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 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) (134-200% 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 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 or earlier. 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.

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 in 4 critical areas:

1. enrollment and retention strategies;
2. coverage expansion;
3. access to and quality of care; and,
4. transition of LIHP enrollees into Medi-Cal or the California Health Benefit Exchange starting in 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 three areas of information, including “Data Requirements FAQ”, “Appendix A: Evaluation Data Specifications”, and “Appendix B: Evaluation Publications and Products”. Stakeholder feedback has been incorporated throughout the proposal development process.
Evaluation Data and Timeline

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 on necessary measures to meet the CMS requirement.

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 #16, 17 and 18 in the “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, 13 and 14 in the attached “Data Requirements FAQ” and “Appendix A: Evaluation Data Specifications”.

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 Administrative 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. 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 June 2014, and the evaluation report will be completed in December 2014 for DHCS review and submission to CMS.

**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 via a Performance Dashboard hosted at [www.coverageinitiative.ucla.edu](http://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.
Table 1: Timing of the LIHP Evaluation

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<th>LIHP Program Year</th>
<th>Major Evaluation Activities</th>
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<td>First LIHP Program Year: 11/1/2010 – 6/30/2011</td>
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| Second LIHP Program Year: 7/1/2011 – 6/30/2012 | - Begin data collection (start July 1, 2011 and phase in data collection from each LIHP as it is implemented)  
  - Evaluation publications (Briefs 1-2, Quarterly Performance Dashboard Reports)  
  - Convening Meetings and Webinars                                             |
| Third LIHP Program Year: 7/1/2012 – 6/30/2013 | - Ongoing data collection  
  - Evaluation publications (Briefs 3-5, Quarterly Performance Dashboard Reports)  
  - Convening Meetings and Webinars  
  - Interim evaluation report in December 2012 (if required)                     |
| Fourth LIHP Program Year: 7/1/2013 – 12/31/2013 | - Ongoing data collection; Final data collection ending in June 2014  
  - Evaluation publications (Brief 6, Quarterly Performance Dashboard Reports)  
  - Convening Meetings and Webinars  
  - Final evaluation report in December 2014                                     |

In addition to the Performance Dashboard, UCLA will develop an interim report (if required by the State), a final evaluation report, and six proposed policy briefs under the evaluation. 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.

Task 1: Technical Assistance to LIHPs related to Data Collection (July 2011 to December 2011)

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. For a complete list of requested variables, please see “Appendix A: Evaluation Data Specifications” in the attached Low Income Health Program Evaluation document. 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 2: Data Collection, Cleaning and Management (July 2011 to December 2014)**

After receiving quarterly data from each of the 27 LIHPs, 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 3: Quarterly Performance Dashboard and Website (July 2011 to August 2014)**

UCLA will prepare and release findings on a regular basis, beginning in Fall of 2011. 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. 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.

Likely Performance Dashboard metrics have been suggested by LIHPs and other stakeholders, 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. 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
   - 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 4: Policy Brief #1 on Increasing Take-Up in Public Programs: Successful Strategies in California’s Low Income Health Program (September 2011 to March 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. 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. In developing this policy brief, we will focus on these evaluation questions:

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 the LIHP?
3. What proportion of LIHPs 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?

During the original HCCI program, many of the ten 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 existing LIHPs that began as HCCI counties. As more and more LIHPs are launched, sharing in best practices around enrollment will be vital to increase enrollment and prepare for 2014.

**Task 5: Policy Brief #2 on Engaging Safety-Net Patients in Care: How the Low Income Health Program is Improving Care Seeking Behaviors of Patients (January 2012 to June 2012)**

This Policy Brief 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. Possible areas of innovation include, but are not limited to, outreach and enrollment strategies to engage eligible population; increasing adherence to the
assigned medical home; encouraging continuous enrollment to minimize churn; efforts to enhance care continuity through provider network, appointment and referral system design; use of care managers or other allied health professionals to promote successful care navigation and reduction of unnecessary emergency room use; and, coordination between mental/substance use and physical health needs.

Information on the innovations implemented by LIHPs will be collected through key informant interviews. 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. In developing this policy brief, we will focus on these evaluation questions:

1. How have LIHPs successfully promoted 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)?

**Task 6: Policy Brief #3 on How California’s Low Income Health Program is Preparing the State to Enroll Individuals into the Medi-Cal Expansion in 2014 (September 2011 to December 2012)**

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. 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 Jan 1, 2014 through December 31, 2016.

This brief will discuss the Medicaid eligibility issues that have arisen in LIHPs, starting with the estimated 15-20 counties that are expected to begin LIHP on July 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.
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. The following evaluation questions will be used to guide the policy brief:

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?

Task 7: Policy Brief #4 on How California’s Low Income Health Program is Preparing the State for Implementation of the Health Benefit Exchange in 2014 (September 2011 to December 2012)

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, 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.

**Task 8: Policy Brief #5 on The Impact of Care Coordination on Health Care Utilization: Successes and Lessons Learned in California’s Low-Income Health Programs (September 2012 to April 2013)**

This Policy Brief will focus on sharing methods of chronic illness management among LIHPs, including coordination of care for mental/substance use and physical health comorbidities. This issue has come up repeatedly in conversations with the LIHPs and DHCS due to the added mental health benefits required by the LIHP-MCE. LIHPs will provide lessons learned for each other and safety net providers nationally in coordinating care for this type of population. Innovative methods implemented in LIHP will be presented, as well as best practices learned during the HCCI program.

The following evaluation questions will guide the analyses:

1. What care coordination or chronic illness management practices are used in LIHPs?
2. Have care coordination practices in LIHPs resulted in reductions in ER use and inpatient days related to chronic illness and mental health?
3. What barriers exist to providing care coordination in county systems, networks and facilities?
4. What lessons have LIHPs learned in effectively managing the complex health care needs of patients with multiple comorbid conditions?

Data will be collected through key informant interviews and linked to claims/encounter data to quantify the impact of LIHP programs to manage chronic illness and coordinate care.

**Task 9: Policy Brief #6 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 (January 2013 to June 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. 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. 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?

**Task 10: 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 11: 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.
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 will 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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1 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.