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Smooth Transitions into Medi-Cal: Ensuring Continuity of Coverage for Low Income Health Program Enrollees

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SUMMARY: In 2014, over 500,000 California residents will transition from the Low Income Health Program (LIHP) to new health coverage provided by Medi-Cal or subsidized health plans offered in *Covered California*. This Policy Note focuses on the transition of more than 470,000 lower-income LIHP enrollees into a state-operated Medi-Cal program. If a county-based approach is adopted, expanding the existing local LIHPs, adjustments to the plan will be needed. The LIHPs continue to grow; one-third of those potentially eligible for the Affordable Care Act's optional Medi-Cal expansion have already been enrolled in the LIHP. The Department of Health Care Services has made considerable efforts to involve stakeholders in the planning process for the transition. Including providers, consumer advocates, and other stakeholder groups will enhance the transition to Medi-Cal, regardless of the implementation approach. Further recommendations include: engaging in automatic Medi-Cal eligibility determination methods, establishing procedures for data transfer that will provide adequate time for Medi-Cal enrollment, creating an extensive communication and outreach plan and evaluating the need for special transition plans for populations in need of additional assistance.

Background

The Low Income Health Program (LIHP) is a county-based program included in California's "Bridge to Reform" §1115 Medicaid Demonstration Waiver, and was created to prepare for health coverage options authorized through the Affordable Care Act of 2010 (ACA). More than 500,000 California residents with incomes at or below 200 percent of the Federal Poverty Level (FPL) were enrolled in the LIHP between July 2011 and December 2012. Partial federal financial participation allows the LIHPs to provide health coverage to low-income Californians who will be eligible in 2014 for the 100% federally-funded Medicaid expansion or subsidized health coverage through California's health insurance exchange, *Covered California*.[1] The local LIHPs have made significant progress in enrolling residents who will be eligible for Medi-Cal, California's Medicaid program. Exhibit 1 compares estimates of Medi-Cal eligibility to LIHP enrollment for each region. Information on LIHP enrollment by those individuals eligible for subsidized coverage in *Covered California* is provided in a separate Policy Note: *Promoting Enrollment of Low Income Health Program Participants in Covered California*.

Exhibit 1. Share of California's newly eligible Medi-Cal population enrolled in LIHP, December 2012

California Regions	Newly-Eligible for Medi-Cal in 2014[1]	LIHP Medi-Cal Expansion (MCE) enrollees December 2012	Share of Newly-Eligible for Medi-Cal enrolled in LIHP
Northern California and Sierra Counties	80,000	22,748	**28%**
Greater Bay Area	180,000	93,452	**52%**
Sacramento Area	100,000	7,661	**8%**
San Joaquin Valley	180,000	11,975	**7%**
Central Coast	70,000	11,251	**16%**
Los Angeles[2]	390,000	205,172	**53%**
Other Southern California	410,000	121,044	**30%**
Total	**1,410,000**	**473,303**	**34%**

[1] *Source*: UC-Berkeley-UCLA CalSIM model, Version 1.8; UCLA analysis of Low Income Health Program enrollment data as of December 31, 2012. LIHP enrollment data updates available at: http://healthpolicy.ucla.edu/programs/health-economics/projects/coverage-initiative/blog/default.aspx [2] Los Angeles data are self-reported.

Notes: (1) For definitions of regions see Table 7-2 Regions in California, CHIS Methodology Report Series #5, page 7-7, http://healthpolicy.ucla.edu/Documents/Newsroom%20PDF/CHIS2009_method5.pdf (2) LIHP enrollment data reflects only MCE enrollees with incomes up to 133% FPL.

Seventeen LIHPs were operational in December 2012 (Exhibit 2) and two more programs opened in March 2013. One of the nineteen is the County Medical Services Program (CMSP), a consortium of 35 counties, while the remaining eighteen LIHPs are single county programs. Nearly 94 percent of the state population resides in a county with a LIHP.[2] Upper eligibility limits vary by county from 25% to 200% of FPL.

LIHP enrollees are split into two groups based on family income: Medicaid Coverage Expansion (MCE) enrollees with incomes at or below 133% of FPL and Health Care Coverage Initiative (HCCI) enrollees with incomes above 133% up to 200% of FPL. MCE enrollees make up 94.7% of current LIHP participants and are the focus of the Medi-Cal transition activities described here.

LIHP Enrollment

Program enrollment reached 499,678 in December 2012; 473,303 of this total were LIHP-MCE enrollees (Exhibit 2). In October 2012, Santa Cruz LIHP implemented an enrollment cap which will remain in effect until July 2013. A waiting list has been initiated by the county.

LIHP enrollees are 33% Latino, 17% African American, 12% Asian/Pacific Islander and 32% White; 21% of LIHP enrollees report a language other than English as their primary language (14% Spanish, 5% Asian/Pacific Islander); and, 57% of LIHP enrollees are 45 years or older.[3]

The Medi-Cal Expansion: Two Models

Currently, state legislators and the governor are determining whether to engage in a state-operated expansion of Medi-Cal or to require each county to use existing LIHPs and/or county indigent health programs to expand Medi-Cal by serving individuals up to 133% FPL. A county-based expansion would require federal approval and, if approved, the federal share of expansion funds would be transferred to the counties.

Counties with LIHPs would likely build on their current programs by increasing income eligibility and expanding services to meet Medi-Cal requirements. Counties not

operating a LIHP would need to create new infrastructure and develop a new local expansion program to meet federal and state requirements. The Initial Transition Plan and this Policy Note focus on the steps necessary to effectively transition the current LIHP enrollees to a state-operated Medi-Cal expansion. If a county-operated expansion is chosen, eligibility and enrollment plans would stay largely the same while activities planned for data transfer, managed care, and communication and outreach would need to be customized to ensure a consistent, yet flexible, implementation that could be accomplished by all counties to meet the new eligibility thresholds, benefits and network requirements.

Over One Million Eligible

More than 1.4 million Californians are expected to fit new eligibility criteria for Medi-Cal.[4] The expansion as defined by the ACA increases the number of individuals eligible for Medi-Cal in two key ways:

- *Allows California to expand Medi-Cal eligibility to new populations*: Childless adults, who were categorically ineligible for Medi-Cal, would be eligible for the Medi-Cal expansion.
- *Raises income-eligibility level:* The Medi-Cal income-eligibility limit would increase to 133% of FPL for non-elderly adults.[5]

Medi-Cal expansion eligibility is limited to U.S. citizens and qualified aliens.[6]

Exhibit 2. LIHP enrollment by county: LIHP MCE enrollment and total enrollment as of December 2012

LIHP Counties	LIHP-MCE Enrollment December 2012	Total Enrollment (HCCI + MCE) December 2012
Alameda	40,697	49,687
CMSP[1]	44,882	44,882
Contra Costa	10,004	12,124
Kern	6,393	6,807
Los Angeles[2]	205,172	205,357
Orange	33,428	43,173
Placer	2,344	2,344
Riverside	26,593	26,593
Sacramento	2,274	2,274
San Bernardino	25,946	25,946
San Diego	32,254	32,339
San Francisco	9,267	10,306
San Joaquin	1,753	1,753
San Mateo	8,519	8,671
Santa Clara	13,007	13,718
Santa Cruz	2,140	2,140
Ventura	8,630	11,564
TOTAL	**473,303**	**499,678**

[1] CMSP is the County Medical Services Program, a consortium of 35 counties.
[2] Los Angeles data are self-reported.

Initial Transition Plan

Although LIHPs will provide coverage until December 31, 2013, the §1115 Waiver states that "by July 1, 2013, the State must begin implementation of a simplified, streamlined process for transitioning eligible enrollees from the Demonstration [LIHP] to Medicaid [Medi-Cal] or the Exchange [*Covered California*] in 2014 without need for additional determinations of enrollees."[7] The Department of Health Care Services (DHCS) collaborated with the UCLA Center for Health Policy Research and UC Berkeley Center for Labor Research and Education for assistance in developing a transition plan for a state-based Medicaid expansion starting in 2014. The Initial Transition Plan was submitted to the Centers for Medicare and Medicaid Services (CMS) on August 1, 2012.[8] In this policy note, we provide a brief summary of the transition plan and explain the importance of each element.

Eligibility Determination

The Transition Plan States: DHCS will transition LIHP-MCE enrollees to Medi-Cal on January 1, 2014 without a new application, in order to ensure that LIHP enrollees do not experience a break in coverage. If it is necessary to collect new eligibility data from LIHP enrollees, such as income, family size or tax filing status, every effort will be made to collect this data prior to October 2013 to allow for a smooth transition.

Implementation Status: DHCS is exploring eligibility determination methods for the LIHP transition. The primary option under consideration utilizes existing LIHP collected information on income and family characteristics.

This option is modeled after the eligibility determination process planned for existing Medi-Cal enrollees, but uses information collected by local LIHPs. Under that model, the enrollees would be transitioned to Medi-Cal on January 1, 2014 based on the currently available LIHP eligibility data and undergo a new Medi-Cal eligibility determination using Modified Adjusted Gross Income (MAGI) based methodologies at their next regularly scheduled renewal date in 2014 (typically, 12 months after their last LIHP redetermination). An alternate method is also being considered which involves performing the MAGI-based eligibility determination for all LIHP-MCE enrollees prior to the transition. This method would necessitate data collection by the LIHPs and a subsequent transfer of information to CalHEERS, the California Healthcare Eligibility Enrollment and Retention System, for a MAGI eligibility determination. The chosen process is likely to be used in both county- or state-operated Medi-Cal expansion options.

Methods to Utilize Existing Data Sources

The Transition Plan States: Local LIHPs will supply enrollee data to DHCS in a format that allows for Medi-Cal eligibility verification through the Medi-Cal Eligibility Data System (MEDS). LIHPs submit quarterly data reports for program evaluation to UCLA, including data on enrollees' care utilization and medical home location. These data, combined with eligibility data provided by the LIHPs to DHCS' MEDS will be used to facilitate enrollment in Medi-Cal and managed care plans and to calculate capitation rates for Medi-Cal Managed Care Plans (MMCP) for this new population.

Implementation Status: A key component of the data transfer is moving LIHP enrollee data into MEDS, the DHCS system for Medi-Cal eligibility verification and enrollee identification. Information from MEDS will allow for the transition of LIHP enrollees to Medi-Cal and enrollment in a MMCP. Most LIHPs plan to utilize their local county Statewide Automated Welfare Systems (SAWS) for this purpose.[9] For counties who do not plan to use the local SAWS, DHCS has developed a secure file transfer process for the county to send LIHP enrollee information directly into DHCS to populate MEDS (this connection is called the 'MEDS option'). These counties will be exporting information from their LIHP system of record and transmitting it to DHCS. An overview of county decisions related to the LIHP to MEDS data transfer is provided in Exhibit 3.

Managed Care Plan and Medical Home

Transition Plan: The transition plan aims to promote continuity of care with the assigned medical home under LIHP, offer plan choice, and promote seamless coverage. LIHP enrollees will receive communications that inform

them of the availability of a MMCP that includes their current LIHP medical home at least one month prior to January 1, 2014. LIHP enrollees will be given a choice to enroll in the MMCP that contains their LIHP medical home or a different plan, if offered in their area. If the enrollee takes no action, they will be enrolled into the plan originally offered that contains their medical home. The network will be assessed to determine the overlap between LIHP and MMCP networks and ensure an adequate supply of primary and specialty care providers, in accordance with Knox-Keene requirements.

Implementation Status: The process of identifying current medical homes will be facilitated through UCLA and will partially use LIHP evaluation data already collected from each county. LIHPs will be required to submit current medical home assignment information to UCLA on a regular schedule for all current enrollees. UCLA will then extract these data and send files to DHCS under current data transfer agreements using secure file transfer protocols (SFTP). These data will be matched to client information housed by DHCS, and used to inform the MMCP of the new beneficiary's current LIHP medical home to guide assignment.

Exhibit 3. LIHP data systems by county and plans for data transfer to MEDS

LIHP Counties	LIHP System of Record for Enrollee Data (Highlighted cells indicate a capability to communicate with MEDS)	System for transfer of LIHP data to MEDS in 2013
Alameda	One E-App	MEDS option
CMSP	C-IV and CalWIN	C-IV and CalWIN
Contra Costa	Basic Health Care and Health Care Initiative System	MEDS option
Kern	Paper system until October 2012	MEDS option
Los Angeles	LEADER	LEADER
Monterey	C-IV	C-IV
Orange	AuthMed	CalWIN
Placer	Service Management Access Resource Tracking (SMART)	CalWIN
Riverside	Health CRM	C-IV
Sacramento	CalWIN	CalWIN
San Bernardino	C-IV	C-IV
San Diego	San Diego Administrative Services Organization and AuthMed	CalWIN
San Francisco	One E-app	MEDS option
San Joaquin	One E-app	C-IV
San Mateo	One E-app	MEDS option
Santa Clara	MIA database	CalWIN
Santa Cruz	One E-app	CalWIN
Tulare	CalWIN	CalWIN
Ventura	D-Base program	CalWIN

Note: MEDS Option is a secure connection created for the county by DHCS which allows for data transfer from the LIHP directly to DHCS.

Recommendations

Four recommendations to promote a smooth transition to Medi-Cal are described here:

1. Engage in automatic eligibility determination procedures
2. Facilitate timely data transfers
3. Develop an intensive and extensive Communication Strategy
4. Prepare special plans for populations in need of additional assistance

Communication and Outreach Strategy

The Transition Plan States: DHCS will develop a strategy to notify LIHP enrollees of the upcoming transition and provide transition assistance. LIHPs, other relevant county personnel, service providers and community-based organizations will be engaged in the strategy to develop and disseminate communications related to the transition.

Implementation Status: DHCS has recognized that a successful transition should incorporate provider and consumer organizations that regularly interact with the LIHP population. Some venues for involving these organizations in promoting successful communication already exist and will be utilized: LIHP conferences, quarterly LIHP advocate calls and bi-weekly LIHP – DHCS phone calls to discuss LIHP implementation, operations, and transition planning.

DHCS and the Blue Shield of California Foundation created an additional opportunity to engage the LIHPs, other related county personnel, community-based organizations, stakeholders and consumer advocates. A LIHP Transition Planning Workgroup was created to apply the expertise and experience of LIHP stakeholders in the development of communications and outreach planning. The first meeting was held in November 2012 and this group will continue providing guidance to DHCS in three key areas:

- Messaging for LIHP enrollees and applicants describing the Medi-Cal or *Covered California* transition-related activities.
- Regional community engagement and support for the LIHP transition.
- Technical assistance to counties as they are asked to transition the LIHP enrollees into Medi-Cal and other available coverage options.

Groups in Need of Additional Assistance

The Transition Plan States: DHCS will identify populations that may need additional assistance during the transition and evaluate their specific needs for targeted transition plans.

Implementation Status: Initial steps have been taken to engage advocates and providers who are knowledgeable about these enrollees. DHCS will gather further information on groups in need of special consideration through the LIHP Transition Planning Workgroup meetings.

Recommendation 1: Engage in Automatic Medi-Cal Eligibility Determination Procedures

A smooth transition to Medi-Cal is best supported through the primary option for Medi-Cal eligibility determination: utilizing LIHP-collected data for Medi-Cal eligibility determination. Federal Medicaid regulations (CMS-2349) appear to allow for these redeterminations to be made after March of 2014.[10]

This method promotes a smooth transition through:

- Increasing the likelihood of continuous eligibility for health coverage as the current MCE population will not be required to provide new information to DHCS or their local LIHP in order to be enrolled in Medi-Cal on January 1, 2014.
- Reducing the burden on LIHPs that would be responsible for following-up with LIHP-MCE enrollees who did not provide adequate documentation for Medi-Cal eligibility determination prior to the transition.
- Spreading redeterminations throughout the calendar year will be operationally easier for counties in 2014 and beyond. County social services agencies are responsible for Medi-Cal redeterminations, meaning that the 500,000 LIHP-MCE enrollees that transition

to Medi-Cal will represent a new population for the social services agencies to serve and maintain. Avoiding large numbers of redeterminations at one point in the year will minimize the impact of this increased work load.

- Providing time for DHCS to enroll new members in managed care plans, communicate these assignments to the new members and provide the managed care plans with information regarding the new member's LIHP medical home.

The alternate method being considered involves performing the MAGI-based eligibility determination for all LIHP-MCE enrollees prior to the transition. However, it is more difficult to implement. The risk for coverage gaps increases because tax data matches may not be available for many LIHP enrollees with incomes below the tax filing threshold of $9,750, equivalent to 87% of FPL for a single adult.[11]

Recommendation 2: Facilitate Timely Data Transfers

One major challenge in the transition process is transmitting data from LIHPs to DHCS in time to facilitate MMCP and medical home assignments prior to January 1, 2014.

Enrollment-related data transfers need to begin by July 2013 to process data, prepare mailings, and communicate information to MMCPs. In order to assess network adequacy and set managed care rates for the future Medi-Cal population, administrative data will need to be processed earlier in 2013. These data transfers require significant coordination and communication between DHCS, UCLA, and LIHPs.

Recommendation 3: Develop an Intensive and Extensive Communication Strategy

Specific recommendations for the communication and outreach strategy, provided by stakeholders, include:

- Provide access to telephone or in-person assistance.
- Provide transition information in multiple settings including provider offices, through county eligibility workers, LIHP mailings, internet, and community based meetings.
- Provide culturally appropriate transition information in multiple languages.
- Provide training to county and community-organization staff responsible for coordinating the transition.

Recommendation 4: Prepare for Special Populations

Additional support or alternative processes should be considered to facilitate a smooth transition for enrollees with complex conditions. These populations may include: previous Ryan White enrollees with HIV/AIDS diagnoses, LIHP enrollees using case management, enrollees with chronic and complex behavioral health conditions, enrollees who will experience a change in provider as a result of the transition and enrollees with open treatment authorizations.[12] Carefully planned support strategies that complement other aspects of the transition process are essential to success of the transition among these vulnerable groups.

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Notes

1. Under the Affordable Care Act, the federal government will match 100% of the health care costs for those newly eligible for Medi-Cal from 2014 to 2016. The federal matching percentage will decrease gradually until 2020, when it will reach 90%.
2. Source: Analysis of data from the 2010 Census and current number of operational LIHPs as of April 1, 2013 from DHCS.
3. Source: Low Income Health Program Performance Dashboard: Aggregate Program Report July 1, 2011-September 30, 2012. Race/ethnicity data not provided for Placer County. Language data not provided for San Diego County.
4. The Supreme Court decision in June 2012 made the Affordable Care Act Medicaid expansion for non-elderly adults optional for states. California's legislature is expected to address this issue in the spring and summer of 2013.
5. Individuals with incomes above 133% up to 138% of FPL may also be eligible for Medi-Cal due to a five-percent income disregard applied for all beneficiaries.
6. Qualified aliens may include lawful permanent residents who have lived in the United States for more than 5 years. Additional criteria may also apply.
7. Source: Centers for Medicare & Medicaid Services Special Terms and Conditions of the §1115 Waiver available at: http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/Publications/CaliforniaSTCs11-2-10.pdf
8. Initial Transition Plan as submitted to CMS is available at: http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/LIHP%20TRANSITION/CAWaivrInitLIHPTrnstnPln.pdf
9. Three Statewide Automated Welfare Systems (SAWS) are currently used at the county-level: CalWIN, C-IV and LEADER.
10. CMS-2349-F: Final Medicaid Regulations released in March 2012: www.medicaid.gov/AffordableCareAct/downloads/CMS-2349-F-RegulatoryImpactAnalysis.pdf
11. Based on 2012 FPL of 100% = $11,170 and the IRS tax filing threshold of $9,750 for single adults provided in IRS 1040 Instructions available at: http://www.irs.gov/pub/irs-pdf/i1040gi.pdf
12. Treatment authorizations are approvals for medical, pharmacy or dental services. An open treatment authorization refers to an approved service that has not yet been provided.