, the individuals experiencing homelessness and/or mental illness, and justice-involved and re-entry people. Many eligible people live in families with mixed immigration status and are reticent and fearful about applying. These concerns were addressed through community outreach and in the Spanish language media, with funding provided by the California Health Endowment. Behavioral health providers discussed using peer navigators to help people apply and pull the required documentation together and once they get them enrolled, keeping them enrolled, as long as they remain eligible. Potential strategies for outreach and enrollment of justice-involved persons have been developed in partnership with the county probation and jails, but were on hold pending resolution of the county's large enrollment backlog.

Once individuals are enrolled in coverage, interviewees expressed concerns that they might drop off due to the complexity of the renewal forms. To try to address this issue, Alameda County implemented strategies to help eligible people retain coverage, such as reminder calls, reminder notices from both the county and FQHCs, and offers of one on one assistance.

## ***Health Care Literacy and Access***

Many interviewees in Alameda County noted that while the county was very successful with enrollment, enrollment does not equal access and access does not equal good health outcomes. Health care literacy has been a concern as many new enrollees who may not have had insurance coverage in the past need additional resources to understand how to use their new coverage. Use of health fairs or other community events have been helpful in spreading awareness about services, but ACHCSA customer service still experienced high volumes of questions from new enrollees regarding how to use their coverage. Addressing this issue required adding staff, extending hours and providing overtime and training so that staff could fill multiple roles with beneficiaries.

Interviewees also noted that the “health literacy” focus may miss the fact that low-income persons use health care resources in a way that best suits their needs. Encouraging Medicaid enrollees to use resources other than the emergency room might require changes in business practices, by offering “convenient care”, same-day appointments, evening physician availability, and pharmacy services onsite to ensure access and increase utilization.

### ***Provider Issues***

As in many counties, Alameda County experienced issues with availability of primary care providers participating in Medicaid, even prior to the expansion of Medicaid. To try to address this challenge, Alameda Health System (county public hospital) increased the base pay of primary care providers to try to attract and maintain primary care providers, but this strategy alone was ineffective. Special efforts were made to increase the strength of the local FQHC infrastructure, which helped address some of the primary care concerns. Because lack of space also impacted the availability of primary care, several clinics were either expanded or new clinics were built. Some interviewees also recommended looking outside of existing networks or Medicaid providers, particularly including independent physicians of color whose practices are already embedded in low-income communities and who can often provide culturally competent, same-day or evening services.

The addition of so many newly-eligible patients has practices considering different models of care, including group sessions and phone follow-up instead of in person visits for some issues. The FQHCs found that they had 30,000 new Medi-Cal clinic members and 38,000 people with pending applications, with implementation of the ACA, although many of them were already enrolled in the LIHP. Many of their clinics have staffed up according to the services being provided that are billable and in consideration of providing case management and care coordination.

Another significant challenge faced by Alameda County was the early financial failure of a non-governmental, not-for-profit Medicaid managed care plan known as Alameda Alliance for Health, which ACHCSA and the public hospital had both helped to launch. This managed care entity experienced serious fiscal challenges and was under receivership at the time of RTI’s site visit. County leaders believed these challenges had resulted primarily from a combination of badly-timed electronic information systems failures and much higher than expected initial demand from new beneficiaries for assistance with benefits issues. In addition, some county stakeholders suggested that the financial stability of future Medicaid managed care plans would be challenged by what they perceived as low capitated rates for the Medicaid-eligible population relative to that population’s very high needs and challenging health care service utilization patterns, such as very high no-show rates and the lack of familiarity in accessing preventative care.

The availability of behavioral health providers that met Medi-Cal requirements for reimbursement of services was also a challenge for Alameda County. Certification

requirements meant that some traditional behavioral health providers, such as peer support counselors, are unable to bill for services. To address this challenge, Alameda County provided special training for behavioral health providers on how to meet Medi-Cal requirements and how to bill for services.

Various county agencies were interested in improving cross-sector care coordination, particularly between the primary care and behavioral health systems. These agencies agreed that care coordination would be facilitated by the development of inter-agency data-sharing agreements, but had been largely stymied in these efforts by a combination of federal regulations and incompatible data systems.

### ***Funding and Staffing Issues***

The Demonstration provided federal Medicaid funding for the LIHP population, who were previously provided health services through county-only funds. Alameda County was able to use a local tax that met the requirements of a certified public expenditure towards the non-federal share of Medicaid financing that was needed for the Expansion (in California, the non-federal share is paid for with county funds). Additionally, the county made effective use of MAA funding, with \$18.7 million for providing Medicaid services and outreach to the Medicaid-eligible population. The county attributed much of its success to contracting out approximately 70 percent of its services, finding this to be a more efficient way of funding the program, while also allowing them to handle diversity challenges. Alameda County is one of the most diverse counties in the country and by contracting for services, they were able to utilize community health centers and providers that already had significant penetration in indigent care and their staff members already knew the population and were often community members.

## **Cook County, Illinois: "CountyCare"**

### ***Expansion Date, Mechanism, Population Covered, and Special Population Focus***

Illinois received approval through a Section 1115 demonstration to expand Medicaid coverage in Cook County for uninsured, non-pregnant Cook County residents, ages 19-64 without dependent children, with incomes at or below 133 percent of the FPL and otherwise ineligible for Medicaid, on October 31, 2012. The Demonstration was in effect through June 30, 2014. Individuals enrolled in Medicaid under the Expansion were enrolled in CountyCare, a new Medicaid managed care entity established by Cook County Health and Hospitals System (CCHHS) that became operational on February 1, 2013. This enabled Medicaid payments to cover care to the expansion population that had previously been delivered through CCHHS providers, such as the John H. Stroger, Jr. Hospital (formerly known as Cook County Hospital) and CCHHS clinics largely as uncompensated care. CountyCare expanded its provider network to include other community hospitals and FQHCs that were also serving the eligible population within Cook County.

CountyCare aimed to enroll eligible, but uninsured consumers in Cook County, particularly those who were patients within their provider network. Additionally, Cook County focused on getting coverage for the vulnerable Cook County jail population that would be in effect upon their release and provide continuity with necessary care they were receiving while incarcerated.

### ***Integration with the State***

CCHHS was the lead agency for the county's Medicaid expansion prior to 2014. The CCHHS Chief Executive Officer at the time, Dr. Ram Raju, proposed the idea to the state of a county-only demonstration that would enroll and provide coverage to eligible individuals in a CCHHS-led managed care entity under a Section 1115 demonstration. The Cook County Board of Commissioners, CCHHS and the State of Illinois worked together to develop the Section 1115 demonstration, negotiate it through approval with CMS, and implement the program, once approved. CCHHS and the state Medicaid office found ongoing frequent and ongoing communication was critical so CountyCare and Medicaid officials usually have weekly meetings. As one stakeholder noted, it has been important to ensure that state agency officials and CCHHS officials understand each other, even when state and county officials use different vocabularies related to health care programs and concepts. Consultants to CCHHS/CountyCare, who were former state officials helped in bridging gaps in understanding and creating a positive working relationship between the county and state.

### ***Key Partnerships***

Multiple partnerships were required to implement the distinctly different aspects of pre-2014 Medicaid expansion in Cook County. The following is a summary of the different tasks involved and the partnerships that made this implementation possible.

Charitable foundations in Chicago that were concerned about health care access issues had supported early workgroups, prior to the waiver. These workgroups identified barriers and solutions to gaining care for persons with mental illness and/or experiencing homelessness who were part of the expansion population and considered the implications for providers in trying to meet this population's needs. A charitable foundation also facilitated a workgroup co-chaired by a Cook County judge that involved many representatives from the justice system (e.g., probation officials, prosecutors, the public defender, and treatment providers) to discuss the implication of Medicaid expansion in 2014; when the opportunity to early-enroll Cook County residents presented itself, the group had already discussed enrollment opportunities at all points in the justice system.

In addition to organizing their own grassroots outreach staff, CCHHS partnered with many entities to reach newly-eligible individuals. For example, many predominantly African American churches hosted the CEO of CCHHS to speak to their congregation on Sundays to raise awareness of CountyCare. CCHHS also partnered with community organizations to do outreach within their communities and at their events. The Cook

County Board President convened the Sheriff's Office, CCHHS, and others to develop the operational partnership for jail-based enrollment process at intake that started April 2013; the deadline and political will supporting this collaboration was viewed as critical to making this happen. One such organization was TASC, an existing service provider that provides pre-release planning and re-entry services across Illinois, and eventually became the organization contracted to assist with enrollments at the Cook County Jail. The trust that developed between TASC and the correctional officers once TASC was conducting enrollment assistance during the jail intake process took time, but was also a helpful partnership to ensure smooth implementation. Finally, FQHCs who were marketing CountyCare to their own patient populations provided feedback to CountyCare on what was successful and what did not work as well with regard to messaging, communication, and outreach.

The partnership between CCHHS and Illinois' Medicaid program was critical to ensuring that CountyCare enrollment assisters had the information they needed to help people apply for Medicaid successfully, and that enrollment systems were in place. In addition, FQHCs invested their own resources in helping their eligible patient population enroll. Having well-trained staff available to conduct enrollment assistance is critical in avoiding incorrectly-completed applications that would add to the burden of application processing. Furthermore, a partnership with the Cook County Clerk's Office allowed applicants without a birth certificate to indicate only that they had been born in Cook County, and the Clerk's Office would verify them without the applicant having to produce the birth certificate.

Creating the CountyCare health plan required partnerships with providers to create a sufficient network in addition to CCHHS's hospitals and clinics. The benefit to these providers was gaining Medicaid reimbursement for care that had been previously uncompensated for the most part. Multiple benefits accrued to CountyCare from its provider partnerships. With more providers in-network, CountyCare could expand CCHHS's capacity to serve the newly-eligible population most efficiently (for primary care and specialty care) and in their own communities, given Cook County's geographic dispersion. These providers helped enroll their patients in CountyCare, often with their own resources. The FQHCs also helped to recruit hospitals to join the CountyCare provider network, because it was in their patients' interest to maintain continuity of care with hospitals with which the FQHCs had existing referral relationships. The resulting provider network included all the FQHCs in Cook County, with more than 130 primary care access points, and many area hospitals beyond CCHHS's John H. Stroger, Jr. Hospital and Provident Hospital.

CountyCare contracted out for back-room managed care plan tasks (processing claims) and carved out behavioral health care to a separate vendor. However, CountyCare benefited from partnerships with providers to inform its other operations. For example, many FQHCs analyzed data on their own patients' health care conditions to help CountyCare project what the demand would be for services and potential expenditures for the newly-eligible population. Additionally, the process of developing

contracts to include FQHCs in the provider network was the result of shared learning between the FQHCs and CountyCare.

The development of a new provider network under CountyCare built upon existing relationships that FQHCs and community hospitals historically had with CCHHS providers in serving the Medicaid expansion population. The advent of CountyCare both formalized some of those relationships, and created new partnerships. For example, after CountyCare implementation, CCHHS implemented a more formal referral and scheduling processes for community providers referring patients for specialty care. In addition, CountyCare contracted with Medical Home Network, to provide analytic reports drawn from clinical and claims data. These reports were provided to primary care sites providing medical home services to members and included a system of real-time electronic alerts on members from area hospitals' Emergency Departments. CountyCare also contracts with Medical Home Network to deliver care management services to patients in their network, supplementing the care management services that CountyCare contracts for through its Third Party Administrator (TPA).

### ***Eligibility Determination and Enrollment***

Enrollment for the expansion population during the demonstration was into both Medicaid and the CountyCare plan. By July 2014, CCHHS estimates that 154,000 applications were submitted for Medicaid under CountyCare, resulting in the enrollment of more than 113,000 people. The success of the enrollment process can be attributed to the collaboration between the state and CCHHS; partnerships with FQHCs who provided enrollment assistance; and strong implementation of enrollment assistance during the pretrial intake process at the Cook County jail.

Applications are submitted by enrollment assisters through an electronic application system. CountyCare utilized enrollment assisters at CCHHS locations, such as Stroger Hospital, and at the FQHCs in the CountyCare network. Staff were available to take applications via phone, including applications from individuals that had called the CountyCare hotline. The application assisters also made outbound calls to people who had been served by CCHHS clinics and other providers in the CountyCare network to try to help them fill out an application over the phone. Applicants later sent signed documents back to central processing at the state. CountyCare provided funding for additional dedicated DHS staff members (approximately 100) to process incoming applications generated through the CountyCare application process. One enrollment simplification was that the Cook County Clerk's Office verified an applicant's place of birth if the applicant indicated that he or she had been born in Cook County, so that an application would not be rejected because of a missing birth certificate.

In addition to enrollment assistance provided through health care providers and hotlines, a workgroup identified pretrial jail intake as the appropriate time to provide application assistance because jail releases can be unpredictable, and it is difficult to organize an eligibility screening or enrollment process post-release. In contrast, the jail

intake process is highly structured. The Cook County Sheriff's Office facilitated the necessary infrastructure to be installed at the jail--most significantly, hard-wiring computers that could have access to four information systems that facilitate populating Medicaid applications with accurate information.

An early barrier to enrolling jail-involved people in Medicaid was a state law that prohibited a person from submitting a Medicaid application until 30 days prior to their scheduled release from jail. This required knowledge of the release date before any application could be submitted on behalf of a person who completed an application during intake or at jail, which enrollment assisters in Cook County Jail estimated based on additional information from the client. However, the state law changed as of January 2014, removing this prohibition and thus opening the path to submitting applications to Medicaid at any time.

Enrollment simplifications for applications initiated at pretrial intake also facilitated enrollment. Because approximately 40 percent of detainees did not know their Social Security Number (SSN), the policy evolved to allow the verification of incarceration form to be used as proof of residency and identification, even in cases in which the SSN is missing from the application. By doing this, enrollment assisters do not waste time completing applications that would expire by the time the detainee was able to find his or her SSN, or by the time the SSN could be verified.

By the fall of 2013, CountyCare's enrollment assisters had tested and learned how to use the state's new online application system, Application for Benefits Eligibility (ABE). CountyCare enrollment staff estimate that there was no drop-off in the number of applications processed as a result of the transition to the new system; they continued to receive approximately 500 applications per day. Again, the most important aspect in ensuring a successful roll-out of ABE was close communication and planning between the county and many state agencies, so that all entities understood the correct procedures and processes for completing a Medicaid application.

Statewide Medicaid expansion in 2014 resulted in changes. Entities other than Cook County began accepting Medicaid applications starting October 1, 2013, for coverage starting no earlier than January 1, 2014, when the statewide expansion was implemented. The majority of people who enrolled were initially in fee-for-service. Several areas of the state, including Cook County, required Medicaid beneficiaries to choose a Medicaid health plan, starting summer/fall 2014. CountyCare was no longer the only choice available to Medicaid enrollees in the expansion population. CountyCare became one of the managed care options along with more than 15 other health plans available to choose in Cook County. Starting July 1, 2014, CountyCare's enrollment assister staff could help someone apply for Medicaid, but then the enrollee would have to make an active choice to enroll in CountyCare in an additional selection process after receiving notice of Medicaid enrollment. Individuals who enrolled in CountyCare prior to July 1, 2014, would have the option of choice among the multiple plans upon renewing enrollment.

## ***Outreach Strategies***

Three key elements of CountyCare's outreach strategies during the demonstration included: (1) partnerships with churches who promoted enrollment in CountyCare; (2) outreach to patients at provider sites such as FQHCs; and (3) outreach and enrollment with the justice-involved population. After CountyCare's Section 1115 demonstration expired on June 30, 2014, and it became one of many managed care plans under Illinois's Medicaid program, CountyCare was subject to stricter rules around marketing its managed care plan consistent with Medicaid managed care rules.

When CountyCare began operations, there was very little funding for advertising. Outreach strategies included partnerships with community organizations and attendance at community events to spread the word about the availability of Medicaid coverage under CountyCare. The CEO of CCHHS at the time, Dr. Raju, reported that every Sunday, he went to 3-4 mega-churches, each with thousands of people in their congregations; once there, the pastor would introduce him and encourage people to apply for CountyCare coverage. The credibility and trust that the pastor had with the community were important in getting church members to consider applying.

Health care providers also enjoy the trust of their patients, and so providers also became an important site for outreach and enrollment. Outreach strategies varied by provider site, but included:

- Using trained outreach staff who were located at the health center front desks to screen people and encourage those who are uninsured and potentially income eligible to apply before doing a warm hand-off to enrollment specialists.
- Having clinic staff available to walk through the documentation required for applications, make copies, review the application to ensure that necessary signatures were included and mail the application on behalf of applicants.
- Setting up computers in office waiting rooms to help people enroll.
- Making telephone calls, sending text messages, and mailing letters to patients who would likely be Medicaid eligible and offering them application assistance.
- Messaging that conveys the importance of comprehensive coverage through Medicaid, that makes the hassle of the paperwork in applying worth it.
- Building relationships with local community organizations that could do outreach and make referrals to the local clinic.
- Relying on clinics as a source of information about application and enrollment for people whose application was delayed due to state application backlogs.

- Leveraging existing screening processes for other charity care programs to screen and refer eligible people to CountyCare.
- Outreaching to patients hospitalized at CCHHS hospitals and providing them with application assistance.
- Asking about enrollment status of family members of individual who seeks care and offering follow-up assistance to those family members who may need it.

A third significant outreach strategy was CountyCare’s focus on enrolling the justice-involved population. CountyCare contracted with TASC, an existing independent case management agency that was providing post-jail re-entry services, to expand the services they were providing to include outreach and application assistance at Cook County Jail. A team of seven enrollment assisters is in place at the jail 365 days a year, 1:30 p.m.-9:30 p.m. and has been integrated into the regular intake process. Enrollment assisters are prepared with extensive training and a script to ensure that the screening and application process occurs efficiently--it can take as little as six minutes per detainee--and does not hold up the intake process. Enrollment assisters wear branded uniforms that identify them as part of TASC, different from Cook County Jail staff. Additional information about the pretrial intake enrollment process in Cook County is available from other sources.<sup>4</sup> As of July 2014, TASC estimated that they had initiated 15,000 applications in jail since April 2013. TASC case managers help start the enrollment process at the jail discharge lounge and electronic monitoring section, and with people who are leaving jail-based treatment services. TASC also helps clients that are on probation enroll.

On July 1, 2014, the CountyCare demonstration program ended, and instead CountyCare became a Managed Care Coordination Network, one type of managed care entity under Illinois’ current Medicaid program. This change restricted the type of outreach and marketing CountyCare could do for its plan, because state rules require that any managed care plan seek state approval for marketing and advertising strategies, in part to ensure that all managed care plans have equal opportunities to market in similar venues. For example, outreach by Medicaid managed care plans through churches is now prohibited under state rules.

### ***Health Care Literacy and Access***

Stakeholders reported that primary care capacity in the county was sufficient, in part due to the use of nurse practitioners. Yet, others voiced concern that despite the availability of primary care--and in many cases, having primary care practices organized as medical homes--newly-enrolled individuals needed help navigating the network of health care providers, getting preventive care, and using providers outside hospital

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<sup>4</sup> National Association of Pretrial Services Agencies. “Enrolling Offenders in Medicaid at Pretrial Jail Intake: A Case Study of Cook County, IL.” (No date). Available at: [http://www.napsa.org/diversion/library/ACA%20and%20the%20Pretrial%20System%20\(Appendix%20A-%20Cook%20County\)%20-%20NAPSA%202014.pdf](http://www.napsa.org/diversion/library/ACA%20and%20the%20Pretrial%20System%20(Appendix%20A-%20Cook%20County)%20-%20NAPSA%202014.pdf).

emergency departments. One initial issue to accessing primary care was CountyCare's assignment of a primary care provider to every enrollee. Some enrollees had relationships with physician practices that had provided them with "free" care prior to Medicaid coverage, but when they returned to that physician practice after enrollment in CountyCare, the practice could not see them until they had called to request reassignment to that practice. Other concerns over individuals' health literacy centered on the need to educate people about how to select a physician, make physician appointments, and pick up a prescription--simpler issues on top of an individual's needs for care coordination across providers, or self-management of a chronic disease.

Some stakeholders also expressed concern over the shortfall of providers in specialty care, substance abuse, and mental health to meet the demand of newly-eligible Medicaid enrollees. One psychiatric care provider noted a substantial increase in volume with the initial Medicaid expansion. Exacerbating access to behavioral health care in the first year was the inexperience of the behavioral health care network vendor that CountyCare contracted initially in working with a low-income population with complex needs; as a result, the behavioral health services that providers often use to meet the needs of this population (i.e., Assertive Community Treatment) were not covered. CountyCare changed its contractor after the first year; however, under both behavioral health benefit managers, obtaining prior authorizations for care has been challenging. Still, one stakeholder we spoke with noted that having a provider network broader than CCHHS provides greater access for individuals who are newly-enrolled in CountyCare but had previously relied on CCHHS providers for free care.

Whether attributable to lack of provider capacity, enrollees' confusion over how to use services, or both, stakeholders identified a need for greater care coordination and care management for the newly-enrolled population. Although the providers organized under the Medical Home Network's umbrella (a subset of in-network CountyCare providers) are contracted for care management services, CountyCare continues to explore options for providing care management through their TPA. Some providers expressed concern about how care management and care coordination are defined, and whether people's needs are slipping through the cracks because it is not clear what responsibilities fall to the health plan versus other providers.

Yet, there are also signs that CountyCare has increased access to care for newly-enrolled individuals. Expenditure data from CountyCare suggests that medication adherence is high, and exceeding expectations. This may be a sign that providing access to commercial pharmacies through CountyCare is a success. Individuals with pent-up demand are accessing services like eye glasses and surgeries that they had delayed.

### ***Provider Issues***

Providers in Cook County faced two changes with early Medicaid expansion--first, the demand for more or different services from people newly-insured by Medicaid (compared to Medicaid beneficiaries historically), and second, the transition to operating

as a provider contracted by the new managed care entity CountyCare. To some extent, providers were ready for the demand. Community hospitals, FQHCs, and CCHHS providers had already served many patients newly-enrolled in CountyCare as “free care” patients, and FQHCs had already been expanding and developing as medical homes. One provider noted that with Medicaid expansion, they began to see more new patients with substance abuse issues who had been assigned to their clinic for primary care by CountyCare. Several providers noted the medical complexity of newly-enrolled individuals with regard to physical diagnoses as well as behavioral health issues. Another FQHC noted that they had expanded the number of clinic sites in preparation for 2014 and had implemented evening and Saturday hours, so they were able to handle the demand for increased capacity.

In many ways, the transition to being contracted by CountyCare, a managed care entity, had more significant implications for providers’ operations than the increase in demand from individuals who became Medicaid-eligible under CountyCare. For employees at CCHHS hospitals and community-based health centers, serving patients that are now enrolled in CountyCare means that the model of care can evolve more towards managing the health of a population, rather than reacting to emergent and urgent issues. Within CCHHS, the medical leadership is attempting to change care delivery towards more team-based care and population-wide health improvement, in part in preparation for a transition towards contracting with other managed care entities as well as with CountyCare, and a likely future of value-based payment models. This is an area of significant activity and attention now that enrollment processes and the overall CountyCare network has been established. CCHHS staff are in the process of adapting to a new health care landscape in Illinois that requires them to learn about various processes regarding Medicaid managed care, including communicating CCHHS’ participation in various plans, how to authorize referrals, and billing.

The transition to serving as a CountyCare contractor and Medicaid provider is especially stark for providers of behavioral health care services and services for individuals experiencing homelessness. These providers have a history of operating under rules established by a different state agency than the Medicaid agency. Medicaid has different regulations about what types of providers can bill for mental health services, for example, to which these providers are adapting. These providers also struggle with how to fund housing services that fee-for-service Medicaid will not cover, for Medicaid-enrolled individuals, and are looking forward to possible outcomes-based payment models that would provide more flexibility in how to organize care. In particular, the specialty substance abuse treatment system blends housing, job assistance services, and treatment; Medicaid does not pay for this complete bundle of services.

### ***Funding and Staffing Issues***

Delays in hiring administrative staff due to the Cook County’s employment rules is a key challenge that has impeded CountyCare’s development as a managed care plan. CountyCare became operational on February 1, 2013, several months after the waiver

was approved. However, contractors managed the process for months until permanent county employees could be hired, due to the lengthy hiring process within Cook County government. The executive director of managed care at CCHHS, the first CountyCare employee, was hired June 2013; the second employee was not hired until four months later. At the time of the RTI site visit, only about ten people were on staff out of 23 funded positions and contracted consultants are still in place.

With regard to provider staffing, CCHHS was able to hire 250 new employees after the waiver was approved to fill positions in ambulatory care, and almost all in primary care. The majority of hires were nurses and medical assistants, along with physicians and a small number of behavioral health providers. Behavioral health providers and organizations that serve the homeless are also increasing staff to meet potential demand, but are finding it difficult to invest the money in hiring up-front without knowing if they will get a sufficient stream of clients to support these new provider teams.

The FQHCs that invested their own funds in outreach may not have recouped that investment within the first year of Medicaid expansion. Their continued support and enrollment assistance will depend on the implications of expanded Medicaid eligibility for revenue from health care service delivery.

The establishment of CountyCare through the Section 1115 demonstration allowed CCHHS to begin its transformation from a place patients used only when they were sick, to one that emphasizes preventive care and wellness. CountyCare has also provided significant revenue to CCHHS, amounting to about 12 percent of CCHHS' total budget in 2013 and nearly half in 2014. CountyCare readies CCHHS in the new managed care environment of Medicaid that will put nearly all Cook County Medicaid beneficiaries into managed care plans. Some neighborhoods in Cook County will have more than 15 plans from which individuals can choose, and people who do not choose a plan will be auto-enrolled. One of the key challenges to CountyCare's viability as a health plan is if people select a different managed care plan at renewal or are auto-enrolled to a different plan. CountyCare's hope is that their experience with the Medicaid population will make them the plan of choice for this population because they understand their needs and can more effectively communicate with this population and address their health care needs than other competing managed care plans.

## **Cuyahoga County, Ohio: "MetroHealth Care Plus"**

### ***Expansion Date, Mechanism, Population Covered, and Special Population Focus***

The State of Ohio received approval to expand its Medicaid program to Cuyahoga County on February 5, 2013, under a state Section 1115 demonstration waiver. Medicaid coverage was extended to non-pregnant adults aged 19-64, with income at or below 133 percent of the FPL who were otherwise ineligible for coverage under Medicaid. Beneficiaries enrolled in the demonstration were patients of the MetroHealth System who previously had been receiving uncompensated care. There was a cap on

enrollment in the demonstration of 36,000. The non-federal-state match necessary for the Expansion was financed by the county with funding from two annual county tax subsidies that was used to leverage \$64 million in annual federal Medicaid matching funds. Cuyahoga's expansion emphasized the enrollment of frequent emergency department users, persons with behavioral health needs, and persons with chronic diseases. It included a particular focus on the use of care coordination to try to improve the care provided to these populations.

### ***Integration with the State***

The MetroHealth System served as the lead organization for the county's Medicaid expansion. They initiated contact with the state Medicaid office and had their first discussion with them at the end of 2010 about the possibility of pursuing a Medicaid expansion under a Section 1115 demonstration. They were particularly interested in expanding Medicaid coverage sooner rather than later because they had seen an explosion in the uncompensated care they were providing. During the year before the Demonstration was implemented, they had provided over \$130 million of "free" care and thought it was becoming unsustainable. They had also made an investment in developing a PCMH approach to care and believed that the demonstration would allow them the opportunity to further develop that model. Cuyahoga County has two health and human services levies from county property taxes to fund health and human services, which includes treating patients at MetroHealth Medical Center. MetroHealth worked closely with Cuyahoga County so that the county was able to use their health and human services levy dollars to provide the non-federal Medicaid share to support the Demonstration. The MetroHealth System worked very closely with the state on developing the Section 1115 demonstration and negotiating it through approval with CMS and implementing the program, once approved. Interviewees attributed success in the approval and implementation of the demonstration to several state integration factors:

- Maintaining frequent, open communication between MetroHealth leadership and state contacts.
- The involvement of former Medicaid agency personnel within the MetroHealth waiver team leveraged existing relationships to negotiate the needs of the waiver.
- Commitment by the state Medicaid agency to moving the Section 1115 demonstration forward even in the face of political challenges.

There was uncertainty about whether Ohio would move forward with a statewide Medicaid expansion under the ACA given the Supreme Court decision. State approval of the Medicaid Expansion under the ACA occurred through the state's bipartisan controlling Board for Medicaid Expansion, rather than through the legislature and did not occur until the end of October 2013. This short timeline made planning for the transition

from the Demonstration in Cuyahoga County to the end of the Demonstration and statewide implementation in 2014 somewhat difficult.

County stakeholders interviewed also expressed concern that requirements in the transition to the ACA sometimes seemed to have been designed without county input or an understanding of county-level processes and were not always feasible to implement. Specifically, with the ACA expansion, a centralized state system for processing applications was procured from another state rather than utilizing the county-based Medicaid system, which resulted in system integration issues, and the need to complete two applications for Medicaid and social service programs, when before, a single application worked for all programs.

### ***Key Partnerships***

The MetroHealth System partnered with two FQHCs that had National Committee for Quality Assurance level 3 recognition, Neighborhood Family Practice, and Care Alliance. Neighborhood Family Practice was located in the same area as MetroHealth so there was some overlap in the patients. Care Alliance has a focus on individuals experiencing homelessness and residents of public housing. MetroHealth also partnered with existing private mental health agencies in the community. For each of the partners, there was an incentive to participate since Medicaid reimbursement would pay for services that had generally been provided on a sliding scale or at no cost to patients. Each provider also was actively engaged in outreach and enrollment within their target populations.

Key to the success of the partnerships with other providers was that each partner already had a relationship with MetroHealth which often provided specialty care to their population. To support the care coordination aspects of the program, it was also key that all providers were using the same electronic medical records (EMR) system, known as EPIC, which allowed for sharing of data between providers. MetroHealth also partnered with the county jail and is both screening people for coverage and providing health care for them. One of the things they added to the jail was the EPIC EMR, so that medical records are accessible, promoting continuity of care across providers. MetroHealth also has a re-entry project with the county jail, placing one of their social workers at the jail.

Because MetroHealth was not set up to pay claims, they also contracted with a commercial TPA to manage the claims process. One key to the success of the waiver was that the TPA was committed to learning more about the Medicaid market and used their own funds to support development of the claims process to meet the needs of the waiver.

Another key partner in the expansion was the Cuyahoga County government. The Cuyahoga County government had a good relationship with the MetroHealth System prior to the waiver. Because of this relationship, the Cuyahoga County government was willing to use county tax dollars as the non-federal match needed to support the

implementation of the waiver. The county also provided the support needed to process enrollment applications.

### ***Eligibility Determination and Enrollment***

Interviewees credited the success of enrollment to two factors. First, they were able to use the shared EHR (EPIC) across sites to support enrollment. Initially, they had an auto-enrollment function that allowed anyone already enrolled in the MetroHealth System charity care program or the FQHCs programs within the last 90 days to be enrolled without having to take any action. This process was largely supported by data that was already included in the shared EHR (EPIC) used by all sites. In addition, the EPIC system was to help identify additional potentially eligible individuals to target for in reach within each organization. Under the charity care program, they did not have to verify citizenship, but they worked with Cuyahoga County to access the state system to compare this list against the state list which showed state citizenship. The state allowed the use of this process to auto-enroll up to 10,000 individuals. Another strategy used by the program was to use presumptive eligibility for new individuals coming into the emergency department. For those individuals, self-verification was accepted and individuals then had 30-60 days to provide additional documentation.

The second factor that impacted the success of enrollment was meeting people where they were. The FQHCs in particular were successful at using bilingual staff to help Spanish-speaking individuals enroll in the program. By first using in-reach to enroll individuals at all partner organizations, they were able to use the knowledge of their existing populations to target their approach.

When Ohio implemented statewide Medicaid expansion in 2014, those individuals who had been enrolled in the county-specific Medicaid expansion program were transitioned over using a batch processing of individuals. Before the solution of batch processing of waiver enrolled individuals, there were significant concerns about how to transition over the existing enrollees. To address this issue, the Demonstration was extended to April 2014. By April 2014, some individuals had already moved themselves over to the Medicaid program. Communication was sent out to all individuals on the time frame for the transition. When individual affected by the batch processing were complete, letters went out to let them know they were enrolled in Medicaid. In addition, there were specific concerns about the processing of renewals for enrollees that had been in the Demonstration. The state allowed a rolling renewal process so that not all renewals needed to be processed at the same time.

### ***Outreach Strategies***

Cuyahoga County was very successful at enrolling individuals who were already accessing their services or services through their partner organizations. FQHCs did in-reach within their health centers to see who might be eligible and outreached to these individuals to get them enrolled when they came to the center. They also call potentially

eligible patients and went to their homes, if necessary to explain the program to them. With the statewide expansion and the end of the demonstration, MetroHealth's role has changed and they have expanded their outreach efforts within and outside of the county through the media. The county has also expanded their outreach efforts, which include placing a person at probation, one at TASC, and one at the jail to try to get people enrolled when they get out.

### ***Health Care Literacy and Access***

A primary focus of the Cuyahoga County expansion was the use of care coordinators. Care coordination addresses many of the issues that other counties may be facing with regard to health care literacy and access as care coordinators help patients negotiate their coverage and find the appropriate resources to meet their needs. The primary challenge facing health care literacy during the transition from the waiver to the ACA was how to provide funding for the care coordinators who cannot bill for their services to Medicaid. MetroHealth decided that retaining these positions was critically important and is providing that funding without Medicaid reimbursement.

While care coordinators provided a great deal of help in addressing health care literacy and access, challenges still remained in access to specialty services including dental, pharmacy, and behavioral health because of the lack of supply of providers to meet the increased demand for services that had not been covered previously for the expansion population.

### ***Provider Issues***

Cuyahoga County was able to proactively address potential provider issues through the expansion of its PCMH and the introduction of care coordinators and MyChart to the expansion population. Most individuals enrolled through the waiver were existing MetroHealth patients so higher volumes in patients did not create specific issues. However, the introduction of care coordination and the coverage of non-emergency care did result in some shifting of resources from emergency room visits to additional needs for primary care, specialty care (specifically dental), and behavioral health. MyChart also provided a way for patients to schedule appointments using the Internet which was more efficient for those with access to those services. However, the greatest impact on providers was the introduction of pharmacy benefits which overwhelmed the system as individuals were now able to fill prescriptions they may not have previously been able to access.

### ***Funding and Staffing Issues***

Cuyahoga County was very successful in finding local revenue through use of the health and human services tax that could be used towards the non-federal share of Medicaid financing and in financing the county expansion. In addition, MetroHealth was able to contract with a TPA to administer claims at no cost to the county. This commercial payer was willing to provide these services as a way to learn more about

the Medicaid market and based on feedback from the interviewees they were very responsive to the needs of the waiver.

The primary impact on staffing was within the Cuyahoga County case workers responsible for processing enrollment. Because of hiring requirements, it took a bit of time to get the approval for hiring additional staff and in order to be efficient in onboarding new staff there was a need to bring in new classes of several people. Because of the complexity of the number of different programs they provide enrollment support for, it is typically around six months before a new person can carry a full caseload. Staffing losses increased during the transition to the ACA so overtime was utilized to try to address the increased caseloads, although this stressed limited county resources, both in terms of personnel and finances.

Cuyahoga County is in a similar position as Cook County in that with the end of the Demonstration, they are not the only available vehicle for a Medicaid Expansion beneficiary to be enrolled in the program, but are one of multiple plans that a Medicaid beneficiary may choose. Interviewees believe that they are well positioned to be the plan of choice as a result of their experience in working with this population and the linkages developed with FQHCs and providers that have had long-standing relationships with the newly Medicaid-eligible. Interviewees also said that the Demonstration allowed them to transition to the necessary business model for competing in this market and improving their financial performance.

## **King County, Washington: "Transitional Bridge" Demonstration**

### ***Expansion Date, Mechanism, Population Covered, and Special Population Focus***

In 1987, Washington State piloted a state-funded managed care program to extend health coverage to certain groups of low-income adults and children not eligible for Medicaid. This pilot was extended statewide and became known as the Basic Health Plan (BHP).<sup>5</sup> Due to state budget pressures, BHP capped enrollment and had a waiting list of over 150,000 individuals in 2011. Washington received approval effective January 1, 2011-December 31, 2013, to extend Medicaid coverage through a Section 1115 Medicaid Demonstration, "Transitional Bridge Demonstration", to individuals in BHP as well as individuals enrolled in two additional state-only funded medical care programs:

- Non-pregnant adults aged 19-64 who were enrolled in BHP and had incomes at or below 133 percent of the FPL.
- Individuals aged 19-64 years with incomes at or below 133 percent of the FPL, who were physically or mentally incapacitated and expected to be unable to work

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<sup>5</sup> Not to be confused with the BHP authorized under the ACA that provides an option for states to cover individuals from 133 percent to 200 percent of the FPL.

for a least 90 days (prior to the demonstration, these individuals were in a state-funded program called Medical Care Services).

- Individuals aged 19-64 years who had incomes at or below 133 percent of the FPL, who had a primary incapacity of drug or alcohol addiction (prior to the demonstration, these individuals were in a state-funded program called the Alcohol and Drug Addiction Treatment Support Act).

Enrollment in the Demonstration was capped at 43,300 enrollees annually, and enrollees were subject to more cost-sharing than is typically imposed in the Medicaid program. This Demonstration served as a bridge to receive federal Medicaid funding for these individuals until January 1, 2014, but otherwise did not have a significant impact on Medicaid expansion. The significant expansion did not occur until Washington State expanded Medicaid statewide through the ACA to all adults at or below 133 percent of the FPL.

King County did not pursue Medicaid expansion efforts beyond the statewide expansion. However, an estimated 29 percent of Washington residents live in the Seattle metro area (King County),<sup>6</sup> and King County has an extensive system of health care service provision through the county as well as a history of doing targeted outreach and enrollment in Medicaid. With such a high proportion of state residents, King County's efforts to outreach to and enroll individuals in the Medicaid expansion have a significant impact on Washington State as a whole. King County focused on all uninsured, with added attention on the Hispanic/Latino, Black/African American, Asian/Pacific Islander, and other vulnerable populations (i.e., those experiencing homelessness, people with serious mental illness and other disabilities).

### ***Integration with the State***

Washington State facilitated the transition of the demonstration target populations into the Section 1115 demonstration. The state also took the lead in administering the statewide Medicaid expansion in 2014. The state and the county communicated frequently about the implementation of the Expansion and the ongoing program. The state health care authority (HCA) is an active participant in the First Friday Forum, a forum that has been occurring in King County for the past 13 years and serves as a venue for sharing upcoming changes and discussing issues and concerns. King County Executive leadership was also noted to be particularly strong. The County Executive set a vision and promoted a call to action to enroll all of King County's uninsured individuals in Medicaid or the health insurance Marketplace. Numerous interviewees cited the importance of the strong support of the County Executive and the high priority given to expansion efforts in enrolling eligible beneficiaries.

The county worked closely with the state and from site visit interviews, both entities expressed respect for the work of the other. The state conducted about 25 statewide

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<sup>6</sup> The Kaiser Commission on Medicaid and the Uninsured. "The Washington State Health Care Landscape." June 2014.

trainings on revised eligibility criteria for Medicaid and the Marketplace and on the use of the new portal for submitting Medicaid and Marketplace applications. The state also trained individuals to become certified as application assistors. The county in turn facilitated these trainings throughout the county. The county relied on the state to help trouble-shoot issues that arose in submitting applications through the online portal and to help clarify nuances in eligibility policy. The state had no outreach budget to promote Medicaid and Marketplace expansion, so they looked to the counties to outreach to their communities. Therefore, King County took an active role in preparing for statewide Medicaid expansion through the ACA. Public Health--Seattle and King County took the lead on outreach in King County, leveraging the use of an experienced team of outreach workers who had been doing Medicaid outreach through various grant funded activities for many years. Site visit interviewees from the state praised the work of King County's outreach team, noting that the high number of Medicaid expansion enrollees in King County is likely attributable in no small part to their outreach efforts.

### ***Key Partnerships***

To facilitate the vision of enrolling all of the eligible uninsured, the County Executive established the County Executive's Leadership Circle. The Leadership Circle was comprised of local leaders from the business, health care, labor, education, and government sectors. These leaders were charged with spreading the word about health coverage opportunities throughout their respective sectors, rapidly disseminating information about enrollment events and initiatives sponsored by King County and area organizations, and advising the County Executive on the county's health coverage enrollment initiative. Several county and community-based site visit interviewees noted the importance of the Leadership Circle, the high priority health coverage was given among other county priorities, and the strong support of the County Executive for all outreach activities.

The First Friday Forum is sponsored by Public Health--Seattle and King County and brings together over 100 local community-based partners, county, and state agencies monthly to share information about implementation progress at the state level, outreach activities conducted by the county and community-based organizations, and to trouble-shoot issues enrolling individuals into health coverage. Site visit interviewees uniformly praised the First Friday as a successful model of information Exchange between the state, county, and local partners.

King County's program for people experiencing homelessness did extensive outreach to area housing agencies to train case managers to become application assistors.

Hospital-based interviewees spoke of various partnerships to design and implement their outreach and enrollment work. Hospitals worked with community clinics and the Washington State Hospital Association. The hospital association served as conduit to pass outreach and enrollment toolkits developed by hospitals to all other hospitals statewide. Behavioral health providers spoke of regularly attending coalition

meetings with other providers; at these meetings attendees shared their best practices for outreach and application submission.

The King County Outreach team worked with community partners with whom they already had established outreach and enrollment relationships from previous outreach activities, and they reached out to new partners to ensure that the county's outreach team hosted or attended outreach events in every community in King County. To identify partners, the Outreach team undertook a systematic investigation of which community-based organizations were located in the county and who was doing outreach. If there was no entity in a specific geographic area conducting outreach, the team identified potential partners amenable to partnering on outreach activities.

### ***Eligibility Determinations and Enrollment***

King County had no singular involvement in processing Medicaid eligibility for county residents prior to or during the Transitional Bridge Demonstration. Washington's Department of Social and Health Services (DSHS) processed Medicaid eligibility along with eligibility for other social services, such as cash, food, and disability assistance. With the statewide Medicaid expansion in 2014, Washington split the eligibility determination process. DSHS continued to process applications for social services, while the HCA (a government agency that administered Medicaid and the state's public employee benefits program) began processing Medicaid applications. A third entity, the state's health insurance Marketplace, Healthplanfinder, administered the online portal through which an individual could apply for a qualified health plan on the Marketplace or apply for Medicaid. Collaboration between the three entities was reported by interviewees to be productive given the enormity of building the Healthplanfinder system and merging the Medicaid eligibility system with Healthplanfinder.

There were early challenges in setting up the new online application portal; state and county interviewees reported that there were issues with system glitches and non-functioning websites as the open enrollment period started in 2013. County interviewees and community-based organizations interviewed reported that the state did a good job working with them to trouble-shoot errors and find work-arounds to systems issues when needed.

Washington implemented a key simplification--data from DSHS, Medicaid, and several national databases were merged into the online portal so that when application assistors began a Medicaid application certain sociodemographic (i.e., SSN) and possibly income information (from national employment databases) pre-populated the application as long as the individual had been in a DSHS or Medicaid program in the past. One ideal feature reported by the state to be missing was synchronicity between the online portal and DSHS's online portal, Washington Connections. While Healthplanfinder can send information to Washington Connections; Washington Connections cannot send information to Healthplanfinder. As a result, someone applying for DSHS services may not be automatically forwarded to Healthplanfinder to check for possible enrollment in Medicaid.

Despite steps taken by the state to integrate data systems and pre-populate data, issues remain, particularly for vulnerable populations such as individuals experiencing homelessness or incarcerated individuals. Government-approved identification, SSNs, mailing addresses, and email addresses are challenging for some populations to provide. Interviewees noted that they had to help applicants create email addresses; find a mailing address to use, and/or draft self-attestations of address and income to successfully complete applications. King County pursued a unique strategy to facilitate Medicaid enrollment among the incarcerated. They secured a Memorandum of Understanding from Washington State to allow application assistors to submit an application for an incarcerated individual and if the person was found eligible, the individual could be enrolled in Medicaid up to 30 days prior to his/her release date. If the release date changed, the application assistor had to contact the state to change the start date of enrollment to align with the 30 day window.

### ***Outreach Strategies***

Because the Transitional Bridge demonstration encompassed a roll-over of individuals in state-funded programs into a federal-state Medicaid financial partnership, there was no specific outreach and enrollment to do at the county level. Instead, site visit interviewees spoke of their general approach to outreach and enrollment pursuant to the statewide Medicaid expansion. County leadership expressed that their goal was to push information out through every means possible so that county residents constantly saw the message that health coverage was available and that there were individuals available to help them apply for coverage.

Contacting uninsured patients and integrating application assistance in to clinical work flows has been a key strategy used. The medical and behavioral health providers and social service providers interviewed contacted their uninsured patients. These providers had staff trained to be application assistors, and they offered their application assistance services. Many providers allocated time before or after a visit to provide application assistance. Front office staff was trained to screen for insurance and hand-off an uninsured individual to an application assistor. King County's homeless program integrated application assistance in to the workflow of their medical mobile vans which they brought to areas where individuals experiencing homelessness were concentrated. The county's jail health program had limited capacity, so they identified incarcerated individuals with certain high needs, chemical dependency, HIV, pregnancy, and the frail elderly and integrated application assistance into their discharge planning.

Many community-based organizations held enrollment events at their agencies. The county's outreach staff hosted or attended hundreds of outreach events, particularly around the 2013 open enrollment period for the health insurance Marketplace. Examples of event locations included detention centers, food banks, libraries, schools, soup kitchens, churches, and hospitals. The county hosted a website listing the time and place of enrollment events, and they initiated a campaign whereby an individual texted the county their phone number and the county would text a reminder for

upcoming enrollment events. Establishing partnerships with local organizations was a key driver to the success of this strategy. Without the willingness of organizations to host events and help spread the word about upcoming events, this would have been an unsuccessful strategy.

Several interviewees expressed that in order for these strategies to be successful, the health care providers and staff at partner organizations needed to be well-informed about who was eligible for what program (Medicaid versus qualified health plans on the Exchange), eligibility requirements, and the application process because these front-line individuals were the first contact uninsured individuals had. Several county and provider interviewees discussed the development of fact sheets and the time they took to ensure that everyone interacting with an uninsured client was properly informed. Other interviewees noted that they had to use education to combat the negative press surrounding the roll-out of the Healthcare.gov website.

To complement their outreach efforts, several county and provider interviewees reported that they wished they had had more granular data about where the uninsured are located within the county; where newly Medicaid-enrolled individuals reside in the county, and the race/ethnicity of enrollees. Without this information, they found it difficult to identify the hotspots in need of additional outreach. Because the state processed Medicaid applications, the interviewees have been looking to the state for these data, but the state did not have it available to date.

### ***Health Care Literacy and Access***

King County is home to many ethnic groups, and for many English is not their first language. While the Medicaid and state-based Exchange had materials translated into several languages, the county's outreach team secured grant funding to translate outreach materials into additional languages spoken in King County. They also conducted focus groups with certain ethnic groups to better understand what types of outreach materials these groups would be more likely to respond to. Even among those for whom English was a first language, literacy is a pervasive issue. For example, site visit interviewees noted that when working with the justice-involved population, all materials about Medicaid eligibility and enrollment given to individuals should be at a 4<sup>th</sup> grade reading level.

Once individuals were enrolled, interviewees from the King County outreach team, providers, and community-based organizations similarly expressed the challenge of working with populations who were unfamiliar with how to use health insurance and how to access the health services now available to them under Medicaid. The county as well as one provider noted that the welcome information sent by Medicaid to new enrollees is not easy to understand and that many people are not familiar with health insurance related terms such as "co-payment." Certain populations, such as people experiencing homelessness and newly arrived immigrant populations, had a particularly challenging time given their lack of exposure to the United States health care system, and interviewees reported that extensive education was needed to help them learn how to

engage with the system. The county also addressed this challenge by handing out fliers about how to use benefits at all their enrollment events.

Lack of access to medical care was not uniformly mentioned as a pervasive challenge by site visit interviewees. Issues with access to post-acute care, mental, and behavioral health was raised by some interviewees, since there is a shortage of these Medicaid providers. Poor access to behavioral health services was particularly concerning for young men needing these services and newly-eligible through the statewide Medicaid expansion. However, several county and provider interviewees noted that lack of coordination between social services, such as supportive housing, and medical services is of particular concern, specifically for newly-eligible Medicaid populations, and they expect this to be a key challenge moving forward.

### ***Provider Issues***

After Washington State rolled out expanded Medicaid coverage in January 2014, medical and behavioral health providers who were interviewed noted an increase in the number of individuals with Medicaid coverage seeking care. Several providers noted that they were expecting an initial spike in demand but they were surprised that the demand had not subsided. One hospital reported that after ACA roll-out the amount spent on charity care had dropped by 50 percent, and another noted that the percentage of uninsured patients receiving care has gone down considerably. Among the behavioral health providers, there were conflicting opinions as to whether or not the newly-enrolled Medicaid population was of average or higher than average clinical need.

To address the rising demand for services, providers were hiring clinical and administrative staff and referring patients to other clinics. Several providers had plans to hire additional clinical staff to meet demand for services, particularly the behavioral health providers. Two behavioral health providers noted that with the increase in the number of Medicaid covered individuals seen at clinics, they would be hiring more administrative staff, including a billing specialist just to process Medicaid billing. One hospital based interviewee reported that they began referring individuals to local community health centers because the hospital's primary care clinics were at capacity.

Other notable issues raised by providers included lower reimbursement rates and churning. A couple of behavioral health providers noted that state Medicaid reimbursement rates are lower for certain behavioral health services that were previously paid for through county-based programs, which negatively impacted their revenue. Another interviewee expressed concerns over reductions in supplementary funding such as DSH funding; these funding sources are being reduced under the assumption that Medicaid reimbursement stemming from increased Medicaid coverage will cover the costs of providing care. Anecdotally, the interviewee reported this reimbursement neutrality is not going to happen given low Medicaid reimbursement rates. Another provider noted that churning on and off insurance is higher in the Medicaid population and without timely notification that a client is currently not on

Medicaid, any services rendered during a period of ineligibility cannot be billed, which has negatively impacted revenue. One provider and one county interviewee also expressed concern about funding in-person assistors once external grant funds to support these assistors are exhausted because they believe clinic funds alone cannot sustain those positions.

### ***Funding and Staffing Issues***

During the site visit, there was no mention of the impact of the Transitional Bridge Demonstration on funding or staffing constraints within the state, county, medical and behavioral health providers or community-based organizations. However, there were notable changes after the Medicaid expansion roll-out that were unique to the state and county. At the state level, additional staff were not hired to work on Medicaid expansion and Marketplace roll-out. Instead, work was reallocated among existing staff. Unanticipated challenges with the online portal through which Medicaid and Marketplace applications were accepted and processed and the revised eligibility processes took more time to work through than expected, resulting in stretching personnel and extended work hours. The county noted that because of these challenges, their outreach staff worked closely with the state to develop work-arounds when certain system errors occurred, the outreach staff then shared with community-based in person assistors who were also experiencing the same challenges. County staff working with the jail population noted that they did not have the capacity to assist all the potentially eligible individuals, so they had to target specific populations.

## APPENDIX B. KEY CHARACTERISTICS OF COUNTY PROGRAMS

**TABLE B-1. Key Characteristics of County Programs**

Community (Expansion Dates)	Mechanism	Group Coverage	Any Special Population Focus	Other Key Features
Alameda County, California  "Bridge to Reform" (11/01/2010)	Section 1115 demonstration	<ul style="list-style-type: none"> <li>• Medicaid expansion--non-pregnant adults ages 19-64, income at or below 133% FPL</li> <li>• Health Care Coverage Initiative--non-pregnant adults from 133-200% FPL otherwise ineligible for Medicaid</li> </ul>	<ul style="list-style-type: none"> <li>• Persons on probation</li> <li>• Persons with chronic diseases</li> <li>• Persons with behavioral health needs</li> </ul>	<ul style="list-style-type: none"> <li>• Integrating behavioral health with medical care</li> <li>• Focus on comprehensive management of chronic diseases</li> <li>• Creative use of mass media</li> <li>• FQHC Advanced Primary Care Practice CMS demonstration site</li> <li>• State-based health insurance marketplace</li> </ul>
Cook County, Illinois  "Illinois/Cook CountyCare" (10/31/2012)	Section 1115 demonstration	<ul style="list-style-type: none"> <li>• Expansion population prior to 2014 enrolled in new managed care plan, operated by the county safety-net institution, for uninsured adults ages 19-64, without dependent children, income at or below 133% FPL, who are otherwise ineligible for Medicaid and reside in Cook County</li> </ul>	<ul style="list-style-type: none"> <li>• Jail-involved individuals</li> </ul>	<ul style="list-style-type: none"> <li>• Development of CountyCare managed care plan (led by CCHHS) to enroll for newly-eligible under early expansion</li> <li>• Partnership with FQHCs to expand access beyond CCHHS</li> <li>• Partnership with Medical Home Network to leverage electronic data feedback and exchange between some providers</li> </ul>
Cuyahoga County, Ohio  "Ohio/MetroHealth Care Plus" (02/05/2013)	Section 1115 demonstration	<ul style="list-style-type: none"> <li>• Uninsured adults, ages 19-64, who are non-pregnant, income at or below 133% FPL, who are otherwise ineligible for comprehensive Medicaid and reside in Cuyahoga County</li> </ul>	<ul style="list-style-type: none"> <li>• Frequent emergency department users</li> <li>• Persons with behavioral health needs</li> <li>• Persons with chronic diseases</li> </ul>	<ul style="list-style-type: none"> <li>• Qualified members of MetroHealth's existing charity program automatically enrolled using Hospital Care Assurance Program data</li> <li>• Expands scope of covered services</li> <li>• Developing and expanding medical home models</li> <li>• Federally facilitated health insurance marketplace</li> </ul>
King County, Washington  "Transitional Bridge Demonstration" (01/03/2011)	Section 1115 demonstration	<ul style="list-style-type: none"> <li>• Non-pregnant adults, ages 19-64</li> <li>• Income up to 200% FPL for Basic Health</li> <li>• Income up to 133% for Medical Care Services (Disability Lifeline, or Alcohol and Drug Addiction Treatment and Support)</li> </ul>	<ul style="list-style-type: none"> <li>• Individuals experiencing homelessness</li> <li>• Persons with severe mental illness</li> <li>• Persons with chronic diseases</li> </ul>	<ul style="list-style-type: none"> <li>• Primarily a state expansion but with a large population focus in King County</li> <li>• Incredibly diverse ethnic population</li> <li>• Developing plans for covering supported housing under Medicaid expansion</li> <li>• State-based health insurance marketplace</li> </ul>

To obtain a printed copy of this report, send the full report title and your mailing information to:

U.S. Department of Health and Human Services  
Office of Disability, Aging and Long-Term Care Policy  
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Washington, D.C. 20201  
FAX: 202-401-7733  
Email: [webmaster.DALTCP@hhs.gov](mailto:webmaster.DALTCP@hhs.gov)

NOTE: All requests must be in writing.

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