PACIFIC HEALTH CONSULTING GROUP LLC

72 Oak Knoll Avenue
San Anselmo, California 94960

Phone 415-459-7813 • Fax 415-459-1541
bwunsch@pachealth.org

Assessment of Enrollment and Retention in Healthy Families and Medi-Cal for Children

A Report to the Contra Costa County Administrator

Prepared by Bobbie Wunsch
Pacific Health Consulting Group

September 15, 2002

Assessment of Enrollment and Retention in Healthy Families and Medi-Cal for Children

Executive Summary

This report provides recommendations for Contra Costa County's outreach, enrollment and retention activities for the Healthy Families and Medi-Cal programs.

As the Contra Costa Board of Supervisors has understood for a long time, children's access to health care is important to children themselves, to their families, as well as to society at large. Health care can influence children's physical and emotional health, growth, and development and their capacity to reach their full potential as adults, and be contributing members of their communities. All children are at increased risk of developing preventable conditions if appropriate care is not provided when they are sick or injured. When children fail to receive necessary health care, their lives and the lives of their families can be affected for many years, as well as potentially become a burden on already stretched and limited county resources.

Access to health care services dramatically improves within 12 months of health insurance enrollment. One study showed that at 12 months, 99% of the children had a regular source of care and 85% had a regular dentist. The percentage of children reporting any unmet need or delayed care in the past six months decreased, the percentage of children seeing a provider increased and the proportion relying on the emergency room decreased. Parents also related a significant decrease in stress, which has important implications for education because the well-being of the entire family can be critical to a child's readiness to learn.

An impetus for the drive for enrolling as many children as possible into health insurance programs is the link between health insurance and school performance. According to *The Link Between School Performance and Health Insurance: Current Research*, from the Consumers Union, good health is connected with improved school performance and having health insurance is linked to better health. Poor health has been found to affect school performance in many ways, including contributing to absenteeism, affecting concentration level in the classroom, producing disruptive behavior, and affecting students' abilities to participate in extracurricular activities. Access to health insurance is a solution to many of society's concerns, while also improving the quality of life for individual children and families.

The Board of Supervisors requested an outside assessment of the county's outreach and enrollment initiative, to better understand the effectiveness of the system. This report's recommendations focus on how to enhance the effort to make in more effective in the long run. Healthy Families and Medi-Cal are two complex state programs funded

in part by the federal government, whose goals are to provide coverage and access to health care for low income children. Contra Costa County undertook a significant process with a large number of partners to reach out to as many children as possible, enlisting major foundation support to launch the process. Given the significant strides already made, it is important that the county continue to work in partnership with the state, which must make its own changes to make the program better, and with local partners, who must continue to stay as involved as they have been.

This report provides recommendations and review of information on the following:

- Organizational structure for the Contra Costa Outreach and Enrollment program, including organizational functions, reporting structures, accountability, integration and coordination among and within County divisions and departments.
- Integration of Healthy Families enrollment and Medi-Cal eligibility
- Best practice models for streamlining and, where possible, integrating with community-based efforts
- Analysis of Contra Costa County Medi-Cal and Healthy Families continuation rates compared to other California counties and with commercial insurance programs.
- Retention strategies in Medi-Cal for Children and Health Families
- Participation in Health-e-app.

The analysis of findings and recommendations is based on the following:

- meetings with Contra Costa County staff to review assumptions and current program performance, key indicators, and major issues, to present analysis of key data elements, to review recommendations and discuss implications for program changes;
- review of written materials, staffing plan and data regarding enrollment activities, targets and last three years' performance in Medi-Cal and Healthy Families outreach and enrollment in Contra Costa County;
- site visits of a sample of community-based enrollment and outreach sites as well as county sites, including meetings with key staff at each site, to gain understanding of key issues on the ground;
- feedback solicited from current outreach, enrollment and eligibility workers to gain further insight into key issues;
- assessment of feasibility of participating in Health-E App for Contra Costa County; and
- review of best practices throughout California and a survey of other counties outreach, enrollment and retention efforts.

A. Planning Assumptions

- Having health insurance and access to health care services is a key determinant of good health for children. The County of Contra Costa should embrace this concept in every possible way, at every point of entry for children into the system.

- There are four key components to a successful health insurance program:
  1. outreach to eligible individuals without insurance or without adequate insurance,
  2. enrollment of eligible individuals/families into the most comprehensive insurance program available,
  3. retention of enrolled individuals/families in insurance and
  4. access to and utilization of health care services for those who enroll.

- The Medi-Cal/Healthy Families outreach and enrollment program needs to be integrated fully in an ongoing way into the infrastructure of the Contra Costa Health Services and into other relevant departments throughout county government. Building ongoing outreach, enrollment and retention efforts into the infrastructure of the county's programs should be the goal of this effort. As new children enter the system, whatever the system may be, regular ongoing pro-active measures should assure that families have been screened, children enrolled in one of the public coverage or insurance programs, and utilization of services secured.

- The key points for integrating this effort are Contra Costa Health Services – Financial Counseling, Public Health, Contra Costa Health Plan, Mental Health Services, Community Services Department, and Employment and Human Services Department.

- State funds that currently support a majority of the outreach and enrollment activities will probably not continue. They will either be dismantled totally in the impending state budget or be reduced dramatically. Reliance on these funds to support this program's sustainability cannot be counted on.

- Every client accessing any type of services in the county, but particularly in Health Services or EHSD, should be asked whether or not he/she has health insurance. If the answer is "no", the client should be screened for the appropriate program at that time.

- Utilization of health care services is an important ingredient in retaining health insurance. Point of service enrollment at county and community clinics should be a priority. "In-reach" for existing clients has proven most successful in other counties.

- The recent expansion of the Basic Adult Care program to children, now called Basic Health Care program, will allow children to be screened at the point of service in county clinics. If they do not qualify for Medi-Cal or Healthy Families and are income-eligible, they can be enrolled in the Basic Health Care program. This allows Contra Costa County to have options for the full range of children's situations. With these programs now in place, integrated point of service enrollment and aggressive retention activities should be the center point of the new program.

B. Recommendations

1. In its past decisions, Contra Costa County's Board of Supervisors has consistently committed itself and the County's resources to ensuring access to health care services for all children and enrollment in appropriate health insurance and health coverage programs. The integration efforts that follow would be supported if the Board of Supervisors reiterate, at this time, its long standing support for access to health services for children, both through health programs and outreach and enrollment.

2. All outreach, enrollment and retention activities should be built into the existing infrastructure, particularly in the Contra Costa Health Services and Employment and Human Services Department. While state and other grant funds should be used to support these efforts when available, the efforts need ongoing operational support in an integrated way. Responsibilities for different segments of the health insurance access effort should rest with already existing and appropriate agencies within Contra Costa County in order to increase stability of the program.

3. A regular county position of health insurance/access coordinator should be established to coordinate and facilitate all insurance enrollment and retention activities, county information updates and training on public-sponsored health insurance activities, expansion of coverage, etc. This position should have appropriate access to decision-making authorities so that barriers can be addressed, problems solved, and successes promoted countywide. The Health Insurance/Access Coordinator:

    - should be located in Public Health;
    - should facilitate a Steering Committee composed of the appropriate representatives from Financial Counseling, EHSD, CCHP, Mental Health, Community Services Department and Public Health – each of whom have responsibility for segments of the health insurance activities within the county;

- should facilitate and organize the Health Access Coalition as well as report to other county committees, commissions and advisory groups that would benefit from information and advocacy about related health insurance committees. Careful consideration about how the Health Access Coalition links and intersects with Public Environmental and Health Advisory Board's (PEHAB) Access to Care Committee should be reviewed with consideration given to establishing the Health Access Coalition as a subcommittee of PEHAB, which is appointed by and reports directly to the Board of Supervisors;
- should be responsible for organizing the county's ability to track outreach activities, enrollment targets and retention targets;
- should implement a tracking system similar to the Consumer Union's Tracking Program for Health Families as soon as possible, adapting the current database, and incorporating all the programs and divisions under the same Entity Number to share information more effectively; this work must be coordinated with the State, which must provide better data;
- should be responsible for implementing an ongoing countywide education and training program on insurance activities and work closely with the enrollment efforts of the Financial Counselors, the retention efforts at CCHP, and EHSD.

4. A Steering Committee of Public Health, EHSD, CHDP, CCHP, Mental Health, Community Services Department, financial counselors should meet regularly - at least monthly - to identify key barriers in the system, analyze system difficulties, problem-solve and monitor integration. It should report regularly to the Health Access Coalition and to senior staff at CCHS and EHSD.

5. **Outreach** to the uninsured target populations representing the core public health function of access to care should remain in Public Health, with monitoring by the Health Insurance/Access Coordinator.

   - Outreach should be accomplished through the variety of public health programs such as CHDP, Family PACT, PCG, CPSP, WIC, community education, prevention and wellness programs, public health nursing, and home visiting, etc.
   - Public Health managers of these programs should work closely with the Health Insurance/Access Coordinator on these efforts.
   - Each of these programs should be equipped to conduct application assistance, outreach, education on access and enrollment for any client in need.
   - These programs should be required to provide data to the data tracking component of the program.

6. **Enrollment** of individuals/families in insurance programs should be coordinated by and be the responsibility of Financial Counselors through the county clinics and hospital. With each expansion in health insurance or health coverage programs (Healthy Families, Healthy Families to Adults, BAC to Basic Health Care), the financial counselors are continually updated on the technical information necessary to assist clients. They are also located at the service delivery points of entry at the health centers where both enrollment and access can be accomplished.

    - The current Healthy Families Enrollment Assistors/CAAs located in the health centers should be reassigned to report to the Financial Counselors with whom they already interact regularly.
    - Some Community Health Workers can be integrated into other Public Health programs such as CHDP, WIC, Clinical Services or CCHP, to enhance the capacity of those programs to assist with enrollment and retention.
    - Some administrative interns and student workers can be assigned to work with Financial Counseling, when available.
    - With the changes occurring soon in CHDP, Public Health must work to redesign efforts in CHDP to incorporate enrollment strategies at CHDP provider offices.
    - Employment and Human Services Department, through all of its programs, should continue its aggressive enrollment of eligible clients in the Medi-Cal program and when possible should also enroll eligible clients in the Healthy Families program. Legislative changes about who can enroll children in Healthy Families and assurance from the state that current funding to provide for additional staff needed to expand to Healthy Families enrollment are essential to this change.
        - EHSD should engage with Health Services in training related to all aspects of improving access to health care services, including comprehensive knowledge of Healthy Families, Basic Health Care, etc.
        - EHSD's involvement in the Health Access Coalition is essential.
        - Bay Area counties have made a proposal for Medi-Cal families with Share of Cost, supported by the Medi-Cal Policy Institute: if the family wants to enroll in Healthy Families, social services workers should be able to determine eligibility and fee collection for premiums. Contra Costa County should actively support this effort.
        - EHSD's Medi-Cal Advocate positions should be continued to assure its continued ability to maintain aggressive enrollment.

7. **Retention** of members on public health insurance programs can be most effectively organized by the Member Services Department at Contra Costa Health Plan. The vast majority of the clients enrolled are managed by CCHP including those on Basic Health Care. Among the key responsibilities of the health plan are the education of members on how to use the health care system, health education and retention of members in the plan. For those children who are not CCHP enrollees, it will be important to use the Health Access Coalition, and use the Coalition to share best practices.
   - In addition, CCHP should continue to take an active role in sponsoring health fairs and enrollment activities in coordination with Public Health and include such information in their health education materials and newsletter.
   - Basic health education can include consumer education about how to use the Contra Costa County health system, how to make an appointment, whom to call for questions, etc., encouraging people to use the health system.

8. The Community Services Department's CAAs and parent advocates, who assist families with applications, should continue to be integrated into ongoing education and training with the Health Access Coalition.

9. The Health-e-app is already being implemented in Contra Costa County's outreach and enrollment effort. It should be utilized to every extent possible in all community-based as well as county entry points.

10. An emphasis should be placed on Point of Service Enrollment, using the opportunity at the time of service at county clinics, community clinics and soon at private providers offices through the CHDP Gateway Program to enroll eligible children by on-site screening and enrollment or in the case of the private provider offices by a "quick phone linkage" to enrollment workers.

11. At every available outreach or enrollment contact, information and encouragement about using health services should be another priority of the contact. Materials about available services, information about how to make appointments and when should be key to the encounter.

12. Advocacy by the Board of Supervisors and every relevant county department will continue to be necessary to promote changes in the Medi-Cal and Healthy Families programs to ensure easier access for eligible children and adults.

13. As resources are declining, the best possible return on investment seems to be the integration of outreach and enrollment activities, the enhancement of retention strategies, and the ability to track progress throughout the county's departments. Key to the integration is the effective working together of the Steering Committee and the departments' leadership.

Assessment of Enrollment and Retention in Healthy Families and Medi-Cal for Children

Table of Contents

Executive Summary i

I. Purpose of Report 1

II. Background 2

- A. Uninsured Children 2
- B. Why Health Insurance is Important 6
- C. History of Healthy Families/Medi-Cal Outreach and Enrollment 10
- D. History of Medi-Cal Application Changes 12
- E. Enrollment Barriers 19
- F. Retention Challenges 21
- F. Access to Care 26
- G. Survey of Best Practices 27
- H. Survey of California County Activities in Outreach, Enrollment and Retention 31

III. Contra Costa County System for Outreach, Enrollment and Retention 44

- A. Organization Structure, Transition, Staffing and Budget 44

IV. Assessment 47

- A. People Interviewed 47
- B. Key Findings 47

V. Recommendations for Change 49

- A. Planning Assumptions 50
- B. Recommendations 51

VI. Bibliography 57

I. Purpose of Report

This report provides recommendations within the context of the federal and state history of the Healthy Families and Medi-Cal programs and best practice models for outreach, enrollment and retention among target populations in Medi-Cal, Healthy Families and other similar programs. Healthy Families and Medi-Cal are two complex state programs funded in part by the federal government, whose goals are to provide coverage and access to health care for low income children. Contra Costa County undertook a significant process with a large number of partners to reach out to as many children as possible. The County enlisted major foundation support to launch the process. The Board of Supervisors requested an outside assessment of improving the system, which has made a good start, using best practices. The recommendations focus on how to enhance the effort to make in more effective in the long run.

It is important to note that the county must continue to work in partnership with the state, which must make its own changes to make the program better, and with local partners, who must stay as involved as they have been to date.

Recommendations and review of information are provided on the following:

- Organizational structure for the Contra Costa Outreach and Enrollment program, including organizational functions, reporting structures, accountability, integration and coordination among and within County divisions and departments.
- Integration of Healthy Families enrollment and Medi-Cal eligibility
- Best practice models for streamlining and, where possible, integrating with community-based efforts
- Analysis of Contra Costa County Medi-Cal and Healthy Families continuation rates compared to other California counties and with commercial insurance programs.
- Retention strategies in Medi-Cal for Children and Health Families
- Participation in Health-e-app.

Efforts were made to look closely at appropriate staffing ratios of outreach and enrollment workers for effective recruitment and retention of Healthy Families and Medi-Cal applicants and participants. Unfortunately there is currently not enough information available statewide to make recommendations on this issue.

The analysis of findings and recommendations is based on the following:

- meetings with Contra Costa County staff to review assumptions and current program performance, key indicators, and major issues, to present analysis of key data elements, to review recommendations and discuss implications for program changes;

- review of written materials, staffing plan and data regarding enrollment activities, targets and last three years' performance in Medi-Cal and Healthy Families outreach and enrollment in Contra Costa County;
- site visits of a sample of community-based enrollment and outreach sites as well as county sites, including meetings with key staff at each site, to gain understanding of key issues on the ground;
- feedback solicited from current outreach, enrollment and eligibility workers to gain further insight into key issues;
- assessment of feasibility of participating in Health-E App for Contra Costa County; and
- review of best practices throughout California and a survey of other counties outreach, enrollment and retention efforts.

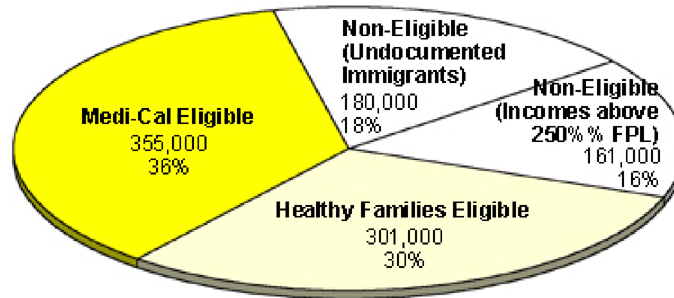
It was hoped that an analysis of staffing ratios and target numbers of potential applicants could be undertaken. Unfortunately, these data were not available.

II. Background

A. Uninsured Children

According to the UCLA Center for Health Policy Research, 1 million (nearly 1 in 10) of California's children are uninsured. Of these children, about 656,000 are eligible, but not yet enrolled in, the state health programs of Medi-Cal or Healthy Families. These data and the data that follow only emphasize the continued importance of outreach, enrollment and retention activities. So many children are currently eligible but not enrolled in these important public insurance programs in counties throughout California. What is not known at this time is the complexity of reaching these families and how many of these families have been enrolled before in either Medi-Cal or Healthy Families.

California's 1 Million Uninsured Children



Source: Brown ER, Ponce N, Rice T, Lavaredda SA. The State of Health Insurance in California: Findings from the 2001 California Health Interview Survey Los Angeles: UCLA Center for Health Policy Research, 2002.

According to the UCLA Center for Health Policy Research's recently released *2001 California Health Information Survey* (CHIS), of the 2.6 million California children who are eligible for Medi-Cal, more than eight in ten are enrolled. The CHIS also estimates that of approximately 750,000 children who were eligible for Healthy Families in 2001, about 458,000 (61%) were enrolled. As of June 7, 2002, 562,614 children were enrolled statewide, an increase of 23% in one year. Of those, 67% were Latino, 16% were white, 13% were Asian or Pacific Islander and 3% were African-American.

Other data, such as those from the 100% Campaign (a collaborative effort of Children Now, Children's Defense Fund and The Children's Partnership to ensure that all of California's children obtain health coverage) show that an estimated 1.3 million of California's 1.8 million uninsured children (72%) qualify for Medi-Cal or Healthy Families.

Under current eligibility rules, children who are citizens or noncitizens with legal documentation to live in the United States are eligible for either Medi-Cal or Healthy Families, if their family income is 250% of the federal poverty guidelines or below. The specific program for which they are eligible depends on a complicated variety of factors, including their age, family income, allowed deductions from income, and family size. Therefore, children in the same family may be eligible for different programs, creating confusion and fragmentation to what could be a seamless system of coverage.

California has received federal approval to extend enrollment in Healthy Families to parents of eligible children in families with incomes up to 200% of the federal poverty

level. The Governor had proposed delaying this expansion due to the State's severe decline in tax revenues, but it is now expected to be implemented in the period October 2002 to January 2003. If it is implemented, an estimated 281,000 parents (about 20% of uninsured parents) will be eligible for Healthy Families. It is hoped that it will be easier to enroll and retain children on Healthy Families once adult members of the family are able to be enrolled.

The CHIS interviews identified reasons why eligible children were not enrolled. Of the 355,000 uninsured children eligible for Medi-Cal, parents of a third of the children interviewed for the study thought that their children were not eligible. Another 8% reported being unsure about their children's eligibility as the reason for not applying, and less than 1% did not know the program existed. This shows than more than 40% of uninsured, eligible children could be reached by effective educational outreach strategies. Parents of 12% of the children objected to some part of the program, particularly the heavy burden of paperwork that has been a hallmark of Medi-Cal. Only 3% of the parents objected to the stigma connected to a welfare program and 4% did not perceive the need for coverage. Families eligible for Healthy Families had similar issues, but the proportion of those who need effective education about the program is significantly higher than the Medi-Cal program (60% among Healthy Families eligible families compared to 42% of Medi-cal eligible families). Nearly one quarter of parents of Healthy Families-eligible children did not know the program existed, nearly 20% believed their children were not eligible, and an additional 14% did not know if their children were eligible.

Enrollment in Medi-Cal statewide dropped by 283,234 children between 1996 and 1999. Healthy Families, begun in 1998, covered 133,273 children by July 1999. In January 1998, Medi-Cal placed a moratorium on dropping most families from Medi-Cal when they lost cash welfare. This was intended to give the state and counties time to develop policies and reprogram their computers to carry out changes made by the new welfare law. Approximately 240,000 children were affected by the moratorium, as the counties worked through a huge backlog of cases.

According to a study just released (June 2002) by the Kaiser Commission on Medicaid and the Uninsured, *Reaching Uninsured Children Through Medicaid: If You Build It Right, They Will Come*, the Medicaid enrollment decline among children and their families declined was largely a result of welfare changes. However, in 1999, enrollment rose in many states. Forty percent of all low-income children (under 200% of poverty) were enrolled in Medicaid or SCHIP in 2000, 52% of poor children and 30% of near-poor children. However, one fifth of low-income children still lack coverage, although most are eligible for either Medicaid or SCHIP.

According to the most recent census data, one out of five children nationwide and a quarter of all children under age six were enrolled in Medicaid in 2000. Children's

enrollment grew from fewer than 10 million children in 1980 to over 21 million in 1999, the last year for which national administrative data are available. During this time, there has also been a steady decrease in the proportion of children covered by Medicaid who receive welfare.

A report from the Medi-Cal Policy Institute, *The Impact of the Proposed 2002-03 Budget on Medi-Cal and the Healthy Families Program*, found that the proposed 2002-03 California budget assumes a 4.9% (304,100) increase in the Medi-Cal caseload from 2001-02 to 2002-03, largely because of policy changes enacted over the past several years. The total public assistance caseload is expected to decline by 1% because of families leaving CalWORKs. The family-based portion is expected to decrease 2.8%, which is a smaller decline than the 6.6% drop that occurred over the previous two years. An increase of 137,400 children statewide enrolled in the Healthy Families Program is also assumed in the proposed state budget. However, the budget also proposed to decreases spending for Healthy Families-related costs in other departments, including outreach activities.

According to the 100% Campaign, currently 46,000 children are statewide enrolled in Food Stamps but are not receiving Medi-Cal or Healthy Families.

Given these estimates and as more and more children statewide are enrolled in these public insurance programs, it will be more difficult to enroll the remaining children due to barriers in the state-mandated program requirements and procedures and the fact that 100% will never be enrolled. Efforts in counties like Contra Costa will need to be re-organized to focus on maintaining enrollment and to educating new parents, either newly arrived or with new babies. The population of parents is always evolving.

Contra Costa County's Uninsured

It is extremely difficult to pinpoint the number of uninsured children in Contra Costa County. There are competing methodologies and the numbers fluctuate regularly. The best estimate is that of the recent California Health Interview Study of 2001 of the Center for Health Policy Research at UCLA. Based on interviews statewide, the CHIS estimated that there are approximately 52,000 uninsured children and nonelderly adults in Contra Costa County. This is 6.2% of the nonelderly population, amid a range of 4.6% – 7.9%, or 39,800 – 68,358 residents. By subtracting the adults (whose range was 5.1% - 9.2%), the range of uninsured children is estimated to be 8,800 – 12,500. However, it is important to note that the Center states that the sample size of children was too small to estimate a number with statistical confidence.

- According to the US Census and Children Now, 13.6% of Contra Costa County's approximately 258,500 children under age 18 lived in poverty in 1997 (35,000 children) and 27% had incomes below 185% of poverty in 1999-2000 (69,795 children).

- According to the US Census, in 1999, approximately 30,000 Contra Costa County families had incomes below 250% of poverty (the federal poverty line was $13,880 for a family of three and $16,700 for a family of four; 250% of poverty was between $34,700 and $41,750 that year).
- According to the State Department of Health Services, there are currently 41,234 children in the county who are Medi-Cal beneficiaries and 6,228 children enrolled in Healthy Families, for a total of 47,462. About 9% of all nonelderly in the county and 15% of the county's children have Medi-Cal or Healthy Families.

B. Why Health Insurance is Important

"Lack of insurance means that many low-income families take their children to the doctor at the last minute, often relying on the emergency room as their primary source of care."[1]

"My daughter complained of an earache and I waited a few days before taking her to the doctor to see if she would feel better. I felt horrible waiting while my child was in pain and I wondered if I would have waited if I had health insurance." (CDF's focus group report --The Waiting Game) [2]

Children's access to health care is important to children themselves, to their families, as well as to society at large. Health care can influence children's physical and emotional health, growth, and development and their capacity to reach their full potential as adults. All children are at increased risk of developing preventable conditions if appropriate care is not provided when they are sick or injured. When children fail to receive necessary health care, their lives and the lives of their families can be affected for many years.[3]

Access to health care services dramatically improves within 12 months of health insurance enrollment. One study showed that at 12 months, 99% of the children had a regular source of care and 85% had a regular dentist. The percentage of children reporting any unmet need or delayed care in the past six months decreased, the percentage of children seeing a provider increased and the proportion relying on the emergency room decreased. Parents also related a significant decrease in stress, which has important implications for education because the well-being of the entire family can be critical to a child's readiness to learn.

Parents want their children to receive routine preventive care, to have a place to go when they are sick and to have a health provider monitor their child's development. Parents want someone to explain children's allergies, to help manage their asthma or to say when glasses or psychological counseling are needed. Studies show that uninsured children, surrounded by the most expansive and expensive health system in the world,

frequently cannot find their way to the care they need. Compared to insured children, uninsured children receive only limited access to health services.[4]

An impetus for the drive for enrolling as many children as possible into health insurance programs is the link between health insurance and school performance. According to *The Link Between School Performance and Health Insurance: Current Research*, from the Consumers Union, good health is connected with improved school performance and having health insurance is linked to better health. Poor health has been found to affect school performance in many ways, including contributing to absenteeism, affecting concentration level in the classroom, producing disruptive behavior, and affecting students' abilities to participate in extracurricular activities.
Access to health care can influence children's physical and emotional growth, development, and overall health and well-being. Untreated illnesses and injuries can have long-term—even lifelong—consequences. For example, untreated ear infections can lead to hearing loss or deafness. Children who are unable to hear well can have trouble performing well in school and trouble interacting normally with their families and friends. Language or other developmental delays due to untreated neurological problems also can frustrate normal development and social interactions.[5]

Overall, lack of insurance undermines children's health and damages their chances to lead a healthy life. Without public subsidies or employer-provided health plans, families with incomes near poverty levels would have to pay a prohibitive 40 percent of their income for family coverage.[6]

Dental care is a serious issue for uninsured families. Oral diseases affect not only the teeth, gums and the rest of the mouth, but they also can lead to serious general health problems and significant pain, interference with eating, overuse of emergency rooms, as well as lost school and work time. Preventive methods such as the use of fluoride and dental sealant are comparable in effectiveness to immunizations against infectious disease, but these services are not always readily available.[7]

Usual Source of Care

- Uninsured children are ten times less likely than insured children to have a regular provider.[8]
- In California, 27% of uninsured children compared to approximately 6% of insured children do not have a usual source of care, such as a doctor's office.[9]
- Of the uninsured children who do receive routine care, 24% overall and 52% of poor children receive the care in a setting other than a physician's office. Children who do not have a physician's office as their usual source of care are less likely to be taken to a physician when care is needed and are more likely than insured children to use higher-cost emergency rooms or clinics.[10]

Likelihood of Doctor and Dental Visits

- In California, 56% of uninsured children compared to approximately 25% of insured children did not have a doctor visit in the last year. [11]
- In California, 55% of uninsured children compared to approximately 20% of insured children did not have a dental visit in the last year, or 2.5 times less likely to receive dental care. [12]

Withholding Care Due to Costs

- Twenty-one percent of parents of uninsured children compared to 3% of parents of insured children were forced to delay or skip needed medical care for their child because they did not know how to pay for it.[13]
- Twenty seven percent of parents of uninsured children compared to 7% of parents of insured children were forced to delay or skip needed dental care for their child during the past year because they did not know how they would pay for it[14]
- Parents of uninsured children are seven times as likely as parents with insured children to have delayed or skipped filling prescriptions for their child.[15]
- Uninsured children are less likely than those with insurance to receive medical care for injuries, even serious injuries. Among children who are uninsured, one study found that as many as 30% of all children with injuries and 40% of all children with serious injuries may not receive medical attention.[16]

Unmet Health Care Needs

- Uninsured children are almost three times as likely as insured children to have an unmet health care need within the past year.[17]
- Uninsured children are approximately twice as likely as insured children to not receive care from a physician for acute earaches, recurrent ear infections, asthma, or sore throat with a high fever.[18] These can lead to hearing loss, central auditory processing disorder, and life-threatening emergencies.
- Uninsured children are 30% less likely than insured children to have received medical care when they are injured.[19]
- Children's health status varies significantly by type of insurance. Among insured children, those covered by Medicaid or other forms of public health insurance are the most likely to have health problems: 17% had a serious illness in the past year and 16 percent were in fair or poor health. In contrast, children covered by private health insurance are the least likely to have health problems: only 5% were in fair or poor health.[20]

- A California study found that newborns who were uninsured were more likely to be sick but received fewer services in the hospital than newborns who had insurance coverage.[21]
- Children living in low-income areas have two to four times as many preventable hospitalizations as children living in high-income areas. These rates are likely to be due to poorer general health status, poorer access to preventive and routine care when needed, as well as to lack of insurance among low income families.[22]
- Uninsured children with chronic medical conditions also have been found to have insufficient access to routine medical care. According to a national survey sponsored by the Robert Wood Johnson Foundation, 17% of uninsured children did not receive medical treatment needed for a chronic illness such as asthma, diabetes or other conditions serious enough to keep a child from functioning at school.[23]
- A study in New York found that they hospital death rate was 1.46 times higher for uninsured children than for those who were insured. The uninsured children were more likely to be admitted to the hospital in a critical condition, and their needs for care were more urgent on admission.[24]

Unmet Preventive Care

- Uninsured are five times more likely to use the emergency room as a regular source of care[25]
- In California, 68% of uninsured children compared to approximately 30% of insured children did not have a well-child doctor visit in the last year. [26]
- Uninsured children between ages 1 and 3 are approximately twice less likely as insured children to have up-to-date immunizations.[27]

Other Issues

- Twenty percent of parents of uninsured children ages 5-18 compared to 3% of parents with insured between the same ages have kept or would keep their child out of a sporting of athletic event because of fear that they might get injured and have no way of being covered.[28]
- Uninsured children—when they receive needed care—are often charged more than insured children. Since insurers, including Medicare and Medicaid, negotiate large discounts with hospitals and physicians, providers often offset by raising the costs to uninsured individuals such as children."[29]

C. History of Healthy Families/Medi-Cal Outreach and Enrollment

The State Children's Health Insurance Plan

The State Children's Health Insurance Plan (SCHIP) was created in the Balanced Budget Act of 1997 (the BBA), appropriating $24 billion over five years and $40 billion over ten years to help states expand health insurance coverage to children whose families earn too much income to qualify for Medicaid (Medi-Cal in California), yet not enough to afford private insurance coverage. SCHIP, the single largest expansion of health insurance coverage for children since the enactment of Medicaid, presents a significant opportunity reduce the number of uninsured children in the United States. However, it has not always been easy, nor has each jurisdiction been successful in identifying and enrolling all eligible children.

SCHIP offers states federal matching funds — with matching rates considerably higher than standard Medicaid rates — to expand health care coverage for children using Medicaid, a separate state children's health program, or a combination of the two. In response to this new opportunity, all states have expanded coverage for children since 1997; most states have elected to cover children in families with incomes up to 200% of the poverty line or higher. Census data reveal that the proportion of low-income children with publicly-funded coverage under Medicaid or SCHIP rose in 1999 and 2000 and that this resulted in a reduction in the percentage of low-income children who lack insurance coverage.

The federal government reports that states have aggressively sought to simplify their application, enrollment and re-enrollment processes to ensure that eligible families can easily apply, enroll and remain enrolled. Steps such as using a joint and mail-in applications, offering presumptive eligibility, allowing retroactive eligibility, and providing continuous eligibility are all considered important strategies for simplifying the enrollment process and providing opportunities for families to apply and remain enrolled in Medi-cal for Children (MCC) and the Healthy Families (HF) program.

California's program, Healthy Families, is a state- and federally-funded health coverage program for children with family incomes above the level eligible for no cost Medi-Cal and below 250% of the federal poverty line.[30] Healthy Families provides low cost, comprehensive physical health, mental health, dental and vision coverage to uninsured children in low wage families. Families participating in the program choose their health, dental and vision plan. Families pay premiums of $4-$9 per child per month (maximum of $27 per family) to participate in the program.

California law requires the Department of Health Services, in conjunction with the Managed Risk Medical Insurance Board (MRMIB), to develop a conduct a community outreach and education campaign to help families learn about and apply for Medi-Cal and Healthy Families. The state's activities to increase enrollment in Medi-Cal and

Healthy Families focused in two primary areas: 1) removing administrative barriers and 2) a community-based outreach campaign. In the last two years, the state has allocated millions of dollars each year for outreach activities for counties and community-based organizations. At the time of this writing, the budget for 2002-2003 is still uncertain, but it is clear that major cuts in the outreach and enrollment efforts will be sustained.

Effects of Welfare Changes

When the welfare system changed, there was considerable cause for concern that families no longer eligible for cash assistance would lose their Medicaid coverage nationwide, despite guarantees in the law, or that families discouraged from Temporary Assistance for Needy Families (TANF) would also be discouraged from applying for health insurance. Nationally, children whose families lost benefits or moved to a different form of welfare assistance who were still eligible for Medicaid undoubtedly fell through the cracks in the system, with no health coverage. However, Contra Costa County's Employment and Human Services Department, responsible for this task here in the county, has a formal, written procedure for identifying cash applicant families who do not follow up or who are denied cash assistance, as well as for "diversion" applicants.

According to a Medi-Cal Policy Institute Issue Brief, *Medi-Cal After Welfare Reform: Enrollment Among Former Welfare Recipients*, the number of actual former welfare recipients enrolled in Medi-Cal rose steadily throughout the 1990s. The number of former welfare recipients with Medi-Cal increased sharply in 1998 and 1999, after CalWORKs began, and then leveled off in 2000. It is important to note that the number of people leaving welfare varied widely during this period. However, the percentage of all people enrolled in Medi-Cal after they left welfare – called the "take-up rate – actually fell between 1992 and 1997 from 32% to 27.6%. However, this decline in former recipients' enrollment rate reversed in 1998 and take-up began to increase rapidly, again tied to the start-up of CalWORKs. It is also important to note that there is wide variation in enrollment rates among former welfare recipients by county, ranging from a low of 17.7% in Sierra County to a high of 78.2% in San Francisco County for a statewide rate of 48.8%. Contra Costa County is slightly below the state rate, at 43.0%. The variation in rate is a factor of how well counties succeed in reaching former welfare recipients.

Many families with Medicaid-eligible children apply for cash assistance but do not finish their applications or are denied assistance due to welfare rules that irrelevant to their children's Medicaid eligibility. Other families may not be receiving ongoing cash welfare, but have been found eligible by their welfare agency for one-time "diversion" payments or for noncash services. Nationwide, thousands of children are leaving the cash assistance system each month when their parents find employment or when their family's welfare case is closed for other reasons. Children in all of these situations in

California are almost certain to be eligible for Medi-Cal and are at high risk of being uninsured if not for Medi-Cal.

D. History of Medi-Cal Application Changes

Streamlining application and enrollment processes for Healthy Families and MCC has been a critical strategy for increasing enrollment of uninsured and eligible children into HFP and MCC. An important and shared goal of MCC and HFP is to make the application and enrollment process for both programs as consumer-friendly and efficient as possible, so that children receive immediate access to preventive and medical services. Improved coordination between MCC and HFP is a key step towards streamlining enrollment.

According to *Streamlining Application and Enrollment for the Health Families Program and Medi-Cal for Children,* a report from the California Department of Health Services, an important goal of the programs should be to assess applicants to either program without delay and burdensome, duplicative requirements.

MCC and HFP have continuously explored opportunities to improve coordination and streamline application and enrollment processes. The state has adopted many strategies, including a shortened (4-page) joint application described below, the introduction of 12-month continuous eligibility, and the elimination of quarterly status reports under Medi-Cal. These strategies will be supported by the statewide introduction of Health-e-App, described below, the nation's first online enrollment system for public health programs.

Another promising approach is to streamline MCC and HFP application and enrollment processes for children applying to, or already enrolled in, other public programs. Called "Express Lane Eligibility," this approach seeks to expedite enrollment for children who have already provided contact, income and other eligibility information to another public program, particularly those with income requirements similar to MCC and HFP.

Two recent California laws have created the nation's first Express Lane Eligibility enrollment policy to link uninsured California children who participate in certain nutrition programs to subsidized health coverage. These implement Express Lane Eligibility through Food Stamps (SB 493) and the School Lunch Program (AB 59). Using information already provided by uninsured Food Stamp enrollees, the state and counties will be able to more efficiently enroll eligible children and families into the Medi-Cal and Healthy Families programs. In addition, school districts will now be allowed, with a parent's consent, to release information on school lunch applications in order to expedite Medi-Cal enrollment for children. Also, children under age 6 receiving free

lunches (children with incomes below 130% of the federal poverty level) will be deemed income-eligible for Medi-Cal, thus speeding their access to health coverage.

While the implementation of Express Lane Eligibility has been delayed for several years, until at least 2005, due to budget constraints, a re-design of the CHDP program called the CHDP Gateway will also assist in allowing newly enrolled CHDP clients to be presumptively eligible for Medi-Cal for 60 days. This will allow an important assessment of continued eligibility to occur while making it possible for these children to access both preventive and other comprehensive health care services using Medi-Cal. As the CHDP Gateway program unfolds over the next few months, it will become another important linkage for outreach and enrollment and will focus efforts directly on provider offices and locations (point of service enrollment addressed later in this report) rather than on community outreach and enrollment efforts.

Keeping Applications Simple

A simple, family-friendly application process is at the core of an effective enrollment strategy. For years, states relied on lengthy and complex Medicaid applications and required interviews at welfare offices. Recently, however, complicated applications have been replaced with shorter forms; mail-in applications have made welfare office interviews unnecessary, at least for pregnant women and children; and an increasing number of states have begun to rely on self-declarations and computerized data exchanges in lieu of applicant-supplied verification of eligibility. In Contra Costa County, all Medi-Cal applicants, except minor consent services) use the mail-in process and need not participate in a face-to-face interview.

Neither federal nor state Medi-Cal rules require a lengthy, cumbersome mail-in application. Recent federal guidance has encouraged states to take advantage of the flexibility accorded them under federal law to eliminate verification requirements that can be barriers to care. Some 34 states have implemented Medicaid applications for pregnant women and children that are shorter than four pages. States that have developed joint applications (for Medicaid and for their separate child health program) have designed streamlined joint forms that are six pages or less (including instructions). The model joint application form developed by the federal agency that oversees Medicaid is two pages.

Until 1999, California stood alone among the states that administer a separate child health program alongside its Medicaid program and that have created a joint application for both programs in requiring families to figure out the program for which they are likely to be eligible.

In short, there is nothing inherent in either the Medi-Cal program or in the fact that California administers its two child health programs through separate entities that

prevents California from developing a simpler and shorter application and a more seamless mail-in application process for Medi-Cal and Healthy Families.

California's Attempts To Keep It Simple

California has taken some important steps to revamp its Medi-Cal enrollment process. Pregnant women and children no longer have to meet a resource requirement for Medi-Cal, when family net income is at or below the appropriate federal poverty level amount, depending on the age of the child and size of the family. They can submit their applications by mail. In addition, when it enacted the Healthy Families program, the California Legislature required a joint application to be developed for pregnant women and children so that families would not have to sort their way through two enrollment systems to determine which health program covered their child. In record time, the Department of Health Services (DHS) and the Managed Risk Medical Insurance Board (MRMIB), with substantial public input, created a new mail-in packet through which families and pregnant women can apply for either Medi-Cal or Healthy Families. The state also made funds available to community-based organizations to help applicants complete the required forms.

Despite these efforts, families are having difficulty making their way through the process, and enrollment is lagging far behind expectations. Even allowing more time for transition to the new mail-in enrollment system, there is widespread agreement that further steps are needed to simplify the process. DHS and MRMIB plan to revise the new 28-page mail-in packet and have assembled a working group to solicit feedback on how the application process is working and suggestions on the changes that need to be made. In addition, members of the Legislature continue to be attentive to the issue, interested in learning whether decisions made by the Legislature and by the Administration have promoted or hindered the goal of providing coverage to uninsured California children.

The mail-in application's length and confusing format was due largely to the design of the joint application process, and specifically to the decision to require families – rather than the reviewing agencies – to determine, at least initially, if their children are eligible for Medi-Cal or Healthy Families. This screening process accounts for four pages in the application packet, not counting the related instruction pages. It requires applicants to sort through financial eligibility rules and to make complicated calculations in order to decide which other forms within the packet they must complete and which documents (verifying the information provided on the forms) they must submit. The process can be difficult, and errors have been commonplace.

In April 1999, the state developed a four-page Healthy Families and Medi-Cal Mail-In application. This application:

- eliminates all mathematical calculations
- requires less information about citizenship or immigration status

- asks families to submit one pay stub to verify income
- has a pre-addressed envelope for returning the application to one site for both programs and
- is available in eleven languages (English, Spanish, Vietnamese, Cambodian, Hmong, Lao, Armenian, Cantonese, Korean, Russian and Farsi).

Health-e-App

Health-e-App was developed through a partnership among the California Health Services Agency, the California HealthCare Foundation (CHCF), and the Medi-Cal Policy Institute, in a contract with Deloitte Consulting to develop a software package for use by Certified Application Assistors (CAAs) to help people apply for health insurance completing electronic application of Healthy Families and Medi-Cal. It is an easy-to-use, streamlined way to submit health benefit applications for children.

Health-e-App is one of the nation's first efforts to use the internet to enroll low income children and pregnant women in the state's public insurance programs. This software was piloted in San Diego County at three clinics, a public elementary school, a church and at WIC offices. After the success of the pilot, the state set a goal of statewide implementation by September 2002. However, this has been delayed.

Benefits of this electronic interface between the state and county include

- Ability to electronically tie an applicant to current databases at the county, such as tracking enrollment in Food Stamps.
- Reduction in the amount of time and potential errors resulting in completion of information.
- Additional information, such as the Enrollment Entity (EE) number, CAA name and number are available to provide a more direct point of contact regarding the applicant.
- Reduction in paper.
- Earlier arrival of information for the county than by mail.

The rollout process is recommended to involve the following staff or departments:

- County Finance Department
- County Information Technology Department
- County Manager/Board
- County Sponsor(s)
- EDS Single Point of Entry

- EDS/Other consortium technical contacts
- County Case Workers.

Elements necessary to implement the system include a computer with internet access and an internet browser such as Netscape Navigator or Microsoft Internet Explorer.

Many counties working with the software have found that with some modification, Health-e-App could support a “universal application” approach to a wide range of county and state programs which gather information from potential beneficiaries. These include County Medical Services Programs, Breast and Cervical Cancer Early Detection Programs, Prostate Cancer Programs, Food Stamps, other county programs, WIC, county-provided health insurance initiatives, CHDP, Adult Medi-Cal applications, presumptive eligibility and express lane eligibility. Some counties have also found it beneficial to interface electronically with state programs. At the same time, this software could be the foundation for a county-driven electronic universal application. Such an application minimizes the number of step in the application process for potential beneficiaries and for the agency administering the application. However, the universal application would have to 1) be easily modified to adjust to new or changed program eligibility rules, 2) provide the same or very similar results as current practice, 3) be easy to use and 4) be portable. Some counties already using Health-e-app have begun to express some concerns about its flexibility.

Contra Costa Health Services implemented the Health-e-apps program in September 2002 and equipped Certified Application Assistants with the appropriate technical devices and skills to participate in the program. Fourteen of Contra Costa Health Services’ CAAs have been trained and registered to use the system. Employment and Human Services Department will not be included in this roll-out, as county welfare departments have not been included.

The rise in the statewide Medi-Cal caseload described earlier is attributable to a number of recent policy changes that have extended eligibility and/or simplified enrollment processes as well as to changes in the national and state economy. Substantial [1]enrollment increases are expected in categories related to the extension of eligibility to parents in families with incomes of up to 100% of the Federal Poverty Level and changes that increase children’s eligibility. Anticipated statewide enrollment increases between 2001-02 and 2002-03 are assumed to be due to the following:

- Providing 12 months of continuous Medi-Cal enrollment for children (55,540)
- Eliminating quarterly status reporting for families (28,000)
- Expanding the 1931(b) programs to parents in families with incomes up to 100% of the Federal Poverty Level (34,971)

- Accelerating enrollment for Medi-Cal through the single point-of-entry program (6,970)
- Providing Medi-Cal to former foster youth up to age 21 (537).[31]

At the time of this writing, we are still waiting for the outcome of the negotiations on the 2002-2003 state budget. It is unknown which, if any, of these programs will be eliminated or reduced. We do know that the implementation of Express Lane Eligibility programs will be delayed for several years. The Quarterly Status reports were eliminated last year, but proposed for reinstatement in 2002-2003. It is widely expected but by no means certain that the Quarterly Reports will not be reinstated in the final outcome of the state budget.

Verification Issues

While California state regulations specify in detail what Medi-Cal items must be verified, the regulations also give county eligibility workers discretion to impose additional verification requirements. According to the state report, *Streamlining Application and Enrollment,* the MC210 does not identify the elements on the form that will need to be verified but rather states that the applicant "*may* be asked to give proof and/or more detailed information on residency, property/resources, income, or work history."

On the other hand, the mail-in application form does identify required verification. At the same time, there are reports of local counties asking for additional documents. Thus, Medi-Cal's verification requirements appear to vary depending on which form is used and which county is revising the application.

Extensive verification requirements can create significant barriers for families applying for Medi-Cal. Written verification of income and other factors often take a considerable amount of time for applicants to gather and require the cooperation of third parties who may not be willing or able to provide the information. Requests for verification can be particularly difficult for low-income working families, because they have little time during the work week and little flexibility to take time off from work to gather the necessary paperwork. Verification also can be particularly burdensome for homeless and migrant families, and it can lengthen the time it takes for the reviewing agency to process applications.

State regulations require verification, prior to approval of eligibility, of blindness, disability or incapacity (generally not relevant to applications for pregnant women and children), alien status, situations where the parent and a public or private agency will not accept legal responsibility for a child, identity, unearned income (which can be verified through state computer data exchanges or through applicant-supplied documents), in-kind income, earned income, child care costs, the cost of care for an incapacitated person and other deductible expenses, resources (which should not be a factor for pregnant women and children), health care benefits, and residency.

Data collected by Los Angeles County on the Medi-Cal mail-in applications received between the end of June and the end of August, 1998 show that verification requirements are creating problems for families. Lack of required documentation was the most significant problem area for the applications processed during that period – almost one-third (32%) of the applications were missing documents. These data are consistent with the experience of other states. When states have reduced verification requirements in their Medicaid programs, the percentage of applications denied for procedural reasons has declined sharply.

Contra Costa County's Employment and Human Services Department has been a leader statewide in working to support applicants to the program. Through its advocate program, Medi-Cal eligibility workers use advocates to remind applicants of necessary paperwork needed and work to contact applicants for follow-up. At the time of this writing, it is unclear how proposed state budget cuts will impact the ability of Contra Costa County's Employment and Human Services Department program to continue the advocate program and the outstationing of eligibility workers.

Successful Programs for Simplifying Application and Enrollment Processes

- **North Carolina's Health Choice for Children Program** has successfully implemented strategies to simplify the application and enrollment procedures, using a joint application for Medicaid and SCHIP, guaranteeing eligibility for 12 months in Medicaid and SCHIP, providing a simplified two page application in English and Spanish, allowing mail-in applications, cross-training eligibility workers to determine both programs' eligibility in one review, and notifying families automatically when it is time for them to reenroll their children in either program.

- **Ohio's Healthy Start** eliminated onerous eligibility verification requirements, such as proof of residency and birth date for children applying for Medicaid, which includes their SCHIP program. In addition, the state uses a two page simplified application, allows them to be mailed in and eliminated the requirement for face-to-face interviews before determining eligibility.

- **Oklahoma's SoonerCare** has been successful in outreach and enrollment by simplifying their application process in the following ways: the application was shortened from 16 pages to one; outstationed eligibility workers travel the state and conduct on-site enrollment at community-based sites; and they eliminated the asset tests and now accept self-declaration of income.

E. Enrollment Barriers

National data presented in the Kaiser Commission's *Enrolling Uninsured Low-Income Children in Medicaid and SCHIP* show that low-income uninsured children typically live in two-parent, working households and have little contact with the welfare system. Nearly all low-income parents say that having health insurance coverage for their child is very important, though many cannot afford to pay for it on their own. Most low-income parents (81%) view Medicaid as a good program, but have difficulties accessing it.

Health Insurance and Small Business

Many uninsured children come from working families whose employers do not offer health insurance. The California HealthCare Foundation sponsored a study, *Why Don't More Small Businesses Offer Health Insurance?* to explore the reasons. The primary challenge was cost. Small firms not offering health insurance tended to underestimate substantially the costs of coverage and were willing to pay on average on 40% of what they perceived to be the cost. Recent returns to double-digit increases in health insurance premiums and the current recession mean that cost will likely be an increasingly important barrier to small firms' ability to offer health insurance to their employees.

Another reason, more likely to offer hope for remediation, was low awareness of market protections and options. While information about the health insurance market is not likely to dramatically increase the number of small firms offering health insurance, it may make a difference for some. In particular, the survey identified a group which was predisposed to beginning to offer health insurance in the next two years. This group is a promising target for outreach and education efforts about the health insurance market, especially web-based strategies.

Other challenges that need to be addressed in reaching and enrolling eligible children include the following:

- **Complexity of Public Insurance Programs**. The number of programs, each with separate criteria and enrollment procedures, provides a significant barrier for families.

- **Immigrant Fears Still Exist**. The fear of retaliation from the Immigration and Naturalization Services remains a prevalent barrier to enrollment among immigrant families, despite resolution of the Public Charge issue in favor of health benefits. This fear of repercussions is particularly strong among legal residents who are seeking citizenship.

- **Resource and Systems Limitations**. Infrastructure and bureaucracy often create large barriers, especially within county welfare systems.

- **Lack of Information.** As shown in the CHIS interviews, many families are simply unaware of the availability of Healthy Families or of their children's eligibility for it.

- **Complexity of Forms.** A state report found that state health forms required college-level reading skills and ask for four times as much information and supporting documentation as federal income tax forms. The new shortened form was developed with this in mind. A study conducted by the UCSF Institute of Health Policy Studies, Barriers to Enrollment in Healthy Families and Medi-Cal: Differences by Language and Ethnicity, found that even with the shortened application, a larger than average share of Spanish-speaking Latinos described the application as difficult to understand. As a result, 32% of Spanish-speaking Latinos in their study reported not completing their application contrasted with 16% of non-Latinos and 12% of English-speaking Latinos.

- **Disparities Between High and Low Uninsurance Areas.** While only 25% of children live in high uninsurance areas, 40% of uninsured children live in these areas. Enrollment efforts need to focus on these areas, both because they include a large concentration of uninsured children and because take-up rates of public and private coverage have historically been lower in these areas.

- **Stigma of Enrollment in Public Programs.** Some parents do not want their children to be labeled as users of public systems, as described earlier in the CHIS interviews.

Table 1 below shows the reasons the Managed Risk Medical Insurance Board (MRMIB), which administers Healthy Families statewide denied coverage to children in the nine Bay Area counties. The most common reason was "income application not completed in 20 days" (17,800 or 46%). The regulations state that all documentation and information for eligibility must be presented to MRMIB within seventeen calendar days. The second most common was "Below 133% of poverty and age less than six years" (4,529 or 12%), followed by "Below 100% of poverty and age greater than six years" (4,015 or 10%). Both of these reasons mean that the child is eligible for Medi-Cal. Contra Costa County's top three reasons were the same as the Bay Area as a whole, as well as the state.

The most common reason for denial – incomplete application – could be remedied through more effective enrollment follow-up. The second and third most common reasons – income eligible for Medi-Cal – offers an opportunity to enroll these children into Medi-Cal. These three reasons, which could all result in more children insured with adequate staffing and systems for recruitment and application assistance, account for 71% of all of the county's 4,931 denials. With improved tracking through systems such as Consumers Union's system, these children could be enrolled quickly. Another 8%

have incomes between 201% and 300% of the federal poverty line, who still are likely to be unable to afford premiums. About 7% are not eligible because of immigration status.

Table 1: Healthy Families Program Children Ineligibility by County
For 12 Months Ending August 4, 2002

County/ Ineligibility Reason	Below 100% FPL and Age >= 6 yrs*	Below 133% FPL and Age < 6 yrs*	From 200% to 250% FPL**	From 251% to 300% FPL**	Above 300% FPL**	Not Eligible Due to Date of Entry***	Currently Enrolled in Non-SOC M/C+	Income Application Not Completed in 20 Days+	Missing/Invalid Emp. 90 Day Coverage Info+	Child < 1yrs (prior to 12/99)++	Child 19yrs or older++	Ineligible Immigration Status***	Other	No Reason Coded	Invalid Reason	Total
Total CA Ineligibles	47,523	49,068	4,273	13,542	7,334	2,030	25,963	161,075	19,208	1,454	2,199	17,017	474	11,142	2,036	364,338
Bay Area	4,015	4,529	733	1,907	1,083	299	2,569	17,800	2,171	204	270	2,125	48	1,137	203	39,093
Alameda	980	1,232	147	417	275	78	526	4,319	606	74	81	563	14	266	49	9,627
Contra Costa	**495**	**566**	**55**	**221**	**130**	**44**	**308**	**2,359**	**312**	**17**	**32**	**283**	**2**	**130**	**27**	**4,981**
Marin	107	96	21	32	13	5	79	471	64	4	8	26	0	32	3	961
Napa	127	160	16	51	19	5	81	417	56	4	4	38	0	45	6	1,029
San Francisco	321	307	87	189	93	28	265	1,301	131	12	28	178	1	91	14	3,046
San Mateo	315	373	99	181	107	21	146	1,840	230	14	23	297	7	102	9	3,764
Santa Clara	1,065	1,136	172	502	331	84	703	4,406	471	49	67	568	16	292	63	9,925
Solano	291	324	47	132	54	19	200	1,223	177	20	15	104	3	77	21	2,707
Sonoma	314	335	89	182	61	15	261	1,464	124	10	12	68	5	102	11	3,053

Source: California State Department of Health Services. Managed Risk Medical Insurance Board. Healthy Families Program Children Ineligibility Statistics by County, as of 8.4.02. HFP Table 16.

* Eligible for Medi-Cal. ** Income too high to qualify. *** Immigration issue.

\+ Not in compliance with regulations. ++ Age not eligible.

F. Retention Challenges

Enrollment retention is a concern. According to a study from the 100% Campaign:

- One in four children lost coverage in Healthy Families a year after enrollment.
- 162,000 children losing coverage compared to the 536,000 covered.
- Over half of Medi-Cal families lost coverage a year after discontinuing cash assistance.
- 60% of non-cash Medi-Cal families covered in 2000 lost coverage within a year.
- There is significant county variation in retention (82% to 22%).
- Healthy Families and Medi-Cal children have more rules to keep coverage compared to employer coverage.
- Some leave because of other coverage.

- Others lose coverage because they do not follow the rules, such as annual renewal or payment of premiums.

Five critical junctures in the coverage process where children are most likely to lose coverage are:

- Transition between Medi-Cal and Healthy Families
- Annual Review
- Monthly premium payments
- Communications from Medi-Cal or Healthy Families
- Access to Care.

According to the State Department of Health Services, nearly 65% of Healthy Families' 72,500 disenrollment cases (about 22,000 children or 30%) may be attributed to a family's failure to recertify annually or pay monthly premiums (about 25,000 children or about 35%). In 31% of applications received by the Single Point of Entry (SPE), applicants indicate that they do not want their children to be enrolled in Medi-Cal if they are eligible. Below is a chart of SPE applications for the nine Bay Area counties.

Retention and Disenrollment Benchmarks

There are a number of different definitions and ways to measure retention, or its flip side, disenrollment. They provide a range of numbers to debate the effectiveness of retention efforts.

- In the insurance industry, the retention rate generally refers to the year to year stability of the enrolled population. The retention rate answers the question: if 100 children enroll today how many will still be enrolled at the end of the a year?
- MRMIB calculates the *retention rate in the HFP* for all new enrollees who renewed during the annual renewal period.
- Healthy Families also uses an *adjusted disenrollment rat*e which assesses the reason for disenrollment and uses only the reasons it considers "potentially avoidable."
- Another measure is the number of total disenrollments divided by the number of total enrollments over the course of the programs.
- Disenrollment can also be measured by the number of disenrollments in the current year divided by the number of currently enrolled members, as seen in Table 2.

In evaluating the HFP retention rate, DHS staff identified comparable benchmarks. Enrollment in the HFP is most analogous to enrollment in the individual insurance market. It is an individual purchase decision. Families pay a premium. The consequence of non-payment is disenrollment. Data from National Blue Cross/Blue Shield Association, which shows Individual Market Data of 70-75% retention provide the closest approximation of a benchmark for enrollment in the HFP.

Disenrollment In The Healthy Families Program

MRMIB calculated that the retention rate in the HFP for all new enrollees from July 1998 through December 1999 was 76%, meaning that 76% of those enrolled renewed during the annual renewal period. Later groups of new enrollees were not included in this analysis because they have not had the opportunity to be enrolled for a year. Most recent data is somewhat contradictory to these data.

The flip side of the retention rate is the coverage "lapse" rate or disenrollment rate. Many factors influence disenrollment rates:

- Ineligibility at Annual Eligibility Review or attaining age 19
- Obtaining other coverage
- Failure to comply with program rules

Some of these factors are the result of "good news," in which the family has found private coverage for their child; others are inevitable given current program rules: the child is no longer eligible for coverage in the program; others are hard to evaluate in terms of whether they are good or bad news for the family. For example, it is unknown why many families stop paying their child's premiums.

California reports that its *adjusted* disenrollment rate for Healthy Families is 16%, which means that for every 100 children who enroll, 16 are disenrolling for *possibly avoidable reasons*, instead of the overall number of disenrollments. But overall, the total disenrollment rate (*disenrollment for any reason*) may be as high as 47%, with Contra Costa County at 54%, as shown in Table 2. Table 2 shows the number of Healthy Families subscribers and the number of disenrollments by county, with the percent of disenrollments to enrolled subscribers for the nine Bay Area counties for the 12 months ending June 7, 2002. Contra Costa County is in the middle of the group. This includes all disenrollments, both avoidable and unavoidable.

There have been a total of 279,707 disenrollments from Healthy Families through 8/9/02 (regardless of reason) and a total of 824,796 ever enrolled as of 6/7/02, showing a total disenrollment rate of 34%.

Table 2: Healthy Families Enrolled Subscribers and Disenrollments by County
For 12 Months Ending June 7, 2002

County	(A) Number Currently Enrolled	(B) Number Disenrolled in Previous 12 Months	(C) Percentage of Disenrolled to Enrolled B÷A
California	562,614	262,182	47%
Alameda	12,088	5,723	47%
Contra Costa	**6,228**	**3,373**	**54%**
Marin	1,641	882	54%
Napa	1,337	784	59%
San Francisco	10,003	4,089	41%
San Mateo	4,820	2,089	43%
Santa Clara	16,272	8,889	55%
Solano	3,140	2,442	78%
Sonoma	6,143	3,252	53%

Source: California State Department of Health Services. Managed Risk Medical Insurance Board. Healthy Families Program Subscribers Enrolled by County, Healthy Families Program Disenrollment by County, as of 6.7.02.

Unavoidable Disenrollments

As of May 2002, there were 354,406 cumulative disenrollments from Healthy Families, of which 5,570 were described by MRMIB as unavoidable and 10,467 as avoidable. This information is not currently available by county.

Some disenrollments are "unavoidable" given current program rules. Unavoidable disenrollments in the HFP account for 8% of all children. For example, when subscribers reach age 19, they are required to be disenrolled. This disenrollment as a system failure of the HFP; it is the federal law that restricts SCHIP eligible children to those under age 19. Other "unavoidable" disenrollments include

- those that result from the child no longer being eligible at the Annual Eligibility Review,
- those that result from a family's failure to provide citizenship or immigration documents, and
- those that are the result of an applicant's request.

While these are classified for analysis purposes as unavoidable, they are in some cases reflective of federal standards (immigration documentation) and in others of state policy choices (birth certificate documentation).

Possibly Avoidable Disenrollments

The largest groups of disenrolled children are those that have disenrolled for "possibly avoidable reasons." These account for 16% of children enrolled in the HFP.

The caveat "possibly" is used because the two largest reasons for possibly avoidable disenrollments are catch-alls:

- non-payment of premiums is recorded as the reason for disenrollment when the program does not have other information on why the family disenrolled — these disenrollments are the result of a variety of factors including financial hardship, attaining Medi-Cal or employer based coverage, moving out of state, family income increasing above eligibility levels or dissatisfaction with the program. For some families, the exact reason will never be known because the family can not be contacted.
- "non return of Annual Eligibility Review materials". All the reasons listed above may be the underlying reason for disenrollment of these families. In addition, the program's Annual Eligibility Review materials may influence this category. Whether the materials are simple to understand and presented in the family's language.

The DHS analysis suggests that there are opportunities to improve retention rates. It is important to note that these improvements would require substantial commitment from the State. Improvements in the billing process would appear to offer the greatest area for gains in retention rates. Ideas include:

- Redesign HFP billing statements
- Eliminate premium pro-ration. Begin premium payment obligations at first day of the first full month of coverage
- Translate all written correspondence into top 5 languages: English, Spanish, Chinese, Vietnamese, Korean
- Administrative Vendor initiate a courtesy telephone call 15 days prior to disenrollment for nonpayment
- Include e-mail address as a field on the program application so that reminder notices can be sent to families regarding overdue payments.

In addition, more information is needed on disenrollments in the two large catchall categories of non-payment of premium and Annual Eligibility Review information not returned. Without this information, the following administrative improvements may decrease disenrollments for these two broad categories.

- Telephone survey/follow-up for Annual Eligibility Review packets not received
- 30-day reminder to applicants disenrolled for Annual Eligibility Review not received and incomplete still can turn in documents with break in coverage

Another area that may prove useful in increasing retention rates is to involve application assistants more fully in the Annual Eligibility Review process. Ideas in this area include:

- CAA authorization on application to permit CAAs to assist with problems on initial application and Annual Eligibility Review
- CAA authorization on application to inform or remind applicant that Annual Eligibility Review is due

MRMIB has decided to focus their improvements on the billing system and the Annual Eligibility Review (AER), thereby achieving a better level than the current retention rate of 76%. The following are some of the steps that have been outlined by MRMIB to help increase retention:

Non-payment of premium:

- Courtesy phone call 10 days prior to disenrollment for non-payment of premium
- Re-design billing statement
- Enhanced Interactive Voice Response System for billing inquiries Opening of Parent Expansion

Annual Eligibility Review (AER):

- Courtesy phone call 30 days prior to disenrollment for not submitting AER Package
- Second AER Disenrollment letter reminder

Material Translation

- Translation of all correspondence (including billing statements and program materials) into Chinese, Korean, and Vietnamese

Application Re-Design

- Implement CAA Authorization on application to assist applicants and subscribers in completing application and AER packages.

While retention statistics that use the same methodology as above are not available for Contra Costa County from MRMIB, a comparison for the twelve months ending June 7, 2002 shows that California had 262,182 disenrollments and 562,614 current enrolled children (46% disenrollments to current enrollment) while Contra Costa County had a higher rate of disenrollments – 3,373 disenrollments and 6,228 currently enrolled (54%).

F. Access to Care

Access to care has been recognized as an important retention activity. When children have a medical home, they are much more likely to maintain their coverage. As described above, national statistics show that uninsured children are significantly less likely to have preventive and primary care and to have more unmet health needs than insured children. Program evaluations for Healthy Families have not been completed

yet, it is important to remember that the goal of having health insurance is in fact to obtain preventive and other health care services easily and in a timely fashion.

If enrollment efforts do not include as essential components 1) ensuring a medical home for children and 2) providing an understanding of where and when to access care and easy access to the medical home, then the value of health insurance for the family will be limited. Point of service enrollment – enrollment of children without insurance – at the time of service at county and community clinics, in particular, seems to be one of the most cost-effective enrollment opportunities. The link then can easily be made between health insurance and health access.

G. Survey of Best Practices

A number of studies already quoted above describe effective strategies to make enrollment and retention more likely. Key lessons learned include

- Successful outreach and enrollment programs at the local level build an ongoing relationship with the family to help them obtain insurance, use services appropriately and retain coverage over time.
- More rigorous evaluations of outreach, enrollment, access and retention programs are needed to determine which activities are most successful.
- To date, there has been limited dissemination and replication of these strategies throughout the state.
- The state should determine whether Medi-Cal and Health Families enrollment is associated with more appropriate use of health care services by children.
- The lack of sufficient and sustainable funding presents a major challenge for local organizations involved in these activities.
- Due to high turnover rates among certified application assistants, local programs have implemented continuous training programs.

A study conducted for DHS by the Center for Adolescent Services Research Center found that successful outreach programs

- Build on prior experiences
- Use tracking systems to monitor whether applications result in enrollments
- Collaborate with WIC programs
- Give out information and make application appointments.

Successful strategies within three components of outreach include

- *Identification of the Target Population*
    - Use census data and a Geographic Information System to create maps of low-income uninsured children
    - Administer brief surveys to all children in a school to obtain estimated of the number of uninsured children as well as those needing follow-up
    - Collaborate with publicly funded programs that have similar eligibility requirements, such as WIC, including outstationing staff at the WIC office
    - Use health fairs as an opportunity to educate parents about health insurance and to set up appointments for enrollment
- *Use of Media and Communication*
    - Use press releases and news stories to disseminate information, rather than purchase expensive advertising
    - Use school mailings to reach large numbers of potentially eligible children, such as mailings for the school lunch program – these should be followed up with personal contact
    - Word-of-mouth, especially in tight-knit ethnic minority communities, including using parents to talk with other parents
- *Use of Incentives*
    - Ice cream party for each class that returns 100% of circulated surveys
    - Small gifts for teachers to acknowledge their critical role in the process

Successful strategies in enrollment are less well-known. Overall, nearly two of every three applications to Healthy Families are completed with assistance. Even the strategies listed below are not a surefire way to assure that a family will move from interest to enrollment.

- *Enrollment Sequence*
    - Schedule appointments with application assistants to help families complete the application
    - Schedule evening and week-end hours to accommodate working parents
    - Provide transportation vouchers and incentives
    - Send promotoras to follow up on missed appointments
    - Focus on one school at a time, with workers stationed at the school all day and in the evenings to meet with parents, until every potentially eligible child has been reached

- *Productivity Standards*
    - These vary based on type of program and where it is located. Urban school-based programs reported the highest average monthly enrollments per full-time staff. The highest reported standard is 25 applications per month, accounting for 25 children. In rural areas, the number may be as low as seven per month.

Knowledge of **successful strategies for appropriate use of health care services** is limited by small evidence demonstrating the impact of enrollment on utilization.

- *Appointment Assistance, Reminders, Follow-up and Written Information*
    - Provide written information about how to obtain care
    - Provide education and assistance in scheduling an appointment either in person or by phone
    - Maintain a database to keep track of time a family is contacted.
    - Contact families 30 to 60 days after they have enrolled to remind them to make an appointment with their primary care provider and dentist, either by phone or in person
    - Help families make appointments directly
    - Provide classes in how to use the health care system.
- *Client Tracking Systems*
    - All of the follow-up strategies require an information system that contains accurate contact information and application status.

Successful strategies for retention focus on potentially avoidable disenrollments. Each stage in the reenrollment process is essential for children to maintain coverage.

- *Reminders*
    - Contact families regularly (at least three times a year) to follow-up on enrollment status, answer questions and prepare families for reenrollment
    - Use tracking sheets that remind the outreach worker to follow up with every family at reenrollment time.
- *Advance Payment of Premiums and Change of Address Forms*
    - Encourage families to pay multiple months of premiums at enrollment

Creating a Sustainable Infrastructure to Support Best Practice Activities

Most successful programs view the application process as more than single transaction, but rather the beginning of a yearlong relationship with multiple contacts. In order to establish and maintain these relationships, programs report that they need a sustainable infrastructure, with

- data and tracking systems
- long term funding
- ongoing training
- action-oriented collaboration
- access to information resources.

Without appropriate **tracking systems**, it is nearly impossible to develop an ongoing relationship with newly enrolled families. Many organizations have developed them using Microsoft Access or other commercial software packages. Consumers Union has commissioned consultants to develop a customized database application that can be used to track outreach, enrollment and retention. *Healthy Tracker* is a stand-alone database built on Filemaker Pro that is ready to use and available free to interested outreach entities. Contra Costa has begun to incorporate components of the *Healthy Tracker* into the Outreach and Enrollment Initiative's database in order to more carefully follow-up on clients.

Other organizations engage in **continuous quality improvement**, producing regular reports that allow them to evaluate the effectiveness of particular strategies and to revise them accordingly.

Other Resources

Ongoing training is provided for CAAs through a number of resources, including the National Health Foundation's CHAMP Program in Los Angeles and the Child Abuse Prevention Council in Sacramento. The California Rural Indian Health Board holds monthly conference calls with all outreach workers at all Indian Health programs throughout the state, updating staff, reviewing statistics, answering questions, and providing guest speakers.

Curricula such as Community Health Councils, Inc.'s Health Insurance and Health Services, a Consumer Education Curriculum, can train staff to educate community members about the importance of health care, health insurance, health coverage programs for children and adults, and where to go for health services.

H. Survey of California County Activities in Outreach, Enrollment and Retention

The Department of Health Services has awarded contracts for schools and organizations to provide direct outreach and enrollment activities for HFP and MCC. In March 2001, DHS requested applications for both community-based and school-based/school-linked efforts, and in July 2001, announced their intent to award contracts. A total of $11.5 million was disseminated statewide for these local efforts. The two year contracts were scheduled to end in June 2003, but the current state budget crisis will end many of them sooner.

Enrollment Entities (EEs) are organizations registered with the State of California Department of Health Services with staff trained as Certified Application Assistants (CAAs). CAAs help families complete the Health Families/Medi-Cal for Children application form. The EE employer may claim a $50 application assistance fee from the state for every successful application. When a CAA assists enrollees in completing their Annual Eligibility Review, which must be completed by every HFP participant yearly, the EE may claim a $25 fee.

Below is a list of some of range of activities carried out throughout the state. Afterwards follows an inventory of selected outreach, enrollment and retention activities in selected counties.

- **CHAMP,** the Children's Health Access and Medi-Cal Program, trains school, hospital, and agency employees to help low- and moderate-income families enroll their children in health care programs. CHAMP offers a program-integrated approach to outreach and enrollment so that all uninsured children can obtain access to regular health care. LAUSD CHAMP hires parents from the community to serve as Health Care Community Representatives, training them to educate other parents about children's health insurance programs and to help families enroll in these programs at school sites. Health Care Advocates provide training, mentoring and support to the parents. Outreach and enrollment staff members conduct presentations and other outreach activities, in addition to organizing health insurance enrollment events. The LAUSD CHAMP program is a pilot program of Consumers Union's Healthy Kids, Healthy Schools Project. As a result, District Medi-Cal enrollment rates have increased 28.81% over the previous 12 months.

- The **49ers Academy**, a middle school in the Ravenswood City Elementary School District, focuses on outreach coupled with intensive follow-up. This project is a partnership between the San Mateo Department of Public Health and the 49ers Academy. The school's two counselors screen all students for

health insurance as a part of the regular intake process. Students without health coverage are provided with information about Healthy Families and Medi-Cal, and are referred to an on-site Outreach Specialist to assist them with the enrollment process. Because the Outreach Specialist is also a Medi-Cal eligibility worker, he/she can help address insurance issues for the entire family. In addition, the Outreach Specialist provides education about the benefits of health insurance and follows up with parents once their children are enrolled to ensure that they can effectively use available health care services.

- Alum Rock Union Elementary School District's **Healthy Students=Healthy Schools** (HSHS) uses two strategies to reach out to families in the district: Mass Enrollment Events and Request for Information Forms sent to families in the back-to-school packets that include the School Lunch Program application. The mass enrollment events led to the enrollment of 1,487 children with an average enrollment per event of 135 children. Outreach using the School Lunch Program is estimated to have led to the enrollment of approximately 1,500 children. In addition, the state's enrollment statistics for Healthy Families for the last year showed that enrollment in the district's service area increased by 50%. The Food Service Director or other school personnel return the completed RFI form to the District's HSHS Coordinator. The HSHS health care outreach and enrollment staff contacts parents to screen for eligibility, and then schedule individual appointments at convenient school sites or invite them to attend enrollment events. HSHS staff make follow-up calls to applicants to inquire if their applications have been successfully processed and to offer assistance in completing forms received from their insurance providers.

- The **Student Health Outreach Project** (SHOUT) is an initiative of the Children's Defense Fund that involves students in the effort to enroll children in free and low-cost health insurance programs. SHOUT works with high school students, undergraduates, and medical school students to reach uninsured children and sign them up for Medi-Cal for Children, Healthy Families, or other insurance programs. The SHOUT project recruits the students, trains them, and helps link them to community-based organizations engaged in the outreach and enrollment process. SHOUT also provides technical assistance to individual students who want to incorporate health insurance outreach into their current activities, such as working in an after-school program or attending church. At Stanford University, one SHOUT project involves a group of medical students who run a free clinic in nearby East Palo Alto. Most SHOUT participants are not trained Certified Application Assistants (CAAs). Instead, they partner with community-based organizations who have CAAs on staff to help families with the enrollment process.

- **Health Insurance Outreach** of Pasadena Unified School District (PUSD) uses District Outreach Workers who are bilingual school district employees. They promote and coordinate outreach for Medi-Cal, Healthy Families, and other free or low-cost health insurance programs. The PUSD program conducts outreach in a variety of ways, including: distributing flyers, pencils and rulers, and making presentations at parent meetings, back-to-school nights, open houses and to other school staff. Program staff members follow up with each family who expressed an interest in health insurance for their children. Outreach workers provide Parent Education Classes to inform parents about low-cost and no-cost health insurance and to educate parents on how to effectively access health services once they are enrolled in the programs. PUSD staff have learned that enrollment is more successful the closer it occurs to the initial point of contact, so they schedule appointments for the same day or within 24 hours.

- **The Solano Kids Insurance Program** (SKIP), a program of the Solano Coalition for Better Health, has developed a social services marketing model that provides outreach to community-based organizations, faith organizations, schools, and businesses. In 1999, outreach linked with the School Lunch Program back-to-school mailing produced more than 1,000 responses from families. Other outreach efforts include: use of a dedicated school phone line, coordination with school nurses and principals, and enrollment event coordination. Information about SKIP is included in both kindergarten and new student enrollment packets in most school districts. SKIP uses incentives to encourage families to complete enrollment. SKIP uses targeted flyer distribution, brochures, posters, and focused advertising that includes bus, newspaper, and free publicity, including local cable access. SKIP personnel have learned that enrollment is more successful the closer it occurs to the initial contact with a family, so they schedule appointments for application assistance on the same day or within 24 hours of the initial contact. SKIP has increased its number of walk-in enrollment sites as part of its overall strategy to increase access. SKIP's Certified Application Assistants (CAAs) make appointments to help families complete health insurance applications and follow up on missed appointments. In addition to paid staff members (some of whom are bilingual) and CAAs, SKIP encourages volunteers to donate time in the office to make follow-up phone calls and to serve as CAAs.

- The **Monrovia Unified School District** (MUSD) **Healthy Start** program conducts outreach and enrollment for Healthy Families and Medi-Cal for Children throughout the district (grades K-12) to enroll all eligible students. At the high school level, HF/MCC outreach is part of MUSD Healthy Start's "Teen Dayz," monthly events that focus on the health needs of students. This program distributes posters printed in both English and Spanish throughout the community to market free and low-cost health insurance available for

children. Word-of-mouth referrals also have proven to be a very effective outreach method. Healthy Start staff provide information to parents who are signing their children up for the after-school program and also focus on enrolling high school students in health insurance through "Teen Dayz" events. Healthy Start staff who are Certified Application Assistants are available as needed to help families enroll their children in a health insurance program.

- The **Santa Maria-Bonita School District Healthy Start** Program has a dedicated full-time position for Healthy Families/Medi-Cal application assistance. In addition, all Healthy Start staff are trained Certified Application Assistants. As a result, staff are continually booked with scheduled appointments for application assistance and also see a large number of parents that drop-in for assistance. Healthy Families/Medi-Cal outreach is integrated into all Healthy Start activities. The Santa Maria-Bonita Healthy Start program maintains a consistent and clear outreach message that is communicated through multiple channels. Each year, a Healthy Families/Medi-Cal outreach flyer is sent home with every student in the school district. The flyer is also distributed at regular community events like church services and PTA meetings. Healthy Start staff ask all clients at the initial point of contact if they are aware of Healthy Families/Medi-Cal. They make presentations in all parent education classes (ESL, literacy, and GED). The program has developed a radio advertisement in Spanish and English that is regularly broadcast in the community. The program provides "full service" for families that receive Healthy Families/Medi-Cal application assistance. As a trusted entity, the school district provides families with important information on utilization and preventive services to assist families in using the services and retaining the health benefits. Furthermore, this program tracks and follows-up with families to ensure enrollment occurs.

- The **Health-insurance Access Through Schools** (HATS) program is an innovative effort to expand health coverage to uninsured children in San Diego County through school-based outreach. HATS offers local school districts the opportunity to have bilingual outreach workers stationed at school sites to reach out to low-income families and enroll them in California's state-sponsored children's health insurance programs - Healthy Families and Medi-Cal - or other subsidized insurance programs. The program is managed by the University of California at San Diego's Department of Community Pediatrics. The University provides interested school districts with funding to hire workers who will do outreach and provide application assistance, and the districts allocate work space and telephones for these workers at selected schools. The University trains the outreach workers and then manages the program within each school site. In addition, the University has a Program Supervisor who ensures that each outreach worker becomes a state Certified

Application Assistant (CAA), oversees the daily operations, and maintains a database to monitor and evaluate outreach progress. This structure allows the HATS program to operate without additional school district costs and with minimal disruption to schools' academic commitments. The University also assists the districts in becoming enrollment entities. HATS uses various outreach tools such as flyers, telephone calls, individual meetings, and group presentations to inform parents about health coverage options for their children. Interested parents can meet with an outreach worker at their child's school to receive assistance with the health insurance application form. The outreach worker follows up with families to ensure that their child or children become enrolled in the appropriate health insurance program. The HATS outreach workers maintain contact with the families, continuing with follow-up and assisting with problem resolution when necessary until the child or children are successfully enrolled in a health insurance program.

- The **San Diego Kids Health Assurance Network** (SD-KHAN) formed an Outreach Committee to identify effective outreach strategies that would expand health insurance coverage for children. The SD-KHAN Outreach committee is responsible for facilitating a coordinated campaign with public/private partners to link uninsured children/youth with health care options. SD-KHAN established a toll-free telephone information and referral system to help maintain a coordinated method of linking children with a health coverage option in the county. Operators are available to answer questions and to refer interested families to the appropriate health insurance program or to a local Certified Application Assistant (CAA). Modeled after the Health-insurance Access Through Schools program (HATS), HealthLink stations CAAs at school sites in San Diego City Schools once a week to help families enroll their children into a subsidized health insurance program. The CAAs use the school district's health information exchange card to contact parents who do not list a medical provider or health insurance plan for their child and to help families apply for children's health insurance.

- **Healthy Families and Medi-Cal for Children Outreach and Enrollment Project** of the San Francisco Bay Area is a school-based outreach and enrollment project that is part of the Health Access Foundation. Health Access conducts outreach and enrollment for Healthy Families and Medi-Cal for Children in the City and County of San Francisco, using a family-centered model, which has been successful in informing and enrolling uninsured, low-income children and their families. Health Access works in collaboration with the local school district and other community organizations distributing simple educational literature for partners and service providers, as well as a simple, one-page Request for Information [RFI] form. The RFI forms are distributed to families via the school district. If parents are interested in receiving information on low- or no-cost health insurance for their children, they can

complete the RFI and mail it back to Health Access in a postage-paid envelope. Health Access and partner agency staff use the completed RFI to follow up with the families. Certified Application Assistants (CAAs) make multiple attempts to contact the parents, including contacting them at alternative times, such as during evenings and different days of the week. CAAs provide an initial intake to assess eligibility and describe some of the benefits provided by Healthy Families and Medi-Cal for Children (HF/MCC), and then invite applicants to participate in a face-to-face enrollment appointment. Adults are referred to other available health care programs and encouraged to contact the CAA if they have additional questions or concerns about HF/MCC.

- **California Health Collaborative (Collaborative), Fresno,** is a nonprofit health organization based in Fresno. The Collaborative administers three health insurance outreach and enrollment programs--Access for Infants and Mothers (AIM), Fresno County Medi-Cal Outreach Partners, and Interagency Healthy Families/Medi-Cal for Children Outreach Project. Fresno County Medi-Cal Outreach Partners promotes awareness of children's health coverage options in the community and to enroll children into state health insurance programs. This program utilizes several outreach and enrollment strategies, including door-to-door outreach, health fairs/community events, and school- and agency-based enrollment events.

- The **ABC Project** enrolls children in health insurance programs in South Central Los Angeles and Long Beach. The project informs families about available health insurance programs and provides application assistance for Healthy Families, Medi-Cal, California Kids, AIM, Kaiser Cares for Kids, as well as referrals to the CHDP program. The project offers follow-up services through case management for enrollees to ensure that they understand how to effectively use the health benefits. The ABC Project conducts outreach in collaboration with local schools, community clinics, community-based organizations, hospitals, WIC sites, and churches. At each of these sites, the ABC Project has established "outstations" where an outreach worker usually spends one half-day per week. Project staff follow up with enrollees at 30-, 60-, and 90-days to ensure that they are effectively using their health benefits and to answer questions or provide other assistance relating to their health benefits.

- The **Healthy Families Outreach Campaign** of El Concilio seeks to maximize health care access for children and families in San Joaquin County, including increasing enrollment into state-sponsored children's health insurance programs. El Concilio is a nonprofit social services community-based organization in San Joaquin County which focuses its outreach at schools, community partners, faith community, ethnic and cultural outreach,

employers, small business, health fairs and special events. The campaign uses enrollment events, geographic canvassing and residential outreach, in-office appointments and enrollment assistance at fixed sites, and home visits to conduct outreach in each focus area. Lodi Unified School District, in partnership with El Concilio, uses the School Lunch Program/RFI mailing effort as one school-based strategy to enroll children into state-sponsored health insurance programs. Interested parents return the RFI to the school with their child and the school sends the form to the district school nurse, or the parents can call the district school nurse. The district nurse reviews the RFI and sends the form to the Lodi Community Center. At the Community Center, a representative from El Concilio then contacts interested parents to answer questions, schedule an appointment for application assistance, and help parents complete the children's health insurance application forms.

In addition, the successful implementation in Santa Clara and San Francisco counties of an insurance product for children who do not qualify for Medi-Cal or Healthy Families called Healthy Kids has allowed more children to be enrolled in both Medi-Cal and Healthy Families as well as the new insurance product. By enabling all families to participate regardless of immigration status and other factors, all children in a family can be enrolled in a seamless system of insurance. One child may be on Medi-Cal, two on Healthy Families and one on Healthy Kids. Contra Costa County's recent expansion of the Basic Adult Care program to include children in the Basic Health Care program should result, if enrollment strategies follow, in more children enrolled in Medi-Cal and Healthy Families as they are screened for Basic Health Care.

The following inventory was created to capture what is happening statewide vis-à-vis outreach, enrollment, and retention for Medi-Cal and Healthy Families and to identify changes made by Social Services to aid these efforts. Efforts underway are usually within health departments, at community health centers, at community-based organizations and at local Medi-Cal managed care health plans and schools. This survey was conducted as a part of this project specifically for Contra Costa County. It was done in April and May 2002 in telephone interviews.

Questions asked included:

1. What specific outreach activities are you currently engaged in? How are they paid for? What kinds of targets (numbers) or results are you hoping to achieve? Do you have a collaborative community-wide to work on this project?

2. Who does enrollment for Healthy Families and where is it done? Can Medi-Cal only be done by Social Services? How do your enrollment assistants help get people to Medi-Cal? How do you track your success at enrollment? Hoe many people are doing this? Do you have any standards for their performance or productivity?

3. How do you measure retention? What specific strategies do you use to track and monitor and follow-up on retention?

4. What kind of tracking system do you use? Have you used the Consumers Union's Healthy Tracker system?

5. How has Social Services changed what and how they do enrollment?

Inventory of Outreach, Enrollment and Retention Strategies in Selected Counties
Medi-Cal and Healthy Families
May 2002

County	Contact	Outreach Strategies	Enrollment Strategies	Retention Strategies	Tracking System	Social Service Changes
Alameda County*	Camilla Chavez (510) 776-7567	▪ Schools, churches, family resource centers, special events, businesses, door-to-door, TV, 800 #, flyers ▪ ***Target:*** 100 apps/event ▪ ***FS:*** S	▪ CAAs team up with SS Staff at event/site. ▪ Call Center – apps in person or via phone. ▪ Teams do HF, Medi-Cal and Alliance apps ▪ Worked with a different community collaborative for each of 10 enrollment events	▪ Phone follow-up to discuss enrollment, navigate system, discuss first appoint ▪ Goal: "close" 5 cases/day	Internal database	Also does HF apps, some team-up with CAAs
Fresno County*	Ron Torres (559) 226-6387	▪ Schools, social workers, health department, health fairs, events, flyers ▪ ***FS:*** S	▪ CAAs at 9 school sites, ▪ Call Center planned but dropped due to state budget ▪ CAAs help with Medi-Cal and do HF apps	▪ Phone contact at 1, 3, 6, 11 months	Internal database, were hoping to use Consumers Union if state funding had continued	Not much contact with social services, had planned to start next fiscal year
Imperial County*	Robin Raecker (760) 482-4704	▪ Small businesses, chambers, schools, churches, community centers, geographic gap areas. ▪ Very successful small business outreach. Learned that before educating employees then had to educate employers. ▪ Apps are precoded for tracking ▪ ***FS:*** C, F, B	▪ CAAs at events, CBOs, hospitals, health department clinics, businesses ▪ Appointments done by in-house and outreach staff ▪ Some CAAs help with Medi-Cal apps, some refer to Social Services	▪ Just started sending reminders at re-enrollment. ▪ Retention is a big problem	Consumers Union website and then call to get specific county reports. Track failures and follow-up with staff training	Training others to provide assistance with Medi-Cal apps

* Working with community collaborative(s).

Key: FS: Funding Source; F: Foundation; C: County; S: State; FG: Federal government; B: Business

County	Contact	Outreach Strategies	Enrollment Strategies	Retention Strategies	Tracking System	Social Service Changes
Kern County*	Gail Ortiz (661) 868-0525	▪ Outreach to CHDP and WIC contacts, via door-to-door, events, health fairs ▪ ***Target:*** Of those interested, 40% complete app ▪ ***FS:*** S	▪ CAAs at events, home visits, clinics, hospitals, schools ▪ Target enrollment of 600-1,500/month ▪ CAA starts Medi-Cal app, Social Services completes	▪ None for HF	Internal database and paper tracking	Better exchange of information between Public Health and Social Services, established key contacts
Marin County*	Barb Clifton (415) 472-1663	▪ Schools, child care centers, events, preschools, nonprofits, support groups, businesses ▪ ***FS:*** F, C	▪ CAAs at clinics, CBOs, hospitals ▪ ***Target:*** 500/year at start, now 200/quarter ▪ CAAs do joint app for Medi-Cal and HF, also refer to Social Services	▪ Just starting to look into it	Consumers Union site being looked at. State reports	Continue to just do Medi-Cal
Riverside County*	Consuela Edmond (909) 358-4933	▪ Media campaign with print ads, internet information, community calendars, health fairs, presentations, billboards, displays in 259 community sites ▪ ***FS:*** S	▪ CAAs at WIC sites, immunizations clinics, hospitals, mobile health vans, community sites. ▪ CAAs do Medi-Cal and HF ▪ ***Target:*** 1,400 current fiscal year. ▪ Each CAA target of 60 apps/month	▪ Phone contact one month after enrollment ▪ CAAs help with annual re-enrollment	Internal database; not aware of Consumers Union	Much quicker enrollment for Medi-Cal now. Not doing HF apps or HF information
San Diego County*	Monica Buhlig (619) 692-8519	▪ Businesses, schools, child care, events, head start, WIC, faith-based organizations, family resource centers, 800 # ▪ ***FS:*** FG, C	▪ CAAs at CBOs, clinics, schools, health department, businesses. Refer to Medi-Cal except for joint apps	▪ Retention work-group in collab. ▪ Brochure to newly enrolled clients regarding use of services Phone follow-up system, different for each program	Internal databases at each program tracks statistics	Beginning to distribute HF apps

[*] Working with community collaborative(s).

Key: FS: Funding Source; F: Foundation; C: County; S: State; FG: Federal government; B: Business

County	Contact	Outreach Strategies	Enrollment Strategies	Retention Strategies	Tracking System	Social Service Changes
San Francisco County*	Francis Culp (415) 554-2795	▪ Key focus is via school districts, also health fairs, events, CBOs, TV, radio, flyers, print ads ▪ ***FS:*** S, F	▪ CAAs at hospitals, health centers, events, Medi-Cal offices ▪ CAAs will help with Medi-Cal app and refer to Social Services ▪ ***Target:*** 1,200 this fiscal year	▪ CAAs phone contact at 2, 6, 11 months	Paper tracking and internal database. Fiscal intermediary reviewed Consumers Union system, chose not to use it	Social Services will do joint apps
San Mateo County*	Toby Douglas (650) 573-2095	▪ Public Health clinics, schools, childcare councils, CBOs, faith-based organizations, labor council, events, health fairs ▪ ***FS:*** S, F, FG	▪ CAAs at health department clinics, CBOs ▪ CAAs do joint apps and initial Medi-Cal app, then refer to Social Services ▪ ***Target:*** double enrollment in next 3 years	▪ Just beginning to look at this ▪ Medi-Cal is about to start a system of automatically re-enrolling people, not waiting for re-enrollment forms form clients	Paper tracking by all agencies, entered into internal database	Closer working relationship with Public Health, more proactive approach to completing apps, better communication, sometimes fill out joint apps
Santa Barbara County*	Tara Brown (805) 681-5217	▪ Clinics, health fairs, schools, hospitals, housing authority, preschools, churches, CBOs, brochures, social marketing campaign ▪ ***FS:*** C, FG	▪ CAAs at clinics, hospitals, schools, CBOs. ▪ Assist with Medi-Cal apps and refer to Social Services ▪ ***Target:*** None	▪ None at this time	Paper tracking and reports from state	Expansion of eligibility workers at CBOs
Santa Clara County*	Susan Karlins (408) 793-6569	▪ Clinics, community centers, schools, special events, faith-based organizations, some businesses, county child support, flyers, radio PSAs, TV and print ads, Call Center 800 # ▪ ***FS:*** C, F, S, B, City of San Jose	▪ CAAs at CBOs, clinics, school districts, call center ▪ Some assist with Medi-Cal apps, others refer to Social Services offices ▪ ***Target:*** 72,000 eligible ▪ Have enrolled 34,000	▪ Internal database	Internal database, data about ready to come out of this. Aware of Consumers Union system	Working with them to do HF apps at Social Services offices

* Working with community collaborative(s).

Key: FS: Funding Source; F: Foundation; C: County; S: State; FG: Federal government; B: Business

County	Contact	Outreach Strategies	Enrollment Strategies	Retention Strategies	Tracking System	Social Service Changes
Santa Cruz County*	Claudine Wildeman (831) 454-4236	▪ Child care providers, schools, businesses, special events, health fairs, housing authority, farmers market, brochures, 800 # ▪ ***FS:*** F, S, C, FG	▪ CAAs at clinics, CBOs ▪ Help fill out Medi-Cal and HF apps and refer to Social Services ▪ ***Target:*** 2,000 enrollees in 00/01 and 850 this year. Performance standards vary per agency	▪ CAAs make calls soon after enrollment and then at 6 and 11 months	Paper tracking and internal database tracks general numbers for all agencies. More sophisticated system starting 7/1/02. Have not used Consumers Union	Expanded outstations to CBOs and some schools, responding to 800 #. Lead in providing training
Solano County*	Jackie Wolfram (707) 863-4430	▪ Schools, businesses, chambers, nonprofits, WIC, CHDP, rec centers, child advocacy groups, neighborhood groups, faith-based groups, special events. PSAs, materials, ads in papers and buses and theaters. ▪ Marketed programs via health insurance education programs ▪ ***FS:*** S, C, B	▪ CAAs at insurance plans, Healthy Start program, school districts, CBOs, WIC, CHDP ▪ Refer to Social Services for Medi-Cal	▪ Medical students track each client making at last 3 phone contacts a year	Paper tracking and internal database for enrollment numbers. Soon will have retention numbers	Improved "look" at public events, stronger working relationship with Public Health, strong interest level in program success
Sonoma County*	Cathy Frey (707) 542-7242 ext. 13	▪ Health centers, CBOs ▪ ***FS:*** S	▪ CAAs at health centers and CBOs ▪ CAAs help with Medi-Cal, HF and walk-in apps to Social Services office. Enrollment tracking stopped due to budget	▪ No coordinated tracking of retention, some follow-up by individual CAAs	Paper tracking and internal database. Not familiar with Consumers Union	Not sure

* Working with community collaborative(s).
Key: FS: Funding Source; F: Foundation; C: County; S: State; FG: Federal government; B: Business

County	Contact	Outreach Strategies	Enrollment Strategies	Retention Strategies	Tracking System	Social Service Changes
Ventura County*	Steve Lehman (805) 289-3371	▪ WIC, public health clinics, schools, daycare, some businesses, CBOs, local groups. Collaboration is entirely related to school readiness. ▪ Tried incentives (pencils, etc.) to encourage referrals, and found that business cards and magnets were most effective. They have integrated HF/Medi-Cal education in what they call "neighborhoods for learning" – geographically based collaboratives provide training and education on many issues, using the National Health Foundation curriculum CHAMP ▪ ***FS:*** C, S	▪ CAAs at clinics, hospitals, CBOs. CAAs do Medi-Cal and HF apps	▪ Annual postcard reminders, automatic client dial-up phone system with recorded messages and app assistance	Paper tracking and state reports	Improved access to databases, expansion of outstationed eligibility workers
Alameda Alliance for Health*	Duane Oshinomi (510) 747-4555 Troy Lam (510) 747-4500	▪ Schools, churches, special events ▪ ***FS:*** C, F, Alliance	▪ CAAs at events, churches, schools ▪ CAAs do Medi-Cal and HF apps	▪ Follow-up calls to anyone who disenrolls, reminder post cards at 10 months, assist with filling our re-enrollment forms	Internal database	Not sure
Inland Empire Health Plan	Ed Moreno (909) 890-2760	▪ Events, health fairs, telecenter, faith-based organizations, schools, clinics, hospitals, businesses, flyers ▪ ***FS:*** S, Health Plan	▪ CAAs at clinics, hospitals, schools, insurance offices, dental plan. Refer to Medi-Cal for apps	▪ Postcard reminder for re-enrollment ▪ Will begin tracking soon	State reports, using Consumers Union a little	Not sure
Central Coast Alliance for Health*	Jan Wolf (831) 466-4335	▪ Health fairs, special events, housing authority with other collaborative members	▪ None	▪ None now, had to stop due to staffing issues	None	Not sure

* Working with community collaborative(s).

Key: FS: Funding Source; F: Foundation; C: County; S: State; FG: Federal government; B: Business

III. Contra Costa County System for Outreach, Enrollment and Retention

A. Organization Structure, Transition, Staffing and Budget

The Contra Costa County Outreach and Enrollment program has four main components:

- Contra Costa Health Services, which assists clients at public health clinics, CHDP, Mental Health, CCS and WIC, and financial counselors at county primary care sites and the Contra Costa Regional Medical Center
- the Health Access Coalition, comprised of a range of community-based providers, advocacy groups, and county agencies
- Contra Costa Employment and Human Services Department, which uses its Medi-Cal Eligibility Workers and Medi-Cal Advocates
- Health Assistance Centers at West Contra Costa Unified School District, La Clinica de la Raza and the Perinatal Council.

In addition, the Community Services Department has worked actively to ensure that all eligible children in its day care programs are enrolled in Medi-Cal and Healthy Families. Through extensive training of its staff and parent advocates and through the use of additional Medi-Cal Administrative Activity (MAA) funds, the Community Services Department has had good success in both enrolling and retaining its families in the public insurance programs.

Contra Costa Health Services has coordinated the overall outreach and enrollment effort, by creating contracts with the three community-based Health Assistance Centers, conducting enrollment and outreach activities through several Health Services programs and community sites and staffing the Health Access Coalition. Employment and Human Services carried out the Medi-Cal enrollment and application efforts as well as a key focus on retention activities, while the Health Assistance Centers focused outreach and enrollment activities in specific geographic areas of the county.

Contra Costa Health Services has also assigned student worker Certified Application Assistants to its primary care sites and public health sites, including WIC, on a regular, part-time basis.

Each of the subcontractors was responsible for hiring and training staff, conducting outreach and education activities in the community, and providing enrollment assistance to families. They were also encouraged to attend the Health Access Coalition meetings

to enhance information sharing and to obtain updates about Medi-Cal and Healthy Families.

East County was targeted with two Health Assistance Centers because it was found that there were a large number of eligible families and that while La Clinica had a strong presence in Pittsburg, other East County communities needed more comprehensive outreach. West Contra Costa Unified School District (WCCUSD) provided a school-based outreach component.

The Consumers Union provided technical assistance to WCCUSD's outreach efforts to families who applied to the Free or Reduced Price Meal Program, a methodology shown to be effective in reaching eligible families. This effort, with applications completed by CCHS staff, resulted in a substantial number of requests for more information. Between October 2000 and September 2001, over 500 Healthy Families applications and 158 Medi-Cal applications were completed.

La Clinica offered Healthy Families enrollment assistance to 186 individuals on site and by telephone contact. There were 41 families assessed as eligible for Medi-Cal who were referred to a Medi-Cal eligibility worker for application assistance. During the project, an eligibility worker was outstationed to La Clinica to make this referral easier. A La Clinica staff member is a certified enroller dedicated to eligibility screening and application assistance on site at the Pittsburg clinic.

The Perinatal Council Health Assistance Center offered Healthy Families enrollment assistance to 127 families and Medi-Cal application assistance to 16 families. Its outreach worker and Perinatal Case Manager provided outreach, education, assistance and follow-up to families in need of health care coverage from Pittsburg to Brentwood and worked with the Antioch School District, receiving forms completed by all parents when registering their children for school. The Perinatal Council staff telephoned or mailed information to all parents. The Health Assistance Center in Brentwood rents space to other nonprofit agencies, all of which have Spanish-speaking staff and all of which ask their clients if they have health insurance for their children. Why a client does not have insurance, s/he is referred to the Perinatal Council.

Contra Costa Health Services has worked closely with schools with "Request for Information" (RFI) packets for families enrolling in the Free or Reduced Price Meal Program. Approximately 2,000 RFIs were distributed. Of 500 distributed at Meadow Homes Elementary, 130 (26%) were returned. From these, 61 families were assisted in enrollment and 69 already had health insurance.

Enrollment Sites

Participating enrollment sites in the Outreach and Enrollment Initiative include Antioch Health Center; Brentwood Health Center; Concord Public Health Clinic; Pittsburg Health

Center; CIS, Richmond; Health On Wheels Van; Richmond Health Center; Center for Health, Richmond; Stanwell Office, Concord; and Bay Point Health Center.

During an intensive period of outreach and enrollment supported both by state and foundation funding, the Outreach and Enrollment Initiative during 2001-2002 was able to track its efforts carefully through the various sites of outreach and enrollment. As funds have been reduced, both outreach efforts and tracking have been reduced somewhat. Specific data on this current period are not available at the same level.

Budget and Staffing

The Medi-Cal Outreach/Healthy Families Program budget for FY 2001 – 2002 was $549,103. Most of it was in salaries – approximately $420,000 or 76%. Most of the salaries were for enrollment specialists, outreach workers, and student workers - $222,200, plus benefits. The next largest line item was subcontracts to community-based organizations - $95,000 or 17%. General operating expenses, covering communications, space, and materials, totaled nearly $14,000; travel was $2,000; and indirect expenses were $14,750. The state contract funded $300,000 (55%) of the total and the county general fund made up the difference.

The staffing pattern includes

- 5 student workers half-time
- 3 community health workers working 32 – 40 hours
- 1 temporary Health Education Specialist
- 1 clerk doing data entry
- 1 program manager.

Transition

Midway through 2001-2002, the Outreach and Enrollment Initiative made the structural transition from Contra Costa Health Services Administrative Unit to Public Health's Family, Maternal and Child Health Programs. This change in the program's oversight was intended to strengthened its efforts and to tie the outreach and enrollment program more closely to other public health outreach activities. The Public Health Department is focusing on better integration with other programs in order to institutionalize the effort.

IV. Assessment

The assessment of the Contra Costa Medi-Cal and Healthy Families outreach and enrollment effort began with a series of interviews with key personnel involved throughout the county.

A. People Interviewed

- Sandy Baldwin, Employment and Human Services Department, Medi-Cal Policy
- Stephan Betz, County Administrator's Office
- Wendel Brunner, MD, Director, Public Health
- Milt Camhi, Director, Contra Costa Health Plan
- Linda Crippen, CalWORKs Program Analyst, Martinez
- Mary Foran, Assistant Director, Contra Costa Health Services
- Pat Godley, Chief Financial Officer, Contra Costa Health Services
- Paula Hines, CHDP Program, Public Health
- Rebecca Kalfos, Community Services Department
- Jeanette Lopez, Mental Health Financial Counseling, Antioch
- Lorena Martinez-Ochoa, Project Manager, Outreach and Enrollment Initiative, Public Health
- Nancy McCauley, Director of Marketing, Contra Costa Health Plan
- Cheri Pies, FMCAH Director, Public Health
- Christina Reich, Community Services Department
- Wanda Session, Financial Counseling, Contra Costa Health Services
- Tom Tingley, Division Manager, Employment and Human Services Department

B. Key Findings

- The County of Contra Costa, the Board of Supervisors and particularly the Contra Costa Health Services and Employment and Human Services Department are to be commended for taking a leadership role statewide in promoting and implementing outreach, enrollment and retention efforts as well as the recent major change in expanding the Basic Adult Care Program to include uninsured children, now called the Basic Health Care Program.
- Given impending and somewhat unknown fiscal constraints because of the state budget and the overall state economy over the next two years, it is essential to maintain and sustain the progress that has been made in the county's outreach, enrollment and retention programs as well as the expanded access to care programs.

- Maintaining progress that has been made is essential.
- There is currently no clearly articulated vision of how the Outreach & Enrollment program should operate and how its segments can be integrated, reducing fragmentation throughout the county. Clients must often work with multiple staff in different departments involved in the system of enrollment and coverage.
- The outreach and enrollment effort needs to be incorporated into the infrastructure of the Contra Costa Health Services and integrated into all programming provided. Currently, this is not the case.
- Ongoing concerns about consistent funding will exist as long as the outreach and enrollment effort is not integrated into the daily operations of the Contra Costa Health Services.
- Given impending and potential funding cuts for this type of activity, there appears to be some reluctance to consider increasing further integration, particularly in a time of budget cuts, reduced funding and increased responsibilities for staff. Participating staff are fully committed to the enrollment effort and to ensuring that all children are screened and enrolled in the appropriate insurance or coverage program. Participating staff are also concerned about the lack of both continuity in enrollment efforts and the coordination of those efforts.
- Outreach events are helpful in raising awareness about Healthy Families and Medi-Cal. Public events are also effective in spreading the word about programs but are not proven effective enrollment tools. They should be chosen carefully, given available resources. Applications require extensive documentation for enrollment, which families were not prepared to do at public events. Only 10% of people who received one-to-one contact at a public enrollment events returned for an appointment.
- Retaining families on health coverage requires as significant a planning effort as outreach and enrollment. Families have financial constraints and competing priorities which result in non-payment of premiums or lapse in coverage. They don't always understand how health insurance works or how to keep track of paperwork. Some families do not value preventive health care in the same way as urgent care. Others never use health services and see no value in paying insurance premiums. Outreach, enrollment and retention strategies implemented in other CCHS programs, need to tie coverage to service utilization. This education of the clients can be done at various venues, such as clinics, through home visitors, and community partners.
- The Health Access Coalition has established a strong collaborative relationship between Contra Costa Health Services and the community-based organizations. Collaboration allowed the sharing of resources, facilitation of referrals and successful coordination of outreach activities. This effort should continue.

- Collecting relevant data and tracking whether families who were assisted actually were enrolled is a major challenge. A database designed to document all outreach and enrollment efforts was created in 2000 and was in place at the start of this audit. In January 2002, the database was adapted to better capture the data being collected and reports to be generated. However, it does not link to the State Healthy Families or Medi-Cal programs. Through the database, the number of individuals assisted to enroll in Medi-Cal and Healthy Families can be tracked, but not the number of actual enrollments.
- The use of part-time students workers for outreach and enrollment, often placed at the county clinics, may not be the most effective use of staffing at this time. A more unified approach coordinated with the financial counselors would be more effective at this juncture.
- Planning needs to take place to be ready to implement the CHDP Gateway program in conjunction with outreach and enrollment efforts, driven by the state's timing.
- With the expansion of the Basic Health Care program to children, enrollment should be focused on the point of service at the county clinics and coordinated by the Financial Counselors.
- Coordination and communication among CCHS, Community Services Department and EHSD on enrollment efforts can be stronger. There is no doubt that Contra Costa Health Services is working more closely with the Employment and Human Services Department than ever before. The Medi-Cal Advocates working for the Employment and Human Services Department received many referrals of families who had recently lost their coverage or were in danger of imminently losing coverage, and were able to many families retain their Medi-Cal coverage. Communication has not been regular and on-going due to time and financial constraints.
- Between July 1, 2001 and March 31, 2002, the County's program assisted with 1,265 Healthy Families forms, 814 Medi-Cal applications, 71 annual forms, 44 California Kids forms, 20 Kaiser Care for Kids forms, 12 "Add Child" forms, and 2 AIM applications.

V. Recommendations for Change

The following planning assumptions were used to develop the recommendations for change. They are based on best practices, the current California budget environment, and the findings from the assessment.

A. Planning Assumptions

- Having health insurance and access to health care services is a key determinant of good health for children. The County of Contra Costa should embrace this concept in every possible way, at every point of entry for children into the system.

- There are four key components to a successful health insurance program:
    1. outreach to eligible individuals without insurance or without adequate insurance,
    2. enrollment of eligible individuals/families into the most comprehensive insurance program available,
    3. retention of enrolled individuals/families in insurance and
    4. access to and utilization of health care services for those who enroll.

- The Medi-Cal/Healthy Families outreach and enrollment program needs to be integrated fully in an ongoing way into the infrastructure of the Contra Costa Health Services and into other relevant departments throughout county government. Building ongoing outreach, enrollment and retention efforts into the infrastructure of the county's programs should be the goal of this effort. As new children enter the system, whatever the system may be, regular ongoing pro-active measures should assure that families have been screened, children enrolled in one of the public coverage or insurance programs, and utilization of services secured.

- The key points for integrating this effort are Contra Costa Health Services – Financial Counseling, Public Health, Contra Costa Health Plan, Mental Health Services, Community Services Department, and Employment and Human Services Department.

- State funds that currently support a majority of the outreach and enrollment activities will probably not continue. They will either be dismantled totally in the impending state budget or be reduced dramatically. Reliance on these funds to support this program's sustainability cannot be counted on.

- Every client accessing any type of services in the county, but particularly in Health Services or EHSD, should be asked whether or not he/she has health insurance. If the answer is "no", the client should be screened for the appropriate program at that time.

- Utilization of health care services is an important ingredient in retaining health insurance. Point of service enrollment at county and community clinics should be a priority. “In-reach” for existing clients has proven most successful in other counties.

- The recent expansion of the Basic Adult Care program to children, now called Basic Health Care program, will allow children to be screened at the point of service in county clinics. If they do not qualify for Medi-Cal or Healthy Families and are income-eligible, they can be enrolled in the Basic Health Care program. This allows Contra Costa County to have options for the full range of children’s situations. With these programs now in place, integrated point of service enrollment and aggressive retention activities should be the center point of the new program.

B. Recommendations

1. In its past decisions, Contra Costa County’s Board of Supervisors has consistently committed itself and the County’s resources to ensuring access to health care services for all children and enrollment in appropriate health insurance and health coverage programs. The integration efforts that follow would be supported if the Board of Supervisors reiterate, at this time, its long standing support for access to health services for children, both through health programs and outreach and enrollment.

2. All outreach, enrollment and retention activities should be built into the existing infrastructure, particularly in the Contra Costa Health Services and Employment and Human Services Department. While state and other grant funds should be used to support these efforts when available, the efforts need ongoing operational support in an integrated way. Responsibilities for different segments of the health insurance access effort should rest with already existing and appropriate agencies within Contra Costa County in order to increase stability of the program.

3. A regular county position of health insurance/access coordinator should be established to coordinate and facilitate all insurance enrollment and retention activities, county information updates and training on public-sponsored health insurance activities, expansion of coverage, etc. This position should have appropriate access to decision-making authorities so that barriers can be addressed, problems solved, and successes promoted countywide. The Health Insurance/Access Coordinator:

    - should be located in Public Health;
    - should facilitate a Steering Committee composed of the appropriate representatives from Financial Counseling, EHSD, CCHP, Mental Health,

Community Services Department and Public Health – each of whom have responsibility for segments of the health insurance activities within the county;

- should facilitate and organize the Health Access Coalition as well as report to other county committees, commissions and advisory groups that would benefit from information and advocacy about related health insurance committees. Careful consideration about how the Health Access Coalition links and intersects with Public Environmental and Health Advisory Board's (PEHAB) Access to Care Committee should be reviewed with consideration given to establishing the Health Access Coalition as a subcommittee of PEHAB, which is appointed by and reports directly to the Board of Supervisors;
- should be responsible for organizing the county's ability to track outreach activities, enrollment targets and retention targets;
- should implement a tracking system similar to the Consumer Union's Tracking Program for Health Families as soon as possible, adapting the current database, and incorporating all the programs and divisions under the same Entity Number to share information more effectively; this work must be coordinated with the State, which must provide better data;
- should be responsible for implementing an ongoing countywide education and training program on insurance activities and work closely with the enrollment efforts of the Financial Counselors, the retention efforts at CCHP, and EHSD.

4. A Steering Committee of Public Health, EHSD, CHDP, CCHP, Mental Health, Community Services Department, financial counselors should meet regularly - at least monthly - to identify key barriers in the system, analyze system difficulties, problem-solve and monitor integration. It should report regularly to the Health Access Coalition and to senior staff at CCHS and EHSD.

5. **Outreach** to the uninsured target populations representing the core public health function of access to care should remain in Public Health, with monitoring by the Health Insurance/Access Coordinator.

   - Outreach should be accomplished through the variety of public health programs such as CHDP, Family PACT, PCG, CPSP, WIC, community education, prevention and wellness programs, public health nursing, and home visiting, etc.
   - Public Health managers of these programs should work closely with the Health Insurance/Access Coordinator on these efforts.
   - Each of these programs should be equipped to conduct application assistance, outreach, education on access and enrollment for any client in need.

- These programs should be required to provide data to the data tracking component of the program.

6. **Enrollment** of individuals/families in insurance programs should be coordinated by and be the responsibility of Financial Counselors through the county clinics and hospital. With each expansion in health insurance or health coverage programs (Healthy Families, Healthy Families to Adults, BAC to Basic Health Care), the financial counselors are continually updated on the technical information necessary to assist clients. They are also located at the service delivery points of entry at the health centers where both enrollment and access can be accomplished.

   - The current Healthy Families Enrollment Assistors/CAAs located in the health centers should be reassigned to report to the Financial Counselors with whom they already interact regularly.
   - Some Community Health Workers can be integrated into other Public Health programs such as CHDP, WIC, Clinical Services or CCHP, to enhance the capacity of those programs to assist with enrollment and retention.
   - Some administrative interns and student workers can be assigned to work with Financial Counseling, when available.
   - With the changes occurring soon in CHDP, Public Health must work to redesign efforts in CHDP to incorporate enrollment strategies at CHDP provider offices.
   - Employment and Human Services Department, through all of its programs, should continue its aggressive enrollment of eligible clients in the Medi-Cal program and when possible should also enroll eligible clients in the Healthy Families program. Legislative changes about who can enroll children in Healthy Families and assurance from the state that current funding to provide for additional staff needed to expand to Healthy Families enrollment are essential to this change.
     - EHSD should engage with Health Services in training related to all aspects of improving access to health care services, including comprehensive knowledge of Healthy Families, Basic Health Care, etc.
     - EHSD's involvement in the Health Access Coalition is essential.
     - Bay Area counties have made a proposal for Medi-Cal families with Share of Cost, supported by the Medi-Cal Policy Institute: if the family wants to enroll in Healthy Families, social services workers should be able to determine eligibility and fee collection for premiums. Contra Costa County should actively support this effort.
     - EHSD's Medi-Cal Advocate positions should be continued to assure its continued ability to maintain aggressive enrollment.

7. **Retention** of members on public health insurance programs can be most effectively organized by the Member Services Department at Contra Costa Health Plan. The vast majority of the clients enrolled are managed by CCHP including those on Basic Health Care. Among the key responsibilities of the health plan are the education of members on how to use the health care system, health education and retention of members in the plan. For those children who are not CCHP enrollees, it will be important to use the Health Access Coalition, and use the Coalition to share best practices.
   - In addition, CCHP should continue to take an active role in sponsoring health fairs and enrollment activities in coordination with Public Health and include such information in their health education materials and newsletter.
   - Basic health education can include consumer education about how to use the Contra Costa County health system, how to make an appointment, whom to call for questions, etc., encouraging people to use the health system.

8. The Community Services Department's CAAs and parent advocates, who assist families with applications, should continue to be integrated into ongoing education and training with the Health Access Coalition.

9. The Health-e-app is already being implemented in Contra Costa County's outreach and enrollment effort. It should be utilized to every extent possible in all community-based as well as county entry points.

10. An emphasis should be placed on Point of Service Enrollment, using the opportunity at the time of service at county clinics, community clinics and soon at private providers offices through the CHDP Gateway Program to enroll eligible children by on-site screening and enrollment or in the case of the private provider offices by a "quick phone linkage" to enrollment workers.

11. At every available outreach or enrollment contact, information and encouragement about using health services should be another priority of the contact. Materials about available services, information about how to make appointments and when should be key to the encounter.

12. Advocacy by the Board of Supervisors and every relevant county department will continue to be necessary to promote changes in the Medi-Cal and Healthy Families programs to ensure easier access for eligible children and adults.

13. As resources are declining, the best possible return on investment seems to be the integration of outreach and enrollment activities, the enhancement of retention strategies, and the ability to track progress throughout the county's

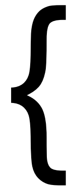
departments. Key to the integration is the effective working together of the Steering Committee and the departments' leadership.

The following organizational chart describes the functional analysis of the recommendations provided.

Restructuring
Insurance Outreach, Enrollment and Retention
Contra Costa County
FOR DISCUSSION ONLY

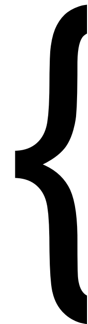
FUNCTIONS

Health Insurance/ Access Coordinator implements key responsibilities:



Health Access Coalition – advocacy and training
Steering Committee – for systems improvement
Data Tracking
Continuing Education and Updates

Health Insurance/ Access Coordinator provides technical assistance:



Function	**Department**
Outreach	Public Health through all public health programs
Enrollment	• Financial Counselors • EHSD
Retention	Contra Costa Health Plan Member Services Department

VI. Bibliography

California State Department of Health Services. Streamlining Application and Enrollment for the Healthy Families Program and Medi-Cal for Children. June 2001.

Children Now. California County Data Book 2001.

Children's Health Campaign: Promising Ideas in Children's Health Insurance, May 1999.

Community Health Councils, Inc. Health Insurance and Health Services: A Consumer Education Curriculum. April 2000.

Consumers Union. Healthy Kids Make Better Learners: A Guide to School-Based Enrollment in State-Sponsored Health Insurance Programs. 2001.

Amy Cox, Jacob Klerman and Ingrid Happoldt. Medi-Cal After Welfare Reform: Enrollment Among Former Welfare Recipients. Medi-Cal Policy Institute Issue Brief Number 4, December 2001.

Peter Cunningham. Targeting Communities With High Rates of Uninsured Children. *Health Affairs.* Web Exclusive.

Families Foundation. One Step Forward, One Step Back.

Jocelyn Guyer, et.al. Missed Opportunities: Declining Medicaid Enrollment Undermines the Nation's Progress in Insuring Low-Income Children. Center on Budget and Policy Priorities. October 1999.

Kaiser Commission on Medicaid and the Uninsured. Enrolling Uninsured Low-Income Children in Medicaid and SCHIP. Key Facts. May 2002.

Peter Long. Local Efforts to Increase Health Insurance Coverage among Children in California. Medi-Cal Policy Institute. February 2002.

---. County Efforts to Expand Health Coverage among the Uninsured in Six California Counties. Medi-Cal Policy Institute. February 2002.

Cindy Mann. The Ins and Outs of Delinking: Promoting Medicaid Enrollment of Children Who are Moving In and Out of TANF System. Center on Budget and Policy Priorities. March 1999.

---, Reaching Uninsured Children Through Medicaid: If You Build It Right, They Will Come. Kaiser Commission on Medicaid and the Uninsured. June 2002.

Carolyn Schwartz and Earl Lui, The Link Between School Performance and Health Insurance: Current Research. Consumers Union. October, 2000.

Medi-Cal Policy Institute. The Impact of the Proposed 2002-03 Budget on Medi-Cal and the Healthy Families Program. March 2002.

---. Opening the Door: Improving the Healthy Families/Medi-Cal Application Process. October 1998.

---. Using Market Research to Improve Enrollment of Families Eligible for Medi-Cal and Healthy Families. March 2002.

Nalini K. Pande. Improving Retention in the Medi-Cal and Healthy Families Programs. Meeting the Challenge: Successful Strategies for Healthy Families, Medi-Cal and Other Health Coverage Outreach and Enrollment Initiatives. Presentation. May 2002.

UCLA Center for Health Policy Research. 2001 California Health Information Survey. June 2002.

UCSF Institute of Health Policy Studies. Barriers to Enrollment in Healthy Families and Medi-Cal: Differences by Language and Ethnicity. Policy Brief 3, February 2001.

US Census Bureau. Table DP-3: Profile of Selected Economic Characteristics 2000, for Contra Costa County.

US Department of Health and Human Services. The State Children's' Health Insurance Report: Annual Enrollment Report. October 1, 1998 – September 30, 1999.

Jill M. Yegian. Why Don't More Small Businesses Offer Health Insurance? Summary Report on the California HealthCare Foundation/Mercer Survey. California HealthCare Foundation. March 2002.

Endnotes

[1] Kaiser Commission.
[2] Children's Defense Fund. *Accessing Health Services: Moving Beyond Enrollment.*
[3] Margaret Edmunds and Molly Joel Coye, Editors*. America's Children: Health Insurance and Access to Care.* Institute of Medicine. 1997.
[4] Children Now. *California's Working Families and Their Uninsured Children: A Big Problem with an Affordable Solution*. 2000.
[5] Margaret Edmunds and Molly Joel Coye, Editors*. Op.cit.*
[6] Cathy Schoen and Catherine DesRoches. *New York City's Children: Uninsured And At Risk.* Findings from The Commonwealth Fund Survey of Health Care in New York City, 1997. The Commonwealth Fund, May 1998.
[7] Margaret Edmunds and Molly Joel Coye, Editors*. America's Children: Health Insurance and Access to Care.* Institute of Medicine. 1997.
[8] Children's Defense Fund. *Accessing Health Services: Moving Beyond Enrollment.*
[9] Urban Institute.
[10] Margaret Edmunds and Molly Joel Coye, Editors*. Op.cit.*
[11] Urban Institute.
[12] Urban Institute.
[13] Wirthlin Worldwide Survey of American Families: Comparison of Household with insured children vs. uninsured children eligible for SCHIP/Medicaid Coverage.
[14] Wirthlin Worldwide Survey of American Families: Comparison of Household with insured children vs. uninsured children eligible for SCHIP/Medicaid Coverage.
[15] Wirthlin Worldwide Survey of American Families: Comparison of Household with insured children vs. uninsured children eligible for SCHIP/Medicaid Coverage.
[16] Margaret Edmunds and Molly Joel Coye, Editors*. Op.cit.*
[17] Urban, Children eligible for Medicaid but not enrolled: How Great a Policy Concern?
[18] Stoddard et al. May 1994, New England Journal of Medicine.
[19] Kaiser Commission.
[20] Cathy Schoen and Catherine DesRoches. *New York City's Children: Uninsured And At Risk.* Findings from The Commonwealth Fund Survey of Health Care in New York City, 1997. The Commonwealth Fund, May 1998. Health status measures are based on parent's rating of their child's health.
[21] Margaret Edmunds and Molly Joel Coye, Editors*. Op.cit.*
[22] Margaret Edmunds and Molly Joel Coye, Editors*. Op.cit*.
[23] Margaret Edmunds and Molly Joel Coye, Editors*. Op.cit*
[24] Margaret Edmunds and Molly Joel Coye, Editors*. Op.cit*
[25] Children's Defense Fund: Accessing Health Services: Moving Beyond Enrollment.
[26] Urban Institute.
[27] Urban, Children eligible for Medicaid but not enrolled: How Great a Policy Concern? and DHS CDC data on immunizations.
[28] Wirthlin Worldwide Survey of American Families: Comparison of Household with insured children vs. uninsured children eligible for SCHIP/Medicaid Coverage
[29] Wileawski, Irene, "Gouging the medically uninsured: a tale of two bills." Health Affairs, September/October 2000. Vol. 19, No. 5 pp. 180-185.
[30] The federal poverty line is $18,1000 for a family of four in 2002, as reported in the Federal Register for Department of Health and Human Services programs. http://aspe.hhs.gov/poverty/02poverty.htm.
[31] California State Department of Health Services. Streamlining Application and Enrollment for the Healthy Families Program and Medi-Cal for Children. June 2001.