



The California Endowment



The Path to Accessing Health Coverage: Outreach, Enrollment, Retention and Utilization

Caroline Rivas, M.S.W.
Lark Galloway-Gilliam, M.P.A.
Community Health Councils, Inc.

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Policy Report

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Community Health Councils is a non-profit, community-based health advocacy, policy and educational organization. Our mission is to improve health and increase access to quality healthcare for uninsured, under-resourced and underserved populations.

SARAH AND JOHN RECENTLY MARRIED CREATING AN INSTANT FAMILY OF FIVE.

They have three children, two from Sarah's and one from John's previous marriage, and a combined family income of \$48,000. John is self-employed and Sarah recently had to cut back her work hours. As a result, Sarah is not eligible for her employer-sponsored insurance, leaving the family uninsured. Sarah's friend tells her about the Medi-Cal and Healthy Families programs. After reviewing the eligibility requirements, Sarah believes the children will be eligible for Healthy Families. She mails in the application along with her paycheck stub and John's federal income tax return from last year as proof of the family's income.

After a few weeks, the family receives a letter in the mail stating that the application for Sarah's two children has been sent to the county Medi-Cal office, and they currently have temporary free Medi-Cal coverage. Sarah is also informed that John's child's application is missing acceptable proof of income, and therefore the child is still uninsured. Sarah doesn't understand why only two of the children are enrolled and then enrolled in the Medi-Cal and not the Healthy Families program. She contacts the Healthy Families program only to learn that a stepparent's income does not count towards determining the eligibility of stepchildren. Using only Sarah's income, her children were not eligible for Healthy Families. Sarah also learned that under the Healthy Families' rules, individuals who are self-employed must not only submit a federal income tax return, but also a Schedule C or a three-month profit and loss statement income tax form.

Sarah is referred to a Certified Application Assistant¹ (CAA) near her community for help in assessing which documents she needs to submit for John's child. The CAA quickly realizes that after calculating and adding back the depreciation expenses, Sarah will need to submit a profit and loss statement in order to qualify John's child for the Healthy Families program. As they talk, Sarah tells the CAA that she is pregnant. The CAA informs Sarah of another state health coverage program, Access for Infants and Mothers (AIM), which can provide health coverage for her pregnancy. In the end, with the assistance of a community-based application assistance program and the drawing together of three different programs in California, the three children and Sarah receive health care coverage.

¹ Certified Application Assistant (CAA) is the term used by California in the Medi-Cal and Healthy Families programs for individuals who have passed the state approved certification class. For the purposes of this report, the term Assistor will be used in reference to CAAs, outreach workers, promotoras and others who assist families, unless otherwise noted.

Sarah and her family are just one family among the more than 60 million² low-income uninsured adults and children across the nation that rely upon publicly sponsored health care coverage programs. The development and expansion of these programs represents a growing commitment to reducing the economic gap for health care coverage and the number of uninsured through outreach, enrollment, retention and the appropriate utilization of health care. The most significant progress has been made in reducing the number of uninsured children. From 1996 to 2002, the number of uninsured children dropped from 23 percent to 19 percent.³ Today, more than 29 million children receive their health coverage through the Medicaid and State Children's Health Insurance Program (SCHIP) programs.⁴

The expansion of health care coverage for children has been incremental and consequently resulted in a series of independent and often incongruent systems, structures and policies that must be mitigated if we are to ensure all children are successfully enrolled and retained in available health care coverage programs. The incremental expansion and efforts to eliminate barriers to coverage are reflected in public policy defining the scope and perimeters of outreach, enrollment, retention and utilization strategies within and between programs. This policy brief will explore California's Outreach, Enrollment, Retention and Utilization policies and strategies over time. Specifically, this policy brief will outline: (1) the expansion of public coverage programs; (2) program and system improvements; and (3) the expanding role of the public and private sectors. Arising from these policies and strategies, the brief will identify future challenges and opportunities and put forward principles to strengthen Outreach, Enrollment, Retention and Utilization in California.

Expansion of Coverage Programs in California

There are three publicly sponsored and two privately sponsored health care coverage programs for children living below 300 percent Federal Poverty Level (FPL) in California. The growing number of health care coverage programs for low-income children and families has driven nationwide trends that reveal a dramatic reduction in the number of uninsured children over the past four years. California has an estimated 3.3 million⁵ children covered by the state's Medicaid program, Medi-Cal. An additional 700,000⁶ children are enrolled in Healthy Families (California's SCHIP program). As of April 2005, 73,000⁷ children have been enrolled in one of the 10 county-sponsored Children's Health Initiatives, or Healthy Kids programs. The myriad of program options reflects the incremental growth that has occurred over the past five decades to incorporate greater numbers of previously uninsured children.

² Summary Report, SCHIP: HHS Continues to Approve Waivers That Are Inconsistent with Program Goals, GAO-04-166R, January 5, 2004.

³ Kaiser Commission on Medicaid Facts, *Enrolling Uninsured Low-Income Children in Medicaid and SCHIP*, March 2005.

⁴ *Ibid.*

⁵ A 100% Campaign Fact Sheet, *Providing Health Insurance to Every Child in California*, December 2004.

⁶ *Ibid.*

⁷ Frazer, H., Wong, L., Schnyer, C., *First 5 Commissions: Key Partners in Children's Health Initiatives*, Issue Brief, Volume 5, Number 3. San Mateo, CA: Institute for Health Policy Solutions, April 2005. p. 3.

MEDI-CAL

Medi-Cal, a federal- and state-funded program, is often referred to as a “patchwork” of programs and services.⁸ Established in 1965 as a health benefit to individuals receiving welfare, over the years Medi-Cal has grown to respond to the health care needs of the uninsured as well as those of select groups with special health needs.⁹ As program eligibility was extended, it enabled the state to outreach and include greater numbers of uninsured children and families. Medi-Cal provides coverage for the largest number and most diverse needs, including pregnant women, children, aged, blind, disabled and individuals receiving cash assistance (Supplemental Security Income or CalWORKS, California’s welfare-to-work program for families) who meet specific eligibility criteria with family incomes up to 250 percent FPL.¹⁰ The expanded eligibility has resulted in additional regulations and a long and complex list of eligibility criteria.¹¹ To qualify for Medi-Cal, individuals must fall under one of the designated categories (aid codes) and within varying income guidelines (See Table 1).¹² Determining eligibility for Medi-Cal is indeed complex; for children alone, the categories, guidelines and eligibility rules vary depending upon age, income, residency status and/or participation in other cash aid programs.

Medi-Cal is the only program offering coverage to both the children and their eligible parents. The California Department of Health Services (CDHS) has responsibility for oversight and administration of the program, while eligibility determination, verification and renewal take place at the county level departments of Social Services.

HEALTHY FAMILIES

The Healthy Families program is a result of the first major federal expansion of public health coverage programs since the enactment of Medicaid. SCHIP, which was rolled out in 1997, gave states matching federal funds to either expand their existing Medicaid programs and/or establish a new children’s health coverage program. California is considered a “combo state” as the implementation of SCHIP included Medi-Cal expansions and a separate insurance program, Healthy Families. In California, legislation establishing Healthy Families was enacted in 1997 and implemented in July 1998. The Medi-Cal expansion included an asset waiver for children’s eligibility and at the time of implementation expanded coverage to 6-18 year olds in the Medi-Cal program from 85 percent to 100 percent FPL and established 12-month continuous eligibility. Healthy Families expanded coverage to children between 100 percent and 200 percent of the FPL depending upon age.¹³ In 1999, Healthy Families was expanded to cover children up to 250 percent FPL. The Healthy Families program is administered by the Managed Risk Medical Insurance Board (MRMIB) at the state level.

8 Boyle, R., Pande, N., and Lynch, L., *The Guide to Medi-Cal Programs*, Second Edition, California HealthCare Foundation, March 2004. p.2.

9 Ibid.

10 Ibid. p.4, 10. The working disabled are the only group in 250 percent FPL in Medi-Cal.

11 Ibid.

12 Maternal and Child Health Access, *Health Care Countable Income Comparison Chart (After Deductions)*, April 2005.

13 California HealthCare Foundation, *Healthy Families 101, An Overview*, January 2005. p.4.

TABLE 1. HEALTH CARE COUNTABLE INCOME COMPARISON CHART (After Deductions)

(Effective 4-1-2005 through 3-31-2006)

Number of Persons	MAINTENANCE NEED LEVEL 19 and up, also to calculate Medi-Cal Share of Cost	1931(b) RECIPIENT Parent & Children thru age 18	1931(b) APPLICANTS Parent & Children thru age 18	100% FPL MEDI-CAL Children age 6 thru age 18	133% FPL MEDI-CAL Children age 1 thru 5	TRANSITIONAL MEDI-CAL 185% FPL	200% FPL MEDI-CAL Pregnant women, infants - 1 year	250% FPL Healthy Families (except for infants born to AIM moms), Working Disabled Medi-Cal	300% FPL KP Child Health Plan, Healthy Kids, AIM, & AIM infants under age 2
1	\$ 600	\$ 398	\$ 798	\$ 798	\$ 1,061	\$ 1,476	\$ 1,595	\$ 1,994	\$ 2,393
2	\$ 750	\$ 653	\$ 1,070	\$ 1,070	\$ 1,422	\$ 1,978	\$ 2,139	\$ 2,673	\$ 3,208
3	\$ 934	\$ 808	\$ 1,341	\$ 1,341	\$ 1,784	\$ 2,481	\$ 2,682	\$ 3,353	\$ 4,023
4	\$ 1,100	\$ 961	\$ 1,613	\$ 1,613	\$ 2,145	\$ 2,984	\$ 3,225	\$ 4,032	\$ 4,838
5	\$ 1,259	\$ 1,094	\$ 1,885	\$ 1,885	\$ 2,506	\$ 3,486	\$ 3,769	\$ 4,711	\$ 5,653
6	\$ 1,417	\$ 1,229	\$ 2,156	\$ 2,156	\$ 2,868	\$ 3,989	\$ 4,312	\$ 5,390	\$ 6,468
* Count pregnant women as 2	* 2 adults = \$ 934								
Each additional person, add	\$ 14	\$ 14	\$ 272	\$ 272	\$ 362	\$ 503	\$ 544	\$ 680	\$ 815

Program Name	Income Limits and Costs
MAINTENANCE NEED LEVEL (MNL)	Medi-Cal allows families a portion of their income for living expenses, called the Maintenance Need Level or MNL. Once other eligibility requirements are met, family size and income determines whether family members can get Medi-Cal at no cost or with a Share-of-Cost (SOC). The MNL determines how much the SOC will be.
1931(b) MEDI-CAL	The income eligibility numbers are lower due to significant income deductions for "recipients." There is no Share-of-Cost with 1931(b). Families may be eligible under the 1931(b) figures or the 100% FPL figures.
HEALTHY FAMILIES	Maximum income allowed is 250 percent of the Federal Poverty Level (FPL), and families are allowed to claim the same deductions the Medi-Cal program allows. Infants (below one year) are eligible if the family income is 200-250 percent FPL. AIM infants under 2 are eligible up to 300 percent FPL.
MINOR CONSENT	Minors can receive limited scope Medi-Cal under this program for pregnancy, STD care or Mental Health services. There are no income or immigration restrictions for this program.
AGED & DISABLED	People who are 65 and older, or meet the Social Security definition of disabled, can qualify for this program if their countable income (income after allowed deductions) is less than \$1,028 for an individual or \$1,422 for a married couple (if both apply). All SSI recipients qualify for Medi-Cal.
BREAST & CERVICAL CANCER	Men or women who are diagnosed with breast cancer or women diagnosed with cervical cancer can qualify for this Medi-Cal program if their income is below 200 percent FPL.
FOSTER CARE & ADOPTION	Children who receive federal adoption assistance or foster care maintenance payments must be covered by Medi-Cal. Children leaving the state foster care program at age 18 may retain full scope Medi-Cal benefits regardless of income until they are 21.
TUBERCULOSIS	The patient's countable income must be below \$1,243 per month. Limited to outpatient TB related services.

* FPL (Federal Poverty Level) is the amount of income the federal government says a family requires to meet its basic needs. Also known as Federal Income Guideline (FIG).
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LOCAL HEALTH COVERAGE PROGRAMS

In addition to Medi-Cal and Healthy Families, counties have also responded to the growing number of uninsured by developing and implementing local health coverage programs. Despite state and federal efforts in the late 1990s to increase enrollment and expand access to these publicly funded health coverage programs, the persistent presence of uninsured children motivated local counties to take action. With the support of Proposition 10 funding, administered by the state and local First Five Children and Families Commissions (CCFC), and other funding sources, counties have expanded coverage to children with family incomes up to 300 percent of the FPL, who are ineligible for either full-scope no cost Medi-Cal or Healthy Families programs.¹⁴ Starting in 2001 with Santa Clara County, there are now 10 counties in California that offer a local health coverage program, commonly referred to as a Children’s Health Initiative (CHI). An additional 18 counties are either in the planning, implementation or launch phase of a CHI.

While each county has modeled their program after the Healthy Families program, and all seek to provide health coverage for all children, each includes features specific to the county, such as how the program is financed. Their shared goal is to provide health coverage for all children.

10 COUNTIES OPERATING CHIs

Alameda
Kern
Los Angeles
Riverside
San Bernardino
Santa Clara
Santa Cruz
San Francisco
San Joaquin
San Mateo

OTHER STATE PROGRAMS

Adding to the complexity, a number of other state programs pre-dating Healthy Families and the CHI programs have evolved to provide coverage and access to health services for low-income, uninsured children and families. These include the Child Health and Disability Program (CHDP) and Access for Infants and Mothers (AIM) program. CHDP is a preventive health program for children and youth that provides periodic preventive health services to Medi-Cal recipients and to non-Medi-Cal eligibles with incomes less than 200 percent of the FPL. While CHDP itself is not a health insurance program, it often acts as a link to coverage in Medi-Cal and Healthy Families given the eligible population served.

This also holds true for the state program, AIM, which provides low-cost health coverage for pregnant women and newborns. The AIM program targets middle-income families who do not have coverage and are unable to either qualify for no-cost Medi-Cal because of income or who have private coverage with high deductibles (more than \$500) for maternity services. For families who qualify for AIM, newborns automatically become eligible for enrollment in Healthy Families.¹⁵

PRIVATE COVERAGE PROGRAMS

There are also a number of private health coverage programs for low-income children and families who are ineligible for other coverage programs. They include CaliforniaKids (CalKids), a health coverage program

¹⁴ San Mateo Children’s Health Initiative provides coverage to families up to 400 percent of the FPL.

¹⁵ Managed Risk Medical Insurance Board, www.mrmib.ca.gov.

with preventive and primary care services for children ages 2 to 18 up to 250 percent of the FPL, and Kaiser Permanente Child Health Plan, which provides coverage for uninsured children with family incomes of 250 percent to 300 percent of FPL who are not eligible for Medi-Cal, Healthy Families, or employer coverage.

With these new programs and expansions, California has created a series of unique programs, independent systems and administrative structures to provide health care coverage for children and families. Subtle and often significant distinctions exist between regulations and eligibility criteria that drive and define the programs. Consequently, Outreach, Enrollment, Retention and Utilization (OERU) policies and strategies have developed to match the growth in the public health coverage programs and increase access for children and families.

Program and System Improvements and Integrations

Eligibility expansions in Medicaid and the introduction of SCHIP gave states the option of either expanding and integrating the newly eligible populations into a single program or introducing a new and separate public coverage program. As a “combo state”—a combination of an expanded Medicaid program and separate SCHIP (Healthy Families)—families, administrators and advocates find themselves navigating a complex series of independent systems and structures for eligibility, enrollment, renewal and care delivery. To help bridge the programs, California has implemented several OERU policies and strategies to either integrate or “work around” what are often incongruent systems, structural designs and administrative policies. This has included: 1) centralizing and coordinating the processing of applications; 2) streamlining and developing enrollment “gateways”; 3) aligning and simplifying enrollment systems; 4) using information technology to facilitate enrollment; 5) integrating enrollment systems at the local level; and 6) improving efforts to retain coverage.

CENTRALIZING AND COORDINATING THE PROCESSING OF APPLICATIONS

With the implementation of SCHIP, California developed a “joint” mail-in application for Healthy Families and Medi-Cal for Children. Prior to the joint application, Medi-Cal applicants were required to conduct face-to-face interviews at county welfare offices. The mail-in application allows families to either complete the application on their own or with assistance outside the county welfare office. The joint application also assists the family with mixed eligibility, as was the case in the introductory story, in applying to both Medi-Cal and Healthy Families. The once 28-page joint application has undergone two major revisions since its introduction and is currently undergoing a third revision to address policy changes. In addition to the joint application, the state has established a single point of entry to process the joint applications.¹⁶ The state contracts with a private vendor for the processing and tracking of applications. The application is processed by the state vendor for the Healthy Families program and transmitted to the county for Medi-Cal determination.

¹⁶ Ross, J. and Breslin, K., *Losing Ground: Declining Medi-Cal Enrollment After Welfare Reform*, California Budget Project, October 2001. p.13.

STREAMLINING AND DEVELOPING ENROLLMENT “GATEWAYS”

California has adopted innovative ways to outreach and link the enrollment of children and families to points of service of other health and social service programs, known as “gateways.” They include:

- *CHDP Gateway* allows families to pre-enroll through the CHDP provider and receive temporary full-scope Medi-Cal/Healthy Families for up to two months while an application is processed for Medi-Cal and Healthy Families.¹⁷
- *CHDP Gateway for Infants* automatically allows enrollment of deemed eligible infants under 1 year of age into Medi-Cal, without requiring families to complete a joint Healthy Families/Medi-Cal application. These infants generally remain eligible until their first birthday.¹⁸
- *Express Lane Eligibility* allows parents of children, eligible for free lunch through the National School Lunch Program (NSLP), to use information provided on the school lunch application to apply for Medi-Cal.

Maternal and Child Health Access’ Newborn Enrollment

Project, funded by The David and Lucile Packard Foundation and The California Endowment, is a direct result of many of the simplification strategies implemented for eligible infants and pregnant women over the past few years. The CHDP Gateway for Infants now enrolls more than 4,000 infants a month.

Express Lane Eligibility (ELE) was spearheaded by the 100% Campaign, a partnership between The Children’s Defense Fund, The Children’s Partnership and Children Now. ELE is currently being implemented in 10 school districts with their county partners. Some schools are funded by The California Endowment, The David and Lucile Packard Foundation and The Blue Shield Foundation.

¹⁷ Boyle, R., Pande, N., and Lynch, L. p.13.

¹⁸ California Department of Health Services, *CHDP Provider Information Notice No: 04-11*, June 16, 2004.

ALIGNING AND SIMPLIFYING ENROLLMENT

With a growing public will to reduce the number of uninsured children, efforts began at the state and local levels to align the various program requirements, simplify the enrollment process, and help families navigate the system and obtain coverage. These efforts resulted in simplifying procedures in the Medi-Cal program to further parallel Healthy Families, such as:

- Eliminating the assets test for children;
- Providing 12 months of continuous eligibility for children; and
- Eliminating quarterly status reporting for families.

CORE (County Outreach, Retention and Enrollment) is a project of six California counties working together to streamline enrollment and retention processes for children's public health insurance programs. The two-year project is funded by The David and Lucile Packard Foundation and directed by the Center for Children's Access to Health Care at the Institute for Health Policy Studies, University of California San Francisco. The CORE counties are utilizing Quality Improvement (QI) methods to identify and remove local barriers to enrollment and retention. The participating counties are Alameda, Merced, San Francisco, San Mateo, Santa Cruz and Stanislaus. As part of CORE, these counties have formed a cross-county team for the purpose of sharing information, collective learning and problem solving. Each county has also created an in-county workgroup of representatives from their social services and health services agencies, which is responsible for carrying out the QI work at the local level.

Other processes and procedures to accelerate enrollment in Medi-Cal specifically include a two-month bridge under Healthy Families; deemed eligibility for infants beyond the CHDP Gateway process; transitional continuing programs; presumptive eligibility for pregnant women; and accelerated enrollment through the single point of entry. These procedures assume eligibility through methods such as a mother's coverage, links to cash assistance programs and pregnancy as well as information received through the annual Healthy Families program review.

SEAMLESS ENROLLMENT AT THE LOCAL LEVEL

In implementing local health coverage programs, many CHIs have taken steps to ease the burden of navigating the various programs away from families to "behind-the-scenes" eligibility systems and infrastructure support.¹⁹ Many have developed "One Open Door" or "No Wrong Door" approaches that provide a single point of enrollment for multiple programs and create a single pathway for enrolling and retaining children in health care coverage.²⁰ The system moved from a "silo" culture to one offering more coordinated and streamlined assistance that allows families to access all available programs through a single contact at a range of social service venues and community settings.²¹ Additionally, the CHI coverage programs were mirrored after Healthy Families to integrate the programs as much as possible.

¹⁹ Wong, L., Frazer, H., Finocchio, L., Winterbauer, T., Schroeder, G., *Pioneers for Coverage, Local Solutions for Insuring All Children in California*, Executive Summary, San Mateo, CA: Institute for Health Policy Solutions, October 2004.

²⁰ *Ibid.* Introduction. p.13.

²¹ *Ibid.*

USING INFORMATION TECHNOLOGY TO FACILITATE ENROLLMENT

Internet and computer-based programs have been developed and introduced to support integration, reduce application errors and improve processing time. The first tool developed was Health-e-App, a Web-based application for enrolling children and pregnant mothers in Medi-Cal or Healthy Families funded by the California HealthCare Foundation. Health-e-App, with the help of CAAs, allows families to submit their information electronically, select a health plan and provider, and receive preliminary eligibility notification online.²² Pilot tested in 2001, San Diego found the number of application errors was reduced by 40 percent and eligibility determination time decreased from 18 to 13.5 days.²³ Health-e-App is currently available statewide and approximately 150 applications are submitted per day.²⁴

Building off Health-e-App, One-e-App was introduced to broaden the automated enrollment process and concept. One-e-App screens individuals for multiple publicly funded programs through a single electronic application.²⁵ One-e-App eliminates the need for families to complete numerous applications for programs that require the provision of duplicate information to determine eligibility. While not yet widely utilized, several counties are participating in the pilot phase of this program. San Mateo, Santa Clara and Santa Cruz counties are currently using One-e-App to enroll clients in a range of health care programs. Six other California counties, including Los Angeles, Sacramento and San Francisco, are assessing the requirements for and feasibility of implementing One-e-App.²⁶ This one-stop shop approach is designed to improve system efficiencies, data quality, costs and user satisfaction for families, eligibility workers, CAAs and administrators.²⁷

CDHS has also utilized technology to support integration by creating automated systems that assist with determining a family's eligibility status. They include the Medi-Cal Eligibility Data System (MEDS file) and the Automated Eligibility Verification System (AEVS). The MEDS stores eligibility and enrollment data for Medi-Cal and Healthy Families, County Medical Services Program (CMSP), Children's Medical Services (CMS), Food Stamps (FS) and CalWORKS. The Healthy Families administrative vendor maintains the Healthy Families data. The Healthy Families administrative vendor acts like a county in that both determine eligibility for their respective programs and report and update program eligibility to MEDS. Every county social services agency has access to MEDS via an interface, which allows them to check MEDS to verify Medi-Cal or Healthy Families program enrollment for children. In addition, providers are able to check eligibility status when program eligibility has been established. The AEVS is an interactive voice response system that allows providers to access Medi-Cal and Healthy Families program eligibility through the Fiscal Intermediary Access to MEDS Eligibility (FAME) system.²⁸ Using the state's Single Point of Entry Interactive Voice Response (IVR) system, CAAs can get the status of children's Healthy Families Program eligibility and the date an application was forwarded to the county for a Medi-Cal eligibility determination. Of these systems, MEDS is the most central location for program eligibility information.

²² Westpfahl Lutzky, A., Zuckerman, S., Recent Changes in Health Policy for Low-Income People in California, Urban Institute, March 2002. p.13.

²³ Ibid.

²⁴ Health-e-App, www.healthapp.net.

²⁵ California HealthCare Foundation, IHealth & Technology, One-e-App, www.chcf.org.

²⁶ One-e-App, www.oneapp.org.

²⁷ Ibid.

²⁸ Medi-Cal Automated Eligibility Verification System (AEVS) User Guide for Telephone AEVS, California Department of Health Services and Electronic Data Systems Corporation, September 1999.

RETAINING COVERAGE

As efforts to remove barriers at the point of enrollment have been implemented, state agencies have started to focus on retention. Retaining coverage is an important factor, both in terms of continuity of care and the cost-effectiveness of administering the program. Children and families often lose coverage at the time of annual renewal or when they fail to pay the monthly premiums required by some of the programs. Both Medi-Cal and Healthy Families implemented bridging policies that allow families to retain coverage while qualifying for another program when eligibility changes. Medi-Cal allows a one-month bridge for families to apply for Healthy Families. Healthy Families has a two-month bridge to Medi-Cal. Another recent effort focusing on retention was the passage in 2002 of Senate Bill 87, which was designed to reduce barriers to Medi-Cal retention by requiring counties to follow a specific process for redetermining eligibility, including ex parte reviews, direct phone contact and mail request, until eligibility or ineligibility is accurately redetermined.²⁹ In addition, Medi-Cal managed care plans must be informed of redetermination dates for children and families enrolled in the plan.³⁰ Health plans can then remind families to complete the necessary forms.

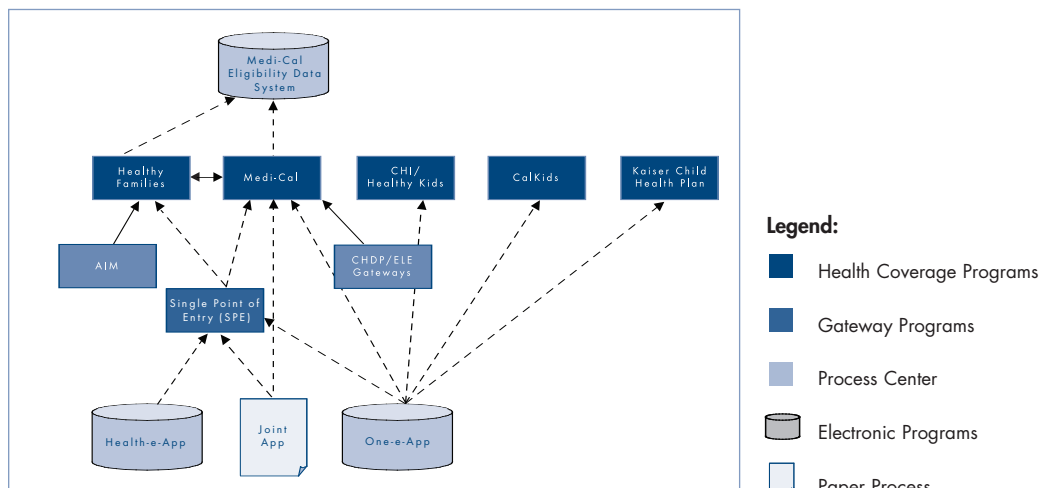
In an effort to retain those children currently enrolled in a health insurance program, some counties have created new and simplified print materials and renewal packets. These include pre-populated renewal forms; specially designed mailers for packets; contacting families by mail and/or phone to remind them of renewal; collaborating with community clinics and/or health plans to keep families enrolled; and convening retention committees.³¹

As a result of these improvement and integration efforts, California has created linkages between the programs that support the capacity to outreach, enroll and retain children and families both at the time of application and as eligibility changes. However, as Diagram A suggests, there remain significant gaps in linking the various programs. Even more evident is the complexity that these linkages have created, all with the worthy intention of increasing a family's ability to access public health coverage programs. This complexity has also led to an expanded role within the public and private sectors. While the program and system improvements and integration efforts have increased access and retention for families, the public and private sectors have also contributed to minimizing the complexity of these programs for families.

²⁹ California Department of Health Services, All County Welfare Letter, No: 02-59, December 23, 2002.

³⁰ Obernesser, W., *Promoting Medi-Cal Retention: Providing Redetermination Dates to Health Plans*, California HealthCare Foundation, September 2004. p.1.

³¹ Hughes, D., UCSF Institute for Health Policy Studies and Brewster, L., Brewster Consulting, *Keeping Eligible Families Enrolled in Medi-Cal: Results of a Survey of California Counties*, California HealthCare Foundation, October 2004. p. 3.

DIAGRAM A: PROGRAM GAPS AND LINKAGES

Expanding the Role of the Public/Private Sectors

Parallel to the simplification measures listed above, several complementary structural changes occurred to increase points of access and assist families in navigating the eligibility, enrollment and health care delivery systems. Funding, in conjunction with training and coordination, has evolved over the years to support the expansion of OERU policy at the state and local levels.

STATE AND FEDERAL FUNDING AND SUPPORT

Outreach activities began with the outstationing of County Department of Social Services Eligibility Workers. Many counties began outstationing or co-locating Eligibility Workers in agencies and organizations outside the county welfare office as early as 1970 in an effort to reach and enroll eligible children and adults into Medi-Cal.³² Under joint administration by CDHS and individual county welfare departments, in 1989 California mandated the placement of outstations at perinatal clinics and in 1990 Congress required outstationing in hospitals and Federally Qualified Health Centers (FQHC) to enroll pregnant women and children.³³ Additionally, many other public and private safety-net providers, who already treated large numbers of uninsured children and families, integrated the Medi-Cal and Healthy Families application process into the overall organizational structure of the facilities.³⁴

By the late 1990s, a number of pilot projects sprung up around the state experimenting with the use of community-based organizations to conduct outreach and enrollment assistance. The requirement that states develop a plan for outreach and enrollment and coordinate public and private health coverage programs was embedded in SCHIP funding. Contracts and grants were first developed with nonprofit community-based organizations. As incentives expanded, tax preparation agents, insurance brokers and health care providers became

³² Blackburn, J. and Aguirre-Happoldt, I., *Medi-Cal Outstationing in California: Findings from a Statewide Survey*, Medi-Cal Policy Institute, 1999. p. 1-2.

³³ *Ibid.*

³⁴ Long, P., *Local Efforts to Increase Health Insurance Coverage among Children in California*, Medi-Cal Policy Institute, February 2002. p. 5.

a part of the mix. During the past eight years, these efforts have received significant, but inconsistent funding from both public and private sources.

With the introduction of SCHIP, CDHS and MRMIB joined efforts to educate and enroll families in Medi-Cal and Healthy Families, with special emphasis on targeting hard-to-reach populations and uninsured children in the state. California allocated \$77.7 million between 1998 and 2001 for outreach and education to increase children's enrollment in the Medi-Cal and Healthy Families programs.³⁵ Media campaigns, community-based outreach efforts, and the training and use of Certified Application Assistants to help families complete an application were key components of this effort.³⁶ The state's funding and strategies included:

- **Application Assistance Fees** – \$50 payments to organizations with CAAs for assisting with an application that resulted in successful enrollment in Medi-Cal or Healthy Families and \$25 payment for each successful Healthy Families Annual Eligibility Review application;
- **Contracting with Organizations** – Working with schools and community-based organizations to increase awareness of programs and assist with enrollments, including troubleshooting with families when they have difficulties with the enrollment process;
- **Outreach Materials** – A series of posters, templates for classified ads and other materials to be used by community-based organizations, private corporate sponsors and health plans to promote the program; and
- **Non-Funded Partnerships** – Health plans participating in Medi-Cal and Healthy Families provide education, application assistance and corporations to help disseminate information.

PRIVATE FOUNDATION FUNDING AND SUPPORT

Both nationally and in California, philanthropic foundations are playing a pivotal role in OERU by supporting health coverage efforts. The Robert Wood Johnson Foundation's initiative, Covering Kids, began in 1997 as a three-year grant to 51 state and local coalitions to design and implement strategies to conduct outreach, simplify enrollment and coordinate health coverage programs for uninsured children who were eligible for Medicaid and SCHIP. In California, several foundations have provided leadership over the years for outreach and education activities and for exploring avenues to remove administrative barriers. From 1998 to 2004, The California Endowment, the California HealthCare Foundation, The California Wellness Foundation, and The David and Lucile Packard Foundation have collectively contributed over \$96.8 million towards areas for policy change, technical assistance, technology solutions and evaluation, with approximately \$12 million towards OERU activities throughout the state.³⁷ The foundations' investments and commitments to children and families accessing public health coverage programs are fundamental to the advancements made thus far and to future considerations.

³⁵ Ross, J. and Breslin, K. p.13

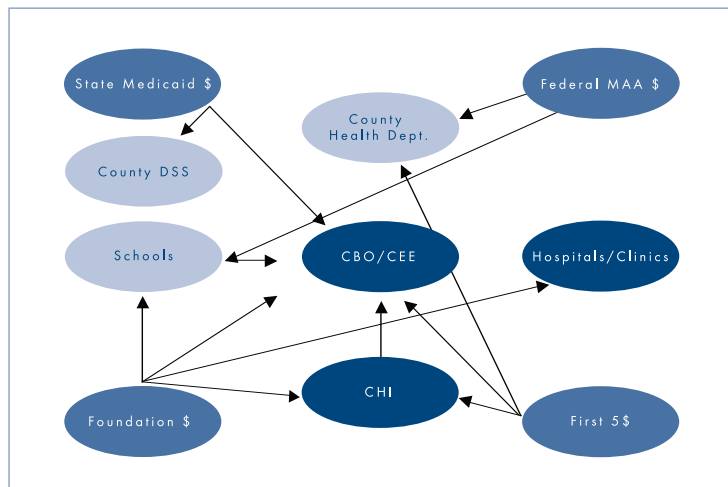
³⁶ Ibid.

³⁷ Analysis conducted by the Institute for Health Policy Solutions for The California Endowment, Spring 2004.

FIRST 5 FUNDING AND SUPPORT

In 2003, the First 5 California Children and Families Commission (CCFC) set aside \$46.5 million for an expanded health insurance program for children ages birth to 5 years who were ineligible for Medi-Cal and Healthy Families.³⁸ Of this amount, \$42.5 million was allocated to assist with premium payments for local CHIs; \$3 million for OERU activities; and \$1 million for quality enhancements and evaluation.³⁹ CCFC has not released the \$3 million to date, giving considerable thought to the distribution and utilization of funds to complement other efforts. The allocation of these funds will add another layer of support for OERU activities throughout the state. Local First 5 Commissions have committed a total of \$34 million annually to finance CHIs in nine Healthy Kids counties, which pays for premium assistance for birth to 5 years of age and other CHI activities, including OERU.⁴⁰

DIAGRAM B: PUBLIC/PRIVATE FUNDING RELATIONSHIPS



TRAINING

As state and federal support for OERU activities increased, an extensive network of organizations and individuals providing assistance emerged to support OERU activities within each county. As the number of assisters grew, so did the need for training to prepare and qualify individuals and organizations to help with the application process. State-sponsored courses provided this standardized training and certified trained individuals (CAAs). Organizations seeking the application assistance fee for helping families complete and submit applications were required to become Certified Enrollment Entities (CEE). Only a CEE was eligible to collect application fees or contract with the state.⁴¹

³⁸ Ibid.

³⁹ Ibid.

⁴⁰ Frazer, H., Wong, L., Schnyer, C. p. 2. Alameda county is excluded as they do not currently receive First 5 funding.

⁴¹ Soto-Taylor, S., *Application Assistance Fact Book*, Managed Risk Medical Insurance Board, March 2002.

Trainings were provided by the state and through contracts to organizations, such as the National Health Foundation, to meet the growing requests. Community-based organizations also assisted the state in training, even in the absence of funding. Between 1998 and 2003, more than 31,000 individuals had been trained as CAAs, and 3,200 enrollment entities were participating in outreach efforts.⁴² Training continues to be essential to OERU to ensure CAAs are knowledgeable of current programs and changes to the application process. As a result of the availability of significant funding and training for OERU, between 1998 and early 2002 60 percent of families completed and submitted applications with assistance.⁴³ These families were successfully enrolled 79 percent of the time, compared to 63 percent for families who did not utilize CAAs.⁴⁴

COORDINATION

Created with the expanded role of the public and private sectors in OERU are a series of new organizational relationships, new opportunities for participation in policy development and a growing need to coordinate activities, share best practices, and provide feedback on the success and challenges of OERU activities occurring in the state and at the local county level. A variety of collaborative efforts have developed throughout the state beginning with the enactment of the Healthy Families Program. These efforts have galvanized into statewide, regional, and local networks of public and private organizations working together to increase understanding, knowledge and capacity to support OERU in otherwise underserved populations and communities across the state.

Establishing an open dialogue between the public and private sectors interfacing with children and families is crucial to maximize the resources of all those invested in providing health coverage and access. Today a diverse cross section of state and local agencies—such as the Department of Health Services, Department of Social Services, and Managed Risk Medical Insurance Board, schools, community-based and advocacy organizations, hospitals, clinics and other agencies—connect with one another to exchange information on challenges and successes to help build and institutionalize effective strategies. Even regions serving different populations, such as urban versus rural, can learn from one another and adapt best practices to fit their needs. As illustrated in some of the projects and activities in the Appendix, the benefits of sharing best practices, strategies and networking are far reaching.

⁴² National Health Foundation, *Increasing Enrollment and Retention in Children's Health Insurance Programs Through Trained Assistors*, The California Endowment, In Press. p.16.

⁴³ *Ibid.* p.1.

⁴⁴ *Ibid.* p.1.

DISCIPLINE DEVELOPMENT

The funding, training and coordination efforts occurring in the public and private sectors allowed OERU activities to expand beyond the initial outreach to families and helping with joint applications to a full spectrum of OERU services. OERU activities now include:

- **Outreach** – The dissemination of basic information regarding program eligibility and benefits and/or any activity leading to direct contact and identification of potentially eligible children and families. This includes the use of educational materials, presentations, in-reach to an organization’s existing client/member base or the out-stationing of County Eligibility Workers or Assistors/CAAs at points of service within the community and schools.
- **Application Assistance** – Step-by-step assistance provided to families in completing one or more applications for health coverage. This includes assessing eligibility; reviewing and gathering required documentation; troubleshooting after submission of an application on behalf of the family; following-up to ensure successful enrollment/approval; and providing post-enrollment assistance with selecting health plan/provider.
- **Enrollment** – The actual enrollment of the applicant into the program and activities associated with the verification of enrollment including follow-up with the applicant and program to ensure receipt of all required documentation.
- **Retention** – Follow-up activities to assist the family with maintaining their health coverage over time, including assistance with annual redetermination.
- **Utilization** – Activities employed to encourage families to use health care services once enrolled. This includes assistance accessing services, setting appointments, changing health plans/providers and encouraging appropriate use of preventive services.

MONITORING AND EVALUATION

As the scope of services broadened, the need for tools to assess and track outcomes and effectiveness also became more apparent. Many in the public/private sector adopted systems for tracking their OERU-related work. Such systems allow for the identification of systemic trends, the evaluation of OERU efforts, the monitoring of enrollment and retention, and in some cases, the tracking of utilization. By tracking OERU activities, organizational and community capacity has been expanded for assisting and tracking families; successful OERU activities have been identified and shared for learning and duplication; and outcomes have been utilized to inform policy and practice.

The breadth of OERU policies and strategies occurring in California is phenomenal. This success can be attributed to the expansion of programs, program and system improvements, and the increasing role of the public and private sectors all with the intent to insure more children and families. However, while substantial, this patchwork of policies and strategies has created a complex system with multiple systems, program structures and funding support. To continue the progress made to date and reduce fragmentation, there are challenges and opportunities to consider when moving forward with efforts to strengthen Outreach, Enrollment, Retention and Utilization in California.

Future Challenges and Opportunities

In spite of program expansions, improvements, and increasing public and private roles in OERU policies and strategies, California still faces the reality of more than 800,000 uninsured children.⁴⁵ California needs to identify OERU policies and strategies that would further reduce the number of uninsured children to move forward. We must begin by assessing and closing the gaps and ascertaining challenges and future opportunities.

ASSESSING AND CLOSING THE GAPS

OERU policy, systems and structures in California and across the nation have developed in response to the ambivalence of government on whether its objective is to increase or limit enrollment in publicly-sponsored healthcare coverage programs such as Medi-Cal and Healthy Families. While significant progress has been made through program expansions, integration and system improvements, inherent gaps remain between the programs. These result in missed opportunities to enroll eligible children and in families losing access to coverage. For example:

- California's decision to create a separate Healthy Families program resulted in a divide between Medi-Cal and Healthy Families information and enrollment systems. The situation is compounded because California has at least four different county data eligibility systems, a separate system at the state level for enrollment and utilization data and a myriad of independent systems for the network of local CHIs and health plans. There is no central or statewide database or system to process applications for all program options. In many instances, there is no formal mechanism to refer or determine eligibility in another program, particularly the low-cost private health plans and CHI programs. In an age of medical ID cards, we have yet to integrate the various information systems. As a result, both policy and electronic interfaces must be developed to ensure families are assessed for eligibility across all programs.
- The vast majority of the information technology and infrastructure resides in and is dependent upon the public sector, and therefore not generally accessible to those within the community providing OERU assistance. Consequently, it is difficult to track and reconcile eligibility or enrollment in a timely manner.

⁴⁵ A 100% Campaign Fact Sheet.

- We continue to rely heavily on a paper application system. Many counties have introduced an application for the Healthy Kids program in addition to the joint Children’s Medi-Cal/Healthy Families application, private health plan for low-income children application forms, and the standard county Medi-Cal 210 application. The financial investment, the value and significance placed on name branding, and the variances in documentation and eligibility requirements among the programs reinforce the need for multiple applications for the Healthy Kids program and the various private children’s health coverage programs.
- While the gateways help identify and outreach to potentially eligible children and families, additional steps must be taken before the family (excepting infants) is enrolled in Medi-Cal beyond the gateway period. Families deemed ineligible must seek enrollment in an alternative program.
- The elimination of quarterly reporting, a simplification strategy that had been in place since January 2000 to support retention, was rescinded in 2003. At the urging of advocates, slightly less onerous semiannual reporting was implemented instead of quarterly reporting. The Mid-Year Status Report (MSR) was created for certain Medi-Cal beneficiaries to complete midway through the eligibility year. Pregnant women, children under the age of 21, and aged, blind and disabled beneficiaries were exempt from the MSR requirements. The state does not have data on the numbers of adults who lose eligibility each month for failing to respond to requests for information.
- If the family applies outside the county social service system, they are often unaware of the relationship to the county welfare system and its reporting requirements. In addition, for the past five years emphasis has been on outreach and enrollment policies and activities and to a lesser extent on retention and utilization. Little funding is directed towards supporting retention or helping families access and utilize their benefits appropriately. In the Medi-Cal program, approximately 20 percent of children “churn,” losing coverage and then re-enrolling, typically within four months of disenrollment.⁴⁶ Consequently, California is spending more than \$120 million to re-process these children. This cost includes outreach and eligibility determination at the county level, enrollment broker costs, and health plan costs for processing new members. This gap in health care for children can pose a risk to the child’s health and well-being.

Coordination, quality and compliance can be a challenge given the multiple structures for administrating the various programs. For example, while CDHS is responsible for developing administrative guidelines, county social service personnel are charged with implementation. This can result in 58 different practices and interpretations of policy.

⁴⁶ Fairbrother, Gerry. *How Much Does Churning in Medi-Cal Cost?*, Cover California’s Kids, The California Endowment, April 2005.

Furthermore, when California implemented Healthy Families as a separate children's program, the decision was made to contract out many of the administrative functions including the screening of applications; forwarding applicant information to the appropriate program; Healthy Families eligibility determinations; premium collection; and annual eligibility review. The benefits of this model are that California reaps the rewards of having a state-of-the-art eligibility system. It can also implement changes more efficiently; negotiate expanded services for the families applying and children enrolling in the Healthy Families program; and bargain competitive rates to generate cost savings to the state. The challenge to this model is that the state relies on the contract vendor's proprietary computer system and is therefore placed in a tenuous position should it wish to change contractors or place additional requirements on the contractor.

Another consideration is the continued bifurcation of the enrollment in Medi-Cal managed care. The state contracts with a private vendor for the Health Care Options program, which helps families select and enroll in a health plan under the Medi-Cal managed care program. Millions of dollars are spent on enrollment in managed care outside of the conventional OERU policies and strategies.

CHALLENGES

Since 2002, more than 600,000 children have enrolled in Healthy Families, while Medi-Cal enrollments have increased by approximately 1.2 million, including more than 400,000 children.⁴⁷ Since then, the economic and political climate in California has shifted, challenging advancements in OERU policy. State budget shortfalls have meant the loss of state revenue to the counties through realignment and funding for community-based OERU activities. In FY 2003-04, the state dropped support for OERU when it cut \$20 million from the Medi-Cal/Healthy Families social marketing/media campaign and \$12 million from application assistant fees and community- and school-based contracts. Today the enrollment level for Healthy Families continues to increase but at a much slower rate. This reduced growth is a result of the elimination of state funding for OERU activities. In the absence of state funding, 83 percent of the joint Medi-Cal/Healthy Families mail-in applications are processed without assistance. This increase in applications submitted without assistance has resulted in a rise in incomplete applications, delaying enrollments and increasing initial denials of eligibility due to missing information.⁴⁸ Public and private sector assistors have proved essential for outreach and enrollment across the state, particularly in the absence of a social marketing or community education campaign.

Incentives and disincentives are also embedded within the various systems of reimbursement. The \$50 application fee can serve as a disincentive to providing a comprehensive range of services in the interests of cost and time. There is also an increasing use of performance standards for counties and state regulations that have changed over time depending on the state's financial situation.

⁴⁷ The Kaiser Commission on Medicaid and the Uninsured, *Total Medicaid Enrollment in 50 States and the District of Columbia*, June 1997 to June 2003, www.kff.org.

⁴⁸ National Health Foundation.

Since the loss of state funding, the majority of OERU activities have been funded by private foundations, local CHIs and county First 5s, among others. Most of these funding sources have competing demands for dollars and/or represent limited funding streams, which are expected to diminish over time. Local CHIs are beginning to struggle with financing the expanded county health coverage programs and supporting OERU activities. As seen in Los Angeles County, OERU activities have enabled the county to enroll nearly 40,000 children in the Healthy Kids programs in less than two years. The need far exceeded the resources, forcing the L.A. CHI to hold enrollments for 6-18 year olds in the Healthy Kids program. Other policy proposals have posed threats to further complicate rather than simplify the system. This included Gov. Arnold Schwarzenegger's FY 2004-05 budget plans to reform the Medi-Cal program by implementing multiple eligibility tiers, co-pays and managed care expansion. Strong opposition to these plans moved the state to withdraw Medi-Cal reform from the FY 2004-05 budget in order to develop a more strategic plan. In the 2005-06 budget, the Governor once again proposed reforming the Medi-Cal program. However, the proposal was on a smaller scale than in 2004-05: eliminating the tiered system, although continuing to impose co-pays, managed care expansion and benefit caps. Once again, many elements of the proposal were rejected with the exception of expanding the use of managed care for families and children into 13 additional counties.

In July 2005, the premiums paid by families in the Healthy Families program increased from \$4 and \$9 per child and a maximum of \$27 for three or more children to \$12 and \$15 per child and a maximum of \$45 per month. The experience of other states demonstrates that increasing premiums results in high drop-out rates.⁴⁹ It is critical that a system of support be in place to prevent the loss of care as families enroll in and drop out of the program.

OPPORTUNITIES

Pushing back against the pressures of the state budget and complexity of the system are statewide policy efforts to ensure all California children have access to health coverage, streamline the children's coverage programs and create a "one open door" approach for children enrolling in and retaining coverage. The policy campaign Californians for Healthy Kids would establish one program for children, with Medi-Cal and Healthy Families falling under this umbrella. It is being led by the 100% Campaign and Pacific Institute for Community Organization (PICO California). From the family's perspective, the system would be seamless as funding and administrators would be behind the scenes. While the Governor vetoed the children's health legislation in October 2005, the 100% Campaign and PICO California are continuing efforts to cover all California children on 2006, including legislation that was introduced this year and currently awaits action through the state assembly.

With the rising number of counties establishing local Children's Health Initiatives and coverage programs, the capacity to outreach and provide coverage to children currently ineligible for publicly-sponsored programs and for greater coordination within counties increases. The policy decision to permit local CHIs to "buy into" the Healthy Families program rather than attempt to establish an independent system and structure is in the FY 2005-06 budget and in discussions underway at the state level.

⁴⁹ Community Health Councils, *The Myths of Medi-Cal Redesign Goals, Medi-Cal Reform*, July 2004.

Technology, specifically the One-e-App, holds promise for creating a single screening tool to assess eligibility for the full range of health care coverage programs and other county services. The system has been piloted and is operational in several communities. One-e-App is a user-friendly system that allows for “real-time” selection of a provider and health plan and submission of an application for eligibility determination. The system allows Application Assistants to view their clients’ verification documents within minutes of faxing them into the system. This technology will not only help bridge the divide between the assistor on the street, but also link the referral and transmission of applicant information between both the public and private programs.

Technology within the county eligibility systems is also progressing. Welfare automation in the 58 California counties is provided through one of the four Statewide Automated Welfare System (SAWS) consortia. SAWS is a major automation initiative managed by the state to support county welfare administration. All 58 counties are expected to be operational under SAWS by July 2006.

In addition, as a result of a corporate merger between Anthem and Wellpoint, the state has committed \$5 million in general fund expenditures for the next three years beginning in FY 2005-06 to reinstate the \$50 application assistance fee. While this will help rebuild a portion of the state’s capacity for outreach and enrollment in California, any future funding allocation must include a system of financial support for both grants and fee-based funding opportunities to reinforce standards for the full spectrum of OERU activities. Given the three-year limit on this funding commitment, these funds must also be part of a larger financial strategy. The state is currently exploring a number of options to increase the federal contribution to health care costs in California. It is important to stabilize funding in this area to meet continuous demand. Funds for outreach and enrollment should be used to leverage and coordinate all funding currently designated for outreach and enrollment at the state and county level, and an effort should be made to explore how this fund could be used as a Certified Public Expenditure to draw down additional federal dollars under AB 495 and other initiatives.

NEXT STEPS

California is on the brink of providing health care coverage for every child under 300 percent FPL. Both the capacity and public will exist. To move forward, steps must be taken to: (1) improve the existing OERU program policy, systems and structures to maximize opportunities for positive outcomes for children; and (2) develop a seamless, efficient health care coverage system that encourages continuous enrollment over time and facilitates access to services. This requires a parallel process to ensure improvements made today support and advance the goal of a seamless system. These issues need to be addressed sequentially because design decisions about program integration influence quality improvement activities, funding and sustainability. This leads to two potential and immediate areas of inquiry. The first pertains to OERU program policy and systems design. The fundamental questions going forward are:

- How do we build an integrated system that facilitates and brings children and families into the system as opposed to screening them out?
- What capacity must exist to achieve an integrated system?

- How do we build capacity and access in the health delivery system?
- How do we align the public and private sector incentives to ensure quality and comprehensive services?
- What is the role of technology?

The second line of inquiry and discussion pertains to OERU activities and the role of the public and private sectors. This should include questions such as:

- How can we reduce duplication, “churning” and achieve cost efficiencies without reducing access and participation?
- How do we evaluate and identify effective strategies and interventions?

There is also an urgent need to develop a comprehensive logic model for OERU within the context of the children’s health care financing system. This would allow practitioners to identify the most important leverage points in the system that will facilitate access to health care for all children. It is likely that some of these points will rest in the policy arena, some will be governed by administrative regulations and others are unique to circumstances in a given community. One of the hallmarks of OERU policies and strategies has been the ability to nimbly adapt to a constantly changing environment. Today, the future lies in:

- Program Integration and Coordination
- Public and Private Sector Coordination
- Technology
- Monitoring and Evaluation
- Funding and Sustainability
- Training.

Appendix

The following programs and activities are examples of coordination efforts in the public and private sectors occurring throughout California to elevate OERU and increase the number of insured children and families.

SCHOOL SYSTEMS

Teachers for Healthy Kids is a partnership between the California Teachers Association and the California Association of Health Plans to increase awareness among teachers and school staff of the importance of health coverage for children and the available options. A key phase of the project, funded by The California Endowment, involved the education of 300,000 California Teachers Association members and staff about children's health insurance issues. Approximately 10,000 teachers statewide were given classroom resource kits with flyers outlining local enrollment information to distribute to parents. To date, the project has supplied outreach materials to more than 78 school districts. The project also encourages districts to coordinate efforts with other Medicaid Administrative Activities⁵⁰ (MAA) billing to assure sustainability of the program. More recently, the project has expanded to coordinate its Express Lane Eligibility sites, the League of California Cities and the local CHIs to expand health coverage opportunities for children.

Connecting Kids to Healthcare Through Schools (Connecting Kids) is a partnership of The David and Lucile Packard Foundation, the Public Health Institute and MRMIB. Connecting Kids largely focuses its efforts statewide in educational settings to increase schools' involvement in the OERU process and to promote the enrollment of children and youth in the available health coverage programs. Connecting Kids serves as a resource for schools, state and local level partners, health plans and other organizations involved in promoting enrollment, retention and utilization of health care services. Connecting Kids developed a series of tools to help school districts identify and outreach to uninsured children and families. Districts can request and receive a Request for Information (RFI) Flyer in 11 different languages to disseminate in back-to-school packets, at back-to-school nights and with the free and reduced-price meals in the NSLP meal application. Since 1999, more than 550 schools, community-based organizations and local partners have used the RFI process to reach out to families and inform them about children's health insurance options. Each year approximately 50,000 forms are returned to the state by parents requesting information and applications for the state-sponsored health insurance programs.

Consumers Union's Healthy Kids, Healthy Schools is a project that has worked with school districts across the state to develop OERU projects. The project has offered tools such as an outreach manual that provides schools and community-based organizations with information on how to develop OERU and how to sustain their efforts through federal reimbursement programs like MAA. Other tools include the Healthy Tracker, a database developed to help programs monitor their OERU efforts. Approximately 300 entities use Healthy Tracker. The project offers a Web site that provides information on school- and community-based programs in California and across the nation. Currently, Consumers Union is working to improve the MAA program to ensure greater school district participation and draw down more MAA dollars for the state.

⁵⁰ Medi-Cal Administrative Activities provides reimbursement from the federal Medicaid Program for outreach and other health-related activities performed by agencies and schools.

CHILDREN'S HEALTH INITIATIVE

The **Los Angeles Children's Health Initiative (L.A. CHI)** was the sixth Healthy Kids program launched in the state. L.A. CHI drew upon the experience and expertise of others in the field to develop the county's Healthy Kids program. L.A. CHI opened enrollment for children ages 0 to 5 in July 2003, scaling up to 0 to 19 in mid-2004. As part of its \$100 million commitment over five years to Healthy Kids, First 5 Los Angeles has allocated up to \$4.7 million per year for OERU efforts in Los Angeles. The L.A. CHI fundraising workgroup is actively seeking support for coalition activities. UniHealth Foundation has supported the feasibility assessment for One-eApp and has taken the lead in identifying funding for implementation. The Los Angeles Department of Health Services (DHS) has submitted a MAA claiming plan to the state and sub-contractors have begun to time study. The Keck Foundation has supported training for CAAs, enabling the training contractors to develop new modules on retention, trouble-shooting, and others. This grant has enabled L.A. to view training as a continuing education opportunity rather than a one-time activity.

The Children's Health Outreach Initiatives (CHOI) project of the L.A. DHS administers this OERU component of Healthy Kids, contracting with 15 community-based organizations. The L.A. DHS contractors provide comprehensive OERU services to families, screening all family members for the full range of free or low-cost health coverage programs for which they may qualify. Since the beginning of the First 5 L.A. OERU grant (July 1, 2003) through March 31, 2005, DHS contractors have assisted almost 53,000 clients with enrollment in Medi-Cal (54%), Healthy Families (23%), Healthy Kids (21%), and other programs such as AIM, Kaiser Child Health Plan, etc. (3%). The California Endowment (The Endowment) also provides funding to 16 organizations in a similar OERU project in L.A., and L.A. DHS and The Endowment work closely to ensure that the projects complement each other.

The L.A. CHI provides a forum for coordination and building support among the various funders, stakeholders and community interests. The L.A. CHI, like many others, is a collaborative process that includes advisory committees, workgroups and public/private partnerships. One of the CHI's workgroups, Program Integration, is charged with recommending system changes to achieve the "no wrong door" approach to enrollment. The group is chaired by the Director of the Children's Health Outreach Initiatives. It has worked on Healthy Kids' operational issues such as ensuring that children with temporary Medi-Cal coverage via the CHDP Gateway are not denied coverage when they apply for Healthy Kids; ensuring that pharmacy co-pays do not affect utilization for children with chronic health conditions; simplifying the redetermination process to make it semi-passive; and making recommendations for the implementation of the enrollment cap for 6-to 18-year-olds. The workgroup has also focused on identifying high-yield enrollment opportunities. One such opportunity is identifying the easiest possible way to enroll children who currently have limited scope/emergency Medi-Cal into Healthy Kids, as these children are almost certainly all eligible. The workgroup began by coordinating with the Department of Public Social Services (DPSS) to mail Healthy Kids information to all families of children ages 0 to 5 with emergency Medi-Cal. It is now working with DPSS and L.A. Care on a simplified enrollment process that would enable families to use their emergency Medi-Cal information to serve as a Healthy Kids application.

Even the monthly DHS contractor meetings provide a forum for agencies to enhance the services they provide to clients. In addition to solving problems and sharing best practices, contractor meetings have featured guest speakers on subjects like the Earned Income Tax Credit, Healthy Rebates for low-income families who purchase health insurance, First 5 California's New Parent Kit, the Healthy Parks initiatives and others. Contractors have used this information to identify new venues for outreach or to provide referrals for additional services to their clients.

The Endowment grantees conducting OERU also convene as part of the L.A. Access Coalition. The Coalition provides a forum for these organizations to share best practices, meet with key county administrators and discuss policy issues impacting children and family health. Coalition members have been able to resolve policy and practice issues as well as enhance OERU activities and efforts.

Highlights

- CHC's Accessing Benefits for Children (ABC) outreach project, a community-based contractor with the L.A. CHI, has found that by partnering with sites where families frequently gather or seek health and social services, assistors can set regular schedules and be available at these sites to help families complete and submit applications. Such partnerships have enabled ABC to complete and submit an average of 50 applications per month. Families develop trust with these assistors as they associate them with a setting they are already familiar with. Without these partnerships, assistors would have to spend additional time and resources on locating families eligible for programs, building trust from the ground up with each family, and scheduling multiple appointments to obtain the documentation needed to complete health coverage applications.
- Citrus Valley Medical Center's GEM project uses a large network of volunteers, or *promotoras*, to reach and educate eligible families about their health insurance options. These promotoras walk in neighborhoods where uninsured people are likely to reside. Going door-to-door, promotoras talk to families one-on-one to describe the benefits of insuring their children. The promotoras encourage families to enroll in appropriate health coverage programs, drop off applications and offer instructions to the family to call the agency for assistance, or make an appointment for them to go into the office. This agency also uses volunteer students needing work experience to assist with routine filing, office work and staffing outreach venues. The ability to have additional unpaid staff frees up trained outreach/enrollment staff to conduct the bulk of the enrollment and follow-up services.
- The L.A. DHS and The Endowment contractors also use a data system developed by L.A. DHS called the Children's Health Outreach Initiative (CHOI) system. This data system allows contractors to input client-level data, receive automated reminders about follow-up, run in-house workload reports, run data cleaning reports to ensure accuracy of data, and submit monthly reports to L.A. DHS electronically. The system allows L.A. DHS to view aggregate data (all client-specific data is encrypted and cannot be viewed by L.A. DHS) on a full range of progress indicators. Use of the system allows DHS to monitor agencies' progress on outreach, enrollment assistance, verification and client follow-up so

they can provide any needed technical assistance on a timely basis. The system also allows L.A. DHS to detect trends and program-wide issues so that they can be discussed at contractor meetings and action can be taken to resolve issues. The system also allows L.A. DHS to identify top performers in the various activities that contractors perform, so they can share their best practices with the group. For example, some agencies excel in assisting a high number of families, while others excel at follow-up and enrollment confirmation.

- From the perspective of L.A. DHS, use of CHOI has enabled quicker identification of program-wide problems and appropriate follow-up action. The system showed, for example, that it was difficult for agencies to confirm the final application status at the 90-day, follow-up point, but that eventually agencies were confirming the enrollments. This led L.A. DHS to identify agencies with high confirmation rates to share their best practices, to discuss as a group what methods agencies were using, and to provide an in-service on Medi-Cal Eligibility Data System (MEDS) and Automated Enrollment Verification System (AEVS) as methods for verifying enrollment electronically.

STATEWIDE COALITIONS

California Covering Kids & Families (CKF) is a network of local and state agencies, CBOs, children and health care advocacy organizations from across the state working together to increase enrollments of uninsured children and families via statewide and local coalitions. As part of the national initiative funded by the Robert Wood Johnson Foundations (RWJF), Community Health Councils (CHC) implemented the project in 1998. CHC is a nonprofit community-based health promotion, advocacy and policy organization based in Los Angeles. The statewide and local coalitions examine outreach, simplification and coordination strategies to improve access of public health coverage programs. CKF provides a vehicle to examine all opportunities to expand coverage and reduce barriers to enrollment in health coverage programs. Today, the coalition is composed of more than 100 members representing 80 different organizations throughout the state. These organizations, many of which are mentioned in this report, collectively represent the 27 counties where approximately 90 percent of uninsured children and adults reside.

The coalition provides a structure to maximize lessons learned locally, capitalize on the expertise of members and create an ongoing forum for dialogue among local and state agencies, advocates and professional associations. CKF also supports four local coalitions in Lake, Fresno, Riverside and Humboldt/Trinity/Del Norte counties. The four regional coalitions provide an opportunity to test programs and assess policy implementation at the local level.

The formation of the statewide and local coalitions has proved to be an enduring strategy for coordination and system improvements. The CKF coalition is committed to improving OERU policies and strategies. It focuses on coordinating stakeholders' information sharing, facilitating interagency collaboration, providing a mechanism for feedback, and testing consumer experiences with systems and policies. The coalition achieves its goals by: holding bimonthly meetings; hosting forums that provide opportunities for dialogue and sharing; engaging state agencies in coalition activities; informing on lessons from other states; identifying problems; and developing recommendations collaboratively. The CKF coalition has provided valuable insight and feedback for system improvements in areas including written materials and notices of action sent by the state to families regarding program requirements; the implementation of the CHDP gateway; the single point of entry; and previous media campaigns.

CKF has organized a series of statewide conferences and workshops on best practices bringing together more than 300 outreach and enrollment programs to examine strategies and lessons learned from OERU stakeholders throughout the state. Forums, such as the Children's Health Coverage Summit, engaged the First 5 California Children and Families Commission, local CHIs and other OERU stakeholders to dialogue and raise recommendations for maximizing and expanding children's coverage in the state.

Highlights

- Solano Kids Insurance Program (SKIP), implemented in 1998, is a centralized one-stop health insurance resource for families. SKIP is a program of the Solano Coalition for Better Health (SCBH). SKIP OERU strategies have included marketing and events, schools, clinic/CHDP, business, faith-based and retention. To date, 29 schools have reached 100 percent health insurance enrollment in the county. SKIP's success in schools can be attributed to working partnerships with superintendents, school nurses and the county Office of Education as well as the strong health and community partnerships established through SCBH. Overall, Solano County has raised the level of awareness by sharing a vision with partners, institutionalizing a variety of best practice models and strategies, and maximizing and leveraging funds. Solano County currently has one of the lowest rates of uninsured kids in the state, estimated at 4.2 percent.
- Community Health Councils (CHC) developed a tracking method and database for the CKF regional projects and CHC's ABC program to inform both program and policy trends. The data collection tools include forms for assistors to capture basic client information; to monitor enrollment and utilization follow up activities at 30 and 60 days, six months, 11 months and 13 months; to follow up on outreach activities; and to document progress notes to manage more complex cases. The database mirrors the forms and allows the projects to track number of applications, enrollments, barriers to enrollment, follow-ups and assess program performance. CHC is able to compile data and conduct additional analysis to assist in program management, evaluation and further inform program design and policy development.

The ability to monitor program activities has proved very useful. Early on, program reporting in CKF showed Sutter Lakeside Community Services that their strategy of door-to-door outreach in targeted areas of rural communities was ineffective. In such a rural region, distance and transportation challenges often limit a family's access to organizations offering assistance. By moving to providing information and assistance at hospitals, clinics, schools and WIC sites as areas more accessible to families, the program's successful outreach increased by 40 percent.

- North Coast Clinics Network (NCCN) learned of the Express Lane Eligibility (ELE) School Lunch Program at a CKF coalition meeting in January 2004. NCCN used this information to facilitate the creation of a Memorandum of Understanding (MOU) between the county-wide Del Norte Unified School District and the county's Department of Social Services (DSS). Within months they implemented the program in Del Norte's seven schools consisting of 5,500 students. The collaboration between the school district and DSS proved to be a success and NCCN outreached to over 600 children with approximately 10 percent enrolling in Medi-Cal. As NCCN assists with renewing the MOU between Del Norte and DSS, they have taken what they learned from this first phase and tailored the state school lunch application to prevent families from applying for health coverage when they are already insured by Medi-Cal/Healthy Families. The second phase, beginning in August 2005, will include revised packets with health coverage information. NCCN will continue to monitor their outreach and enrollment numbers, utilizing the CKF database, and make any necessary modifications for improvements.
- The Fresno Health Consumer Center (FHCC), along with other stakeholders, has been in the planning stages for the past 18 months to implement a local CHI. FHCC has played a leading role in the CHI Steering Committee and their local OERU Committee. The funding received from the California *Covering Kids and Families* project has enabled FHCC to focus on the issue of children's health coverage. Fresno's local CHI will use many of the case management processes created by FHCC to follow up with families to ensure that coverage is in place, benefits/services are used and coverage is maintained. Fresno's CHI will offer a "no-wrong-door" approach. Fresno's CHI also met with the local MAA coordinator and staff to determine the feasibility of participating in the annual time study to draw down MAA funds for local outreach and enrollment efforts.

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Foundations referenced in this report

The California Endowment, www.calendow.org

California HealthCare Foundation, www.chcf.org

The California Wellness Foundation, www.tcdf.org

The David and Lucile Packard Foundation, www.packard.org

The Robert Wood Johnson Foundation, www.rwjf.org

Covering Kids & Families, www.coveringkidsandfamilies.org

Federal and state agencies and programs referenced in this report

California Department of Health Services, www.dhs.ca.gov

CaliforniaKids, www.californiakids.org

First 5 California Children and Families Commission, www.cffc.ca.gov

Kaiser Permanente Child Health Plan, www.kaiserpermanente.org

Managed Risk Medical Insurance Board, www.mrmib.ca.gov

U.S. Department of Health and Human Services, www.os.dhhs.gov

Established county Children's Health Initiatives/Healthy Kids programs referenced in this report

Alameda, www.alamedaalliance.com (administrator)

Kern, www.kccfc.org

Los Angeles, www.chigla.org

Riverside, www.iehp.org (administrator)

San Bernardino, www.iehp.org (administrator)

Santa Clara, www.chikids.org

Santa Cruz, www.scchealthykids.org

San Francisco, www.sfhp.org (administrator)

San Joaquin, www.hpsj.com (administrator)

San Mateo, www.smchi.org

Advocacy, community-based and other(s) organizations and programs referenced in this report

Community Health Councils, www.chc-inc.org

- Accessing Benefits for Children
- California Covering Kids and Families
- Los Angeles Access to Health Coverage Initiative

100% Campaign, www.100percentcampaign.org

- Californians for Healthy Kids

The Children's Partnership, www.childrenspartnership.org

- Express Lane Enrollment

Children's Defense Fund, www.childrensdefense.org

Children Now, www.childrennow.org

Center for Children's Access to Health Care at the Institute for Health Policy Studies, University of California San Francisco.

- CORE Project, www.coreproject.org

Connecting Kids to Healthcare Through Schools, www.connecting-kids.com

Consumers Union, www.consumersunion.org

- Healthy Kids, Healthy Schools

Citrus Valley Medical Center, www.cvhp.org

Fresno Health Consumer Center, www.healthconsumer.org/Fresno.html

Institute for Health Policy Solutions, www.ihps.org

- The Child and Family Coverage Technical Assistance Center (CFCTAC)

Pacific Institute for Community Organization (PICO), www.piconetwork.org

Maternal and Child Health Access, www.mchaccess.org

National Health Foundation, www.nhfca.org

North Coast Clinics Network, www.northcoastclinics.org

Resources

Los Angeles Department of Health Services, www.dhs.co.la.ca.us

Health-e-App, www.healtheapp.net

One-e-App, www.oneeapp.org

Solano for Better Health Coalition <http://skip.solanocoalition.org>

- Solano Kids Insurance Program (SKIP)

Sutter Lakeside Community Services, www.slics.org

Teachers for Healthy Kids, www.teachersforhealthykids.com

***Additional OERU resources and stakeholder organizations**

California Welfare Directors Association, www.cwda.org

First 5 Association of California, www.f5ac.org

Health Access, www.health-access.org

Health Consumer Alliance, www.healthconsumer.org

Latino Coalition for a Healthy California, www.lchc.org


Local Health Plans of California, www.lhpc.org

People Acting in Community Together (PACT) www.pactsj.org

Riverside County Department of Health Services, CKF project, www.rivcoph.org

Western Center on Law and Poverty, www.wclp.org

* This is a partial listing. Many communities and organizations throughout the state have made significant contributions to reducing the number of uninsured children and families in California.



Cover California's Kids

The California Endowment
1000 North Alameda Street
Los Angeles, CA 90012
1.800.449.4149
www.calendow.org

For more information about Cover California's Kids, please visit www.covercaliforniakids.org