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, Jhamirah.Howard@hhs.gov.

COUNTY EXPERIENCES WITH MEDICAID EXPANSION IMPLEMENTATION: Case Study Report

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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.[1] 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:

[1] 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.[2] 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.[3]

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.

[2] 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.

[3] 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 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.