# Local Efforts to Increase Health Insurance Coverage among Children in California

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*Prepared for the Medi-Cal Policy Institute by*

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## Executive Summary

In California, local organizations play a central role in the state's efforts to enroll low-income children in Medi-Cal and Healthy Families. Many successful outreach programs have been designed and implemented at the local level to reach the 726,000 uninsured children who may qualify for Medi-Cal and the additional 535,000 uninsured children who may qualify for Healthy Families.[1] In the past six months, under the state's leadership, these outreach efforts have been extended to ensure successful enrollment, encourage the appropriate use of health services, and support the retention of coverage over time. This background paper examines the practices of a variety of local programs involved in Medi-Cal and Healthy Families outreach to develop a clearer picture of effective strategies.

It is difficult to generalize about local outreach efforts because each project has a unique set of characteristics that has developed in response to the needs of the local community, the history of the agency, and funding sources. Broadly speaking, however, outreach projects can be grouped into three categories based on the primary site of their activities: (1) health facilities, including public and private hospitals and clinics; (2) school-based programs; and (3) community-based organizations (CBOs) such as churches, job-training sites, and cultural organizations. Outreach programs located in different settings employ different strategies and exhibit different strengths and weaknesses:

- Because public and private safety net health facilities already provide health care to large numbers of uninsured children, many have developed Medi-Cal and Healthy Families enrollment systems. They enroll significant numbers of children, but most of them are already accessing the health care system. There is potential for excellent linkages from enrollment to the appropriate use of health care services.

- School-based programs have the potential to reach the largest number of potentially eligible children, including those who are not using the health system. However, there are significant challenges to developing a successful school-based program, including the cumbersome processes involved both in securing access to eligible children and in enrolling them in the school setting.

- Outreach programs administered by CBOs tend to be smaller in scale than those administered by either health facilities or schools, but they play an important role. Through their sustained presence in a community over time, many CBOs have been able to cultivate the trust of community members. As a result of this trust relationship, parents may seek out staff from CBOs for guidance about various issues including health insurance for their children. However, since health insurance is often not their primary activity, CBOs tend to be more vulnerable to changes in funding and high staff turnover.

Despite considerable variation in specific activities undertaken by individual programs, some common themes emerge from this qualitative analysis that are applicable for state and county policy makers:

- 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.

- There is a need at the state level to determine whether Medi-Cal and Healthy Families enrollment is associated with more appropriate use of health care services by children.

- There has been limited dissemination and replication of successful strategies throughout the state.

- 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 (CAAs), local programs have implemented continuous training programs.

## Introduction

Between 1998 and 2001, California focused considerable resources to establish Healthy Families' program infrastructure and implement a massive outreach campaign for Medi-Cal and Healthy Families designed to inform and motivate eligible parents to enroll their children. In the current fiscal year, the Department of Health Services (DHS) and Managed Risk Medical Insurance Board (MRMIB) have focused greater attention on strategies to enroll eligible children, ensure appropriate access to care, and facilitate the retention of benefits over time. Many successful outreach programs have been designed and implemented at the local level. In response to the state's leadership, some local organizations have begun to extend their efforts to include not only outreach and enrollment, but also access and retention. To date, these innovative local efforts have not been well documented. Thus, important opportunities for shared learning and quality improvement among counties, health plans, schools, clinics, and other community-based organizations about promising approaches and potential barriers have been missed.

### Medi-Cal and Healthy Families

In total, more than 3.3 million—one in three—children in the state are enrolled in either Medi-Cal or Healthy Families. Medi-Cal is an entitlement program that guarantees coverage of a specified set of benefits for all children who meet its eligibility and income requirements. Healthy Families is a block grant program that provides subsidized insurance coverage for children who meet its eligibility requirements and have incomes between 100 and 250 percent of Federal Poverty Level (FPL) ($35,300 for a family of four in 2001). Medi-Cal is the larger of the two programs, covering six times as many children as Healthy Families.

### Uninsured Children

In 1999, 1.85 million of California's 10 million children lacked health insurance. Analysis of the characteristics of uninsured children by UCLA's Center for Health Policy Research indicates that

two out of every three uninsured children in California may qualify for Medi-Cal or Healthy Families. Nearly 40 percent, or 726,000 children, qualify for Medi-Cal. Another 535,000 children qualify for the Healthy Families program.[2] The remaining one-third of uninsured children in California live in families that earn more than the maximum annual income to qualify for Healthy Families (250 percent of FPL) or are undocumented immigrant children. The latter are not eligible to participate in these programs except for emergency medical services under Medi-Cal if their families have low incomes.[3]

**Methodology**

This background paper examines local efforts to increase the number of children with health insurance. This author conducted key informant interviews with staff members from seventeen local enrollment projects and collaboratives throughout the state. This qualitative analysis is divided into four sections. The first section highlights the characteristics of the three major settings for community-based outreach and enrollment programs: health facilities, schools, and community-based organizations (CBOs). The second section uses the Access Pathway to identify promising local strategies and practices related to outreach, enrollment, use of services, and retention.[4] The next section reviews the infrastructure required to support implementation of these strategies, and the final section highlights some lessons learned.

Most of the initiatives described in this paper are local in nature and have not been described or analyzed in a systematic manner. In order to identify projects that have implemented innovative strategies for enrollment, access, and retention, the author canvassed key informants throughout the state to generate a list of potential programs. The author then reviewed all publicly available documents about enrollment, access to care, and retention in Medi-Cal and Healthy Families to develop a survey instrument. Primary data were collected through semi-structured telephone interviews with key informants at local programs. A list of programs interviewed is included in Table A1.

Many of these efforts have been designed in response to unique local circumstances. In an effort to provide information that is relevant to the widest range of organizations throughout the state, the author chose to survey organizations operating in urban as well as rural areas, focusing on different racial and ethnic groups, and representing different geographic regions in the state. Thus, the programs described in this paper are not necessarily those programs with the highest enrollment, although several top producers have been included. Although the programs and strategies reviewed in this paper relate to children's health insurance, many could be adapted to reach the adult uninsured population if sufficient resources were made available.

## California's Efforts to Promote Outreach and Enrollment

In order to place local outreach efforts in an appropriate context, it is important to understand the state's outreach efforts in California. State law requires DHS, in conjunction with MRMIB, to develop and conduct a community outreach and education campaign to help families learn about and apply for Medi-Cal and Healthy Families. In the 2000-2001 California budget, a total of $34.2 million was allocated for outreach activities, including statewide media promotion, community outreach, and payments to certified application assistants.[5] The state's activities to increase enrollment in Medi-Cal and Healthy Families can be grouped into two categories:

(1) efforts to remove administrative barriers; and (2) a community-based outreach campaign. However, despite significant efforts and funding, important barriers remain for 1.3 million uninsured children who are eligible but not enrolled.[6]

**Administrative Changes**

The state has adopted many strategies to remove administrative barriers to enrollment in Medi-Cal and Healthy Families. These strategies include a shortened joint application, the introduction of 12-month continuous eligibility, and the elimination of quarterly status reports under Medi-Cal.[7] These strategies will be supported by the statewide introduction of Health-e-App, developed in partnership by the state and the California HealthCare Foundation. Health-e-App is the first online enrollment system for publicly funded insurance programs, which will transmit applications to the Single Point of Entry as soon as they are completed.[8]

Currently, the state is exploring mechanisms to streamline enrollment for children who already participate in other public programs such as the Women, Infants and Children program (WIC), Food Stamps, and the National School Lunch Program. This strategy, often referred to as "express lane eligibility,"[9] has tremendous potential, given that an estimated 700,000 uninsured children participate in one of those programs.[10] Recently, state officials assessed five options under express lane eligibility: (1) referrals with follow-up capability; (2) on-site application assistance; (3) sharing eligibility information; (4) common application; and (5) resumptive eligibility.[11]

State officials have determined that the first three options in this list represent promising strategies that already occur on the local level and could be expanded to the entire state. Although the final two options listed above have merit, there are remaining legal and technical barriers that need to be addressed before they can be implemented.

Many schools and local organizations have already established mechanisms to enable other public programs to refer uninsured children. The school or organization then contacts the family to complete the enrollment process. Multiple counties, school districts, and community-based organizations (CBOs) have negotiated to provide on-site application assistance at WIC programs, Child Health and Disability Providers (CHDP), childcare centers, and food stamps offices. Recently, Governor Davis signed two laws that will permit the sharing of eligibility information between the Food Stamps program and National School Lunch Program and Medi-Cal and Healthy Families. AB 59 will allow school districts to ask families enrolled in the National School Lunch Program if they are interested in learning more about state-sponsored health care. If parents are interested, then the school district can forward income information to county welfare offices or Healthy Families for follow up. SB 493 will allow households receiving food stamps to receive a letter at recertification asking for their permission to submit income and family information to Medi-Cal and Healthy Families. Both policies are expected to increase Medi-Cal and Healthy Families enrollment.[12]

**Community-Based Outreach Campaign**

Beyond these legislative and administrative strategies, DHS has developed a community-based outreach and education campaign to increase public awareness and enrollment in Medi-Cal and Healthy Families among "hard-to-reach" populations.[13] DHS contracts with a variety of local organizations to conduct outreach and enrollment activities. As part of the state's overall

outreach campaign, DHS awarded $6 million in contracts in July 2001 to community-based organizations (CBOs) and $5.5 million in contracts to support collaboration between school districts, county offices of education, city/county government, and community-based organizations to implement school outreach efforts. In addition to these contracts, the state of California provides funding to counties to conduct outreach under Section 1931(b).[14] The state also pays enrollment entities and CAAs to assist families in completing Medi-Cal and Healthy Families applications. CAAs receive $50 for each successful application and $25 for each successful 12-month renewal unless their organization has an outreach contract with the state.[15]

As the state enters the fourth year of the Healthy Families program, its funding strategy has shifted from paying for community education and outreach activities to supporting the development of systematic approaches to increase enrollment and retention.[16] Under these outreach contracts, each contractor is required to enroll a specified number of children in Healthy Families and Medi-Cal from the target populations in their geographic area. For the current fiscal year, the state also requires organizations to conduct and provide documentation of activities related to access to care and retention of benefits.[17]

## Primary Settings for Local Outreach and Enrollment Programs

It is difficult to generalize about outreach and enrollment efforts because each project has a unique set of characteristics that has developed in response to the needs of the local community, the history of the agency, and funding sources. Broadly speaking, however, outreach projects can be grouped into three categories based on the primary site of their activities (Table 1): (1) health facilities, including public and private hospitals and clinics; (2) school-based programs; or (3) community-based organizations such as churches, job-training sites, and cultural organizations.

### Health Facilities

Because public and private safety net providers already treat large numbers of uninsured children and rely on revenues from health insurance, they tend to focus considerable energy on in-reach activities, screening uninsured children when a provider sees them. Typically, the Medi-Cal and Healthy Families application process is integrated into the facility's overall financial screening system. Depending on its size, a facility may have one or more positions dedicated to financial screening and enrollment in insurance programs. Multiple staff members are training to assist in the completion of Medi-Cal and Healthy Families applications. Given the integrated organizational structure, facility-based programs are less affected by reductions in direct funding for outreach.

Beyond in-reach, most clinic programs conduct some outreach activities in the surrounding communities. Several programs reported collaboration with WIC programs, which may be located in the same facility as the clinic or be part of the same parent organization. Because parents of uninsured children do not bring pay stubs and birth certificates to their medical appointments, clinics have to schedule enrollment appointments for parents to return and complete the Medi-Cal/Healthy Families application. Despite the use of incentives and subsidized transportation, most clinics reported difficulty in getting parents to return for the appointment to complete the application. In summary, clinics enroll a significant number of children, but many are already accessing the health care system. They also can provide excellent

linkages to health care services, increasing the likelihood that children will use services once they have enrolled.

### School-Based Efforts[18]

Schools reach the largest number of potentially eligible children. Since school attendance is mandatory, school-based programs have the potential to reach uninsured children who currently are not using the health care system. Despite this enormous potential, it is not easy to establish and maintain a successful school-based program. A lengthy multi-stage process is required to secure access to potentially eligible children in the school setting. Due to the multiple competing demands on the school system, the process can break down at any level. First, the organization needs to convince the superintendent that poor health represents a barrier to children's learning and that increasing health insurance coverage will address these health problems. Further, they must convince him or her that the program is feasible using existing resources. Once an organization has secured district level support, it needs to gain the support of principals to conduct outreach and enrollment activities in individual schools. Finally, the organization needs to work with teachers, school health staff, and parents to reach eligible children and their parents.

Most school-based programs target their efforts to school districts with the highest percentages of potentially eligible children, using National School Lunch Program as a proxy for income. Many school districts throughout the state distribute informational fliers with National School Lunch Program applications to every parent. If parents are interested, they return the request for information. Once a parent has expressed interest, he or she can complete an application at the school or through a referral to County Department of Health staff or a local CBO.

### Community-Based Organizations

Although outreach programs administered by CBOs tend to be smaller in scale than either health facilities or schools, these programs play an important role in Medi-Cal/Healthy Families outreach and enrollment. Through activities addressing multiple issues and their sustained presence in a community over time, many CBOs have been able to cultivate the trust of community members. As a result of this trust relationship, parents may seek out staff from CBOs for guidance about various issues including health insurance for their children. CBOs use the local media such as radio and community newspapers to inform families about the programs. Word-of-mouth proves to be a highly effective outreach strategy in cohesive communities.

Enrollment activities within a CBO are typically funded through a separate grant or contract. Because health coverage may not be a core function, CBOs are vulnerable to delays and reductions in funding. As health insurance is generally not their primary area of interest, however, CBOs have to hire and train outreach staff to become CAAs. Outreach staff may not be familiar with health insurance and need significant training. This combination of funding instability and unskilled staff members can lead to high rates of staff turnover and weaken institutional memory. Ultimately, this instability can lead to multiple starts and stops in activity as funding levels and staffing patterns fluctuate. Compared to health facilities, CBOs have a more limited ability to ensure the use of health care services.