DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, Maryland 21244-1850

Children and Adults Health Programs Group

AUG 1 1 2014

Toby Douglas
Director, Department of Health Care Services
1501 Capital Ave, MS 0000
P.O. Box 997413
Sacramento, CA 99859-7413

Dear Mr. Douglas:

I am writing to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved the attached evaluation plan and supplemental materials for the Low Income Health Program (LIHP) component of California's section 1115(a) demonstration (11-W-00193/9), entitled "California Bridge to Reform Demonstration." Elements of this evaluation plan were updated on April 23, 2013, in response to CMS's initial comments on the draft evaluation plan.

Your project officer for this demonstration is Ms. Mehreen Hossain. She is available to answer any questions concerning your section 1115 demonstration. Ms. Hossain's contact information is:

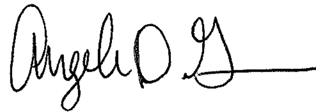
Center for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-0938
Facsimile: (410) 786-5882
E-mail: Mehreen.Hossain1@cms.hhs.gov

Official communications regarding official matters should be sent simultaneously to Ms. Hossain and Ms. Gloria Nagle, Associate Regional Administrator for the Division of Medicaid and Children's Health in our San Francisco Regional Office. Ms. Nagle's contact information is as follows:

Ms. Gloria Nagle
Associate Regional Administrator
Division of Medicaid and Children's Health Operations
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

If you have any questions regarding this approval, please contact Mr. Eliot Fishman, Director, Children and Adults Health Programs Group, Centers for Medicaid & CHIP Services at (410) 786-5647.

Sincerely,



Angela D. Garner
Acting Director
Division of State Demonstrations and Waivers

Cc: Eliot Fishman, Director, Children and Adults Health Programs Group
Gloria Nagle, ARA Region IX
Paul Boben, CMCS
Mehreen Hossain, CMCS

Low-Income Health Program (LIHP) Evaluation Proposal

UCLA Center for Health Policy Research &
The California Medicaid Research Institute

BACKGROUND

In November of 2010, California's "Bridge to Reform" §1115 Medicaid Waiver was approved by CMS. The waiver expanded Medi-Cal managed care for seniors and persons with disabilities, approved pilot projects in the California Children's Services program, approved Delivery System Reform Incentive Payments for public hospitals, and created the Low-Income Health Program (LIHP), which is designed to provide health care to uninsured Californians through locally run programs. LIHP will be funded jointly by local and federal dollars to provide services for individuals aged 19-64, with family incomes of 200% of FPL or below, who are citizens or legal residents (who have lived in the U.S. for over five years) and lack coverage for services provided by the county or local health authority. LIHP is a county-based elective program consisting of two components: LIHP-Medicaid Expansion (MCE) (0-133% of FPL) and a LIHP-Coverage Initiative program (CI) (from 133 through 200% of FPL). The LIHP provides some flexibility for local governments (counties and local health authorities) to select different thresholds for income in developing their programs. Based on currently submitted applications, all 58 counties and two health authorities (the California Rural Indian Health Board and the Pasadena Health Authority) will deliver LIHP-MCE services via 27 separate programs (one applicant, County Medical Services Program, is a consortium of 34 rural counties). Currently, 13 counties have plans to provide services via LIHP-CI as well.

Ten counties are in the process of transitioning programs developed in 2007 under a prior §1115 waiver program to care for the uninsured, called the Health Care Coverage Initiative (HCCI). These 'legacy' counties were able to continue their HCCI programs after the original waiver officially ended on October 31, 2010 and transition into an operational LIHP on July 1, 2011. The UCLA Center for Health Policy Research (UCLA) is contracted with the state to evaluate the impact of the HCCI program from the previous waiver, has experience working with the counties in transmitting and analyzing data, and has produced several evaluation reports and policy briefs that have been helpful to DHCS, CMS, and stakeholders in understanding how the systems functioned and their general impact on health care for the uninsured in California.[i]

An evaluation of the §1115 Medicaid Waiver "A Bridge to Reform" is required by the Centers for Medicare and Medicaid Services (CMS), as specified in the Waiver Special Terms and

Conditions (STCs) (Section IV. 25), as well as the authorizing legislation passed by the California Legislature (AB 342). As a part of the Bridge to Reform, the Low Income Health Program must be evaluated.

GOALS OF THE EVALUATION

A: The LIHP evaluation will monitor the progress of the demonstration and the contribution of LIHP to the "Bridge to Reform" in four critical areas:

1. outreach, enrollment retention, and transition strategies;
2. coverage expansion;
3. access to and quality of care; and,
4. care delivery system redesign in anticipation of 2014.

The primary goal of the evaluation is to provide information to various stakeholders on the impacts of LIHP in each of these areas. As part of creating this evaluation proposal, UCLA sought feedback on the utility of different evaluation activities from all stakeholders and gained insight on the utility of policy briefs and reports suggested in this proposal. UCLA also received valuable information on data available from the LIHPs and the feasibility and effort required to report data to be used in the evaluation. The stakeholders consulted in this process, through conference calls, discussions, e-mail correspondence, and telephone calls, included:

1. DHCS, which will assume responsibility for MCE enrollees in 2014 as they transition into Medi-Cal;
2. Members and representatives of the California Health Benefits Exchange Board, where HCCI enrollees will be eligible for subsidies in 2014 (or eligible for enrollment in the Basic Health Plan depending on legislative action); and
3. Counties or governmental entities with LIHPs and their representatives (CAPH, CMSP, CSAC, and CHEAC), who will be involved in eligibility determination, enrollment of Medi-Cal beneficiaries and maintaining existing public providers and programs for Californians who do not participate in Medi-Cal, the Exchange, or other sources of insurance.

In order to communicate evaluation proposal information to stakeholders, UCLA has created an informational document entitled "Low Income Health Program Evaluation", with two areas of information, including "Data Requirements FAQ", "Appendix A: Evaluation Publications and Products". UCLA has also created and released a detailed "Technical Specification Manual" to guide LIHPs in collection and submission of data for the evaluation. Stakeholder feedback has been incorporated throughout the proposal development process.

EVALUATION DATA SOURCES

The evaluation activities will begin on July 1, 2011, contingent upon funding and availability of data from LIHPs. Continuous data collection for the evaluation will occur throughout the program period, and will begin for each LIHP at the time the local program begins implementation. Data will be collected in several different formats. The evaluation will use a combination of quantitative and qualitative data gathered during the program period:

1. **Monthly summary/aggregate data required by DHCS for CMS progress reports**
   DHCS and UCLA will work together to create a web-based data entry portal for LIHPs to easily submit monthly summary data via the evaluation website (www.coverageinitiative.ucla.edu). This will enable UCLA to complete necessary reporting to the Centers for Medicare and Medicaid Services on measures defined in the waiver Special Terms and Conditions.

2. **Quarterly Evaluation Data Submissions**
   Evaluation data will be submitted via a secure data transfer method for analysis by UCLA. For more information on secure data transfer, please see FAQ #17, 18 and 19 in the attached "Data Requirements FAQ". Data from both the period of LIHP implementation and the year prior to the start of each LIHP will be included in the evaluation. The "pre-" data for the period before program implementation is used to compare each individual's health care use before and during LIHP, and is essential in understanding the impact of LIHP on program enrollees. UCLA acknowledges that major differences exist between the existing programs and the LIHPs in each participating program, and will account for these differences in all analyses.

   For more information regarding the scope and content of requested data, please see FAQ #6, 9, 10, 11, 13, 14 and 15 in the attached "Data Requirements FAQ" and UCLA's "Technical Specifications Manual".

3. **Quarterly Program Progress Reports (PPRs) to collect information required by DHCS**
   PPRs will be downloaded from and submitted to UCLA and DHCS via the evaluation website (www.coverageinitiative.ucla.edu). These reports will include quantitative and qualitative information that is not collected elsewhere, including:
   a. Reoccurring quantitative and qualitative reporting items/questions
   b. Ad hoc questions from DHCS and UCLA for targeted information gathering on specific, time-sensitive topics

4. **UCLA Convening Meetings**

UCLA will host convening meetings to allow LIHPs to learn about evaluation results, share information on their own successes, and learn from the practices of their peer-LIHPs. These annual in-person convening meetings will be held in sites in either northern or southern California locations. In addition, a shorter annual webinar-based convening will be developed for LIHPs to share successes and best practices around specific topics remotely. The proposed budget includes travel expenses for LIHP representatives to attend in-person convening meetings.

5. **DHCS Convening Meetings**
   At intervals throughout the program implementation period, DHCS will hold administrative meetings to provide information, assistance and guidance to LIHPs on administrative topics such as claiming mechanisms. Evaluation convening meetings and DHCS administrative meetings may be coordinated to reduce travel burden on LIHPs. The evaluators will be present at the administrative meetings to better understand implementation activities.

6. **Other qualitative data collection through key informant interviews or web-based surveys**
   LIHPs will be asked to participate in **qualitative data** collection by UCLA and DHCS, in order to enable reporting to CMS, and to provide context and descriptive information regarding program implementation, progress toward health care reform transition, and system redesign efforts. In the previous HCCI evaluation, each county participated in 1 to 2 key informant interviews per year and the UCLA evaluation team held site visits in each county. In the LIHP evaluation, a combination of key informant interviews and web-based surveys will be used to gather this information in the most efficient and minimally burdensome method possible.

LIHPs will also submit claims for health care expenditures to DHCS, using their selected claiming mechanism. Final data collection will be completed by July 2014, and the evaluation report will be completed in December 2014 for DHCS review and submission to CMS.

TIMELINE, DELIVERABLES AND TASKS

The LIHP evaluation will focus on providing near-time reporting and rapid feedback to LIHPs and other stakeholders throughout the program implementation period.

The timing of the evaluation activities and products will be dependent on the speed of program implementation in each of the LIHPs, and may be changed in order to maximize utility of evaluation findings.

Table 1: Timing of the LIHP Evaluation

LIHP Program Year	Major Evaluation Activities
First LIHP Program Year: 11/1/ 2010 – 6/30/2011	

Second LIHP Program Year: 7/1/2011 – 6/30/2012	- Begin data collection (start September 1, 2011 and phase in data collection from each LIHP as it is implemented)
	- Evaluation publications
	  o Brief 1
	  o Quarterly Performance Dashboard Reports
	- Convening Meetings and Webinars

Third LIHP Program Year: 7/1/2012 – 6/30/2013	- Ongoing data collection
	- Evaluation publications
	  o Briefs 2 and 3
	  o System Redesign Innovation Report
	  o Quarterly Performance Dashboard Reports
	  o Interim Evaluation Report (if required)
	- Convening Meetings and Webinars

Fourth LIHP Program Year: 7/1/2013 – 12/31/2013	- Ongoing data collection
	- Evaluation publications
	  o Brief 4
	  o Quarterly Performance Dashboard Reports
	- Convening Meetings and Webinars

Final Evaluation Period: 1/1/2014 – 12/31/2014	- Final data collection ending in June 2014
	- Evaluation publications
	  o Final Quarterly Performance Dashboard Report
	  o Final Evaluation Report

In addition to the Performance Dashboard, UCLA will develop an interim evaluation report (if required by the State), a final evaluation report, four proposed policy briefs, and one system redesign innovation report. These deliverables will require substantial effort by UCLA to assist the counties in preparing data files for secure submission, receiving the files, and analyzing the data contained in these person-level records on health care use and outcomes. Because this

effort is not captured in any one deliverable, they are discussed as additional tasks in this section. Please see the attached timeline of deliverables and activities for more detail.

Task One:

Technical Assistance to LIHPs related to Data Collection
July 2011 through July 2012

UCLA will work with LIHPs to provide specifications for the content of individual person-level or visit-level variables requested as part of the evaluation. Due to delayed implementation of new LIHPs, technical assistance is estimated to continue throughout the first LIHP program year.

For a complete list of requested variables, please see UCLA's "Technical Specifications Manual." Depending on LIHP needs, UCLA can provide detailed file layouts or work with the program to understand the types of data collected and assist in creating a custom file layout to meet data submission requirements. This technical assistance will not only resolve data formatting and time period issues, but also focus on setting up the Secure FTP connectivity that will be needed to submit data in accordance with the HIPAA Business Associate Agreement protecting patient data used in the evaluation.

UCLA has begun providing technical assistance to numerous LIHPs to develop data collection mechanisms and provide guidance on variable construction that meets the needs of the evaluation and each program. These activities have ranged from providing detail on CPT codes used to identify specific types of visits to guidance on working with multiple clinics in the area to consolidate data into one file.

Task Two:

Data Collection, Cleaning and Management
September 2011 to December 2014

Each LIHP of the 27 will begin providing evaluation data after beginning program implementation. Data will be delivered by each LIHP at the start of each quarter for the previous 3-month period. After receiving quarterly data from each LIHP, it will be necessary for UCLA to compile, clean, organize, and process the provided data into useable formats in order to provide feedback through the Performance Dashboard and the policy briefs and evaluation reports. This task is essential to completion of all other tasks.

Enrollment data is essential for determining number of enrollees, months of enrollment, retention of enrollees, and the number of LIHP enrollees who are eligible for successful transition into Medi-Cal or the Exchange in 2014. Combined with county-level population data

from the 2009 and 2011 California Health Interview Survey, UCLA will also be able to estimate the percentage of each county's eligible population enrolled in LIHP.

Utilization data is essential for determining access to care and levels of utilization per enrollee. This information will be essential to the state and to the Exchange in determining the expected cost and the demographic and clinical risk profile of LIHP enrollees as they transition into Medi-Cal or the Exchange in 2014. Utilization is an important measure of the extent to which coverage expansion allows enrollees access to a broad spectrum of health care services.

If provided by LIHPs, laboratory test results will permit assessment of the extent to which selected chronic illnesses are being appropriately managed based on clinically accepted guidelines and benchmarks.

To the extent possible, the data collected by UCLA will be aggregated for use by DHCS to meet reporting requirements to CMS as a condition of the §1115 Medicaid waiver.

Task Three:

Quarterly Performance Dashboard and Website

September 2011 through December 2014

UCLA will prepare and release findings on a regular basis, beginning in the fall of 2011. Finding will largely be disseminated through UCLA's evaluation website, www.coverageinitiative.ucla.edu. This website will serve as a resource and repository of information for the LIHP evaluation, and as a platform for communication between LIHPs, UCLA, and other stakeholders. This website has some general, informational content that is publicly available, and an area accessible only to registered users via a password-protected log-in. All evaluation findings and LIHP-provided program materials are accessible only to registered site users.

Counties have expressed interest in examining individual and overall trends in measures of utilization and enrollment, including emergency room use, inpatient discharges and days, PMPM expenditures, and characteristics of the enrolled population. These measures will be useful to LIHPs in order to plan for the future needs of their population. Further refinements and useful measures such as readiness for Medi-Cal expansion in 2014 can be provided in the Dashboard if possible.

Dashboard reports will provide metrics with point-in-time estimates and monthly or quarterly trends for each LIHP and for the statewide program as a whole. LIHPs will collaborate with UCLA and DHCS to select a final list of standardized measures that will be useful for local program planning and implementation. Measures can be added to or removed from the reports

throughout the program period, based on data availability and according to interest of stakeholders.

Possible Performance Dashboard metrics have been suggested by LIHPs and other stakeholders or identified by UCLA, and are displayed below. Enrollment (1) and Descriptive (2) measures will be generated for each LIHP within 3 months of receiving the first complete data delivery from the LIHP. Utilization (3) and Quality of Care (4) measures will be generated within 6 months of receiving the first complete data delivery from the LIHP. Each measure will be generated for LIHPs that provide the necessary source variables for that measure.

1) **Enrollment Measures:**
   - Total count of current enrollees, by enrollee type (MCE vs. HCCI, new vs. existing)
   - Cumulative count of individuals served by the LIHP to date
   - Percent of target enrollment achieved
   - Enrollment measures may be stratified by descriptive characteristics, such as percent federal poverty level
2) **Descriptive Measures:**
   - Demographic characteristics of enrollees, by enrollee type
   - Proportion of enrollees with chronic conditions
3) **Utilization Measures:**
   - Total count of services provided, by service type including emergency room, inpatient, and outpatient visits (ER, IP, and OP respectively)
   - Rate of service utilization per 1,000 members, by service type (ER, IP, OP)
   - Percent of inpatient visits that were for an ambulatory care sensitive condition
   - Average length of stay of inpatient visits
   - Rate of 30-day hospital re-admission among those enrollees with an inpatient stay during the prior month
   - Proportion of non-urgent outpatient primary care visits that were provided at the enrollee's assigned medical home
4) **Quality of Care Measures:**
   - Provision of (selected) guideline concordant services within the applicable enrollee population. May include measures based on laboratory data, and claims/encounter data including pharmacy. Measures will report on process measures of quality (provision of recommended services) as well as outcome measures of quality (change in health status or clinical outcome).

Other important issues identified by stakeholders related to care seeking behaviors, enrollment processes, best practices in care coordination, and the impact of LIHP on meeting pent-up demand appear to be best suited for one-time publication of policy briefs.

Task Four:

Policy Brief #1 on Increasing Enrollment in Public Programs: Successful Strategies in California's Low Income Health Program
September 2011 through June 2012

This Policy Brief will focus on the in-reach and outreach activities used to recruit and enroll LIHP enrollees in both MCE and CI. Analyses will recognize and evaluate the changing local resources that impact LIHP program size and the implications of these constraints. In addition, this Brief will present data on the numbers and characteristics of individuals enrolled in LIHP, the pace of enrollment ramp-up, and the retention and recertification strategies implemented by the LIHPs.

During the original HCCI program, many of the ten legacy counties worked through significant barriers in terms of outreach/in-reach and enrollment of eligible populations in their program. The new LIHPs could benefit greatly from the lessons learned from early adopters of the LIHP and the legacy counties. As more and more LIHPs are launched, sharing in best practices around enrollment will be vital to increase enrollment and prepare for 2014.

In developing this policy brief, we will focus on these evaluation questions:

1. How have local resources impacted outreach, enrollment and retention efforts?
2. What strategies for recruitment have been successful in LIHP to increase enrollment of eligible patients?
3. What percent of the original enrollment target has been met by the LIHP? How did the original enrollment target set by the LIHP change during the implementation and contracting process?
4. What proportion of LIHP enrollees are new enrollees? What proportion are inmates?
5. What retention and recertification practices are effective in LIHP?
6. What can be learned about expected take-up under ACA from actual LIHP enrollment patterns?

Information will be collected through electronic surveys, key informant interviews, and the quarterly enrollment data submitted by LIHPs. The survey and interview data collection will enable the research team to link program details and characteristics to the change over time in enrollment each month.

Task Five:

Policy Brief #2 on How California's Low Income Health Program is Preparing the State to Enroll Individuals into the Medi-Cal Expansion in 2014
September 2011 through November 2012

This Policy Brief, coordinated by Ken Jacobs at UC Berkeley's Center for Labor Research and Education, will describe the systems that are deployed in participating programs for eligibility determination and enrollment in LIHP and Medi-Cal. It will determine to what extent resources are currently shared between departments of health and social services, and what steps should be taken to allow transition and data sharing if not already in place. This policy brief is designed to respond to DHCS needs around transitional planning for Medi-Cal expansion in 2014 and enrolling as many of the uninsured as possible in Medi-Cal when the 100% FMAP is in effect January 1, 2014 through December 31, 2016. DHCS will consult in the preparation of this brief, as needed, to help shape the research questions.

This brief will discuss the Medicaid eligibility issues that have arisen in LIHPs, starting with the counties that have begun LIHP by February 1, 2011 and expanding to include counties that begin LIHP in later months. UCLA will provide enrollment data for each LIHP and assist in the data collection from the counties. The UC Berkeley Center for Labor Research and Education will: 1) analyze what counties have done with LIHP in terms of what share of eligible population has been enrolled in LIHP; 2) how counties have enrolled beneficiaries, including outreach and in-reach mechanisms; 3) discuss best practices and lessons for Medi-Cal enrollment in advance of the ACA rollout in 2014 in order to provide data or information to the state or social services departments.

Meetings and comments with stakeholders from various entities including DHCS, the California Health Benefits Exchange Board leadership, and counties with local initiative plans informed the development of this policy brief. The following evaluation questions will be used to guide the policy brief:

1. Do the eligibility processes and IT system connections in each program allow for transition of the LIHP-MCE enrollees into Medi-Cal eligibility systems used by county departments of social services?
2. Do LIHPs have the enrollment and eligibility infrastructure needed to carry out this transition? And if not, what specifically would be needed?
3. What decisions and policies must be considered in ensuring a smooth transition from LIHP to Medi-Cal?

Data will be collected through key informant interviews with county, LIHP, DHCS staff, and other state officials, as well as local stakeholders, and experts on MEDS, One-E-App, and other enrollment systems currently in use in counties.

Task Six:

Policy Brief #3 on How California's Low Income Health Program is Preparing the State for Implementation of the Health Benefit Exchange in 2014
September 2011 through January 2013

This Policy Brief, coordinated by Ken Jacobs at UC Berkeley's Center for Labor Research and Education, will describe the preparations undertaken by participating programs and their community partners to prepare for transition of LIHP-CI enrollees to the HBE or Basic Health Plan, in LIHPs that have implemented an HCCI program. It will describe the innovative practices that can be used to facilitate this transition in 2014, and suggest best practices for enrollment and transition. It will also discuss policy considerations for transitioning the exchange-eligible population that was not enrolled in LIHP, including the strategies used to prepare for transition in LIHPs that did not implement an HCCI program. UCLA will provide the analytical support and data collection for this brief, in cooperation with UC Berkeley.

Meetings and comments with stakeholders from various entities including DHCS, the California Health Benefits Exchange Board leadership, and counties with local initiative plans informed the development of this policy brief. The following evaluations questions will guide the development of this brief:

1. How are participating programs preparing to refer LIHP-CI enrollees to the Exchange (or Basic Health Plan) in 2014?
2. What outreach and education practices have programs developed to inform enrollees of the transition?
3. Have programs begun using navigators or other educators to facilitate this process? If so, how?
4. What are the remaining gaps in planning and preparation that should be addressed?

Data will be collected through key informant interviews with county, LIHP, DHCS, and other state officials, as well as local stakeholders. DHCS will consult in the preparation of this brief, as needed, to help shape the research questions. A robust analysis of the available literature suggesting approaches in other states or geographic locations will be included, as well as recommendations made in existing reports.

Task Seven:

Policy Brief #4 on How has the Low Income Health Program Bridged the Way to Health Care Reform? Characteristics and Use Patterns of Eligible Medi-Cal and HBE Enrollees in 2014
September 2012 to September 2013

This Policy Brief will focus on how the LIHP has impacted the profile of Medi-Cal expansion and California Health Benefit Exchange eligible population. The Brief will compare the LIHP-enrolled

population (LIHP enrollment and claims data) to the overall eligible population (using the latest California Health Interview Survey data) to report on the characteristics of each group including race/ethnicity, age, gender, chronic illness, and health care use. It will allow us to meet the needs of planners at the Exchange as well as county leadership in developing plans for addressing pent-up demand in 2014.

The evaluation questions guiding this brief are:

1. What proportion of eligible individuals were enrolled in LIHPs, and what are the characteristics of the enrolled compared to those who are eligible but not enrolled?
2. To what extent have LIHPs reduced "pent-up" demand for care and improved health status among the enrolled?
3. What is the size and profile of the remaining uninsured population?

Data from the California Health Interview Survey, LIHP enrollment data, and administrative claims data from the LIHPs will be used to generate this Policy Brief.

Task Eight:

Low Income Health Program Care Delivery System Innovation Report
September 2011 to May 2013

The report will assess how LIHP is re-shaping the local healthcare environment and experience, including providing care coordination, changing care-seeking behaviors, and redesigning the care delivery system in anticipation of health care reform. The report will present case studies and data from specific LIHPs that have implemented innovative and effective methods to improve positive health care behaviors among enrollees and increase care efficiency. Methods of chronic illness management implemented by LIHPs, including coordination of care for mental/substance use and physical health co-morbidities will also be assessed, to provide lessons learned between LIHPs and from safety net providers nationally. The evaluation questions guiding this report are:

1. How have LIHPs successfully promoted care coordination and engagement in care among enrolled populations with varied experience navigating the health care system?
2. What tools are most effective in encouraging use of primary care and appropriate care-seeking behaviors?
3. What best practices exist in provider networks and network support systems (appointment, referral and utilization management)?
4. What barriers exist to providing care coordination in county systems, networks and facilities?

5. Are care delivery systems changing significantly as a result of LIHP? What additional recommended steps should be implemented in preparation for health reform?

Information on the innovations implemented by LIHPs will be collected through key informant interviews and details reported in the program progress reports' open-ended questions. Additional data drawn from enrollment and claims/encounter data on medical home adherence, enrollment, and health care utilization will be included to evaluate the impact of innovations.

Task Nine:

Evaluation Reports
June 2012 to December 2014

UCLA will compile an interim evaluation report (if required by DHCS) and a final evaluation report to assist DHCS in meeting their needs in reporting results to CMS as part of the overall waiver evaluation requirements. This evaluation report was specifically requested by DHCS. The contents will be determined based on CMS requirements and approval of the evaluation design plan, which was submitted by UCLA through CaMRI and DHCS in March of 2011. The interim evaluation report will include information on the current implementation of each LIHP in terms of benefits provided, network development, enrollment, expenditures, eligibility levels, and other components of the programs. While these reports will use information collected throughout the project, they will focus on lessons learned and overall trends in spending, utilization, quality outcomes, and access to care for LIHP enrollees throughout the state.

Task Ten:

Convening Meetings and Webinars
September 2011 to June 2014

UCLA will host annual convening meetings to bring LIHPs together and share best practices, report on findings from briefs that will be useful to LIHP planning and operations, and generate discussion around pressing issues. These convening meetings will be held once per year in alternating locations (Los Angeles, Bay Area, Sacramento, etc) in order to generate attendance and provide convenience. The first two convening meetings will be coordinated with DHCS scheduled administrative meetings that are likely to occur in October 2011 and October 2012 in order to reduce travel for stakeholders, funders, and LIHP participants. These meetings are vital to understanding progress of counties in implementing their programs to inform the evaluation, and have been very helpful to counties during the HCCI project in sharing innovations and making contact with each other.

OBJECTIVES

Evaluation Year One: September 1, 2011 to August 31, 2012

1. By September 30, 2011, and throughout the grant term, provide technical assistance to counties creating Low Income Health Programs (LIHPs) to assist them in developing data reporting systems that provide data required for the evaluation.
2. By September 30, 2011, and throughout the grant term, support and enable the LIHPs to report monthly aggregate data through a web-based portal designed to facilitate the collection of necessary data for monitoring purposes.
3. By September 30, 2011, and throughout the grant term, provide monthly and quarterly aggregate LIHP data to DHCS to enable submission of key data to the Centers for Medicare and Medicaid Services as required by the waiver Special Terms and Conditions.
4. By November 30, 2011, and throughout the grant term, provide LIHPs with timely feedback on enrollment and demographics through development and dissemination of a LIHP performance dashboard.
5. By December 31, 2011, hold a convening meeting that provides technical assistance and data to county LIHP staff and enables them to share best practices around strategies for enrollment success.
6. By February 29, 2012, and throughout the grant term, provide LIHPs with timely feedback on utilization and program costs through additional analysis disseminated by means of the LIHP performance dashboard.
7. By July 31, 2012, publish one policy brief on LIHP development issues, such as strategies for enrollment, eligibility, and retention, and disseminate these briefs to key audiences among county, state and federal policymakers and LIHP stakeholders.

Evaluation Year Two: September 1, 2012 to August 31, 2013

1. By September 30, 2012, and throughout the grant term, obtain monthly aggregate data (including but not limited to enrollment, applications pending, and total expenditures) from each operational LIHP, for submission of key data to the Centers for Medicare and Medicaid Services as required by the waiver Special Terms and Conditions.
2. By November 30, 2012, and throughout the grant term, provide LIHPs with timely feedback on enrollment, demographics, utilization, and quality of care through dissemination of a LIHP performance dashboard.
3. By December 31, 2012, hold a convening meeting that allows LIHPs to share best practices around care coordination and mental health integration or other concerns identified by the LIHPs.
4. By December 31, 2012, complete an interim evaluation report, if required by DHCS.

5. By June 30, 2013, publish one report focusing on care delivery innovations in LIHP and disseminate this report to key audiences among county, state and federal policymakers and LIHP stakeholders.
6. By August 31, 2013, hold one or more webinar to provide comprehensive in-depth training on topics identified by LIHPs as challenges or barriers to implementation, with potential focus on retention and care coordination.
7. By August 31, 2013, publish two policy briefs focusing on issues related to health care reform transition and characteristics of populations eligible for Medi-Cal and the Health Benefits Exchange and disseminate this report to key audiences among county, state and federal policymakers and LIHP stakeholders.

Evaluation Year Three: September 1, 2013 to August 31, 2014

1. By September 30, 2013, and ending in February 2014, obtain monthly aggregate data (including but not limited to enrollment, applications pending, and total expenditures) from each operational LIHP, for submission of key data to the Centers for Medicare and Medicaid Services as required by the waiver Special Terms and Conditions,.
2. By September 30, 2013, hold third convening meeting that allows LIHPs to share best practices around preparation for health care reform transition, or other concerns identified by the LIHPs.
3. By November 30, 2013, and throughout the grant term, provide LIHPs with timely feedback on enrollment, demographics, utilization, and program costs through dissemination of a LIHP performance dashboard.
4. By December 31, 2013, hold one or more webinar to provide comprehensive in-depth training on topics identified by LIHP counties as challenges or barriers to implementation, with potential focus on transition of enrollees to Medi-Cal or the Health Benefits Exchange.
5. By October 31, 2013, publish one policy brief focusing on describing the characteristics and health care needs of the population that will transition from LIHP to Medi-Cal, and disseminate this report to key audiences among county, state and federal policymakers and LIHP stakeholders.

Evaluation Year Four: September 1, 2014 to December 31, 2014

1. By December 31, 2014, complete final evaluation report and disseminate this report to key audiences among county, state and federal policymakers and LIHP stakeholders.

Qualifications

The UCLA Center for Health Policy Research (UCLA) conducted the evaluation of the Health Care Coverage Initiative (HCCI) under the previous Medicaid Waiver and will evaluate LIHP. The evaluation with be conducted under the auspices of the California Medicaid Research Institute (CaMRI). CaMRI represents a collaboration of several University of California campuses and is working with DHCS to develop and conduct the overall §1115 Medicaid Waiver evaluation. UCLA will lead the LIHP evaluation, assisted by UC Berkeley's Center for Labor Research and Education on several tasks.

The principal investigator on this evaluation is Gerald F. Kominski, PhD, Associate Director of the UCLA Center for Health Policy Research and Professor of Health Services in the UCLA School of Public Health. He will be assisted by two co-principal investigators with extensive knowledge of the programs, the health care safety net, and data quality and analysis. Dylan H. Roby, PhD, Research Scientist in the Center and Assistant Professor of Health Services will serve as one Co-Principal Investigator, while Nadereh Pourat, PhD, Director of Research at the Center and Professor of Health Services will serve as the other Co-Principal Investigator. All three of these investigators played leadership roles in the evaluation of HCCI and the data collection processes created for that project.

The three lead investigators will be assisted in the LIHP evaluation by Anna Davis, MPH, who is a Senior Research Associate at the Center, who will serve as the Project Director. She will supervise a team of analysts working on distinct tasks within the evaluation proposal. Ms. Davis has directed the HCCI project and has provided extensive technical assistance to HCCI counties in the previous evaluation and is providing similar assistance to LIHPs currently.

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[i] UCLA Center for Health Policy Research HCCI Evaluation reports/briefs can be found at http://www.dhcs.ca.gov/provgovpart/Pages/WaiverRenewal.aspx under Resource Documents Appendices 2 through 15.

LOW INCOME HEALTH PROGRAM
Crosswalk of Evaluation Proposals

	Original Evaluation Proposal (3/2/11)	Draft Revision of Evaluation Proposal (6/24/11)	Final Evaluation Proposal (10/10/11)
1)	**County Eligibility and enrollment processes**		
a.	What percentage of eligible individuals are successfully enrolled in the Low-Income Health Program's (LIHP) Medicaid Coverage Expansion (MCE) and Health Care Coverage Initiative (HCCI) programs?	Policy Brief #1	Policy Brief #1
b.	What percentage of enrollees have been retained? What are the barriers to successful retention and recertification? Which models for recertification and reenrollment can be shared among counties to improve their Medi-Cal enrollment and retention after 2014?	Policy Brief #1	Policy Brief #1
c.	Do the eligibility processes in each county allow for transition of the LIHP-MCE enrollees into Medi-Cal eligibility systems used by county departments? Can information on potential eligibles be shared with county departments for outreach and enrollment purposes in 2014 and beyond?	Policy Briefs #1 and #3	Policy Briefs #1 and #2
d.	What systems for LIHP and Medi-Cal eligibility determination and enrollment are deployed in participating counties? Are resources shared between departments of health and social services currently, and what steps can be taken to make sure transition and data sharing is possible? What privacy and policy decisions must be considered to ensure a smooth transition from LIHP to Medi-Cal?	Policy Brief #3	Policy Brief #2

LOW INCOME HEALTH PROGRAM
Crosswalk of Evaluation Proposals

	Original Evaluation Proposal (3/2/11)	Draft Revision of Evaluation Proposal (6/24/11)	Final Evaluation Proposal (10/10/11)
2)	**Coverage expansion**		
a.	What additional services are available to LIHP-MCE and LIHP-HCCI enrollees that were not available through previous HCCI programs or county indigent care programs? How are they being utilized and coordinated?	Policy Brief #5 and Interim*/Final Report	Care Delivery System Innovation Report and/or Interim*/Final Report
b.	How did counties coordinate health care between various providers, including specialists, labs and imaging providers, hospitals, mental health providers, and chronic care management staff?	Policy Brief #2 and #5	Care Delivery System Innovation Report
c.	Is network capacity sufficient to address the demand for care in each county program? If LIHP-MCE and HCCI benefits or networks are different, how does that impact care for the two populations?	Policy Brief #5, Interim & Final Report	Care Delivery System Innovation Report, Interim & Final Report
3)	**Access to care**		
a.	Did MCE and HCCI programs increase access to care for the target population? How did the volume of services provided change during the program implementation period?	Interim*/Final Report	Interim & Final Report
b.	What were the barriers to access prior to and during program implementation? How can these barriers be addressed for a smooth transition to Medi-Cal and the California Health Benefit Exchange (CHBE) after January 2014?	Policy Briefs #1, #3, and #4	Policy Briefs #1, #2, and #3

	Original Evaluation Proposal (3/2/11)	Draft Revision of Evaluation Proposal (6/24/11)	Final Evaluation Proposal (10/10/11)
c.	Have medical home providers been able to expand services to better support self-management for chronic illness care? Have medical home assignments been adhered to by both LIHP-MCE and HCCI enrollees?	Policy Brief #2 and Interim& Final Report	Care Delivery System Innovation Report and/or Interim*/Final Report
d.	Have the MCE and HCCI programs reduced avoidable ER visits and hospitalizations over the program period?	Performance Dashboards and Interim & Final Report	Performance Dashboards and Interim & Final Report
4)	**Quality of care**		
a.	Have MCE and HCCI program enrollees experienced improvements in health as measured by self-assessed health status or clinical measures?	Performance Dashboards and Interim & Final Report	Performance Dashboards and Interim & Final Report
b.	Has the use of preventive services (e.g., cancer screenings, well-exams, and immunizations) increased as a result of the new services available through LIHP?	Performance Dashboards and Interim & Final Report	Performance Dashboards and Interim & Final Report

Low-Income Health Program Evaluation

Frequently Asked Questions

&

Appendix: Proposed Evaluation Publications and Products

Version 15

June 27, 2012

Version Notes

This version was released June 27, 2012.

Summary of changes and updates:

Version Number	Description of Changes / Updates
V12	Removed "Data Specification" appendix from this document. All detailed discussion of data elements is now contained with the "Technical Specification Manual" available online from www.coverageinitiative.ucla.edu. Reorganized FAQs into groups by content area. Added additional FAQs in several content areas. New or updated FAQs are marked as **NEW-V12!**
V13	Added additional FAQs. New or updated FAQs are marked as **NEW-V13!**
V14	Updated UCLA contact information in FAQ 34. Added new FAQs. New or updated FAQs are marked as **NEW-V14!** or **UPDATED-V14!**
V15	Clarified/Updated analysis planned for Performance Dashboards and new release dates. Reporting schedule for Appeals and Grievances reports. Updated FAQ is marked as **UPDATED-V15!**

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Low-Income Health Program (LIHP) Evaluation

Frequently Asked Questions (FAQs)

About the Evaluation:

Q 1: Why is an evaluation necessary?

A: An evaluation of the §1115 Medicaid Waiver "A Bridge to Reform" is required by the Centers for Medicare and Medicaid Services (CMS), as specified in the Waiver Special Terms and Conditions (STCs) (Section IV. 25), as well as the authorizing legislation passed by the California Legislature (AB 342). As a part of the Bridge to Reform, the Low Income Health Program (LIHP) must be evaluated.

LIHP "Program Requirements" published by the California Department of Health Care Services (DHCS) include a general description of the data required for evaluation as a condition of program participation. This "frequently asked questions" (FAQs) document provides additional information on details of the evaluation and data requirements for LIHP. Further modification to these requirements may occur after CMS review of the final evaluation design.

Q 2: What are the goals of the LIHP evaluation?

A: The LIHP evaluation will monitor the progress of the demonstration in 4 critical areas:

1. outreach, enrollment retention, and transition strategies;
2. coverage expansion;
3. access to and quality of care ; and,
4. care delivery system redesign in anticipation of 2014.

The primary goal of the evaluation is to provide information to various stakeholders on the impacts of LIHP in each of these areas. The stakeholders who participated in the development of the evaluation plan during an iterative comment period include:

1. CMS, which is funding the LIHP through matching funds under the §1115 waiver;
2. DHCS, which will assume responsibility for MCE enrollees in 2014 as they transition into Medi-Cal;
3. the California Health Benefit Exchange, where HCCI enrollees will be eligible for subsidies in 2014;
4. LIHP participating providers of services (i.e., FQHCs, public hospitals, etc.), which are likely to be the providers of choice for LIHP enrollees in 2014 and beyond after they transition into Medi-Cal or the Exchange; and,

5. Counties and governmental entities with LIHPs, who will be involved in eligibility determination and enrollment of Medi-Cal beneficiaries and maintaining existing public programs for Californians who do not participate in Medi-Cal, the Exchange, or other sources of insurance.

Q 3: Who will evaluate LIHP?

A: The UCLA Center for Health Policy Research (UCLA) will lead the LIHP evaluation, assisted by UC Berkeley's Center for Labor Research and Education on several tasks. UCLA conducted the evaluation of the Health Care Coverage Initiative (HCCI) under the previous §1115 Medicaid Waiver.

The evaluation is funded by the Blue Shield of California Foundation and the California Department of Health Care Services, with support from the California Medicaid Research Institute (CaMRI).

UCLA researchers have worked in conjunction with DHCS and CaMRI to provide the evaluation required by the STCs of the waiver approved by CMS. As part of this process, UCLA has advised DHCS regarding what data elements are required for evaluation of the program. UCLA will collect data for the evaluation on behalf of DHCS.

Q 4: When will the LIHP evaluation begin, and what will be the products of the evaluation?

A: UCLA will provide Technical Assistance to the LIHPs beginning on July 1, 2011. The evaluation activities will begin on September 1, 2011 (**Table 1**). Data collection for the evaluation will be continuous throughout the program period, and will begin for each LIHP at the time the local program begins implementation. Final data collection will be completed by June 2014, and the evaluation will end in December 2014.

The LIHP evaluation will focus on providing near-time reporting and rapid feedback to LIHPs and other stakeholders throughout the program implementation period. UCLA will prepare and release findings on a regular basis, beginning in the fall of 2011. Further discussion of the specific publications and reports that will be produced during the evaluation can be found in the attached document entitled "**Evaluation Publications and Products**".

Table 1: Timing of the LIHP Evaluation

LIHP Program Year	Major Evaluation Activities
First LIHP Program Year: 11/1/ 2010 – 6/30/2011	
Second LIHP Program Year: 7/1/2011 – 6/30/2012	- Begin data collection (start September 1, 2011 and phase in data collection from each LIHP as it is implemented) - Evaluation publications o Brief 1 o Quarterly Performance Dashboard Reports - Convening Meetings and Webinars
Third LIHP Program Year: 7/1/2012 – 6/30/2013	- Ongoing data collection - Evaluation publications o Briefs 2 and 3 o System Redesign Innovation Report o Quarterly Performance Dashboard Reports o Interim Evaluation Report (if required) - Convening Meetings and Webinars
Fourth LIHP Program Year: 7/1/2013 – 12/31/2013	- Ongoing data collection - Evaluation publications o Brief 4 o Quarterly Performance Dashboard Reports - Convening Meetings and Webinars
Final Evaluation Period: 1/1/2014 – 12/31/2014	- Final data collection ending in June 2014 - Evaluation publications o Final Quarterly Performance Dashboard Report o Final Evaluation Report

Q 5: How will the evaluation communicate feedback to the LIHPs?

A: The evaluation will focus on providing near-time feedback to the LIHPs and other stakeholders. UCLA will prepare and release findings throughout the evaluation period. More detail regarding specific publications and reports that will be produced during the evaluation can be found in the attached document entitled "**Evaluation Publications and Products**".

In addition to an interim evaluation report (if required by the State), a final evaluation report, and the proposed policy briefs produced under the evaluation, UCLA will communicate feedback via the California Coverage Expansion Website, www.coverageinitiative.ucla.edu. This website was developed during the original HCCI evaluation. The Coverage Expansion website will serve as a resource and repository of information for the LIHP evaluation, and as a platform for communication between LIHPs, UCLA, and other stakeholders. This website has some general, informational content that is publicly available. However, the majority of the website is accessible only to registered users via a password-

protected log-in. At this time, the website user group is restricted to LIHPs and their designated personnel. All evaluation findings and program materials are accessible only to registered site users.

Q 6: How do LIHPs request secure log-in accounts to UCLA's evaluation website?

A: To request a secure log-in account for UCLA's Coverage Expansion website, please contact the UCLA evaluation team at CHPR_LIHP@em.ucla.edu. LIHPs may request as many accounts for their program personnel as desired.

By requesting a Coverage Expansion website account, registered users will also be added to UCLA's LIHP evaluation email listserv, and will receive automatic email notification of important evaluation updates including release of new documentation or findings.

Q 7: NEW-V14! What documentation has UCLA released for the LIHPs? Do I have everything I need?

A: In addition to these **Frequently Asked Questions**, LIHP personnel should ensure that they have the most current versions of UCLA's technical documentation:

- Monthly Aggregate Reporting Instructions (see FAQ 9 through FAQ 11)
- Technical Specifications Manual (see FAQ 12 through Q 20)

These materials are accessible on UCLA's evaluation website (see FAQ 6).

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Data Collection and Reporting Requirements:

Q 8: What are the methods of data collection and what data will be required?

A: The evaluation will use a combination of quantitative and qualitative data gathered during the program period. DHCS and UCLA will coordinate and streamline reporting to collect all information required for the evaluation, and most data required by CMS and the State. LIHPs will submit data and information through multiple mechanisms:

A. Monthly Aggregate Reporting – FAQ 9 through FAQ 11
B. Quarterly Evaluation Data Submissions – FAQ 12 through FAQ 20
C. Program Progress Reports – FAQ 21 through FAQ 23
D. LIHP Convening Meetings - FAQ 24
E. Qualitative Data - FAQ 25

Further description of each of these data collection methods and requirements is provided below, with FAQs grouped by data type.

A. Monthly Aggregate Reporting – FAQ 9 through FAQ 11

Q 9: NEW-V12! Why are Monthly Aggregate Reports required?

A: In the STCs, CMS established requirements for monthly reports from DHCS. These reports will help CMS monitor the progress of the waiver. LIHPs must provide limited summary information to inform these reports to CMS.

Q 10: NEW-V12! What data will be required for Monthly Aggregate Reporting? When will reporting be due?

A: DHCS and UCLA have worked together to define the specific data elements required by the STCs to meet CMS reporting requirements, which include the unduplicated number of enrollees and data on applications and application processing.

Reporting will be completed for every month in which the local LIHP was operational, and will be lagged by one month such that July reporting will be required in September. LIHPs will begin reporting after their program implementation start date. Deadlines have been established for monthly aggregate reporting. LIHPs that do not submit data on time will not be represented in the corresponding reports to DHCS and CMS for the month in question.

Please see UCLA's "**Monthly Aggregate Reporting Portal Instructions**" (available to registered website users online from UCLA's Coverage Expansion Website, www.coverageinitiative.ucla.edu) for more information about the specific reporting requirements, including reporting due dates.

It is recognized that data reported in aggregate on a monthly basis may be inaccurate; these data are for rapid monitoring, and are not considered a final record of LIHP implementation/activities. The aggregate reports will be corrected at a later time based on the Quarterly Evaluation Data.

Q 11: NEW-V12! How will Monthly Aggregate Reports be submitted?

A: UCLA has created a web-based data reporting portal for LIHPs to easily submit Monthly Aggregate Reports. The reporting portal is located within UCLA's Coverage Expansion Website, www.coverageinitiative.ucla.edu. A website user account is needed in order to access the reporting portal, which is in the password protected area of the website. To learn how to request a website user account, please see FAQ 6.

Please see UCLA's "**Monthly Aggregate Reporting Portal Instructions**" (available to registered website users online from UCLA's Coverage Expansion Website, www.coverageinitiative.ucla.edu) for more information about how to conduct Monthly Aggregate Reporting.

B. Quarterly Evaluation Data Submissions – FAQ 12 through FAQ 20

Q 12: What are the "Quarterly Evaluation Data" that LIHPs will need to submit for the evaluation?

A: UCLA **requires** two major categories of confidential data for the LIHP evaluation, which UCLA has termed the "**Quarterly Evaluation Data**"

1. ***Enrollment data***, i.e., individual-level enrollment records for each enrolled participant containing data collected upon enrollment/application and recertification including demographic characteristics;

2. ***Utilization data,*** i.e., claims/encounter data for all services provided to LIHP enrollees and paid for by the LIHP, *to the extent available to the LIHP.* Utilization data must be submitted for services including:
    a. inpatient (IP) admissions, including all IP care paid for by the LIHP;
    b. outpatient visits, *including mental health and substance use services*, broken down by visit type (outpatient hospital, clinic, physician, non-physician);
    c. emergency room (ER) visits, including out-of-network ER visits paid for by the LIHP; and,

d. ancillary services including drugs prescribed and laboratory/diagnostic tests ordered.

3. UCLA also requests, but does not require, ***Laboratory-Reported Test <u>Result Data</u>***, (e.g., HgA1C test values) for common lab procedures rendered to individuals with selected chronic conditions.

These data types are routinely collected during enrollment and care delivery. By working with counties involved in the HCCI program, UCLA has identified which data elements are generally feasible for LIHPs to report and are necessary for assessing program impact, including the best formats for reporting such data. UCLA has used this experience to identify data elements required for the LIHP evaluation.

Q 13: NEW-V13! What specific data elements are required for each category of Quarterly Evaluation Data?

A: The specific data elements within each category of confidential data may vary between LIHPs based on their data systems, the availability of data, and the method of storing and processing data. However, UCLA has established a standardized data set request for each type of Quarterly Evaluation Data, to promote consistency between LIHPs to the extent possible.

1. ***Enrollment data*** consist of individual enrollment and demographic records for each recipient ever enrolled into the Low Income Health Program. These data may include a random unique patient ID number, months and category (aid code) of enrollment, date of birth, income and family size or federal poverty level, gender, race/ethnicity, language, citizenship status, disenrollment month, reason for disenrollment, insurance coverage, and self-rated health status (optional).

2. ***Utilization data*** consist of claims/encounter data for all services paid for by the Low Income Health Program. These data include a random unique patient ID number, unique claim identification codes, date of service, place of service, billing, procedure, diagnostic and medication codes, rendering provider identification number, assigned patient centered medical home service indicator, and primary and secondary payer codes.

3. If provided by the LIHP, ***Laboratory test results*** data consist of laboratory records for specific laboratory services provided to enrollees in the Low Income Health Program. These data may include a random unique patient ID number, laboratory service date, laboratory test name and/or service code, and laboratory result value. Data for specific lab procedures for individuals with diabetes and similar chronic conditions are requested.

The specific data elements to be transmitted by each LIHP will be determined by the LIHP in collaboration with UCLA and with DHCS.

For more information regarding the specific data elements requested and UCLA's standard dataset, please see UCLA's **Technical Specifications Manual** ("**TSM**"), available to registered website users online from UCLA's Coverage Expansion Website, www.coverageinitiative.ucla.edu.

Q 14: How will the Quarterly Evaluation Data be used to address the goals of the evaluation?

A: Each of the major types of Quarterly Evaluation Data will play an important role in addressing the goals of the evaluation.

1. ***Enrollment data*** is essential for determining number of enrollees, months of enrollment, retention of enrollees, and the number of LIHP enrollees who are eligible for successful transition into Medi-Cal or the Exchange in 2014. These data will include information gathered at the time of enrollment/application, and will include basic demographic information about enrollees. Combined with county-level population data from the 2009 and 2011 California Health Interview Survey, UCLA will also be able to estimate the percentage of each county's eligible population enrolled in LIHP.

2. ***Utilization data*** is essential for determining access to care and levels of utilization per enrollee. UCLA will use the claims/encounter data provided by LIHPs to generate data summarizing the utilization history for each individual enrollee, and will then compute measures of utilization such as number of inpatient days per 1,000 enrollees. This information will be essential to the state and to the Exchange in determining the expected cost and the demographic and clinical risk profile of LIHP enrollees as they transition into Medi-Cal or the Exchange in 2014. Utilization is an important measure of the extent to which coverage expansion allows enrollees access to a broad spectrum of health care services.

3. If provided by LIHPs, ***Laboratory test results*** will permit assessment of the extent to which selected chronic illnesses are appropriately managed based on clinically accepted guidelines and benchmarks.

To the extent possible, the data collected by UCLA will be analyzed to meet DHCS' reporting requirements to CMS. DHCS must submit quarterly aggregate reports to CMS as a condition of the §1115 Medicaid waiver.

Q 15: NEW-V12! Where can LIHPs find more detailed information about the Quarterly Evaluation Data?

A: UCLA has released a detailed **Technical Specifications Manual (TSM)** to assist LIHP personnel in preparing and submitting the requested **Quarterly Evaluation Data**. The **TSM** includes full discussion of the methods, content, format, and timing of the Quarterly Evaluation Data. Therefore, detailed discussion of the Quarterly Evaluation Data is no longer included in this FAQ document. For more information regarding the specific data elements requested, please see the **TSM**, available to registered website users online from UCLA's Coverage Expansion Website, www.coverageinitiative.ucla.edu.

Prior to the launch of each local LIHP, UCLA will conduct one-on-one teleconferences with LIHP personnel to discuss the evaluation data requirements, and offer technical assistance as needed by the LIHP. UCLA's experience indicates that in most cases detailed specifications will need to be tailored to the individual LIHP. UCLA intends to standardize data between LIHPs to the extent possible, while maintaining a flexible approach to accommodate the individual LIHPs.

To request Technical Assistance, please contact the UCLA evaluation team (See FAQ 34).

Q 16: The STCs state that LIHPs are required to report encounter data. Why is UCLA requesting utilization data at either the claims or encounter level? Doesn't this request increase the data reporting burden on LIHPs?

A: As specified in the STCs and as a requirement of LIHP contracts with DHCS, LIHPs may submit *utilization data* for the evaluation at the claim-level or encounter-level. The level of data submitted by the LIHP will depend on how the data are collected and stored within their existing billing/administrative systems. The specific utilization data elements requested are described in the **TSM**, described in FAQ 15.

UCLA requests that LIHPs provide sufficient detail for each requested data element to ensure maximum accuracy of the evaluation. The success of the LIHP evaluation depends on both the content and quality of the data submitted by LIHPs.

Q 17: For what time period will Quarterly Evaluation Data be required? Why are "Baseline" data required?

A: Data from both the period of LIHP implementation and the year prior to the start of each LIHP will be included in the evaluation. The "pre-" data for the period before program implementation is used to compare each individual's health care use before and during LIHP, and is essential in understanding the impact of LIHP on program enrollees. UCLA acknowledges that major differences exist between the existing programs and the LIHPs in each participating program, and will account for these differences in all analyses.

The specific dates of data reporting will vary for each LIHP, depending on the date of local program implementation. For more information, please see the **TSM**, described in FAQ 15.

Q 18: When will each LIHP begin reporting Quarterly Evaluation Data?

A: Quarterly Evaluation Data collection will begin in September 2011, and will phase in for each LIHP as it is implemented. Each LIHP will begin submitting data after the date of local program implementation. If the LIHP was active for any of the months within a given quarter, data will be submitted for that quarter on the corresponding reporting date, regardless of how many months of implementation occurred within the quarter.

Final data collection for all LIHPs will occur in mid 2014, in order to ensure complete utilization data are available for the final evaluation report. For more information, please see the **TSM**, described in FAQ 15.

Q 19: How frequently will Quarterly Evaluation Data submission be required? Why are LIHPs required to comply with data submission deadlines?

A: In response to concern from LIHPs regarding frequency of evaluation reporting, evaluation data will be reported quarterly, and will be reported approximately one month after the close of each quarter. For example, data for the first quarter of the year (January through March) will be due April 31.

Quarterly Evaluation Data, including enrollment and utilization data, will be reported on a regular schedule by all LIHPs that were operational during the reporting quarter. UCLA has recommended Quarterly Evaluation Data deliveries in response to interest in ongoing and timely evaluation reporting. The LIHP evaluation will focus on providing near-time results throughout the program period.

It is important that all LIHPs report data on time to UCLA. On-time reporting is essential because UCLA has adopted responsibility for several types of reporting required by the STCs, to reduce duplication and reporting burden. UCLA must use the data submitted by LIHPs for rapid reporting to DHCS and CMS. By complying with UCLA's reporting deadlines, LIHPs will ensure accurate and complete reporting to CMS while maintaining efficiency. LIHPs that do not submit data on time will not be represented in the corresponding reporting completed by UCLA during the period in question.

For more information, including reporting due dates, please see the **TSM**, described in FAQ 15.

Q 20: Will LIHPs be required to collect any new data for the Quarterly Evaluation Data reporting that they are not already collecting?

A: Data elements requested for the evaluation reflect UCLA's recommended minimum dataset in order to carry out a complete and rigorous evaluation, and include some data elements that are required for DHCS and CMS reporting.

It is expected that most of the requested data elements will be available in all LIHPs. If a LIHP does not collect one or more of the requested data elements, or collects data in a manner that differs from the method specified by UCLA, it will consult with UCLA and DHCS to determine if the data element is *required*. If a required data element is not collected by a LIHP, UCLA will provide technical consulting to

the LIHP to identify any comparable data elements available. LIHPs will not be required to begin collecting new data they are not currently collecting, unless those data elements are required for DHCS or CMS reporting.

C. *Program Progress Reports – FAQ 21 through FAQ 23*

Q 21: Why will LIHPs be required to complete Program Progress Reports (PPRs)?

A: DHCS must provide regular progress reports to CMS, and will require LIHPs to complete **Program Progress Reports** (PPRs) on a *quarterly* basis to provide information and data required by CMS but not otherwise collected.

DHCS will create the PPR form, and will work with UCLA to distribute and collect them from LIHPs.

Q 22: NEW-V12! Will UCLA evaluation data be used to reduce the requirements for PPRs?

A: Every effort will be made to streamline reporting requirements in order to minimize the burden on LIHPs. UCLA will assume any portions DHCS and CMS reporting requirements that can be fulfilled based on data submitted for the evaluation. However, UCLA's ability to report on behalf of the LIHP is dependent on the quality and timeliness of LIHP data submission. Therefore, UCLA will work with DHCS and the LIHPs to assess which reporting requirements can be met using evaluation data.

Q 23: UPDATED-V15! How will PPRs be collected, and what data are going to be required?

A: PPRs will be a downloaded from and submitted via the evaluation website. These reports will include quantitative and qualitative information that is not collected elsewhere, including:

a. Recurring quantitative and qualitative reporting items, such as tracking of consumer appeals and grievances, estimates of expenditures and utilization, narrative of program milestones, and description of outreach activities.
b. Ad hoc questions from DHCS and UCLA for targeted information gathering on specific, time-sensitive topics

The form/template that will be used for quarterly program progress reports will be developed by UCLA with guidance from DHCS and CMS. The specific qualitative and quantitative data that will be required by DHCS and CMS have not yet been finalized. Attachment I "Quarterly Report Guidelines" of the STCs provides a summary of the topics required in quarterly reports from DHCS to CMS, and will guide the template construction for quarterly PPRs.

In the interim, LIHPs are required to submit the *Appeals and Grievances* portion of the PPRs, which DHCS has finalized and distributed to the LIHPs. After the remaining PPR content has been finalized, the Appeals and Grievances template will be combined with other PPR components.

Appeals and Grievance Reports are due to UCLA (chpr_lihp@em.ucla.edu) **one month after the close of each quarter,** on the following dates:

Table 2: Appeals and Grievances Reporting Schedule

Period	Due Date	Reporting Period Covered
1st Quarter, 2012	April 30, 2012	January 1, 2012- March 31, 2012
2nd Quarter, 2012	July 31, 2012	April 1, 2012-June 30, 2012
3rd Quarter 2012	October 31, 2012	July 1, 2012-September 30, 2012
4th Quarter, 2012	January 31, 2013	October 1, 2012-December 31, 2012
1st Quarter, 2013	April 30, 2013	January 1, 2013- March 31, 2013
2nd Quarter, 2013	July 31, 2013	April 1, 2013-June 30, 2013
3rd Quarter 2013	October 31, 2013	July 1, 2013-September 30, 2013
4th Quarter, 2013	January 30, 2014 (31st is a Saturday)	October 1, 2013-December 31, 2013

D. *LIHP Convening Meetings - FAQ 24*

Q 24: NEW-V12! Who will host LIHP Convening Meetings, and what is the purpose?

A: UCLA will host **convening meetings** to allow LIHPs to learn about evaluation results, share information on their own successes, and learn from the practices of their peer-LIHPs. These annual in-person convening meetings will be held in sites in either northern or southern California locations. In addition, an annual webinar-based convening will be developed for LIHPs to share successes and best practices around specific topics remotely. The evaluation will pay for travel expenses for in-person convening meetings, but UCLA will establish a cap on the number of attendees and the total amount of reimbursement available per program.

At intervals throughout the program implementation period, DHCS will also hold LIHP meetings to provide information, assistance and guidance to LIHPs on administrative topics such as claiming mechanisms. Evaluation convening meetings and DHCS LIHP meetings may be coordinated to reduce travel burden on LIHPs.

E. *Qualitative Data - FAQ 25*

Q 25: What qualitative data will be collected, and what is the purpose?

A: LIHPs will be asked to participate in **qualitative data** collection by UCLA and DHCS, in order to enable reporting to CMS, and to provide context and descriptive information regarding program implementation. In the previous HCCI evaluation, each county participated in one to two key informant interviews per year and the UCLA evaluation team held site visits in each county. In the LIHP evaluation, a combination of key informant interviews and web-based surveys will be used to gather this information in the most efficient and minimally burdensome method possible.

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Data Security:

Q 26: NEW-V12! Is UCLA allowed to receive protected or confidential data for the evaluation?

A: Yes. LIHP data will be protected by a Business Associate Agreement (BAA) set out by DHCS. This BAA will authorize UCLA to receive protected data related to the LIHP program. Each LIHP will receive a copy of this BAA so that they understand the reporting requirements and level of security UCLA will be using to protect the LIHP data. UCLA will ask each LIHP to identify one contact person who is in charge of data security and HIPAA issues within their organization to serve as a liaison to UCLA for data security.

Q 27: How will Quarterly Evaluation Data be safely transmitted to UCLA?

A: UCLA has established a protocol for secure transmission of data with each of the ten existing HCCI counties. This protocol will be shared with each of the new LIHPs.

Secure transmission of data is conducted through a "secure file transfer protocol" (SFTP) connection with UCLA. UCLA will provide technical assistance to the LIHPs to establish this SFTP connectivity. The form to request an STFP account with UCLA is available within the **TSM**, which can be accessed online at UCLA's Coverage Expansion website, www.coverageinitiative.ucla.edu.

A detailed description of the data security policies and procedures in place at UCLA is available upon request. To request a copy, please contact the UCLA evaluation team.

Q 28: How will data security be maintained by UCLA?

A: LIHP Protected Health Information (PHI) will be stored in a HIPAA-compliant secure environment already established at UCLA. DHCS has found UCLA's security protocols to be exemplary, and they have been used in research and evaluation projects approved by the state Committee for the Protection of Human Subjects (CPHS) and the UCLA Institutional Review Board (IRB).

A detailed description of the data security policies and procedures in place at UCLA is available upon request. To request a copy, please contact the UCLA evaluation team.

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General Questions and Concerns:

Q 29: NEW-V12! Will UCLA collect cost claiming data (CPEs or IGTs) from the LIHPs?

A: No. LIHPs will submit claims for health care expenditures to DHCS, using their selected claiming mechanism (CPE or IGT). This data will be submitted directly to DHCS.

No other expenditure data will be collected by UCLA from the LIHPs. The evaluation will only analyze aggregate expenditure data based on this cost claiming, which UCLA will obtain from DHCS.

Q 30: Will data reporting requirements for DHCS and UCLA be duplicative?

A: No. DHCS and UCLA will streamline data reporting requirements to avoid duplication. DHCS is in the process of reviewing reporting requirements to CMS, and will work with UCLA to determine what information can be reported to DHCS by UCLA using quarterly enrollment and utilization data provided by LIHPs and what information may not be captured in this process. This will streamline and reduce the number of data reporting requests and the number of people involved in reporting required by CMS, DHCS, and UCLA.

Q 31: NEW-V12! Are there any further data or reporting requirements that have not yet been specified?

A: The **Monthly Aggregate Reporting** requirements have been fully specified. Please see UCLA's "**Monthly Aggregate Reporting Portal Instructions**" (available to registered website users online from UCLA's Coverage Expansion Website, www.coverageinitiative.ucla.edu) for more information.

The **quarterly quantitative data** required for the evaluation have been fully specified. Barring changes in program design or program requirements, the list of specific data elements requested is final. Please see UCLA's **TSM**, available to registered website users online from UCLA's Coverage Expansion Website, www.coverageinitiative.ucla.edu, for a full description of the Quarterly Evaluation Data.

The requirements for the **Program Progress Reports** have not yet been finalized. See FAQ 23 for more information.

In addition to the data described above (Monthly Aggregate Reporting, Quarterly Evaluation Data) monitoring of LIHP contractual compliance may be required. This may include reporting on compliance with elements of the LIHP contract. The specific reporting requirements and method of reporting have not yet been finalized. UCLA will coordinate with DHCS to streamline collection of these data where applicable. However, monitoring of LIHP contractual compliance is not within the scope of the evaluation.

Q 32: Are all of the data elements previously requested under HCCI also requested for LIHP?

A: No. The goals of the HCCI evaluation were more comprehensive than the goals of the LIHP evaluation, because when the HCCI evaluation was developed, health reform was not on the political horizon at the state or federal level. As a result, more information was requested from HCCI counties to determine best practices across a number of organizational, clinical, and utilization measures.

Because the scope of the LIHP evaluation is focused on issues important to transitioning LIHP enrollees into Medi-Cal or the Exchange in 2014, many data elements previously requested of HCCI counties are not necessary for the LIHP evaluation.

Q 33: Is technical assistance for data delivery available to LIHPs?

A: Yes. UCLA will provide technical assistance to LIHPs, including provision of detailed data file specifications and assistance in developing secure data transfer connections. In addition, UCLA will consult on a case-by-case basis as needed to assist LIHPs in preparation of the requested data files. To request Technical Assistance, please contact the evaluation team.

Q 34: Who can I contact with questions or concerns, or to request technical assistance?

A: UCLA will provide technical assistance to LIHPs, including provision of detailed specifications and instructions for each aspect of the evaluation. In addition, UCLA will consult on a case-by-case basis as needed to assist LIHPs in meeting the evaluation requirements.

Contact Us

For general information about the evaluation, please contact the project team:

Email: CHPR_LIHP@em.ucla.edu

To request Technical Assistance, please contact:

Livier Cabezas, MPAff	Erin Salce, MPH	Dylan Roby, PhD
livier@ucla.edu	Erin.Salce@ucla.edu	droby@ucla.edu
(310) 794-0953	(310) 794-2228	(310) 794-3953

To access names, biographies, and contact information for the full research & evaluation team:

http://coverageinitiative.ucla.edu/Contact.aspx

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Low-Income Health Program (LIHP) Evaluation

Appendix A: Proposed Evaluation Publications and Products

The LIHP evaluation will focus on providing near-time reporting and rapid feedback to LIHPs and other stakeholders throughout the program implementation period. UCLA will prepare and release findings on a regular basis, beginning in the fall of 2011, through a series of focused Policy Briefs and Reports. These documents will present lessons learned in implementing the LIHPs, best practices in enrollment, quality, access, or other issues as determined by the stakeholders. While some of the documents will focus on opportunities for improvement in the LIHPs, others may focus on the implementation of health care reform and how LIHPs can contribute to or inform that transition in 2014 and beyond. The evaluation will begin on September 1, 2011, during the "Second Program Year" of the LIHP demonstration.

The evaluation will produce 3 major types of publications, during the three years of the evaluation from September 2011 and June 2014:

- Currently, four Policy Briefs and one Policy Report have been proposed based on input from foundations, LIHPs, DHCS, and advocates. **Error! Reference source not found.** **Table 3** presents the timing of the proposed Policy Briefs and Report. **Table 4** illustrates details of the proposed Policy Briefs and Report, including the research questions and data sources for each publication.
- In addition, the evaluation will disseminate program-specific "performance dashboard reports" presenting standardized metrics for each participating LIHP. These reports will be regularly updated throughout the evaluation period and released via the password-protected portion of the evaluation website. **Table 5** presents details of the performance dashboard reports to be produced each quarter throughout the evaluation period.
- Finally, UCLA will complete waiver evaluation reports for DHCS and CMS. This will include an interim evaluation report (fall 2012, if required by the State) and a final evaluation report (December 2014) summarizing the overall impact of LIHP on the low-income uninsured population in California under the "Bridge to Reform" §1115 waiver. Evaluation reports will be submitted to CMS by DHCS.

Other reports and briefs may be added, or changes to the brief topics proposed below may be developed, in response to the needs of stakeholders, including LIHP officials, DHCS staff, the Exchange Board, and funders of the evaluation activities.

Table 3: Timing of Evaluation Policy Briefs

LIHP Program Year	Tentative Evaluation Policy Briefs
First LIHP Program Year: 11/1/ 2010 – 6/30/2011	--
Second LIHP Program Year: 7/1/2011 – 6/30/2012	**Brief 1.** Increasing Take-Up in Public Programs: Successful Strategies in California's Low Income Health Program
Third LIHP Program Year: 7/1/2012 – 6/30/2013	**Brief 2.** How California's Low Income Health Program is Preparing the State to Enroll Individuals into the Medi-Cal Expansion in 2014 (with UCB) **Brief 3.** How California's Low Income Health Program is Preparing the State for Implementation of the Health Benefit Exchange in 2014 (with UCB) **Policy Report.** Low Income Health Program Care Delivery System Innovation Report
Fourth LIHP Program Year: 7/1/2013 – 12/31/2013	**Brief 4.** How has the Low Income Health Program Bridged the Way to Health Care Reform? Characteristics and Use Patterns of Eligible Medi-Cal and Health Benefit Exchange Enrollees in 2014.

Note: Additional briefs or changes to the proposed brief topics may be incorporated, based on stakeholder feedback.

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Proposed Evaluation Policy Briefs and Reports

Currently, four Policy Briefs and one policy report are proposed, based on input from foundations, LIHPs, the state, and advocates. These publications are intended to effectively use LIHP data to plan for the expansion of Medi-Cal and the creation of the California Health Benefit Exchange and/or Basic Health Plan. **Table 4** illustrates details of the proposed Policy Briefs and Reports, including the research questions and data sources for each publication.

Table 4: Description of Proposed Evaluation Publications

Title	Planned Release Date	Evaluation Questions	Products and Methods
Brief 1. Increasing Take-Up in Public Programs: Successful Strategies in California's Low Income Health Program	June 2012	1) What strategies for recruitment have been successful in LIHP to increase enrollment of eligible patients? 2) What percent of the overall enrollment target has been met by each LIHP? 3) What proportion of LIHP enrollees are new patients? 4) What retention and recertification practices are effective in LIHP? 5) What does actual LIHP take-up mean for expected take-up under ACA?	This Policy Brief will focus on the in-reach and outreach activities used to recruit and enroll LIHP enrollees in both MCE and CI. In addition, this Brief will present data on the numbers and characteristics of individuals enrolled in LIHP, the pace of enrollment ramp-up, and the retention and recertification strategies implemented by the LIHPs. Information will be collected through electronic surveys, key informant interviews, and the quarterly enrollment data submitted by LIHPs. The survey and interview data collection will enable the research team to link program details and characteristics to the change over time in enrollment each month.
Brief 2. How California's Low Income Health Program is Preparing the State to Enroll Individuals into the Medi-Cal Expansion in 2014	November 2012	1) Do the eligibility processes in each program allow for transition of the LIHP-MCE enrollees into Medi-Cal eligibility systems used by county departments of social services? 2) Do LIHPs have the enrollment and eligibility infrastructure needed to carry out this transition? 3) What decisions and policies must be considered in ensuring a smooth transition from LIHP to Medi-Cal?	This Policy Brief will describe the systems that are deployed in participating programs for eligibility determination and enrollment in LIHP and Medi-Cal. It will determine to what extent resources are currently shared between departments of health and social services, and what steps should be taken to allow transition and data sharing if not already in place. Data will be collected through key informant interviews with county, LIHP, and state officials, as well as local stakeholders, and experts on MEDS, One-E-App, and other enrollment systems currently in use in counties.
Brief 3. How California's Low Income Health Program is	January 2013	1) How are participating programs preparing to refer LIHP-CI enrollees to the Exchange (or Basic Health Plan) in 2014? 2) What outreach and education practices	This Policy Brief will describe the preparations undertaken by participating programs and their community partners to prepare for transition of LIHP-CI enrollees to the HBE or Basic Health Plan, in LIHPs that have implemented an HCCI program. It will describe the

Title	Planned Release Date	Evaluation Questions	Products and Methods
Preparing the State for Implementation of the Health Benefit Exchange in 2014		have programs developed to inform enrollees of the transition? 3) Have programs begun using navigators or other educators to facilitate this process? If so, how? 4) What are the remaining gaps in planning and preparation that should be addressed?	innovative practices that can be used to facilitate this transition in 2014, and suggest best practices for enrollment and transition. It will also discuss policy considerations for transitioning the exchange-eligible population that was *not* enrolled in LIHP, including the strategies used to prepare for transition in LIHPs that did *not* implement an HCCI program. Data will be collected through key informant interviews with county, LIHP, and state officials, as well as local stakeholders. A robust analysis of the available literature suggesting approaches in other states or geographic locations will be included, as well as recommendations made in existing reports.
Policy Report. Low Income Health Program Delivery System Innovation Report	May 2013	1) How have LIHPs successfully promoted care coordination and engagement in care among enrolled populations with varied experience navigating the health care system? 2) What tools are most effective in encouraging use of primary care and appropriate care-seeking behaviors? 3) What best practices exist in provider networks and network support systems (appointment, referral and utilization management)? 4) What barriers exist to providing care coordination in county systems, networks and facilities? 5) Are care delivery systems changing significantly as a result of LIHP? What additional recommended steps should be implemented in preparation for health reform?	The report will assess how LIHP is re-shaping the local healthcare environment and experience, including providing care coordination, changing care-seeking behaviors, and redesigning the care delivery system in anticipation of health care reform. The report will present case studies and data from specific LIHPs that have implemented innovative and effective methods to improve positive health care behaviors among enrollees and increase care efficiency. Methods of chronic illness management implemented by LIHPs, including coordination of care for mental/substance use and physical health co-morbidities will also be assessed, to provide lessons learned between LIHPs and from safety net providers nationally. Information on the innovations implemented by LIHPs will be collected through key informant interviews and details reported in the program progress reports' open-ended questions. Additional data drawn from enrollment and claims/encounter data on medical home adherence, enrollment, and health care utilization will be included to evaluate the impact of innovations
Brief 4. How has the Low Income Health Program Bridged	September 2013	1) What proportion of eligible individuals were enrolled in LIHPs, and what are the characteristics of the enrolled compared to	This Policy Brief will focus on how the LIHP has impacted the profile of Medi-Cal expansion and California Health Benefit Exchange eligible population. Data from the California Health Interview Survey,

Title	Planned Release Date	Evaluation Questions	Products and Methods
the Way to Health Care Reform? Characteristics and Use Patterns of Eligible Medi-Cal and Health Benefit Exchange Enrollees in 2014.		those who are eligible but not enrolled? 2) To what extent have LIHPs reduced "pent-up" demand for care and improved health status among the enrolled? 3) What is the size and profile of the remaining uninsured population?	LIHP enrollment data, and administrative claims data from the LIHPs will be used to generate this Policy Brief. The Brief will compare the LIHP-enrolled population (LIHP enrollment and claims data) to the overall eligible population (using the latest California Health Interview Survey data) to report on the characteristics including race/ethnicity, age, gender, chronic illness, and health care use.

Note: Additional briefs or changes to the proposed brief topics may be incorporated, based on stakeholder feedback.

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Performance Dashboard Reports

The evaluation will disseminate program-specific "performance dashboard reports" presenting standardized metrics for each participating LIHP. These reports will be regularly updated throughout the evaluation period and released via the password-protected portion of the evaluation website, www.coverageinitiative.ucla.edu. **Table 5** presents details of the performance dashboard reports to be produced regularly throughout the evaluation period, and is followed by a list of possible standard metrics to be included in the dashboard reports.

Table 5: UPDATED-V15! Description of Low Income Health Program Performance Dashboard Reports

Title	Release Date	Evaluation Questions	Products and Methods
Low Income Health Program Performance Dashboard Reports	Every 3 months, 45 days after receiving quarterly data from LIHPs, starting in December 2011	1) What are the trends in enrollment and retention within the LIHPs? 2) What changes in utilization and quality of care have been achieved by participating programs? 3) To what extent have LIHPs reduced utilization of services over time by addressing "pent-up" demand? 4) How has care coordination improved? 5) What are the ongoing opportunities for improvement in care quality and care utilization?	Regularly updated program-by-program "Dashboard" reports on key enrollment, health status, utilization, and expenditure measures, *to be selected in collaboration with the LIHPs*. Reports will incorporate point-in-time and monthly or quarterly trend analyses, in order to present current outcomes, as well as changes from the baseline period to the current quarter. Measures will be based on data collected from baseline and project period LIHP-provided claims/encounter data, enrollment data, and laboratory result data (if submitted by the LIHP). Reports will be released to LIHP stakeholders only, via the password protected Evaluation website, www.coverageinitiative.ucla.edu.

Note: Changes to the proposed quality reports may be made based on stakeholder feedback.

UPDATED-V15! Possible Measures to be Included in Performance Dashboard Reports:

Dashboard reports will provide monthly and quarterly metrics for each LIHP and for the statewide program as a whole. Possible measures to include in the dashboard reports are listed below. LIHPs will collaborate with UCLA and DHCS to select a final list of standardized measures that will be useful for local program planning and implementation.

Enrollment (1) and Descriptive (2) measures will be generated for each LIHP within 3 months of receiving the first complete data delivery from the LIHP. Utilization (3) and Quality of Care (4) measures will be generated within 6 months of receiving the first complete data delivery from the LIHP. Each measure will be generated for LIHPs that provide the necessary source variables for that measure. Measures can be added to or removed from the reports throughout the program period, based on data availability and according to interest of stakeholders.

1) **Enrollment Measures:**
   - Total count of current enrollees, by enrollee type (MCE vs. HCCI, new vs. existing)
   - Cumulative count of individuals served by the LIHP to date
   - Enrollment measures may be stratified by descriptive characteristics, such as percent federal poverty level
2) **Descriptive Measures:**
   - Demographic characteristics of enrollees, by enrollee type
   - Proportion of enrollees with chronic conditions
3) **Utilization Measures:**
   - Total count of services provided, by service type, including emergency room, inpatient, and outpatient visits (ER, IP, and OP respectively)
   - Rate of service utilization per 1,000 members, by service type (ER, IP, OP)
   - Average length of stay of inpatient visits
   - Rate of 30-day hospital re-admission among those enrollees with an inpatient stay during the prior month
   - Proportion of non-urgent outpatient primary care visits that were provided at the enrollee's assigned medical home
4) **Quality of Care Measures:**
   - Provision of (selected) guideline concordant services within the applicable enrollee population
     - May include measures based on laboratory data, and claims/encounter data including pharmacy. Measures will focus on process measures of quality (provision of recommended services). If LIHPs opt to provide laboratory-reported test results data to UCLA, the dashboard reports may also include outcome measures of quality (change in health status or clinical outcome).

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Low Income Health Program Evaluation

Detailed Technical Specifications Manual

Version 8
March 4, 2014

UCLA Center for Health Policy Research

UCLA CENTER FOR HEALTH POLICY RESEARCH

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Executive Summary

An evaluation of the §1115 Medicaid Waiver "A Bridge to Reform" is required by the Centers for Medicare and Medicaid Services (CMS), as specified in the Waiver Special Terms and Conditions (STCs) (Section IV. 25), as well as the authorizing legislation passed by the California Legislature (AB 342).

As a part of the Bridge to Reform, the Low Income Health Program (LIHP) must be evaluated. LIHP "Program Requirements" published by the California Department of Health Care Services (DHCS) include a general description of the data required for evaluation as a condition of program participation.

This manual describes one facet of the data required for a rigorous evaluation: the quarterly evaluation data submissions. This "Detailed Technical Specifications Manual" document provides additional information on details of the evaluation and data requirements for LIHP. Further modification to these requirements may occur during the evaluation period.

The following specifications identify the data elements required for a rigorous and targeted evaluation of the LIHP demonstration. It incorporates the elements discussed in the STCs and guidance from CMS and DHCS, and describes the major data types, specific data elements, and data file layouts requested by UCLA as the evaluator.

About the UCLA Center for Health Policy Research

The UCLA Center for Health Policy Research (UCLA) will lead the LIHP evaluation, assisted by UC Berkeley's Center for Labor Research and Education on several tasks. UCLA conducted the evaluation of the Health Care Coverage Initiative (HCCI) under the previous §1115 Medicaid Waiver.

The evaluation is funded by the Blue Shield of California Foundation and the California Department of Health Care Services, with support from the California Medicaid Research Institute (CaMRI).

UCLA researchers have worked in conjunction with DHCS and CaMRI to provide the evaluation required by the STCs of the waiver approved by CMS. As part of this process, UCLA has advised DHCS regarding what data elements are required for evaluation of the program. UCLA will collect data for the evaluation on behalf of DHCS.

By working with counties involved in the HCCI program, UCLA has identified which data elements are generally feasible for counties to report and are necessary for assessing program

impact, including the best formats for reporting such data. UCLA has used this experience to identify data elements required for the LIHP evaluation.

Goals of this Manual

- To serve as reference material with details of file layouts and field definitions,
- Define and document data transaction schedules for all parties,
- Define and document the systems, processes, and practices necessary for successful data exchange,
- Maintain a current log of specific data issues encountered and resolution, and
- Outline program impacts and subsequent recourse for unsatisfactory timing or quality of data transactions.

This manual is a supplement to the contract and other legal binding documents that exist between the parties. Should a contradiction exist, such contracts supersede this document.

How to Use This Manual

This document was designed to be utilized electronically. The Table of Contents allows navigation to specific areas of the document by holding CTRL while clicking on the link. If the Table of Contents does not list the topic being sought, CTRL+F will enable the search function. Type in the word or phrase in the box and this function will search the entire document. In addition, there is an Index to use as reference, and all references within the text of the manual to a specific table, section or appendix are provided as hyperlinks to facilitate navigation throughout the document.

Manual Revision Process

General Updates

As changes in program design, data availability or needs arise, parties may discuss changes to the technical specifications manual. Revisions made to the technical specifications manual will be made on a quarterly basis. Please see the Version History below for a summary of updates.

Specific Code Updates

If any coding or file construction instructions change during the duration of the project or if the state changes any codes during the duration of this project (such as aid code or implementation of ICD-10), UCLA will notify the primary LIHP data contact via email as soon as they become aware of updates to codes. Revisions to codes within this document will include the following steps:

1. When a code becomes no longer valid, a list of obsolete codes is started.
2. The obsolete codes will be listed with the effective date and reason they became obsolete.
3. Codes that are changed and/or code descriptions that are changed will include a strikethrough and the updated code/description will be added with an effective date.

Version History

Version	Date	Author	Updates Summary	Requested By
Version 1	8/26/2011	UCLA Research Staff: Ana Martinez	Initial version	
Version 2	9/2/2011	UCLA Research Staff: Anna Davis	Revision of quarterly enrollment data delivery method to enable reporting of retroactive changes to enrollment status. See Page 8: "Quarterly Enrollment Data", "Method"	LIHP County
Version 3	9/22/2011	UCLA Research Staff: Ana Martinez	Revision of data requested for State inmates (no longer include utilization data); Aid-codes finalized by DHCS, inclusion of guidance for applying new versus existing enrollee definition (as defined in the STCs); Clarification of definitions for claims (paid only).	n/a
Version 4	12/20/2011	UCLA Research Staff: Ana Martinez	Addition of DSM codes in diagnosis fields. Addition of Appendix 6 Data Transmittal Forms Clarification of disenrollment reasons (Table 4).	n/a
Version 5	3/7/12	UCLA Research Staff: Ana Martinez	Revision of data requested for State inmates (no longer include enrollment or utilization data); Removal of Aid Code F5: MCE State Inmate Clarification for Utilization of Medical Home Indicator	n/a
Version 6	6/25/2012	UCLA Research Staff: Erin Salce	Baseline period addition to Table 1: Data Reporting Schedule. Addition to Table 2: Quarterly Enrollment Data Specifications.	n/a

			Addition to Table 4: Disenrollment Reasons Addition of Quality Assurance Procedure form to Appendix 6.
Version 7	3/7/2013	UCLA Research Staff: Erin Salce	Addition of outpatient type of service and billing provider id fields to claims data.
Version 8	2/28/14	UCLA Research Staff: Erin Salce	Updated final data delivery due date.

Glossary and Definitions

Acronym	Term
CaMRI	California Medicaid Research Institute
CMS	Centers for Medicare & Medicaid
CPT	Current Procedural Terminology
DHCS	California Department of Health Care Services
DRG	Diagnosis Related Group
DSM	Diagnostic and Statistical Manual Codes – from Diagnostic and Statistical Manual of Mental Disorders
HCCI	Health Care Coverage Initiative
HCPCS	Healthcare Common Procedure Coding System
ICD-9	Diagnosis Codes – "International Classification of Diseases 9th Edition Clinical Modification"
LIHP	Low Income Health Program
MCE	Medicaid Coverage Expansion
NPI	National Provider Identifier
POS	Place of Service Code
SNCP	Safety Net Care Pool
STC	Special Terms and Conditions
UCLA or the Center	University of California Los Angeles Center for Health Policy Research

Data Types and Specific Data Elements

Types of Quantitative Data LIHPs Will Submit for the Evaluation

Because the goals of the HCCI evaluation differ from those of the LIHP evaluation, it will not be necessary to collect as much data from the LIHPs as was previously collected from HCCI counties.

UCLA requires two major categories of data for the LIHP evaluation:

1. Enrollment data, i.e., data collected upon enrollment and recertification;
2. Utilization data, i.e., paid claims/encounter data from providers for all LIHP enrollees *to the extent available to the LIHP,* for services including:
    a. inpatient (IP) admissions;
    b. outpatient visits, *including mental health and substance use services;*
    c. emergency room (ER) visits, including out-of-network ER visits paid for by the LIHP; and,
    d. ancillary services including drugs prescribed and laboratory claims.

These data types are routinely collected during enrollment and care delivery.

UCLA also requests, but does not require, laboratory-reported test results data, (e.g., HgA1C test values) for common lab procedures.

Summary of Guidelines for Data Layout and Formatting

Detailed information about the requested fields, formatting and layout of each data type can be found below, in the sections Quarterly Enrollment Data, Quarterly Utilization Data , and Optional Quarterly Laboratory-Reported Test Results Data , respectively.

To the extent possible, LIHPs must provide the evaluation data in accordance with the specifications detailed in this manual. If a LIHP is unable to provide data in the requested format or layout, or is not able to provide the data element at all, the LIHP must contact the Center to discuss individual solutions. Contact information for the evaluation team can be found in the section

Contacting UCLA Project Staff.

Early communication with UCLA project staff regarding data requirements will minimize the burden of reporting. Failure to provide sufficient documentation of submitted data or submission of non-standard data will necessitate ongoing communication regarding data

interpretation and use, and may require re-delivery of data in a corrected format. Please contact UCLA to discuss any concerns regarding the requested data elements, in order to streamline evaluation data reporting.

Data Reporting Schedule

Time period that data submission is requested

Data collection for the evaluation will begin in July 2011. Each LIHP will begin submitting data at the time of the first data delivery due date after local program implementation has begun (Table 1). Final data collection for all LIHPs will occur in mid 2014 to ensure that complete enrollment and utilization data are available for the final evaluation report.

Table 1: Data Reporting Schedule

Period	Due Date	Reporting Period Covered
3rd Quarter, 2011	October 31, 2011	July 1, 2011-September 30, 2011
4th Quarter, 2011	January 31, 2012	October 1, 2011-December 31, 2011
1st Quarter, 2012	April 30, 2012	January 1, 2012- March 31, 2012
2nd Quarter, 2012	July 31, 2012	April 1, 2012-June 30, 2012
3rd Quarter 2012	October 31, 2012	July 1, 2012-September 30, 2012
4th Quarter, 2012	January 31, 2013	October 1, 2012-December 31, 2012
1st Quarter, 2013	April 30, 2013	January 1, 2013- March 31, 2013
2nd Quarter, 2013	July 31, 2013	April 1, 2013-June 30, 2013
3rd Quarter 2013	October 31, 2013	July 1, 2013-September 30, 2013
4th Quarter, 2013	January 31, 2014	October 1, 2013-December 31, 2013
Final Enrollment and Claims Files	July 31, 2014	Up to December 31, 2013
Baseline	End of the first year of local program implementation (see Technical Specifications for LIHP Baseline Data)	Legacy counties: Two year period, 7/1/2009-6/30/2011 (includes bridge period) New counties: One year period prior to program start date

Although data from all LIHPs will be delivered on a set schedule, the commencement and duration of data reporting will vary for each LIHP, depending on the date of local program implementation.

Program Duration

All LIHPs will be required to submit *enrollment* and *utilization* data for the duration of their program, beginning at the first reporting due date after the launch of the local LIHP.

- ***For example***, if a LIHP begins implementation on **December 1, 2011**, data must be provided for December 1, 2011 to December 31, 2013 (the duration of the Local Project Period).

- The Due Date for the first evaluation data submission in this case would be January 31, 2012 (Table 1), because the local program began implementation in the 4th quarter of 2011.

If LIHPs elect to submit *laboratory-reported test results* data, they will be requested to provide these data for all enrollees *as available to the LIHP,* for the full duration of the program period. Laboratory results data are only requested for specific clinical tests, described in Table 8.

Baseline Period – Legacy Counties

All LIHPs will provide data for a "baseline" or "pre-" period, in order to establish an internal comparison for assessing LIHP impact within the local program. Legacy counties will submit a two-year baseline to capture enrollment and utilization during the bridge period (September 1, 2010 through June 30, 2011) and a portion of the HCCI program period. Detailed specifications for the baseline can be found in UCLA's manual, Technical Specifications for LIHP Baseline Data, Legacy Counties.

Baseline Period – New Counties

For new counties, baseline data will be submitted at the end of the first year of local program implementation, and will consist of a one-year period prior to the start date, *to the extent available to the LIHP*. To reduce the burden of data reporting, the pre-data are required only for all individuals who are enrolled in LIHP during the first program implementation year.

- ***For example***, if a LIHP begins implementation on **December 1, 2011,** the LIHP would provide one year of baseline data from December 1, 2010 to November 30, 2011.

- This data would be provided at the end of each LIHP's first program year, and would include all LIHP enrollees during the first year. UCLA realizes that this will only capture users of county network services in the pre-period.

Detailed Technical Specifications

Quarterly Enrollment Data

Rationale: LIHPs will provide an **enrollment and demographic data file** on a quarterly basis for all individuals ever enrolled in LIHP. These data will allow monitoring and feedback regarding effectiveness of recruitment efforts, take-up rates, enrollment, retention, and churn of enrollees. Measures of enrollment and coverage expansion are valuable for assessment of the number and characteristics of enrollees who participate in the LIHPs and who will transition to Medi-Cal or the Exchange.

Method: LIHPs will provide a quarterly delivery of a cumulative LIHP enrollee list, with a record for each individual ever enrolled to date. Enrollment status will be recorded for each individual during each month, with monthly enrollment aid code variables documenting enrollee status. This "cumulative approach" will be used to reflect current status and retroactive changes to an individual's enrollment history (due to retroactive enrollment effective to the month of application, or to retraction of enrollment previously reported).

LIHPs may opt to structure this file in one of two ways:

Option 1: The LIHP may "grow" the file at each reporting quarter, to add the months that have occurred since the previous report. If a LIHP opts to use this method, the LIHP would begin by including only three monthly aid code fields (for the first quarter). Thereafter, three additional fields would be added to the data file at each subsequent reporting quarter, to report the most recent reporting quarter while retaining and updating the previously reported enrollment history.

Option 2: The LIHP may begin by establishing and providing fields for each month of planned program operations, providing a "set" file. In this case, every enrollment file delivered by the LIHP would have the same structure and number of fields. At each quarterly reporting time, the LIHP would progressively populate the monthly fields while retaining and updating the previously reported enrollment history, such that data are provided for all months that have occurred to date and data remain blank for months in the future.

If a standard period of retroactive claiming is used for all enrollees in the LIHP in question, UCLA will impute standard retroactive monthly enrollment records for the appropriate number of months allowed by the LIHP.

This enrollee list will also include values for routinely collected demographic variables at the most recent time of application or recertification. If changes in enrollee demographics occur at the time of recertification, demographic data will be overwritten by new values.

All individuals who have ever enrolled in the LIHP as of the date of reporting will be included in each submission of the data file. Enrollment records for enrollees who are **county inmates** should contain the same data elements provided for non-inmate enrollees, to the extent available to LIHPs. Similarly to general-population enrollees, any retroactive changes to county inmate enrollment will be reported through updates to previously reported enrollment aid code fields.

There are no requirements for data related to State inmates. Please contact DHCS with any questions regarding the eligibility and enrollment process for State inmates.

***Variables*:** The requested data elements are basic and generic values that are routinely collected at the time of application. Each LIHP will be responsible for coding enrollment data based on the information provided in this manual. UCLA will provide technical assistance to LIHPs requiring assistance with variable coding. In addition to routine demographic variables, UCLA strongly requests that every LIHP implement a single self-assessed health status question to be asked at the time of initial enrollment and at all subsequent recertifications. This single question is highly predictive of future health care utilization and expenditure. The question language will be provided by UCLA, and can be asked verbally by the application assistant or in writing on an enrollment form.

"Would you say that in general your health is excellent, very good, good, fair, or poor?"
[Answer scale: Excellent/Very Good/Good/Fair/Poor]

This single question is highly predictive of future health care utilization and expenditures, and will be used to help Medi-Cal anticipate its costs for covering LIHP beneficiaries when they transition to Medi-Cal coverage in 2014. This single question would be asked each time an enrollee applies or is recertified for LIHP, and the responses should be included with the enrollment data submitted to UCLA. The question can be asked verbally at the time of application, or in writing on an enrollment form. There is no requirement to implement this recommendation, nor is it required to use the standard language provided above.

The requested data elements are displayed in Table 2.

- The unique enrollee ID number (Field 1) will indicate the ID number of the unique individual. Each individual will retain the same enrollee ID number throughout all application/recertification periods, and the same enrollee ID number will be included in both enrollment and utilization data, to allow merging of the two datasets.

- The monthly enrollment aid codes (Fields 10-12) will be used to reflect the individual's enrollment status during each individual month. The number of monthly aid code fields included in the data will vary depending on the delivery method selected by the LIHP (see "Method" above).The cumulative enrollee file will reflect all months of program implementation for each LIHP, and will record the months in which each individual was enrolled. Any retroactive changes to an individual's enrollment history will be recorded through changes to the historical monthly aid codes.

  DHCS requires that LIHPs classify enrollees using a uniform Aid Code system. The Aid Code distinguishes whether the enrollee is in the MCE or HCCI program, is or is not an county inmate, and is "existing" (enrollment was effective on November 1, 2010) or "new" (enrollment was effective after November 1, 2010). The Aid Codes are listed in Table 3. If LIHPs are not able to immediately implement this classification within the local eligibility system, they may discuss this with UCLA as needed.

- Demographic data (Fields 2-9 and 14-15) may be updated to reflect any changes reported by the enrollee each time the enrollee recertifies eligibility. In the intervening months, LIHPs may continue to populate these fields with the most recent data available (from the current application period for that enrollee) or may leave these fields blank, as preferred by the LIHP based on the structure of the local data system.

- If the LIHP elects to collect data on self-rated health status, the enrollee response will be recorded in Field 16. This data will be updated at the time of each application and/or recertification, to reflect changes in health status reported by the enrollee.

File Layout: Table 2 displays a listing of specific enrollment data elements requested. The layout displayed in Table 2 reflects "Option 1" for file delivery method (see "Method" above). In this option, the LIHP would "grow" the enrollment file each month, adding three additional monthly aid code fields to the data at the time of each delivery. Mock enrollment data for this "growing" file as well as the alternative "set" file option are available upon request. To see sample data in the format and layout requested by UCLA, please contact Erin Salce.

Table 2: Quarterly Enrollment Data Specifications

Field Number	Variable	Description	Variable Name	Variable Format	Allowable Values
1.	Unique Enrollee ID Number	Unique ID for the patient/enrollee; shared across evaluation data files	PID	Character/ String	LIHP-specific
2.	Date of Birth	Enrollee birth date	DOB	YYYYMMDD	Date
3.	Gender	Enrollee gender	Female	Numeric/ categorical	0- Male 1- Female 2- Other 9- Unknown
4.	Ethnicity Code	Enrollee reported race/ethnicity as reported at the time of application/recertification (aligned with HRSA and Census race and ethnicity categories) Is the enrollee Hispanic or Latino: Yes/No	Ethnic	Numeric/ categorical	0- Not Hispanic or Latino 1- Hispanic or Latino 9- Unknown
5.	Race Code	Enrollee reported race/ethnicity as reported at the time of application/recertification (aligned with HRSA and Census race and ethnicity categories) Race of enrollee: Asian / American Indian or Alaska Native / Black or African American / Native Hawaiian or Pacific Islander / White / Other / Unknown[1]	Race	Numeric/ categorical	1- Asian 2- American Indian or Alaska Native 3- Black or African American 4- Native Hawaiian or Other Pacific Islander 5- White 6- Other 9- Unknown

[1] Ethnicity and race can be stored in your data system as a single field (i.e., White, Hispanic/Latino; White, Not Hispanic/Latino; Asian, Hispanic/Latino; Asian, Not Hispanic/Latino, etc), or you can provide 2 data fields, 1 for ethnicity and 1 for race. Please note that if your system uses a different method for collecting race/ethnicity information, you are not required to change it to align with our requested categorization. We will accept data as it is collected in your system currently.

Field Number	Variable	Description	Variable Name	Variable Format	Allowable Values
6.	Primary Language Code	Enrollee reported primary language (primary spoken language is requested if available) as reported at the time of application/recertification[2]	Language	Numeric/ categorical	1- English 2- Spanish 3- European languages 4- Asian and Pacific Island languages 5- Other 9- Unknown
7.	Citizenship Status	Indication of the individual's citizenship status (Citizen vs. Legal Permanent Resident)	Citizen	Numeric/ categorical	0- No: Legal Permanent Resident 1- Yes: Citizen 9- Unknown
8.	Household Income	Household income (as reported for FPL calculation)	Income	Numeric	Continuous values
9.	Household Size	Number of adults and children in the household (as reported for FPL calculation)	Size	Numeric	Continuous values
10.	Month 1 Enrollment Aid Code **	Indication of the individual's enrollment category during the first month of the reporting quarter, using Aid Codes specified by DHCS. Distinguishes whether the enrollee was enrolled at any time during the month, and how the enrollee is classified per CMS and DHCS guidelines. Aid code will be missing/blank in months during which the individual was not enrolled.	Aid_m1	Character/ String	Refer to Table 3: Aid Codes

[2] Please note that if your system uses a different method for collecting language information, you are not required to change it to align with our requested categorization. We will accept data as it is collected in your system currently.

Field Number	Variable	Description	Variable Name	Variable Format	Allowable Values
11.	Month 2 Enrollment Aid Code **	Indication of the individual's enrollment category during the second month of the reporting quarter, using Aid Codes specified by DHCS. Distinguishes whether the enrollee was enrolled at any time during the month, and how the enrollee is classified per CMS and DHCS guidelines. Aid code will be missing/blank in months during which the individual was not enrolled.	Aid_m2	Character/ String	Refer to Table 3: Aid Codes
12.	Month 3 Enrollment Aid Code **	Indication of the individual's enrollment category during the third month of the reporting quarter, using Aid Codes specified by DHCS. Distinguishes whether the enrollee was enrolled at any time during the month, and how the enrollee is classified per CMS and DHCS guidelines. Aid code will be missing/blank in months during which the individual was not enrolled.	Aid_m3	Character/ String	Refer to Table 3: Aid Codes
13.	Disenrollment Reason	Indication of the disenrollment reason, if the individual was disenrolled during the reporting quarter. Standard disenrollment reasons will be provided, and will be aligned with those reported in progress reports in the previous HCCI program.	Disenroll	Numeric/ categorical	Refer to Table 4: Disenrollment Reason
14.	Previous Insurance Coverage	Indicator of any previous insurance coverage in the past 12 months, as reported by the applicant reported at the time of application, if available (e.g., Uninsured, Privately insured, Publicly insured, etc)	Ins_Previous	Numeric/ categorical	1- Uninsured 2- LIHP 3- Medicare 4- Medi-Cal 5- Private coverage 6- Workers Compensation 7- Ryan White 8- Other government 9- Other payer 10- Unknown

Field Number	Variable	Description	Variable Name	Variable Format	Allowable Values
15.	Concurrent Insurance Coverage	Indicator of other concurrent insurance coverage the applicant reported at the time of application, if available (e.g., Uninsured, Privately insured, Publicly insured, etc)	Ins_Current	Numeric/ categorical	1- Uninsured 2- LIHP 3- Medicare 4- Medi-Cal 5- Private coverage 6- Workers Compensation 7- Ryan White 8- Other government 9- Other payer 10- Unknown
16.	Self-Rated Health Status	Enrollee response to single health status question, recommended to be asked at time of application and/or recertification[3] *"Would you say that in general your health is excellent, very good, good, fair, or poor?"* [Answer scale: Excellent/Very Good/Good/Fair/Poor]	SRHS	Numeric/ categorical	1- Excellent 2- Very Good 3- Good 4- Fair 5- Poor 9- Unknown

** Note: depending on the file delivery option selected by the LIHP, this file may initially have 3 monthly aid code fields for the first reporting quarter (a "growing" file), or the file may have fields established for every month of expected program operations (a "set" file). If the LIHP elects to provide a "growing" file, each subsequent file delivery will include three additional monthly aid code fields, such that one field is provided for each month of program operations to date. Previously reported monthly aid codes should be revised as needed to reflect any changes to the enrollment history for each individual.

[3] UCLA recommends use of this question during the application and recertification process, but does not require that LIHPs collect or report this information.

Table 3: Aid Codes

Aid Code	Description
F6	**MCE, County Inmate** Benefits are limited to hospital inpatient services for inmates in county correctional facilities who received those services off the grounds of the correctional facility. Individual is between 19 and 64 years of age with family incomes at or below 133 percent of the federal poverty level, participating in an MCE program, not eligible for Medi-Cal or CHIP, and whose county of last legal residence participates in an MCE program. Note that to the extent possible, the California State Plan provides for inpatient hospital services. Services exclude LTC, pharmacy, dental, mental health, and outpatient services. County staff will make eligibility determinations.
F7	**MCE, Existing (not inmate)** Non-pregnant individuals between 19 and 64 years of age with family incomes at or below 133 percent of the federal poverty level, not eligible for Medi-Cal or CHIP, and were enrolled in the Coverage Initiative under "Medi-Cal Hospital/Uninsured Care Waiver" effective November 1, 2010. Note that to the extent possible, the California State Plan provides for inpatient hospital services with additional services provided with CMS approval. For claiming purposes, any services provided above the minimum core set may vary by county. County staff will make eligibility determinations.
F8	**MCE, New (not inmate)** Non-pregnant individuals between 19 and 64 years of age with family income at or below 133 percent of the federal poverty level, not eligible for Medi-Cal or CHIP. Note that to the extent possible, the California State Plan provides for inpatient hospital services with additional services provided with CMS approval. For claiming purposes, any services provided above the minimum core set may vary by county. County staff will make eligibility determinations. This includes an MCE enrollee whose enrollment was not effective November 1, 2010 (as per the STCs)
F9	**HCCI, Existing** Non-pregnant individuals between 19 and 64 years of age with family incomes above 133 through 200 percent of the federal poverty level, who are uninsured, not eligible for Medi-Cal or CHIP, and who were enrolled in the Coverage Initiative under "Medi-Cal Hospital/Uninsured Care Waiver" effective November 1, 2010. Note that the special terms and conditions provide a minimum core set of services with additional services provided with CMS approval. For claiming purposes, services provided above the minimum core set may vary by county. County staff will make eligibility determinations.
F0	**HCCI, New** Non-pregnant individuals between 19 and 64 years of age with family incomes above 133 through 200 percent of the federal poverty level, who are uninsured, and are not eligible for Medi-Cal or CHIP. Note that the special terms and conditions provide a minimum core set of services with additional services provided with CMS approval. For claiming purposes, services provided above the minimum core set may vary by county. County staff will make eligibility determinations. This includes an HCCI enrollee whose enrollment was not effective November 1, 2010 (as per the STCs)

Table 4: Disenrollment Reasons

Allowable Values	Description
1	Failed/Incomplete Redetermination
2	Relocated
3	Deceased
4	Increased Income
5	New Private Health Insurance Coverage
6	Eligible public state insurance programs for Medi-Cal, Healthy Families, or Access for Infants and Mothers Programs
7	Enrollee Request
8	Other/ Over 65
9	Unknown

Quarterly Utilization Data

Rationale: LIHPs will provide **utilization data at the claim-level or encounter-level, as available,** on a quarterly basis. These data will reflect all enrollee utilization of covered services paid for by the LIHP, including medical, mental health/substance use, pharmacy, ancillary, and other services including add-on services. These data will allow assessment of access to care, timely provision and appropriateness of care, health behavior, and level of pent-up demand for health services resulting from being uninsured. Measures of access to and quality of care are necessary to inform health plans, public insurers, local initiatives and other providers regarding the risks, health care needs, and behaviors of the population newly eligible for Medi-Cal or the Exchange in 2014.

Method: On a quarterly basis, the LIHP will use the cumulative enrollee list most recently generated to select paid claims for all of those individuals who have ever been enrolled.

The preferred method for LIHPs to submit claims data is via a cumulative file (described in option 1 below). If this is not feasible, the "delta file" (option 2) may be utilized.

Option 1: At each reporting period, the LIHP may include all claims for the cumulative program time to date, such that each claims file generated by the LIHP will replace the previous file.

Option 2: At each reporting period, the LIHP may produce a "change" or "delta" claims file, which includes all newly processed claims not provided in the previous claims data delivery. If the LIHP chooses this method, all of the claims data deliveries will be appended together by UCLA to create a single cumulative claims history file.

Data will be provided for the full duration of program operations, beginning after the first quarter during which the LIHP was operational. In addition, each LIHP will provide "baseline" or "pre"-period data for all enrollees to the extent available. This information is covered in greater detail in the section: "Data Reporting Schedule" In summary, baseline data:

- will be submitted at the end of the first year of program implementation;
- will include a 1-year period prior to the program start date, *to the extent available to the LIHP*; and,
- are required only for all individuals who are enrolled in LIHP during the first program implementation year.

In addition, *legacy HCCI counties* will provide data for the period from September 1, 2010 until the date of local LIHP implementation, during which time HCCI programs continued operations.

As before, UCLA acknowledges that major differences exist between the continuing programs and the newly established LIHPs, and will account for these differences in all analyses.

Emergency Room, out of network emergency, and services provided to county inmates:

Emergency room services must be recorded in the utilization data, even if they lead to **hospital admission**. Preferably, the data will include a unique record documenting the ER service. If ER services resulting in admission are not captured by the billing system, the inpatient stay that originated in the ER must include documentation of the source of the admission, such that the ER visit preceding it can be identified.

Utilization data regarding use of **out-of-network emergency room services** *paid for by the LIHP* must include at a minimum: the unique enrollee ID number, the date of service, and the primary diagnosis for each out-of-network emergency room encounter, to the extent possible. Detailed claims/encounter data as requested for in-network services are requested for out-of-network services, to the extent available to LIHPs. See "Table 6: Utilization Data Specifications - Minimum Utilization Reporting for Out of Network Emergency Services and Services Provided to County Inmates" below.

Utilization data regarding use of services by enrollees who are **county inmates** should contain the same data elements provided for non-inmate enrollees, to the extent available to LIHPs, and at a minimum must include the date of service and unique enrollee ID number for each county inpatient visit *paid for by the LIHP.*

No data for individuals who are **State inmates** is requested. After the State inmate has been paroled, he or she will be transitioned to the applicable non-inmate aid code, and will begin receiving the full scope of covered services. At that time, the LIHP will begin providing data regarding use of services by that individual using a general population aid code.

Variables: The requested data elements are core administrative data elements that are gathered through claims-processing. UCLA will accept either claim level or encounter level data from counties, potentially reducing county burden to aggregate claims to the encounter level. The Special Terms and Conditions include a provision (VIII. A.74) requiring each LIHP operating a closed network (and therefore considered for the purposes of the program to be a Managed Care Delivery System) to submit Encounter Data, including at a minimum, data on all inpatient, outpatient and physician services. The utilization data requested by UCLA are aligned with this provision, reducing redundancy of reporting requirements.

The STCs require DHCS and the evaluation to report on utilization of services, broken down by service type. For this reason, UCLA has instituted a standard "Place of Service" code requirement, which uses the Place of Service (POS) Codes established by CMS to indicate the

location where each service was provided. These standard codes are aligned with the national system used for Medicare claiming, and are summarized within this manual in Appendix 1: 2011 Place of Service Codes. The billing system in each LIHP may already use the requested POS code system, but may not include services in every POS category, if the provider network does not include facilities of every type detailed by CMS.

The goal of the POS code system is to enable categorization of claims by service type. If your current data system does not utilize the requested POS codes, please contact UCLA to develop an alternate plan for reporting data such that claims can the sufficiently categorized by UCLA.

***File Layout*:** Table 5 displays a listing of specific utilization data elements requested. Standardization of data availability across LIHPs will improve timeliness of evaluation reporting and comparability of findings, and will minimize the need for communication between UCLA and the LIHP regarding data use and interpretation. To the extent possible, UCLA requests that LIHPs provide data in the layout provided in Table 5.

- If the LIHP is unable to provide data in the layout provided in Table 5, contact UCLA to discuss individual solutions. It may be possible to provide sufficient variables and documentation for UCLA to construct the requested fields.
- If data from various network providers or various service types cannot be reported by the LIHP in a single data file, LIHPs may provide data in multiple separate files.

For LIHPs that provide encounter-structured data, a single record per service will be provided. Please include additional ICD-9 Diagnosis, DSM, ICD-9 Procedure, CPT, and NDC code fields in order to capture all codes billed by the provider.[4] For LIHPs that provide claims-structured data, a header record must be provided for every service, and up to 99 additional detail lines may be provided to capture service detail, such as additional medications or procedures associated with the service.

Legacy HCCI counties will continue to submit claims/encounter data at the level of detail they have been reporting. Counties are asked to combine their utilization data into a single utilization file, in the requested file structure, to the extent possible (Table 5). This will reduce the number of separate data files submitted at the time of each submission.

New LIHPs will provide claims/encounter data at the level of detail available in the local billing system. If the specific fields listed in Table 5 cannot be provided, the LIHP should contact UCLA to discuss individual solutions. It may be possible to submit the combination of source data

[4] If ICD-10 is implemented during this time period, LIHPs may submit claims using this format. An updated code book may be required at that time (Appendix 5: Data Dictionary Template)

fields that would allow UCLA to construct the necessary fields. Technical assistance for this process will be provided by UCLA.

Mock utilization data are available upon request. To see sample data in both claims/"long" format and encounter/"wide" format, please contact Erin Salce.

Table 5: Quarterly Utilization Data Specifications

Field Number	Variable	Description	Variable Name	Variable Format	Allowable Values
1.	Unique Enrollee ID Number	Unique ID for the patient/enrollee; shared across evaluation data files	PID	Character/ String	LIHP-specific
2.	Claim ID	A unique record identification number is assigned to each specific service event (e.g. each Inpatient Stay). This is used to distinguish between service events, and to identify all subsequent records associated with each event.	Claim_ID	Character/ String	LIHP-specific
3.	Claim Line Number	If claims data are submitted, please include a claim line number for each additional claim line record associated with the unique Claim ID (field 2). Claims data typically include multiple lines or records for each service event. This field is used to group record lines into a single service event to which they are associated.	LineNum	Character/ String	00 (Header Record) 01-99 Detail Lines)
4.	Record Adjustment Code	Indication of a record that represents an adjustment to a previously reported unique Claim ID (field 2). This field flags records that do not represent a newly reported service, but are rather adjusting or editing a previously reported service.	ADJ_IND	Numeric/ categorical	0- No 1- Yes
5.	First Date of Service	The first date of service for the record (Fill date for pharmacy records)	SVC_Dt	YYYYMMDD	Date

Field Number	Variable	Description	Variable Name	Variable Format	Allowable Values
6.	End Date of Service	The last date of service for the record -- (discharge date for inpatient stays; either blank or the same as the first date of service for one-day services such as outpatient care)	Last_SVC_Dt	YYYYMMDD	Date
7.	Place of Service[5]	Standard "Place Codes" indicating the *location of care for the service* reported (e.g., Inpatient Acute Care, Inpatient Long-Term Care, Outpatient Hospital, Emergency Room, Clinic, Physician, etc.) [6]	PLACE_CD	Character/ String	Refer to Appendix 1: 2011 Place of Service Codes
8.	Discharge DRG Code	For inpatient admissions, the discharge DRG code (if available)	DRG	Character/ String	DRG Codes
9.	ICD-9 Diagnosis or DSM Code**	Code for the specific medical diagnosis or mental health /substance use diagnosis (include all diagnosis codes available). The first code listed should be the principal diagnosis.	ICD_DX1	Character/ String	ICD-9 or DSM Diagnosis Codes
10.	ICD-9 Procedure Code **	The ICD-9 procedure code for the specific service(s) rendered (include all procedure codes available). The first code listed should be the principal procedure code.	ICD_PROC1	Character/ String	ICD-9 Procedure Codes
11.	CPT/HCPCS /CDT/ Revenue Code**	Procedure code identifies the service(s) rendered. The first code listed should be the principal procedure code.	PROC1	Character/ String	CPT/HCPCS /CDT/ Revenue Code

[5] For the "Place Code" field in utilization data, please use the "Place of Service Codes for Professional Claims" codes in the CPT manual in the "Coding and Billing Issues" section. These align with Medicare reporting requirements, and are used to help delineate the specific entity or location where each service was provided. They will also align with the DHCS/CMS required service reporting categories (as were used in the Program Progress Reports (PPRs) from the HCCI program). Please see Appendix 1: 2011 Place of Service Codes.

[6] Technical assistance for coding of this field will be provided to LIHPs if requested. If the LIHP cannot provide the codes are requested, the source variables or local codes that provide the necessary detail may be substituted.

Field Number	Variable	Description	Variable Name	Variable Format	Allowable Values
12.	National Drug Code**	National Drug Code for the dispensed medication (if applicable)	NDC1	Character/ String	NDC codes
13.	Days Supplied**	The number of days of drug therapy covered by the dispensation recorded in field 12 (if applicable)	DAYS_SUPPLY1	Numeric	Continuous values
14.	Billing Provider ID Number	NEW-V7 Unique ID number for the provider of service (billing provider). If available, **National Provider Identifier** (NPI) number is requested, because it contains valuable information (provider specialty and location of practice). *If NPI number is not available, please also provide a field documenting the specialty of the rendering provider.*	PROV_ID_BILL	Character/ String	NPI numbers
15.	Rendering Provider ID Number	Unique ID number for the provider of service (rendering provider). If available, **National Provider Identifier** (NPI) number is requested, because it contains valuable information (provider specialty and location of practice). *If NPI number is not available, please also provide a field documenting the specialty of the rendering provider.*	PROV_ID_RENDER	Character/ String	NPI numbers
16.	Medical Home Service Indicator***	Indication of service provided at the medical home (as assigned at the time of the service) (Yes/No)	MHS	Numeric/ categorical	0- No 1- Yes
17.	Primary Insurance Code	Indicates the payer for the service (e.g., LIHP). During baseline months, this will indicate the payer for the services received by the enrollee in the baseline period (e.g., private insurance, healthy families, etc.)	Payer_one		Code book TBD
18.	Secondary Insurance Code	Indicates the payer for the service (e.g., LIHP). During baseline months, this will indicate the payer for the services received by the enrollee in the baseline period (e.g., private insurance, healthy families, etc.)	Payer_two		Code book TBD

Field Number	Variable	Description	Variable Name	Variable Format	Allowable Values
19.	Outpatient Type of Service****	**NEW-V7** Indicates the type of service for outpatient visits.	OPTOS	Numeric/ categorical	1- Primary Care 2- Specialty Care 3- Behavioral Health 4- Dental 5- Urgent Care 6- Other Missing/blank- Not an outpatient service

*Place of Service (POS) codes established by CMS will be used. Please see Appendix 1: 2011 Place of Service Codes.

**Please provide all available fields for this data element to reflect maximum detail available for each visit/encounter. Field numbers will differ for each LIHP depending on the structure and content of their data system. If ICD-9 Procedure and CPT codes are not available on the same claim, it is acceptable to only provide one of the two types of procedure codes.

*** The medical home flag should be left blank ("missing") for mental health visits and is intended only for outpatient care services.

****Outpatient Type of Service is intended for outpatient services only and should be left blank ("missing") for any claims that are not for outpatient care. Please contact UCLA if you have any questions concerning the coding of this field.

Table 6: Utilization Data Specifications - Minimum Utilization Reporting for Out of Network Emergency Services and Services Provided to County Inmates

Field Number	Variable	Out-of-Network Emergency Services	Services Provided to County Inmates
1.	Unique Enrollee ID Number	Required	Required
2.	Claim ID	Required	Required
3.	Claim Line Number	Required	Required
4.	Record Adjustment Code	Required	Required
5.	First Date of Service	Required	Required
6.	End Date of Service	Required	Required
7.	Place of Service[7]	Optional	Optional
8.	Discharge DRG Code**	Optional	Optional
9.	ICD-9 Diagnosis Code**	Required	Optional
10.	ICD-9 Procedure Code **	Required	Optional
11.	CPT/HCPCS/Revenue Procedure Code**	Required	Optional
12.	National Drug Code**	Optional	Optional
13.	Days Supplied**	Optional	Optional
14.	Billing Provider ID Number	Optional	Optional
15.	Rendering Provider IP Number	Optional	Optional
16.	Medical Home Service Indicator	N/A	N/A
17.	Primary Insurance Code	Optional	Optional
18.	Secondary Insurance Code	Optional	Optional
19.	Outpatient Type of Service	N/A	N/A

** Please provide all available fields for this data element to reflect maximum detail available for each visit/encounter, if applicable.

Note: required fields are required *to the extent available to the LIHP*. No data are requested for State Inmates.

[7] For the "Place Code" field in utilization data, please use the "Place of Service Codes" in Appendix 1: 2011 Place of Service Codes. These align with Medicare reporting requirements, and are used to help delineate the specific entity or location where each service was provided. They will also align with the DHCS/CMS required service reporting categories (as were used in the PPRs from the HCCI program).

Optional Quarterly Laboratory-Reported Test Results Data

Rationale: LIHPs are requested *but not required* to provide **laboratory-reported test results for selected common laboratory tests** on a quarterly basis. Lab results are an integral measure of quality of care, and if provided, will be used to evaluate the health status and clinical needs of the LIHP population. Analyses will be constructed to evaluate laboratory results within accepted quality of care guidelines, for the population to which they are applicable.

If lab data are not uniformly available, LIHPs that elect to provide this data may submit data for only a portion of their enrollees. Lab data may be drawn from the lab provider (i.e., Quest), Electronic Medical Records, disease registry, or other patient information data system, as applicable.

Method: If provided, lab data will be delivered on a quarterly basis at the time of utilization data delivery. Cumulative lab data will be provided for the full duration of the program implementation period, for the selection of enrollees for which it is available. Lab data are not requested for out of network and county inmate utilization of services. Only lab results for in-network services provided to enrollees in general population aid codes should be provided.

Lab data can be collected from a range of different sources, including the lab provider, the Electronic Medical or Health Record, or a disease registry or other data system, as applicable to the LIHP:

- If the LIHP provides laboratory screenings through its own laboratory, the LIHP will use the cumulative enrollee list most recently generated to select lab results for the quarterly reporting period for those enrollees on the cumulative enrollee list.
- If the LIHP is contracted with a third-party laboratory, the vendor will select all lab results through the appropriate method, which may include use of the cumulative enrollee list, or use of a billing code or other internal data point indicating LIHP as the payer.

Variables: The requested data elements include the date of collection, the type of lab procedure being reported (HgbA1c, LDL, Microalbumin, etc), and the reported lab value. LIHPs may choose to provide lab results data for additional laboratory procedures if desired. However, a specific list of core laboratory procedures will be provided by UCLA, which is likely be limited to less than ten common services.

File Layout: Table 7 and Table 8 display a listing of the specific laboratory results data elements requested. CPT codes are suggested but not required, these codes are provided to assist in the identification of specific tests. If CPT codes are not available, please use the most specific name for test results that is possible.

Mock laboratory result data are available upon request. To see sample data in the layout and format requested, please contact Erin Salce.

Table 7: Optional Quarterly Laboratory-Reported Test Results Data Specifications

Field Number	Variable	Description	Variable Name	Variable Format	Allowable Values
1.	Unique Enrollee ID Number	Unique ID for the patient/enrollee; shared across evaluation data files	PID	Character/ String	LIHP-specific
2.	Date of Collection	The date of collection for the laboratory service	COL_DT	YYYYMMDD	Date
3.	Lab Test Name	Title of lab test	Lab_Name	Character	Laboratory names from Table 8
4.	CPT code for specific lab value being reported	Code that allows interpretation of the lab, indicates the lab service type being reported (e.g. HgbA1c) from Table 8.	Lab_CPT	Character/ String	CPT codes from Table 8
5.	Lab Result Value	The result reported by the lab (value)	Lab_Value	Numeric	Lab result

If Laboratory-Reported Test Results Data are requested for the following laboratory services to the extent possible. If lab data for some or all of the requested services are not available, there is no need to begin collecting this data.

Table 8: Laboratory-Reported Test Results - Requested Clinical Services

Clinical Test	CPT Code(s)
Hemoglobin A1c result	83036, 83037
Fasting Blood Glucose result	82947
Lipid Panel results, or components thereof when ordered separately, including: Cholesterol (total, LDL, HDL), Triglycerides	82465, 83718, 84478
Renal Function Panel results, or components thereof when ordered separately, including: Urine Microalbumin, Creatinine	82040, 82565

If lab data does not include CPT classifications, contact UCLA to discuss other billing codes that can be used to extract comparable records from the data system.

File Transmission

Output Data Structure

Once the beneficiaries are selected using the criteria listed above, LIHPs will create 2 text files, one enrollment and one utilization file. The enrollment file will have one record per beneficiary and the utilization file will have either one record per encounter (if encounter-level data is submitted) or multiple records per encounter (if claim-level data are submitted). An optional third file may be created for laboratory-reported test results, if the LIHP submits laboratory-reported test results to be included in the evaluation.

LIHPs will create text files in a tab delimited file format. Files should be saved using the following naming convention: where mmm = month of the update (e.g., JAN, FEB, etc.) and yy = year of the update (e.g., 06 for 2006), and name=LIHP name.

1- mmmyy.LIHP.ENROLLMENT.name
2- mmmyy.LIHP.CLAIMS.name
3- mmmyy.LIHP.LABS.name (Optional)

The preferred method to deliver files is via a password protected zip file. The zip file will be transferred as described in the Secure File Transfer Protocol (SFTP) section below.

Secure File Transfer Protocol (SFTP)

Prior to sending files, LIHPs will test the encryption process. UCLA offers the ability for clients to post and retrieve files from our secure FTP server. This process expedites data processing and allows for unattended delivery and retrieval of data and reports.

The Center's contact point for FTP servers is: Bryon Trotter (btrotter@ucla.edu), (310) 794-2274

The FTP process at the time of implementation is dependent upon UCLA contract completion with DHCS, due to HIPAA compliance clauses included in the Business Associate Agreement within the contract. Once these are established, data files created by LIHPs can be posted on the UCLA FTP site or pulled by UCLA. UCLA will be bound by the existing CaMRI BAA with the state, but if LIHPs would like to enter into a separate agreement with UCLA, that is also possible.

Any LIHP staff who will be involved with file transfers are required to complete Appendix 2: End User Information Requirements for Client Access to the Center's SFTP Server.

Data Transmittal and Quality Assurance

Under HIPAA, a covered entity must have appropriate administrative, technical and physical safeguards to protect protected health information. (45 C.F.R. § 164.530(c).) Physical safeguards include the implementation of policies and procedures that govern the receipt and removal of hardware and electronic media with electronic protected health information into and out of a facility, and the movement of these items within the facility. (45 C.F.R. 164.310(d)(2)(iii).) The Health Information Technology Act (HITECH Act) extended HIPAA requirements to business associates of covered entities, including this provision for implementing physical safeguards for PHI. (See 45 C.F.R. 164.310.) For the LIHP evaluation, it is necessary that data transmissions from LIHP entities to UCLA be conducted in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and the recently adopted HITECH Act that amended HIPAA.

DHCS has complied with the requirement to implement policies and procedures governing the removal of PHI from its facilities by adopting a data release approval process. This process requires that all information containing PHI that is transferred from DHCS to an outside entity must be documented on a data release approval form, and the release must be approved by DHCS' Privacy Officer and Information Security Officer before it is released. The DHCS procedures also require that a quality assurance check be made of all electronic files before they are transmitted, to verify that the data being sent is the data that was intended to be sent and no more.

The governmental entities that have entered into contracts with DHCS for administering the LIHP are business associates of DHCS and as such are subject to the HIPAA and HITECH Act requirements. Pursuant to these contracts, the LIHPs will be submitting data directly to UCLA. In order to assure that the counties and DHCS meet their HIPAA obligations, a data release approval process for LIHP was established that is similar to the one used by DHCS.

The forms attached in **Error! Reference source not found.** constitute the required documentation to be used by LIHPs. LIHPs must complete the *Data Transfer Approval Forms* for (1) enrollment, and (2) utilization data, and for (3) laboratory results data if applicable. The completed *Data Transfer Approval Forms* must be submitted to UCLA before the date of the first quarterly evaluation data delivery to UCLA.

In addition, the LIHPs must implement a *Quality Assurance* process that is equivalent to or more rigorous than the sample QA form attached in Error! Reference source not found..

Each LIHP will meet with UCLA prior to program launch to discuss these requirements.

Contacting UCLA Project Staff

UCLA will provide technical assistance to LIHPs, including provision of detailed data file specifications and assistance in developing secure data transfer connections. In addition, UCLA will consult on a case-by-case basis as needed to assist LIHPs in preparation of the requested data files.

Contact Us	Research Team
For general information about the project, please contact the project team: Email: CHPR_LIHP@em.ucla.edu To request Technical Assistance, please contact: Jessica Padilla, MPP Project Manager jessicap@ucla.edu (310) 794-0953	Gerald F. Kominski, Ph.D. Principal Investigator (bio) Dylan H. Roby, PhD Co-Principal Investigator (bio) Nadereh Pourat, Ph.D. Co-Principal Investigator (bio) Allison L. Diamant, M.D., M.S.H.S. Investigator (bio) Ying-Ying Meng, DrPH Investigator (bio) Xiao Chen, Ph.D. Senior Statistician (bio) Erin Salce, MPH Research Analyst (bio) Max Hadler, MPH, MA Research Associate (bio)

Joint Responsibilities for UCLA and LIHP Communication

Notification of LIHP staff or data changes

1. By the date of LIHP implementation, each LIHP must submit to UCLA contact information for LIHP project personnel, including all personnel with whom UCLA will communicate regarding IT, data, program implementation, or the evaluation. Thereafter, LIHPs must notify UCLA within one month of any changes to personnel using the table in Appendix 4: LIHP Contact List (external attachment).

2. LIHPs must notify UCLA of any changes to evaluation data file structure when submitting the data file containing these changes.

3. LIHPs must provide a data dictionary documenting the contents and structure of their submitted evaluation data. If data file structure is changed during the project term, a new data dictionary should be submitted with the newly formatted data file. A data dictionary template is attached as Appendix 5: Data Dictionary Template. LIPHs may fill in the provided template or submit a data dictionary in a different format. At a minimum the following information is required:

   - Variable name,
   - Variable type (character, numeric),
   - The allowable variable categories and their meaning/interpretation, and
   - Variable position and length.

Notification of UCLA staff or data changes

1. UCLA will notify LIHPs of any changes to personnel via email, the Coverage Expansion website, and updates to this Technical Specifications Manual.
2. UCLA will revise this manual on a quarterly basis, and will notify LIHPs of any changes to requested data coding or file construction.

Appendix 1: 2011 Place of Service Codes

The following table is extracted from the national POS code that was current at the time this technical specification manual was developed. Please refer to the citation in the footnotes for the most current code set produced by CMS[8]. The billing system in each LIHP may already use this POS code system, but may not include services in every POS category, if the provider network does not include facilities of every type detailed by CMS.

The goal of this POS code set is to enable categorization of claims by service type. If your current data system does not utilize these POS codes, please contact UCLA to develop an alternate plan for reporting data such that claims can the sufficiently categorized by UCLA.

POS Code	Name (effective date) Description
01	**Pharmacy (October 1, 2005)** A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
02	**Unassigned**
03	**School (January 1, 2003)** A facility whose primary purpose is education.
04	**Homeless Shelter (January 1, 2003)** A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters). (See instructions below.)
05	**Indian Health Service Free-standing Facility (January 1, 2003)** A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization. (See instructions below.)

[8] Version: (This reflects Rev. 2248, 06-24-11) http://www.cms.gov/place-of-service-codes/

POS Code	Name (effective date) Description
06	**Indian Health Service Provider-based Facility (January 1, 2003)** A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients. (See instructions below.)
07	**Tribal 638 Free-Standing Facility (January 1, 2003)** A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to tribal members who do not require hospitalization. (See instructions below.)
08	**Tribal 638 Provider-Based Facility (January 1, 2003)** American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to tribal members admitted as inpatients or outpatients. (See instructions below.)
09	**Prison/Correctional Facility (July 1, 2006)** A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders. (See instructions below.)
10	**Unassigned**
11	**Office** Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	**Home** Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	**Assisted Living Facility (October 1, 2003)** Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
14	**Group Home (Code effective, October 1, 2003; description revised, effective April 1, 2004)** A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).

POS Code	Name (effective date) Description
15	**Mobile Unit (January 1, 2003)** A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
16	**Temporary Lodging (April 1, 2008)** A short-term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code.
17	**Walk-in Retail Health Clinic (No later than May 1, 2010)** A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services.
18-19	**Unassigned**
20	**Urgent Care Facility (January 1, 2003)** Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
21	**Inpatient Hospital** A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	**Outpatient Hospital** A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	**Emergency Room-Hospital** A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	**Ambulatory Surgical Center** A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	**Birthing Center** A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate postpartum care as well as immediate care of newborn infants.
26	**Military Treatment Facility** A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).

POS Code	Name (effective date) Description
27-30	**Unassigned**
31	**Skilled Nursing Facility** A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	**Nursing Facility** A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	**Custodial Care Facility** A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	**Hospice** A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35-40	**Unassigned**
41	**Ambulance—Land** A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	**Ambulance—Air or Water** An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
43-48	**Unassigned**
49	**Independent Clinic (October 1, 2003)** A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.
50	**Federally Qualified Health Center** A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	**Inpatient Psychiatric Facility** A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

POS Code	Name (effective date) Description
52	**Psychiatric Facility-Partial Hospitalization** A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	**Community Mental Health Center** A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	**Intermediate Care Facility/Mentally Retarded** A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	**Residential Substance Abuse Treatment Facility** A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	**Psychiatric Residential Treatment Center** A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	**Non-residential Substance Abuse Treatment Facility (October 1, 2003)** A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
58-59	**Unassigned**
60	**Mass Immunization Center** A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.

POS Code	Name (effective date) Description
61	**Comprehensive Inpatient Rehabilitation Facility** A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	**Comprehensive Outpatient Rehabilitation Facility** A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63-64	**Unassigned**
65	**End-Stage Renal Disease Treatment Facility** A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
66-70	**Unassigned**
71	**State or Local Public Health Clinic** A facility maintained by either State or local health departments that provide ambulatory primary medical care under the general direction of a physician.
72	**Rural Health Clinic** A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
73-80	**Unassigned**
81	**Independent Laboratory** A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
82-98	Unassigned
99	**Other Place of Service** Other place of service not identified above.

Note special considerations for Homeless Shelter (code 04), Indian Health Service (codes 05, 06), Tribal 638 (codes 07, 08), and 09 Prison/Correctional Facility settings, addressed here: http://www.cms.gov/place-of-service-codes/

Appendix 2: End User Information Requirements for Client Access to the Center's SFTP Server

1. The end user will need a static, **external** IP address that will be used for authentication purposes. This will be your network's external firewall connection to the Internet or your computer's public external IP address if it has one. It cannot be an address that looks like this: **10.x.x.x** or **192.168.x.x**. If you are not sure about your address please ask your network administrator.

   External IP Address: ____________________

2. You will need to assign the account to a primary user and include the following information: name of organization, primary user's first and last name, phone number and email address.

   Name and Org: ____________________

   Phone and email: ____________________

   Provide the email address and phone number for network administrator.

   Admin contact info: ____________________

3. Please install Bitvise Tunnelier software to communicate with our server; you can download it from this link: http://dl.bitvise.com/Tunnelier-Inst.exe (you may use an existing SSH client but we will not officially support it).
4. Once we have this information your accounts will be created and you will be contacted by phone with the username and password.
5. If you have any questions please contact Byron Trotter btrotter@ucla.edu phone: 310-720-4355.

Appendix 3: BAA between UCLA and DHCS (external attachment)

The BAA is established within the contract between The Center and DHCS. This document is available upon request.

Appendix 4: LIHP Contact List (external attachment)

Please indicate who is working on the LIHP and submit to UCLA. Please add additional lines to accommodate additional personnel.

Name/role	Organization	Email	Phone Number
Project Manager			
Financial Staff			
Data Staff			
If applicable, Contractors from whom UCLA will receive data (TPA, PBM, etc)			

Appendix 5: Data Dictionary Template

LIHP: ______________________________

Time Period: ______________________________

Data Notes: ______________________________

Contact Information

Contact Person:	
Title:	
Phone (Include extension if applicable):	E-mail:

File Name: Enrollment

Description: ____________

Record Count: ____________

Position	Variable Name	Description	Type	Format	Length	Values	Comments

File Name: Utilization

Description: ______________

Record Count: ____________

Position	Variable Name	Description	Type	Format	Length	Values	Comments

File Name: Laboratory (optional)

Description: ______________

Record Count: ____________

Position	Variable Name	Description	Type	Format	Length	Values	Comments