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**Congressionally
Mandated Evaluation
of the State Children's
Health Insurance
Program**

*Site Visit Report: The State of
California's Healthy Families
Program*

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I. PROGRAM OVERVIEW

California's Title XXI program—*Healthy Families*—was created as a “combination program” comprising both a Medicaid expansion and a separate state program component.¹ As detailed in Tables 1 and 2, the state submitted its SCHIP plan to the federal government in November 1997. Approved in March of the following year, the plan included an expansion of Medicaid—called Medi-Cal in California—to 100 percent of poverty for children under age 19, and created the separate *Healthy Families* program to cover children in families with incomes under 200 percent of poverty.

Over the first three years of implementation, California has submitted and gained approval of five separate plan amendments which variously revised program eligibility rules to bring them into alignment with those of Medi-Cal (in 1998 and 1999), raised payments made to community-based organizations assisting families to complete the program application form (1999), permitted “family contribution sponsors” to pay premiums on behalf of enrolled children (2000), increased the claiming period for Child Health and Disability Prevention (CHDP) providers for services rendered prior to a child's enrollment into SCHIP (2000), and exempted Native American children from cost sharing (2000). Of particular note, in November 1999, California raised its upper income threshold for *Healthy Families* to 250 percent of poverty. Most recently, the state submitted a Section 1115 research and demonstration waiver application to extend coverage to the parents of *Healthy Families* enrollees living below 200 percent of poverty. Submitted in December 2000, state officials are awaiting approval of this waiver request.

Healthy Families is administered by the Managed Risk Medical Insurance Board (MRMIB), a quasi-governmental agency housed within the state Health and Human Services Agency. The director of MRMIB, like state agency heads, reports to the Governor, and also to a board of directors composed of three gubernatorial appointees and two legislative appointees (the Board serves without financial compensation). MRMIB's partner in implementing SCHIP is the state Department of Health Services (DHS) which administers Medi-Cal. *Healthy Families* uses

¹As of October 1, 2002, California's program will become a “separate” state SCHIP program, as the federal mandate for phasing in poverty-level coverage of children under age 19 born after September 30, 1983 will be complete. Thus, California's initial Title XXI Medicaid component—an accelerated expansion coverage to children ages 16 to 19 living in families with incomes below poverty—will be subsumed within Title XIX.

TABLE 1: SCHIP STATE PLAN AND AMENDMENTS

Document	Dates			Description
	Submitted	Approved	Effective	
Original Submission	11/19/97	3/24/98	3/1/98 (Medicaid expansion) 7/1/98 (insurance programs expansion)	Expansion of insurance coverage for children through three programs: 1) Expanding the Title XIX program, Medi-Cal, by implementing a resource disregard and making children under age 19, who were born before September 30, 1983, eligible if they are at 100 percent or less of the Federal Poverty Level (FPL); 2) Expanding the state program, Access for Infants and Mothers (AIM), which covers infants up to age 1 from 200 percent to 250 percent of FPL; and 3) A separate child health insurance program, <i>Healthy Families</i> , which provides coverage of children from ages 1 through 19 with family incomes from 100 up to 200 percent of the FPL.
Amendment 1	4/14/99	12/21/99	7/1/00	Request to lower income eligibility for <i>Healthy Families</i> from 200 percent FPL net income to 200 percent of the FPL gross income.
Amendment 2	8/1/99	12/21/99	Retroactive to 10/1/98	Applied for federal funds to increase the fees for CAA's from \$25 to \$50 per successful applicant.
Amendment 3	8/3/99	11/23/99	11/24/99	To expand income eligibility for <i>Healthy Families</i> by disregarding income between 200 to 250 percent of the FPL and by applying Medi-Cal income deductions when determining eligibility. Also, to extend the Child Health and Disability Prevention (CHDP) provider claiming period for services received prior to enrollment from 30 to 90 days.
Amendment 4	2/9/99	/6/99	/1/00	Allows third party payment of premiums. A Family Contribution Sponsor will be permitted to pay the family premium contributions for the first year of enrollment.
Amendment 5	4/17/00	7/7/00	5/1/00 for premiums; 7/1/00 for copayments	To exempt cost sharing for American Indians and Alaskan Native children who meet the eligibility criteria for <i>Healthy Families</i> and provide acceptable documentation of their status.

SOURCE: Centers for Medicare and Medicaid Services (CMS), *California Title XXI Program Fact Sheet*. CMS web site <http://www.hcfa.gov/init/chpfsca.htm>; National Governor's Association. State Children's Health Insurance program Plan Summaries. California S-CHIP Plan Summary. Website <http://www.nga.org/cda/files/CASCHIP.pdf>

NOTES: SCHIP=State Children's Health Insurance Program. FPL=federal poverty level.

TABLE 2: MEDICAID AND SCHIP INCOME ELIGIBILITY STANDARDS^a, EXPRESSED AS A PERCENTAGE OF THE FEDERAL POVERTY LEVEL (FPL)

	Age (in Years)			
	Up to 1	1-5	6-14	15-18
Medicaid standards in effect 3/1/98	Up to 200%	Up to 133%	Up to 100%	Up to 85%
SCHIP Medicaid expansion	NA	NA	NA	85-100%
SCHIP separate child health program	200-250%	133-250%	100-250%	100-250%

SOURCES: Centers for Medicare and Medicaid Services (CMS), California Title XXI Program Fact Sheet. CMS web site <http://www.hcfa.gov/init/chpfsca.htm>; State of California. State Child Health Plan under Title XXI of the Social Security Act: California’s *Healthy Families* program. November 18, 1997 Website http://www.dhs.cahwnet.gov/org/Director/healthy_families/stplan.pdf; Donna Cohen Ross and Laura Cox, *Making it Simple: CHIP Income Eligibility Guidelines and Enrollment procedures: Findings from a 50-State Survey*. Kaiser Commission on Medicaid and the Uninsured, October 2000;

NOTES: SCHIP=State Children’s Health Insurance Program (Title XXI). NA=Not applicable.

^a Income standards are gross

a managed care model statewide, contracting with 26 risk-bearing managed care organizations for the delivery of health services, 5 for the delivery of dental services, and 1 plan for the delivery of vision services.

Under its Title XXI program, California has enrolled the second highest number of children in the nation—over 475,000 as of September 2001. This number translates to roughly 75 percent of its target estimate of 639,000 eligible children. Despite this high enrollment, which has increased steadily over the life of the program, California has fallen far short of spending its federal allotment of funds. In federal fiscal year 2000, the state spent \$194.3 million on *Healthy Families*, or just 25 percent of its allotment for the year of \$765.5 million.

After a rocky start, which saw the state implement a new 28-page “short” application form that garnered national criticism and contributed to initial slow enrollment, California has seen *Healthy Families* evolve into a program popular among politicians, consumers, health plans, and many advocates. *Healthy Families* has confronted serious challenges, however, related to consumer-based resistance to Medi-Cal and subsequent difficulty coordinating the smooth enrollment and referral of children between the two programs. Furthermore, with Hispanic children comprising approximately 75 percent of all eligible children,² California’s

²Schauffler, H. et al. “State of Health Insurance in California, 1998.” University of California, 1999.

enrollment efforts have been hindered by widespread fears of “public charge” among immigrant families who have been slow to accept the Immigration and Naturalization Service’s (INS) clarification that SCHIP and Medicaid enrollment of children do not affect children’s or other family members' applications for citizenship. Some evidence exists that the state is overcoming these barriers, at least with regard to the *Healthy Families* program where Hispanic children now comprise 71 percent of that program’s total enrollment. A new challenge, in the form of an emerging resistance from the provider community frustrated by what it perceives as unfairly low reimbursement rates, has the potential to negatively affect provider participation and subsequent access for enrolled children.

This report is based primarily on information gathered during a visit to California in August 2001. During a five-day visit, 20 interviews were carried out with a broad range of key informants at the state and local levels, including state program administrators, Governor’s staff, state legislative staff, child health advocates, managed care organizations, health care providers and provider association representatives, local social services officials, and staff of various community-based organizations involved with outreach and enrollment (See Appendix A for a complete list of key informants.) In addition to our interviews in the state capitol (Sacramento), we spent time in three local areas—Kern County (a mixed rural/urban region in the agricultural San Joaquin Valley, encompassing the cities of Bakersfield and Fresno); Los Angeles County (which has the highest concentration of both eligible uninsured and enrolled children in the state); and San Bernadino County (one of the most populous and fastest growing regions in the state located east of Los Angeles and comprising several large cities and low-income suburban and desert communities). Combined, the regions we visited account for 35 percent of the state’s population and 40 percent of the population currently enrolled in *Healthy Families*.

II. BACKGROUND AND HISTORY OF SCHIP POLICY AND PROGRAM DEVELOPMENT

During the spring and summer of 1997, the U.S. Congress was considering several bills that would grant states new authority to expand health insurance for children and extend generous federal subsidies to states in support of such expansions. Aware of this, policymakers in California, like those in many states, began planning for this eventuality. Governor Pete Wilson's Chief of Staff convened a workgroup to consider how a new children's health insurance program might work in California and to identify and discuss stakeholders' priorities regarding potential program designs.

As they set about designing the program, policymakers fairly quickly reached agreement that the program should follow a "private insurance model," rather than an expansion of the existing Medi-Cal program a separate program. This occurred for several reasons.

- First, Governor Wilson was outspoken in his dislike of Medi-Cal and had resisted all proposed expansions of the entitlement program in the past. At the same time, he was a champion of "public/private partnerships" and had a track record for supporting programs that embraced this philosophy.
- Second, environmental factors also discouraged the sole pursuit of a Medi-Cal expansion. It was widely believed that many families resisted the program owing to its onerous welfare-based eligibility system and widespread fear of "public charge" among the large Hispanic immigrant population. Furthermore, Medi-Cal was quite unpopular with providers, primarily for its history of paying rates that were considered extremely low.

By the time federal SCHIP legislation was passed, several bills were already before the state legislature, including one produced by the Governor's workgroup. Although the legislature contained many lawmakers who were vocal in their support of a Medi-Cal expansion, it was accepted that the Governor would never sign an expansion. While the final *Healthy Families* legislation also included an acceleration of the federally-mandated phase in of poverty-level Medicaid coverage of children under age 19—thus making California's Title XXI program a "combination" approach—the policy emphasis and priority was clearly laid upon the creation of the new, private-like insurance product.

In keeping with the Governor's philosophy, administrative responsibility for *Healthy Families* was placed under the quasi-governmental Managed Risk Medical Insurance Board (MRMIB). MRMIB was selected because of its experience administering programs similar to

Healthy Families, including the Major Risk Medicaid Insurance Program (MRMIP)³ and the Access for Infants and Mothers Program (AIM).^{4,5}

With its general charge clearly established, MRMIB staff set about developing a Title XXI state plan that would embody the following priorities:

- Emphasis on a broad-based, highly visible outreach and public awareness campaign to promote both *Healthy Families* and Medi-Cal for children;
- Creation of a simplified joint application form;
- Enlisting the assistance of community-based organizations to reach out to and assist parents in completing the application form for their child(ren);
- A generous benefit package that, while not the equivalent of Medi-Cal's, would provide broad coverage of services needed by children, including dental care;
- Use of managed care service delivery across the state;
- Use of cost sharing to encourage pride of ownership, and appropriate utilization; and
- Provisions to minimize crowd out, or the substitution of public for employer-sponsored insurance.

Healthy Families currently enjoys a high level of support from Governor Wilson's replacement, Democrat Gray Davis. During 1999, his first year in office, Davis signed into law the income eligibility increase from 200 to 250 percent of poverty, and currently supports the waiver application to extend *Healthy Families* coverage to parents. In the 2002 State Budget, Davis created—at least symbolically—an entitlement to *Healthy Families* by including language committing the state to full funding for all eligible children.

³MRMIP provides health insurance for persons who are unable to obtain coverage in the individual health market due to pre-existing medical conditions.

⁴AIM provides low-cost health insurance to moderate-income pregnant women and their infants.

⁵At the time, MRMIB also administered a program called the Health Insurance Plan of California (HIPC), which represented a purchasing pool for small employers. This program was disbanded in July 1999.

III. OUTREACH

A. POLICY DEVELOPMENT

At the inception of the *Healthy Families* program in California, state officials made the decision to design a multifaceted outreach campaign comprising both statewide and community-based elements. Responsibility for the outreach program was placed with the Medi-Cal agency—the Department of Health Services (DHS)—and an explicit policy decision was made to jointly market *Healthy Families* and Medi-Cal.

Several policy and funding shifts have occurred during the implementation of California’s outreach campaign. During its first year, 1998, DHS allocated \$6 million to branding *Healthy Families* via statewide advertising and funded a hotline with \$2.5 million. Three years later, in response to reports that the advertising was too vague, the DHS developed a new, more focused campaign with an annual budget of nearly \$16 million.

For community-based outreach, state officials hypothesized that a “finders fee” would encourage community members to conduct outreach. To wit, they developed the Certified Application Assistance program to allow individuals affiliated with a wide range of organizations, termed Enrollment Entities, to receive training in assisting parents with completing the *Healthy Families* application. To compensate these individuals, \$3 million was allocated to paying a \$25 fee for every successful application⁶ and, after one year, 11,000 people had been trained as Certified Application Assistors.

Yet state officials were concerned by reports that the \$25 fee was insufficient to cover the real cost of application assistance and community-based outreach.⁷ Consequently, state officials increased the application payment to \$50. They also called for additional funds to provide community-based organizations (CBOs) with up-front grant monies as a means of strengthening

⁶The fee is paid per program per family. Thus in a family of three children, one application form would be submitted. If one of the children was determined Medi-Cal eligible, and two *Healthy Families* eligible, the CAA would receive \$25 for the Medi-Cal child, and a total of \$25 for the *Healthy Families* children.

⁷Renee Schwalberg, Ian Hill, Hilary Bellamy, and Judith Gallagher. *Making Child Health Coverage a Reality: Lessons from Case Studies of Medicaid and CHIP Outreach and Enrollment*. Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, September 1999.

local community outreach infrastructure. The Governor approved a \$6 million budget for this purpose—an increase from \$1 million in 1998-99—and monies were disbursed via 72 two-year Outreach Contracts. When these contracts expired, DHS again refined its approach to community-based outreach. Hoping to promote more coalition-based efforts (and administer a smaller number of contracts), DHS’ Request for Proposals (RFP) for 2000-2001 asked applicants to propose models for outreach that would draw on the strengths of multiple organizations in a given community. At the urging of public health and maternal and child health officials, the RFP also asked applicant groups to broaden their outreach focus to address retention and utilization of care. In June 2001, 30 CBOs were awarded contracts. In addition, DHS awarded \$6 million to 25 “School-Based Outreach Contractors” to focus on school-based outreach. At this point, the annual outreach budget stood at nearly \$50 million.

For the first two years of the program, state officials struggled with determining what role health plans could play in outreach, and primarily sought to avoid marketing abuses by limiting the activities of health plans. Allowed was outreach that advertised *Healthy Families* and Medi-Cal as a product available through a choice of plans; disallowed was any activity remotely related to direct application assistance. In August 2000, however, after lobbying from the health plans, the legislature and Governor agreed that health plans could be trained and certified as application assistors under specified circumstances,⁸ thus allowing plans to take a more active role in directly assisting families with application and, perhaps, providing a stronger incentive for conducting outreach.

Concurrent with the *Healthy Families/Medi-Cal for Children* outreach efforts, California also used federal Section 1931(b) funds to promote the availability of Transitional Medicaid coverage for families affected by welfare reform. A total of \$83 million was distributed in California to 50 county and city collaboratives.

B. STATEWIDE MEDIA EFFORTS

The basic message of all the state’s outreach efforts is that affordable health coverage is important for children. “A Healthier Tomorrow Starts Today” was the slogan used on all the state’s outreach materials, which feature smiling children of all ages and ethnicities. In 2001, the slogan was changed to “For Your Family’s Health” and the *Medi-Cal for Children* program was

⁸Dental and vision plans were also extended this ability later in 2001.

renamed *Medi-Cal for Families*. The *Healthy Families* brand appears alongside a similarly designed *Medi-Cal for Children* logo on all the advertising and on the front of the application form.

The components of the state-level outreach effort can be summarized as follows:

- **Radio and television advertising:** Radio and television advertisements are broadcast on alternate weeks on both general and Hispanic television and radio stations. Until January 2001, the media message was very general, with the broad goal of branding *Healthy Families* and *Medi-Cal for Children* and educating low-income families about the availability of health insurance. Since then, taking account of public feedback indicating the campaign was insufficiently targeted, the advertisements have become more focused, and a larger component directed at ethnic and under-enrolled communities. They now feature “price points” (the exact cost of the program in premiums and copayments), emphasize the “easy” mail-in application and availability of free application assistance, and prominently display the hotline number. The placing and timing of the advertisements are informed by market research—purchases are all prime time on network affiliates, and during programs that target women aged between 18 and 24 years.
- **Print media and materials:** Printed materials, featuring the hotline number and logos of both *Healthy Families* and *Medi-Cal for Families* are distributed to the CBOs for use in their outreach efforts. To facilitate the recognition of the logos, they were repositioned in January 2000 from a stacked design to a side-by-side arrangement.
- **Toll-free hotlines:** There are two statewide toll-free hotlines for *Healthy Families*, both managed by the vendor, Electronic Data Systems (EDS). The first is the “outreach hotline” which appears on all the statewide outreach materials and responds to initial queries about the program and sends out application forms. Originally, this was the only hotline. But heavy call volume and the creation of “single point of entry” for all mail-in applications, necessitated the creation of a second hotline. The “single point of entry” hotline appears on the application form and is staffed with operators equipped to respond to questions about how to fill out the form. There are also three service lines: the “member line,” for families with children already enrolled in *Healthy Families* who have questions about how the program works; the “Annual Eligibility Review (AER) line,” for responding to queries regarding eligibility renewal; and the “Application Assistor line,” to permit CAAs to call EDS to learn the status of applications they submitted.
- **Fotonovelas:** Aimed specifically at the Hispanic market, Fotonovelas are a comic-book style story-telling device commonly used as an education tool in Hispanic cultures. Each novela tells a story to illustrate a specific message, such as the importance of primary care. Initially only printed in Spanish, the most recent version is bilingual, printed in English and Spanish (October 2001).

C. COMMUNITY-BASED EFFORTS

There are three types of organizations involved with outreach at the local level: Outreach Contractors; Enrollment Entities (EEs) and their affiliated Certified Application Assistors (CAAs); and health plans.

Outreach Contractors. Between 1999 and 2001, 72 CBOs—including clinics, county health and social services departments, legal services organizations, family centers, faith based charities and service organizations catering to specific ethnic groups—were contracted to perform outreach for *Healthy Families* at the community level. In June 2001, new contracts were awarded to 30 CBOs, comprising 191 collaborative partners. School-based contracts were also awarded to 25 organizations, including 18 school districts, four CBOs, and four government agencies. With philanthropic funding from the California Endowment, an additional ten CBO and four school contracts were awarded.

In addition to conducting locally-based outreach for *Healthy Families*, Outreach Contractors are mandated to educate potential enrollees about Medi-Cal as well as *Healthy Families*, and must use logos for both programs on their materials. In actuality, it appears that the primary focus of most contractors is *Healthy Families*. The CBOs that are funded by Medi-Cal (1931(b)), however, tend to be more focused on “children’s health insurance” rather than Medi-Cal or *Healthy Families*.

Outreach Contractors receive monies to build their capacity and infrastructure to conduct outreach and provide application assistance. Typically, this capacity building involves hiring staff with appropriate cultural and linguistic orientation to design and conduct strategies targeted at harder-to-reach children. These efforts can be characterized broadly as follows:

- ***Broad community-wide education:*** Outreach Contractors have sought to raise awareness of the programs by giving presentations, distributing outreach materials, broadcasting on the local media, placing posters in community settings and printing announcements in community bulletins and newspapers.
- ***Forging partnerships with other organizations:*** The contractors have partnered with a broad range of organizations on promotional activities such as conducting outreach at health clinics and WIC sites, working with schools to identify and distributing flyers to participants in the school lunch program, and collaborating with community centers that organize ethnic-specific community events.
- ***Door-to-door and telephone outreach:*** Outreach Contractors also call on low-income parents with potentially eligible children to educate them about the programs and urge them to enroll.

Some specific examples of outreach projects we observed are provided below:

- ***ABC Project, Community Health Councils, Inc. (CHC), Los Angeles:*** The primary strategy of the ABC Project is to forge partnerships with local organizations regularly accessed by the target population, such as schools, clinics, churches, WIC programs, faith-based organizations and businesses. Believing that health insurance coverage for all children should be the message of their campaign, the project markets both *Healthy Families* and Medi-Cal together. Different strategies are used depending on the partner. Collaboration with the clinics, for example, takes the form of the clinic receptionist asking patients at intake whether they have health insurance, and then referring them to an outstationed CHC worker. For faith-based organizations, CHC staff contact pastors and ask if they can make presentations to their congregations. For businesses, ABC has begun contacting human resources staff in small businesses and franchises to promote the program as a potentially valuable benefit for their workers. Under this approach, ABC staff are gaining direct access to employees to discuss their children's health insurance needs.
- ***Ontario-Montclair School District, San Bernardino County:*** Although currently a School-based Contractor, the Ontario-Montclair School District previously held a standard Outreach Contract and, before that, had had staff trained as CAAs. Not surprisingly, outreach by District staff has always focused on the school population. Before they were awarded an Outreach Contract, however, their strategy involved having health assistants in school clinics seek out parents with uninsured children to inform them of *Healthy Families* and persuade them to enroll. These staff, however, found they were too busy with other responsibilities to allocate the time necessary to assist families with filling out the application form. Therefore the District pursued and won an Outreach Contract, which allowed it to hire a dedicated staff person to organize and implement a more sustained campaign. This individual contacted school clinic administrators and nurses, and later school principals. After obtaining the buy-in and support of these leaders, she was able to get involved with the school lunch program (SLP) and began routinely attaching informational flyers, with the project's local toll-free number, to SLP applications. She reports that, consistently, 60 percent of all parents signing up for SLP also contact her to enroll in *Healthy Families* or Medi-Cal.
- ***Clinica Sierra Vista, Kern County:*** This Federally Qualified Health Center, serving 61,000 patients a year at 12 sites, received both Medi-Cal/1931(b) funding and an Outreach Contract from *Healthy Families* in 1999. With these monies, Clinica hired an outreach coordinator and eight outreach workers (who were also trained as CAAs) to conduct "inreach" at their clinics for both programs. Typically, intake receptionists ask patients about the insurance status of their children and, if applicable, refer parents to outreach staff to receive help in completing the *Healthy Families* form or discuss the process of applying for Medi-Cal. Outreach also takes place at Clinica's WIC sites, where workers distribute information and provide direct assistance to parents interested in signing up their children.

Certified Application Assistors. At the time of our site visit, there were nearly 24,000 CAA's across the state, each affiliated with one of 3,600 designated Enrollment Entities (EE). These EE's include schools, providers, hospitals, faith based organizations, insurance brokers or agents, tax preparers, clinics, county and city department's of health, licensed daycare providers, MCH contractors, WIC program agencies, parent-teacher organizations, Indian health services facilities, health plans, and any other organizations that are non-profit and interact significantly with children and parents from low-income families. Following training in August 2000, health plan staff also added to the numbers of CAAs.

Broadly speaking, CAAs conduct outreach for the *Healthy Families* and Medi-Cal programs. However, driven by the \$50 incentive they receive for each successful application, CAAs primarily assist parents to complete the programs' joint application. (The steps in the application process are detailed in the next section.) Rather than spending their time canvassing the community to raise awareness of the program, therefore, application assistors direct their efforts in a manner often referred to as "inreach." That is, the CAAs discuss *Healthy Families* with the people they come into contact with in their everyday work, inquire about their children's insurance status and, if applicable, assist families to complete the form. A doctor's receptionist, for example, might tell an uninsured patient about the program, an insurance broker can inform their customers, or a school nurse might make a presentation about the program at a PTA meeting. We learned of the extensive "inreach" conducted by staff of the Los Angeles County Department of Health Services who work across six hospitals and over twenty health centers to assist parents with uninsured children in applying for coverage.

Health Plans. Health plans are limited in how they can conduct outreach and any strategy they devise must be submitted to the MRMIB and/or DHS for approval. Marketers cannot in any way convey the message that they *are* the *Healthy Families* program or that they are the only plan providing services to *Healthy Families* enrollees. Furthermore, plans are prohibited from making "cold calls" to potential enrollees and, while permitted to design outreach materials, they must identify *Healthy Families* prominently. (The Medi-Cal logo does not have to be used.) Before August 2000, plans were prohibited from assisting families with program applications. Now, however, health plan staff are permitted to receive CAA training and can help parents by taking their names at outreach events in order to conduct follow up, and responding to requests for application assistance. They cannot, however, actively seek out potential enrollees through telephone calls or door-to-door outreach. These limitations have

deterred some health plans from becoming CAAs. Others, however, have become increasingly involved and, beyond providing application assistance, have also designed and produced their own marketing materials (such as brochures, bulletins, billboards and videos), set up booths at community health fairs, and made presentations, when invited, to community groups. Two specific examples of health plan-based outreach we learned of are given below:

- **Blue Cross.** Blue Cross—one of the largest health plans in California with over 193,000 *Healthy Families* enrollees (around 40% of total) and over 701,000 Medi-Cal enrollees⁹—has produced a wide range of outreach materials, including a *Healthy Families* promotional video and matching brochures. The materials are prominently branded with the *Healthy Families* logo, but do not make explicit mention of Medi-Cal. And though the Blue Cross logo also appears on the materials, it is distinctly less conspicuous than that of *Healthy Families*, and the plan is scarcely mentioned in its video. Blue Cross also have outreach programs based in their 7 regional offices, developed specifically to develop culturally and linguistically appropriate strategies; efforts by staff typically involve attendance at health fairs and making presentations to organizations such as health clubs, chambers of commerce, employers, churches and small businesses.
- **LA Care.** LA Care, a relatively small Los Angeles-based plan with nearly 7,400 children enrolled in *Healthy Families*,¹⁰ has worked to maximize its marketing budget by collaborating with grassroots organizations who serve families with potentially eligible children. Strategies involve forging partnerships with schools, faith-based organizations, employers and CBOs, with the aim of utilizing existing channels of communication. Although LA Care is also a Medi-Cal plan (with around 700,000 enrollees), its outreach is explicitly focused on *Healthy Families* for fear that Medi-Cal stigma will deter families. As a result, there is no Medi-Cal logo on LA Care marketing materials.

D. EXPERIENCES AND LESSONS LEARNED

Despite the state’s perception that the initial phase of the outreach campaign had succeeded in branding *Healthy Families*, there was a general feeling among the majority of key informants we interviewed that the state had not initially done a good job of marketing the program statewide. All too often, according to outreach workers and health plan staff, “...the families we worked with had never heard of the program.” Advertisements were widely viewed as “too general” and “not targeted enough at specific communities,” and the effort was criticized

⁹As of October 2001.

¹⁰As of September 2001; MRMIB data “Healthy Families Program Subscribers Enrolled By Health Plan.”

for its “slow start,” its “insufficient” use of bill boards, and for not purchasing sufficient prime-time television slots. In all, the campaign was observed as “spending a lot of money for minimal pay-off.”

Importantly, however, the recent, more targeted media campaign has received positive reviews. DHS staff point out that the program’s new advertisements have led to considerable increases in call volume to the outreach hotline. For example, after launching new commercials which identify specific “price points” for coverage and explicitly discuss the breadth of covered benefits, calls almost doubled from 1,400 to more than 2,700 per day.

The outreach hotline itself, however, also came in for criticism from informants. Although data shows that 500 application forms are now mailed out every day in response to hotline calls, we heard many reports of forms never being received, of inconsistent responses to queries, of problems with the voice-mail prompts and, in general, the “remote feel” of the hotline and its staff. In contrast, outreach workers praised the effectiveness of their own local hotline numbers which provide callers with a personal and “instant” response to questions, and direct assistance with the applications over the phone. Still, it was recognized that the performance of the outreach hotline had improved over time, and DHS has responded to complaints by implementing a query tracking system.

Key informants generally believe that community-based efforts have been much more effective than the statewide outreach campaign. As a neighborhood presence, CBOs were praised for venturing out into the community, building trust, and developing strategies that best meet the needs of their neighborhoods. Opinions varied, however, on the relative effectiveness of the CAAs versus the Outreach Contractors. State officials expressed the opinion that CAAs “win hands down” and are “more cost effective” when judged by the sheer numbers of applications they generate, though they see the functions of the Outreach Contractors and CAAs as complementary. When judged on their capacity to conduct sustained and stable outreach over the longer-term and the ability to support dedicated staff, Outreach Contractors were viewed as more effective by most local informants.

The strategies developed by Outreach Contractors to reach out to their local communities vary considerably—while many appear successful, others have faced unexpected challenges. Notably, while some organizations that were viewed as “obvious partners” have proved to be very successful partners, others have been frustratingly resistant to getting involved. For example, Community Health Councils, Inc. (discussed above) formed very successful

relationships with Los Angeles-area hospitals, but found WIC clinics to be much less responsive. The group also found outreach to the faith-based community “more a failure than a success” because “...many clergy have been disinterested and/or unwilling to be associated with *Healthy Families*.” The CBO, however, is persisting with its efforts. “Persistence and education” are in fact the requirements for forging successful partnerships, according to an outreach worker at the Ontario-Montclair School District in San Bernardino County. As discussed above, she faced considerable challenges when approaching local schools because *Healthy Families* was seen “...as just one more thing on their plate to get in the way of teaching.” Over time, however, she convinced principals and teachers of the connection between health and children’s ability to learn and was able to make inroads. As more parents have enrolled their children in *Healthy Families* and Medi-Cal, “word of mouth” has taken over.

Health plans, meanwhile, credit their “creative” outreach campaigns with bringing many children into *Healthy Families*. Considering their motives honorable, however, health plans viewed the rules imposed by the state to limit their outreach as “excessive and unnecessary,” a view that has not changed since they gained permission to conduct application assistance. Health plans also reported that in some cases families and potential outreach partners were skeptical that their desire to conduct outreach was not merely self-serving, a viewpoint we heard echoed by child advocates. Health plans were defensive of their position, claiming that they would be more effective at outreach if there were fewer rules. Anyway, said one, “the worst that can happen is that a kid gets enrolled.”

Health plans and CBOs all reported that certain populations are still hard to reach, most notably the immigrant Hispanic community that is fearful of “public charge.” Public charge is considered a huge problem in California but, strikingly, one reported to be far more prevalent for Medi-Cal than *Healthy Families*. As a barrier in the Hispanic community, it is reportedly exacerbated by the actions of “notarios,” notary publics from Latin American countries who are not licensed to practice law in the U.S. Notarios are known to warn immigrants against applying for Medi-Cal due to potential for affecting citizenship applications. Informants had conflicting opinions of the effects that the INS’ clarification statement, issued in 1999, has had on easing fears of public charge. Some state officials and one local enroller reported that it has made “a big difference,” but most outreach and Medi-Cal workers declared that it had done little to reduce immigrant families’ fears. Furthermore, these individuals expressed the wish that the state would “do more” to explicitly publicize “that it’s okay to enroll in *Healthy Families* and

Medi-Cal.” In response to these claims, DHS staff reported that state litigation prohibits them from “interpreting INS rules.” For *Healthy Families*, at least, progress in overcoming this barrier is evident—recent state data indicate that Hispanic children now comprise 71 percent of all program enrollees.

Another population reported to be hard to reach was the African American community. There was general uncertainty about why this seemed to be the case, though one outreach worker suggested that it might be linked to under-representation of African Americans among outreach organizations and CAAs, while another mentioned the complex nature of the relationship between African American community leaders and government programs associated with welfare. Finally, advocates also noted barriers in reaching Southeast Asian communities owing to language issues.

Diverse opinions surrounded the question of whether *Healthy Families* and Medi-Cal should be marketed jointly, or separately. Though joint outreach and application is official state policy (as evidenced by the use of dual logos on application forms, advertisements, and printed materials), we heard reports of organizations favoring separate marketing owing to concern that Medi-Cal’s stigma would “turn off” parents before they even had a chance to discuss the new health insurance program. At two of the health plans we interviewed, for example, no mention of Medi-Cal was made during outreach presentations and on plan-generated materials. “Discussing *Healthy Families* allows us to get our foot in the door,” said one marketing chief. “When we meet a family whose children are Medi-Cal eligible, then we discuss the benefits of that program and urge families to apply using the joint form.” In contrast, another plan marketed both programs together because, “...what we are marketing is health insurance, not *Healthy Families* or Medi-Cal.” CBO staff tended to follow this approach stating that “...it is part of our job to educate people about all the possible programs their children might be eligible for,” though they admitted that Medi-Cal stigma was sometimes a deterrent. Staff from the County Departments of Human Services were outspoken in their objection to marketing that focused solely on *Healthy Families*, believing joint outreach “...best serves the population.” Advocates strongly agreed, opining that separate marketing perpetuates the divisions between the two programs, whereas marketing the two programs as “health insurance” represents a shift toward “seamlessness.” Related to this, these advocates also voiced support for the notion that California should follow in the footsteps of other states, like Connecticut and New York, and rename their Medicaid programs after their SCHIP initiative—they suggested that calling the programs *Healthy Families* “A” and “B” would, over time, help to reinvent the image of Medi-Cal.

IV. ENROLLMENT AND RETENTION

A. POLICY DEVELOPMENT

California's first attempt to implement a simplified eligibility process for *Healthy Families* was not a success. With the launch of the new program in July 1998, the state also launched its new joint *Healthy Families/Medi-Cal for Children* application form and began accepting this form by mail. The new form had many problems, however, that quickly became apparent to state officials. First, the effort to develop a form that could account for the policies of both programs and collect information required by each resulted in a 28-page document—not “short” by anyone’s definition. Second, the form required applicants to determine which program they were eligible for (using a set of worksheets), and then figure out where they should mail their application (to either EDS if they believed they were *Healthy Families* eligible, or their county DSS office if they believed they were Medi-Cal eligible). Two envelopes were enclosed in the application packet to enable mailing to either entity. The response from the public, child advocates, and CAAs trained to assist families with the form was immediate and very negative—it was judged as complex, confusing, and difficult to complete. Much to the chagrin of state officials, the form received considerable national attention for its poor design, serving as an example of “what *not* to do” when attempting to simplify enrollment.

California rebounded quickly from its first misstep, however. At the direction of the Governor, MRMIB and DHS convened a multi-disciplinary, interagency work group to redesign the form and consider other policy changes that were needed to “fix” the process. This group, which began its work in the fall of 1998 and included several prominent child advocates, completed a revised form by year’s end and the state was able to implement two critical improvements in April 1999. First, by no longer requiring applicants to calculate and determine their own eligibility, the form was reduced from 28 pages to four; and second, it positioned EDS as the “single point of entry” for all *Healthy Families/Medi-Cal for Children* applications (i.e. from April 1999 forward, all applications were mailed to EDS in Sacramento for review and income eligibility screening).

B. ENROLLMENT PROCESS

As detailed in Tables 3 and 4, *Healthy Families* has adopted and implemented a number of policies to facilitate easier application and more continuous coverage. The program uses a joint SCHIP/Medicaid form of 4 pages, it imposes no assets test, provides 12 months of continuous eligibility and requires verification of few items—income, residency, and birth certificates or immigration status (to prove citizenship). In addition, the program does not require a face-to-face interview as part of the application process, and has supported the development of an extensive network of community-based application assistors to help families to apply for coverage (as discussed in the previous section).

Medi-Cal rules for children are still slightly different from those of *Healthy Families*, although the program has taken several steps since 1998 to align the two programs. For example, Medi-Cal dropped its assets test for children in 1999, and families who end up being found eligible for Medi-Cal also benefit from the new joint form, mail-in process, and community-based application assistance. The program also dropped its requirement for enrollee quarterly reporting and implemented 12-month continuous eligibility for children in January 2001. The only remaining difference of note is that Medi-Cal still collects Social Security numbers of any family members requesting aid, while MRMIB does not require this information.

Families can apply for *Healthy Families* through two methods: (1) Directly by mail, with or without the help of an application assistor or outreach worker; or (2) Indirectly via county social services departments. Each of these avenues is summarized briefly below.

Applying Directly by Mail, with or without Application Assistance. Once parents learn of the *Healthy Families* program, they can call the program's toll-free hotline and request an application form through the mail. Or, if contacted by an outreach worker or provider, they can obtain an application directly from them.¹¹ Once a parent has an application form, they can fill it out and mail it in to the state's Single Point Of Entry (SPE), EDS, including copies of all required documentation as well as a premium payment. Similarly, parents can fill out the form with the help of an assistor. The applicant collects documentation and premium payments and mails the packet in to the SPE.

¹¹The *Healthy Families/Medi-Cal for Children* application form is available in 10 languages.

TABLE 3: SCHIP AND MEDICAID ELIGIBILITY POLICIES

Policy	SCHIP	Medicaid ^a
Retroactive eligibility	No, but services received between application and enrollment are reimbursed if provided by CHDP provider	Yes, 90 days from first day of month of application
Presumptive eligibility	No	No
Continuous eligibility	Yes, 12 months	Yes, 12 months
Asset test	No	No (but yes for adults)
U.S. citizenship requirement	Yes, or qualified alien ^b	Yes, or qualified alien

SOURCE: Centers for Medicare and Medicaid Services (CMS), Framework For State Evaluation Of Children's Health Insurance Plans Under Title XXI of the Social Security Act, 1999: California. March 2000 website: <http://www.hcfa.gov/init/caeval98.pdf>; Kaiser Commission on Medicaid and the Uninsured. Comparison of Medi-Cal and Healthy Families Programs in California. October 2000

NOTE: SCHIP=State Children's Health Insurance Program (Title XXI).

^a Children's coverage groups.

^b State funded program for recent legal immigrants.

TABLE 4: APPLICATION AND REDETERMINATION FORMS, REQUIREMENTS AND PROCEDURES

Characteristic	SCHIP	Medicaid ^a
APPLICATION		
Form		
Joint form	Yes	Yes
Length	4 pages ^b	4 pages
Languages	11 languages	11 languages
Verification Requirements		
Age	Yes	Yes
Income	Yes	Yes
Deductions	No	No
Assets	No	No
State residency	Yes	Yes
Immigration status (residency papers or birth certificate)	Yes	Yes
Social security number	No	No
Enrollment Procedures		
Mail-in application	Yes	Yes
Phone application	No	No
Internet application	Yes ^c	Yes ^c
Hotline	Yes	Yes
Outstationing	No	Yes
Community-based enrollment	Yes	Yes
REDETERMINATION		
Same form as application	No	No
Pre-printed form	Yes	No
Mail-in redetermination	Yes	Yes
Income verification required	Yes	Yes
Other verification required	Changes in family size, if applicable	Yes

SOURCE: Donna Cohen Ross and Laura Cox, *Making it Simple: CHIP Income Eligibility Guidelines and Enrollment procedures: Findings from a 50-State Survey*. Kaiser Commission on Medicaid and the Uninsured, October 2000; Centers for Medicare and Medicaid Services (CMS), *Framework For State Evaluation Of Children's Health Insurance Plans Under Title XXI of the Social Security Act, 1999: California*. March 2000 website: <http://www.hcfa.gov/init/caeval98.pdf>; Kaiser Commission on Medicaid and the Uninsured. Comparison of Medi-Cal and Healthy Families Programs in California. October 2000

NOTE: SCHIP=State Children's Health Insurance Program (Title XXI). NA=Not applicable.

^a Children's programs

^b The form was originally 28 pages long, but has been changed since the start of *Healthy Families*

^c Currently under development

California is unusual in that its SCHIP application form includes a question in which applicants can indicate whether or not they want their application forwarded to Medi-Cal or *Healthy Families*, if it is determined that their children are likely eligible for that program. Specifically, this “check box” was included on the original 28-page form, and retained in the revised 4-page form, at the insistence of legal and other child advocates who were concerned that immigrant families have the opportunity to decline having their application reviewed by Medi-Cal in case that review might adversely affect their child’s or their citizenship status. In the time since *Healthy Families* was implemented, the INS has issued clarification that Medicaid *does not* constitute a “public charge” in the citizenship application process. However, some advocates remain unconvinced of this and steadfast in their belief that the “check box” remain on the application as a protection for immigrant families applying for health coverage.

The state reports that fully 70 percent of all applications received at the SPE are from parents who have received some form of application assistance. The other 30 percent are completed by parents, alone, and directly mailed in. The SPE vendor (EDS) staff review the forms and, with the help of sophisticated financial computer logic, determine if children appear income eligible for *Healthy Families* or Medi-Cal. Depending on the outcome, these applications are handled in one of three ways:

- For children found *Healthy Families* eligible, staff check the application’s completeness. When an application is incomplete, which occurs in nearly 70 percent of all cases, the SPE staff send parents a letter identifying the outstanding items, requesting that parents submit them, and make up to 3 telephone calls to families. After 20 days of no response, the application is “closed.”¹² For families that complete their applications, the application is forwarded to the *Healthy Families* processing unit which enrolls the child, generates a welcome letter, and forwards applicant information to the selected health plan which, in turn, send the families a packet of information regarding the health plan and the process for selecting a primary care provider. If the application was assisted with by a CAA, the Enrollment Entity is informed of the outcome of the application, and paid their fee for each successful application.

¹²The SPE vendor (EDS) reports that between 35 and 40 percent of incomplete applications never get completed, either because EDS is unable to contact families, or families do not submit required documentation. Vendor staff report that, most often, income verification is left out. But parents also commonly fail to include premium payments, copies of birth certificates, immigration documents, or simply fail to sign their application.

- Overall, 30 percent of applications received by the SPE are found to be Medi-Cal eligible. For these children, SPE staff forward the application by Federal Express to the local Department of Social Services (DSS) in the applicant's county of residence. When these applications are incomplete, SPE staff do *not* attempt to obtain missing information before forwarding them to DSS. (Local DSS staff confirmed that between one-half and three-quarters of the applications they receive from EDS are incomplete.) Local DSS office staff typically attempt to contact families by mail to obtain missing verification. Families failing to respond have their applications filed, whereas families who submit required information can have their applications processed without needing to come in for an in-person interview with DSS staff.

Because there is no system to track the flow of documents between the SPE and the counties, state and local officials are unable to report the outcomes of application referrals between the two organizations. By extension, the state does not know how many children have obtained Medi-Cal eligibility as an outcome of the *Healthy Families* outreach and enrollment process.

- Forty-three percent of families applying for *Healthy Families* check the box requesting that their child's application not be forwarded to DSS. If children in these families are in fact determined Medi-Cal eligible, the SPE sends a letter informing them of the outcome of the review process. In that letter, the SPE discusses the Medi-Cal coverage that may be available for their child and urges the family to reconsider and allow EDS to forward its application to DSS. While SPE officials reported that, for several years, it was rare for a family to change its mind about Medi-Cal review, today more and more families are doing so and permitting their applications to be reviewed by Medi-Cal after learning more about public charge.

Applying through a County Department of Social Services. Parents can also initiate an application for health coverage at a county department of social services and, eventually, enroll their children in *Healthy Families* as a result of a referral from DSS to the SCHIP program. Typically, this would begin when a family encounters a DSS eligibility worker, either in a county office or at a provider site (where a DSS worker may be outstationed). DSS workers we interviewed almost always reported that they use the MC-210 application form for Medi-Cal rather than the *Healthy Families/Medi-Cal for Children* application (though they are not prohibited from using the joint form). This was because these workers view their primary responsibility as exploring potential eligibility for an entire family, not just children. Unfortunately, using the much longer MC-210 takes more time and requires the gathering of more information.¹³ For example, to determine eligibility for parents, assets information must be

¹³At the time of our visit, DHS had just completed a revision to the MC-210 that it hopes will make the form clearer, more attractive, and easier to fill out. This version was put into use in November 2001.

gathered. In addition, Medi-Cal uses a different definition of household composition for some family configurations. Medi-Cal also pursues information regarding absent parents, a step that was reported as unpleasant for and resisted by parents.

When this process finds a child that appears to be *Healthy Families*-eligible, the local DSS office will place the child on “share of cost Medi-Cal” (that is, enroll them in the Medically Needy program). At the time of our visit, the protocol was to then provide the family with the toll-free hotline number and urge them to follow up with *Healthy Families*. Effective December 2001, however, the new MC 210 for “share of cost” children is sent directly to SPE for a *Healthy Families* determination so no new application is required. In some, but not all of the offices we visited, DSS staff will also give parents the blank *Healthy Families/Medi-Cal for Children* application form. However, no DSS staff we interviewed reported that they actually assisted families with filling out the form; this was an action they did not think of as their responsibility. In two of the three counties we visited—Los Angeles and Kern—strong ties had been formed between county DSS staff and local CAAs and/or Outreach Contractors. In these cases, DSS staff might also refer families that appeared eligible for *Healthy Families* to these application assistors. In the other county we studied—San Bernadino—no such ties were reported and all referrals were simply to the hotline.

C. REDETERMINATION PROCESS

The eligibility redetermination processes for *Healthy Families* and Medi-Cal are distinct and guided by very different policies, as summarized below.

- For *Healthy Families*, eligibility is redetermined every 12 months. Sixty days prior to the end of the 12-month eligibility period, EDS sends families a renewal notice along with a customized form that has been pre-printed with information submitted on the initial application. Families are instructed to review the application, identify any changes, submit income verification, and sign the form. If families respond and resubmit the form, it is reviewed for ongoing eligibility. If the child is found to still be *Healthy Families* eligible, then they are notified of this and eligibility is renewed for another 12-month period. If income or circumstances have changed such that a child is Medi-Cal eligible, then the information is forwarded to the family’s county DSS office and the family is notified that they will be contacted by DSS. (That is, unless the family has checked the box on the renewal form asking that their application not be forwarded to DSS.) If families do not respond to the renewal notice, a post card is sent 30 days prior to the end of the 12-month period. EDS staff

make up to 3 additional attempts to contact families by telephone before disenrolling the children.

- For Medi-Cal, 12 -month continuous eligibility for children was implemented in January 2001; prior to that, families were required to report changes in income and circumstances to local DSS offices each quarter. Under current policy, families are sent a letter by DSS every 12 months identifying an appointment date and time. During this required face-to-face interview, families complete the MC-210 “revision” form to re-establish eligibility. If circumstances have changed and children now appear *Healthy Families* eligible, they are told to contact the program through its toll-free hotline and may or may not be given the *Healthy Families* form. Once again, no direct assistance is provided to families in completing this form, nor is any application information forwarded from the DSS office to the SPE.

At the time of our visit, CAAs, Outreach Contractors, and health plans had been only minimally involved in the *Healthy Families* redetermination process. Specifically, neither CAAs nor Outreach Contractors reported that they were routinely sent lists of children whose eligibility is up for renewal. Only one health plan we interviewed had received such lists as part of a pilot project. However, beginning in August 2001, health plans receive monthly lists of children undergoing the renewal process. The Request for Proposals for the second round of Outreach Contractor funding also asked CBOs to identify strategies for assisting families with *Healthy Families* and Medi-Cal redetermination. Thus the new Outreach Contractors are now required to include retention assistance activities as part of their scope of work. Consequently, most are using case management tools to track families’ annual renewal dates.

D. EXPERIENCES AND LESSONS LEARNED

Healthy Families received a great deal of criticism during its first year for failing to enroll a higher number of eligible children. Over the last two years, however, *Healthy Families* enrollment has steadily increased to over 475,000 children. As shown in Table 5, this figure represents roughly 75 percent of the estimated target population, and 25 percent of the total estimate of uninsured children in 1999.¹⁴ (This enrollment figure is still relatively small compared to total child Medi-Cal enrollment—in 1998 there were over 2.6 million children enrolled in the program.¹⁵) Most informants we interviewed expressed a fair level of satisfaction

¹⁴According to: Kaiser Family Foundation. State Health Facts Online. Distribution of Children 18 and Under by Insurance Status, 1997-1999, there were 1,909,260 uninsured children in California in 1999.

with the state’s record on this score and acknowledged that the program had recovered well from its “rough start.”

TABLE 5: ENROLLMENT TRENDS

Enrollment Measure	1998	1999	2000	Sep 2001 ^a
Number ever enrolled in federal fiscal year (FFY)	55,495	222,351	477,615	691,875(Aug)
Number enrolled at year end (point in time) ^a	55,106	202,328	363,023	475,795
Percent change in point-in-time enrollment	-	+267%	+79%	+31%

SOURCE: Vernon K. Smith, *CHIP Program Enrollment: June 2000*. Kaiser Commission on Medicaid and the Uninsured, January 2001. Centers for Medicare and Medicaid Services (CMS), *State Children’s Health Insurance Program (SCHIP) Aggregate Enrollment Statistics for the 50 States and the District of Columbia for Federal Fiscal Years (FFY) 2000 and 1999* website: <http://www.hcfa.gov/init/fy99-00.pdf>; Managed Risk Medical Insurance Board. *Healthy Families* Program enrollment history website: <http://www.mrmib.ca.gov/MRMIB/HFP/HFPRptH.html>

^a Most recent enrollment data available.

Less clear is the understanding of retention rates under SCHIP. In part, this is due to *Healthy Families’* eligibility data system which cannot report outcomes of the eligibility redetermination process, per se. Rather, it reports on the broader tally of “case closures,” or disenrollment which may or may not occur in connection with the redetermination process. Furthermore, broad reporting categories mask what’s really going on with retention. State officials and EDS recently calculated that for every 100 children who enroll, 76 are still on the program one year later—an apparent retention rate of 76 percent. Of the 24 who disenroll, one-third lose their coverage because they no longer meet the program’s eligibility criteria (i.e. they “age out” of the program, or their parent’s income changes, etc.), while two-thirds lose eligibility for what are termed “potentially avoidable reasons.” Within this grouping, most are families that EDS never hears from or are unable to find during redetermination, and the next are families disenrolled for nonpayment of premiums.¹⁶

¹⁵According to Kaiser Family Foundation. State Health Facts Online. California: Distribution of State Medicaid Enrollees by Enrollment Group, FFY1998, there were 3,230,462 children enrolled in Medicaid in FY 1998 in California.

¹⁶As will be discussed in the section on “Cost Sharing,” non-payment of premium is a “catch all” reporting category, and could include families who stopped paying their premiums for any of a number of reasons, including moving out of the state, enrolling in private insurance, becoming dissatisfied with *Healthy Families* coverage, or being unable to afford program premiums.¹⁷The population of LA County is 31 percent of the state’s total.

Policymakers and other key informants report they have learned many valuable lessons about factors that contribute to, or undermine, successful enrollment. Some of these lessons are summarized below.

- ***Sometimes what state bureaucrats consider “simple” isn’t simple at all.*** California learned a hard lesson as a result of its first “misstep” with the 28-page *Healthy Families/Medi-Cal for Children* application form. State officials and their stakeholder group (advocates, providers, health plans, and community members) designed the original application with the aim of ensuring that no child applying for *Healthy Families* would fall through the cracks and be missed by Medi-Cal if found ineligible. They hoped that families would be able to grasp the complexities of program eligibility rules and, furthermore, be able to calculate and determine eligibility for the programs on their own. During the site visit, state officials were roundly criticized for this “blunder,” but also commended for their rapid response to correct the mistake. The second time around, state officials and the stakeholder groups agreed that there was too much detail in the application, and aimed to make the process much simpler. The result was a much improved form and the creation of the “single point of entry” approach to application processing.

Enlisting the help of community-based application assistors has been crucial in achieving strong enrollment, but not all has gone smoothly for these initiatives.

Roughly 70 percent of all applications submitted to the program are from parents who have received community-based assistance, a fact attributed to the wide “reach” of the application assistance and outreach contractor programs. Similar to their role in outreach, local groups were described as providing the “trusted voice” that encourages parents to apply and, notably, follow up with an actual application in response to outreach. Whether based in schools, FQHCs, county health clinics or other grass-roots organizations, assistors described the importance of being able to target and reach families that might not otherwise respond to advertisements, ethnic subgroups of the eligible population, immigrant families afraid of government programs, and other “hard to reach” groups.

It was reported, however, that there have been logistical difficulties in the assistance programs, and for the CAA system in particular. At first, CAAs had problems working with the 28-page application. Later, even after the form was simplified, CAAs learned the \$25 fee fell far short of compensating them for the time they spent helping a family to apply, a problem that has reportedly not completely disappeared after the fee was doubled to \$50. State officials report that more than 16,000 of the 23,000 CAAs do not, in fact, actively assist families with applications because they have found it either too time consuming to fit in with their usual daily activities, or economically inefficient. The Enrollment Entities for whom application assistance seems to work best appear to be those with a high enough volume of clients to justify the necessary investment in time and resources. This was true of FQHCs that historically have worked to assist their clients in obtaining health coverage and could now receive reimbursement for performing this function, and also networks of individuals, working independently, who made it their job to contact providers,

employers, day care centers, and other programs or groups that served low-income families with uninsured children.

Despite application assistance, the SPE staff noted that nearly 70 percent of applications are submitted incomplete. To ease this problem, the SPE vendor sought and received funds to carry out more extensive CAA training. The state, in collaboration with the Californian Health Care Foundation, has also developed an online application process--“health-e-app”--with the aim of increasing the rate of completed application and speeding up the enrollment process. Currently being tested in San Diego, the online form will be used by CAAs and Outreach Contractor staff as they assist families with their applications. The structure of screens used in the Internet-based application will prevent application assistors and families from making mistakes while they’re filling out the form, and signatures and verification can be accepted electronically or by fax.

- ***Operations of the state’s vendor, EDS, have been problematic, but systems appear to be improving.*** The state contracted with Electronic Data Systems (EDS) to carry out a large number of administrative functions, and in implementing some of these processes EDS has been challenged and subsequently criticized. CAAs were critical of how long it took for EDS to reimburse them for completed applications, and the fact that sometimes they were never paid fees they believe they were due. County DSS agencies and other community-based enrollers called EDS a “black hole” for referrals, in reference to the fact that EDS are unable to track the status of referred applications, including those sent to county Medi-Cal offices. As a result, the state does not know how many children have obtained Medi-Cal coverage as an outcome of the *Healthy Families* outreach and eligibility process. Many of the CBOs we interviewed, in fact, said that they preferred to refer families whose children appeared Medi-Cal eligible directly to their local DSS office, rather than fill out the *Healthy Families* form and mail it in to the SPE. “It’s just much quicker if we handle it here, at the local level. And this way, at least I’m here to help families when they run into trouble with DSS,” was a scenario often described. Some CBOs also said that they knew of families that sent premium checks in to the SPE and never received them back once it was determined that they were eligible in a non-premium group or had been referred to Medi-Cal.

While the state and EDS acknowledge the problems this has caused, they also described how they are now developing a tracking system that will assign “bar code” numbers to each application form so that its status in the system can be tracked on a real time basis. In addition, the parties believe “they must be doing something right,” and point to high and steadily increasing levels of enrollment as evidence that the arrangements, albeit imperfect, are working.

- ***Involving health plans in Healthy Families enrollment efforts has netted mixed results.*** In response to complaints by health plans, California granted plans the authority to receive training as Certified Application Assistors in January 2001 (as described in the previous section). Since then, however, only a reported one-third of plans have sought out CAA status, and some of those who did have subsequently decided it wasn’t worth their while to provide application assistance. Those

organizations who have opted out of the CAA program—like Blue Cross—still find the rules that guide plan activities burdensome, stating “Unlike other CAAs, plans are not allowed to proactively seek out potential eligibles, nor can we call families back to follow up with them on missing information for their applications. On top of this, plans don’t receive any extra payment for the function.” Still, other MCOs, like Inland Empire Health Plan in San Bernadino, have aggressively taken advantage of the opportunity: “We were the first plan to receive certification, and had all of our phone center staff trained. Since January, we’ve helped over 9,000 kids enroll in the program, more by far than any other CAA in our area.” Regardless of whether they were CAAs or not, health plan officials tended to feel that the state was being too cautious with its rules surrounding health plan marketing, and that they were “missing a key opportunity” to take advantage of plans’ business and marketing acumen.

- ***Healthy Families has had an important “spill over” effect on Medi-Cal eligibility and enrollment policies.*** One of the most important effects of *Healthy Families*, report MRMIB officials, is that “it has been the tail wagging the Medicaid dog.” That is, with strong political support, *Healthy Families* has been free to test numerous innovative strategies for simplifying enrollment and, in response, Medi-Cal has adopted many of these same strategies after learning of their beneficial effects. Specifically, these officials point out that, in just three years, Medi-Cal has dropped its assets test for children, moved to a mail-in approach for its application, reduced verification requirements and, overseen and administered the largest outreach campaign in the program’s history. Most recently, Medi-Cal even adopted 12 months continuous eligibility for children. In most cases, these very same policies had been proposed in years past, but were rejected by either Medi-Cal officials or legislators against the idea of simplifying access to the welfare-based program. Yet today, with the benefits of simplification more clear and the need to coordinate operations of the two programs more pressing, these policies have been readily adopted by Medi-Cal.
- ***Consumers’ negative perceptions of Medicaid (“stigma”), as well as persistent fears of “public charge,” continue to undermine California’s ability to enroll children into Medi-Cal, and also affect coordination between Healthy Families and Medi-Cal. Yet progress is being made in overcoming these problems, and changes in county welfare operations and culture appear to make a huge difference.*** Although nearly seven times the number of children are currently enrolled in Medi-Cal than *Healthy Families*, informants reported that significant barriers to enrollment persist in the forms of consumer resistance to Medi-Cal and fears of public charge among Hispanic immigrant families. Both of these problems endure in part due to their deep roots. Medi-Cal’s eligibility process has, since the program’s inception, been overseen by county social services offices who also administer cash assistance and food stamps. The “welfare culture” of these systems has rubbed off on Medi-Cal to the extent that, according to advocates and other key informants, the application process for years was viewed as intrusive, overly complicated, and very unpleasant. Couple this with the fact that California, under Governor Wilson, passed Proposition 187 which enforced severe restrictions and penalties on immigrant populations who sought public services, causing the fear of “public charge” among immigrant families to become pervasive through the 1990s. Therefore, when the culture of *Healthy Families* and Medi-Cal changed in 1998 to embrace families with uninsured children

and encourage them to enroll, problems were inevitable. From various key informants, we heard such things as “...families simply don’t want Medi-Cal and would rather be uninsured,” “...the program carries so much negative baggage,” “...parents are not afraid of *Healthy Families*, but they’re terrified of Medi-Cal,” and “...families have begged us to stay on *Healthy Families* and even offered to pay premiums to do so.” From one CAA, we heard: “I lose 90 percent of the families that I find Medicaid eligible...they simply walk away.” Similarly, the fact that 43 percent of parents check the box indicating that they do not want their application forwarded to DSS is evidence of the effects of stigma and fear of public charge.

Despite the challenges of consumer stigma and fear of public charge, we heard reports that the situation is improving. One outreach contractor reported that she could persuade 95 percent of the families whose children she found eligible for Medicaid eligible to follow through with DSS, stating “...it is hard, but once I tell them about the program and how it has changed, I can usually talk them into it.” Others believe that fears of public charge are slowly lessening—“...things have definitely improved since the INS clarification.”

On a grander scale, Los Angeles County provides a case study of how a DSS office, working in tandem with its partner county Department of Health Services, can change its culture and approach to Medi-Cal eligibility and turn things around. Specifically, in response to a charge from the County Board of Supervisors to “enroll 100,000 children in 1999,” LA County DSS launched its Child Medicaid Enrollment Project (CMEP). Under this project, the county outstationed over 150 of its staff to provider and other sites throughout the county, partnered with county health clinics to train and deploy eligibility workers in health settings, and aggressively used its share of the state’s 1931(b)/welfare reform outreach monies to develop promotional materials and partner with and conduct outreach to grass roots organizations across the county. According to DSS staff we interviewed, “...the whole culture changed, from one where we worked to keep people out, to one where we seek out every last eligible child.” The effort has borne significant results—under CMEP, LA County met and surpassed its goal by enrolling 112,000 children in 1999. Furthermore, LA County also has emerged as the County with the highest *Healthy Families* enrollment, comprising roughly 145,000 children, or 31 percent of the state’s total enrollment.¹⁷

V. CROWD OUT

A. POLICY DEVELOPMENT

As in many other states, there was concern in the Governor's office and state legislature in California that *Healthy Families* would result in "crowd out." The ensuing debate led to the inclusion of specific policies aimed at preventing crowd-out in *Healthy Families*, namely a three-month "waiting period" to discourage families from dropping their existing employer-based coverage, and an amendment to the state code to make it an unfair labor practice for employers to change coverage or change the cost of coverage to encourage employees to enroll their children in *Healthy Families*, or to refer employees with eligible dependents to *Healthy Families*. Owing to the typically high costs of individual health insurance coverage, the waiting period is waived for children whose current coverage is through an individual policy.

B. POLICY AND PROGRAM CHARACTERISTICS

The state has three main crowd out prevention strategies:

- Children are ineligible for *Healthy Families* if they have been covered by an employer within three-months of applying for the program, with the exception of children covered by individually-purchased insurance. The state has the option of increasing this three-month "waiting period" to six if crowd out becomes a concern.
- Insurance agents and insurance companies are prohibited from referring dependents to *Healthy Families* when they are already have employer-sponsored coverage.
- If they provide coverage to dependents, employers are not allowed to refer employees to *Healthy Families*, nor can they change the extent and price of their coverage in a way that might encourage employees to switch to *Healthy Families*.

California includes a series of questions on its application form to examine applicants' insurance status. These questions include:

1. Do the children [being applied for] have other health, dental or vision insurance?
2. Were any of the children insured by an employer in the last 90 days?
3. If "yes", check the main reason why health insurance stopped and give the date it stopped (lost job, moved etc.).

C. EXPERIENCES AND LESSONS LEARNED

MRMIB officials do not currently perceive crowd-out as an issue in *Healthy Families*, and have thus not considered increasing the waiting period to six months. State data indicate that just under 5 percent of children are denied coverage because they already have insurance or have voluntarily dropped insurance within 90 days of application. Another 4.8 percent are enrolled in *Healthy Families* even though they had insurance within the previous 90 days because their coverage was lost through no fault of their own (i.e., an employer stopped offering dependent coverage, an applicant's parent lost his/her job and employer-sponsored insurance, or COBRA coverage ended).

At the local level, few key informants believed that employers were changing their behavior by dropping or reducing the scope of dependent coverage. Still, health plan officials voiced fears that employers may drop coverage in the future, particularly if parents are brought into *Healthy Families*.

On the consumer side, too, the three-month waiting period was cited as a “real deterrent” to families tempted to drop employer-sponsored coverage for their children, a step that staff assisting with applications and health plans say they always discourage. Providers, though, fear that the state's planned expansion of coverage for parents to 250 percent of poverty will encourage crowd out and thus erode the base of privately-insured patients they serve. It was, in fact, a provision the California chapter of the American Academy of Pediatrics actively opposed.

“Underinsurance,” a status applicable to individuals who possess insurance that is either very expensive or very limited in scope, was cited as an issue with implications for crowd out. Specifically, in Kern County, informants described how “chronically underinsured” agricultural workers in the region were dropping coverage for their children and “going bare” for three months in order to become eligible for *Healthy Families*. Expressing frustration with this situation, officials from the Kern Family Health Plan and local enrollers wished that the waiting period could be dropped for such “underinsured children.” In keeping with this sentiment, these and many other of the officials we spoke with supported California's current exemption for children covered by individual policies; permitting these children to switch to broader, less expensive *Healthy Families* coverage was viewed as “fair” and “equitable.” Advocates also voiced concern on behalf of children who are insured but lack dental and vision benefits, benefits that are covered by *Healthy Families*. To address this gap, they suggested that *Healthy Families* should be permitted to “wrap around” inadequate coverage and provide coverage of dental and vision care.

VI. BENEFITS COVERAGE

A. POLICY DEVELOPMENT

The Governor and state legislators chose the state employee's health benefits package, termed CalPERS, as the model for *Healthy Families*. It was perceived as a comprehensive package that reflected the most generous of employer offerings. In addition, the choice potentially avoided any resentment that may have come from higher-income families that the government was giving low-income families a richer benefits package than that received by state employees.

In actuality, California did go beyond basic CalPERS coverage to include such additional services as comprehensive vision and dental care. In addition, the state built links between *Healthy Families* and Medi-Cal's EPSDT program—called the Child Health and Disability Program, or CHDP—by permitting CHDP providers to bill *Healthy Families* for children they served and referred to the program that were subsequently enrolled.

B. POLICY AND PROGRAM CHARACTERISTICS

Overall, the benefits covered by *Healthy Families* are quite broad—the package includes the full range of preventative, primary, acute, therapeutic and behavioral health services commonly needed by children. As stated above, *Healthy Families* coverage goes beyond the benchmark package of CalPERS by covering comprehensive vision and dental care.

In comparison to Medi-Cal, the only services that are not covered are non-emergency transportation, ICF/MR services, personal care, residential substance abuse services, and orthodontic services.¹⁸ In addition, *Healthy Families* imposes limits on several services, including occupational, physical and speech therapies, alcohol and drug services, and skilled nursing (services that, under EPSDT, are available on an unlimited basis to Medi-Cal beneficiaries). *Healthy Families* actually surpasses Medi-Cal in its coverage of well-child care; the program has adopted the periodicity schedule endorsed by the American Academy of Pediatrics which calls for several more well-child visits than that used by the CHDP program.

¹⁸Orthodonture is only covered for children with severe malocclusions qualifying them for coverage under the California Children's Services program. In these instances, children are referred to CCS and that program provides and pays for the care.

According to the health plan officials we interviewed, commercial insurance packages tend to be comprehensive in California, particularly among larger employers. Therefore, *Healthy Families*' broad coverage was sometimes described as comparable to employer coverage. The most notable "extra" benefit *Healthy Families* provides is dental coverage, although some over-the-counter medications, hearing aids, and corrective lenses are covered by *Healthy Families* and are not usually covered by private insurance. In addition, the cost sharing requirements of *Healthy Families* were described as lower than those of private insurance products.

C. EXPERIENCES AND LESSONS LEARNED

"Tremendous" and "fabulous" were words used typically to describe the *Healthy Families* benefits package in California. Health plans perceived it to be comparable to or better than private insurance. One plan even expressed the opinion that the package is *too* generous, because a more limited package could be extended to more children.

Legislative staff did, however, note that residential alcohol and drug services and personal care nursing were "gaps," and providers that behavioral health and certain drugs were "overly restricted." Although child advocates reported that they were "amazed" at how few complaints they received relating to these services, they voiced concerns that the "silence" might also be due families' lack of understanding of grievance reporting procedures. On the dental side, orthodontics was a subject of "lots of complaints," apparently owing to coordination problems with referrals to CCS.

VII. SERVICE DELIVERY AND PAYMENT ARRANGEMENTS

A. POLICY DEVELOPMENT

From the start, California's goal was to deliver *Healthy Families* services entirely through managed care arrangements. Through its procurement process, MRMIB has achieved this goal, establishing contracts with health maintenance organizations (HMOs) in 43 of the state's 58 counties, and Exclusive Provider Organization (EPO) arrangements in the remaining 15 (more rural) counties. In all, *Healthy Families* works with 26 health plans (comprising 24 HMOs and 2 EPOs), 5 dental plans, and one vision plan.

Medi-Cal, in contrast, has implemented mandatory managed care at a slower pace. Beginning in earnest in the early 1990s, but dating back to the mid-1970s, the state has used a series of Section 1915(b) "freedom of choice" waivers to implement managed care systems in 22 counties. Medi-Cal's managed care system is complex, with different models being used in various counties. For example, the "Two Plan Model," currently in 12 counties, places commercial managed care plans in competition with a "local initiative," a plan typically comprising a network of public hospitals and clinics and private providers. Meanwhile, in five counties, single county-run systems termed "County Organized Health Systems" handle all Medicaid enrollees through networks of public and private providers. Finally, under "Geographic Managed Care," currently in place in Sacramento and San Diego Counties, the state contracts with multiple commercial managed care plans for the care of Medi-Cal enrollees. Today, approximately 52 percent of Medi-Cal beneficiaries are enrolled in some form of managed care.¹⁹ Typically, managed care enrollment is mandatory for TANF- and poverty-related eligibility groups, and voluntary for SSI and others groups, in the 22 managed care counties. In the 36 counties without managed care, fee-for-service arrangements are used.

While not immediately apparent, the managed care systems used by *Healthy Families* and Medi-Cal are fairly well aligned. For example, all but 4 of *Healthy Families*' 26 health plans also participate in Medi-Cal, and all but 4 of Medi-Cal's 26 plans also participate in *Healthy Families*. In counties where health plans participate in both *Healthy Families* and Medi-Cal, the provider networks they extend to families and children are often quite similar. And while fee-for-service arrangements under Medi-Cal remain in 36 of the state's 58 counties, it is

¹⁹"Medi-Cal Managed Care." *Medi-Cal Facts*, No. 8. Oakland, CA: The Medi-Cal Policy Institute, March 2000.

worth pointing out that 88 percent of the state’s population reside in the 22 counties where both programs have implemented managed care arrangements.

B. POLICY AND PROGRAM CHARACTERISTICS

1. Service Delivery Arrangements

During the enrollment process, families select from among the available medical and dental plans in their counties; all *Healthy Families* enrollees receive vision care through the single contracting plan. Of the 26 health plans, ten are commercial managed care organizations, 12 are “Local Initiatives” under Medi-Cal’s “Two Plan Model,” and 4 are “County Organized Health Systems,” again part of Medi-Cal’s managed care system.²⁰ While there is generally a high degree of overlap in the networks offered by plans participating in *Healthy Families* and Medi-Cal, *Healthy Families* was described as offering its enrollees a somewhat broader network of participating physicians. This is primarily due to the fact that *Healthy Families* has contracted with Blue Cross, Blue Shield,²¹ and HealthNet throughout the state; Medi-Cal, on the other hand, contracts with Blue Cross and HealthNet in only selected counties, and does not contract with Blue Shield at all.

Outside of the 22 counties where *Healthy Families* and Medi-Cal both operate managed care systems, the service delivery systems of two programs differ in two ways. First, in 21 counties, *Healthy Families* contracts with managed care organizations whereas Medi-Cal relies on traditional fee-for-service arrangements. Second, in the remaining 15 counties, *Healthy Families* has an EPO, a network of primary care and specialty physicians from which enrollees can select providers to receive needed care while Medi-Cal offers no specific network of providers and enrollees must find participating fee-for-service providers on their own.

Both *Healthy Families* and Medi-Cal employ similar “carve out” arrangements for certain types of care. Specifically, plans are not responsible for providing services to treat conditions eligible for coverage under the California Children’s Services (CCS) program (the state’s Title V/Children with Special Health Care Needs program), nor are they responsible for services needed by children with Serious Emotional Disturbances (SED). Under these arrangements, providers identify children suspected of having either a CCS- or SED-eligible

²⁰All plans received “commercial” licenses in order to participate in *Healthy Families*. This required considerable work on the part of plans that had historically served only a Medi-Cal population—namely, the Local Initiative and County Organized Health Systems.

²¹Blue Cross and Blue Shield are separate organizations in California.

condition, and then refer these children to the county CCS program or the county mental health program, respectively. These systems, in turn, make an eligibility determination; if they ultimately serve the children, they are reimbursed directly by *Healthy Families* and Medi-Cal on a fee-for-service basis.

The CCS and SED “carve outs” were created for three primary reasons. First, many policymakers and advocates worried that managed care systems did not have the capacity to effectively serve children with special health care and behavioral health needs. Second, these individuals also worried that capitated arrangements created the wrong financial incentives and might result in plans’ reluctance to extend to these children all of the services they required. Third, California possesses a very well established and respected CCS network of credentialed providers and county-based nurse case managers who, it was believed, provided the best system of care for children with chronic illnesses and disabilities. Similarly, county mental health networks were also perceived to be better equipped to address the needs of children with SED than were health plans. To foster strong linkages between the managed care and CCS/SED systems, both *Healthy Families* and Medi-Cal require health plans and county CCS and SED programs to develop Memoranda of Understanding that detail the respective responsibilities of each and outline specific referral and payment protocols.

The dental care arrangements used by *Healthy Families* and Medi-Cal differ considerably. *Healthy Families* contracts on a capitated basis with 5 dental plans covering the entire state, while Medi-Cal covers dental services through fee-for-service systems in all but 2 counties. Of the 5 dental plans working with *Healthy Families*, 3 are DMOs—dental managed care organizations—while 2 are EPOs; the key difference being that DMOs require each enrollee to select a primary dentist who is responsible for managing all of the enrollee’s dental care, while EPOs offer enrollees an open network, and enrollees are free to seek care from any provider in the network.

Recently *Healthy Families* launched a new initiative called the Rural Health Demonstration Projects. For this initiative, MRMIB provides funding to allow plans to increase access in rural areas by developing innovative models for better serving selected underserved groups. Specifically, Alaska Natives, Native Americans, and persons involved with forestry, fishery, and migrant farm work were identified as “special populations.” Monies were awarded to health, dental, and vision plans to support models in the areas of extended clinic hours, provider recruitment efforts, mobile vans in rural regions, telemedicine to promote access to specialty care in rural regions, and special dental access demonstrations. While health, dental

and vision plans are the fund recipients they work in collaboration with local providers to implement the models.

2. Payment Arrangements

Healthy Families pays each of its contracting plans—health, dental, and vision—on a capitated, full-risk basis. Capitated rates, which are negotiated annually with participating plans, are paid on a per child, per month basis in two rate cells—one for children under age one, and another for children ages 1 to 19. While specific rates are proprietary, MRMIB was able to share figures indicating that the average monthly per member cost for health, dental, and vision coverage was just under \$85 for children ages 1 to 19, and \$200 for infants. These figures exclude of costs related to care for CCS and SED children; health plans’ capitation rates do not include amounts for this care, as they are directly reimbursed by MRMIB to CCS and SED providers on a fee-for-service basis.

As discussed above, Medi-Cal operates a mix of capitated and fee-for-service systems to support the delivery of care. And while it is very difficult to directly compare the rates the two programs pay—given their differences in benefits coverage, rate cell structure, service bundling, and population coverage—we learned that capitation payments for an “average family” ranged from \$90 to \$100 per member per month. Therefore, it appears that the two programs pay roughly similar capitation rates.

From our interviews with state and local officials and providers, it appears that health plans use a mix of approaches to pay providers in their *Healthy Families* networks. In urban areas such as Los Angeles, it is common for plans to sub-capitate primary care providers for the management and delivery of all ambulatory services. In rural regions, though, it is more common for plans to pay network providers on a fee-for-service basis, often employing what was termed as an “enhanced Medicaid fee schedule.” As described to us, *Healthy Families* plans often offer physicians a fee schedule that enhances Medicaid rates by 5 to 20 percent, depending on the procedure, as an incentive to obtain their participation in the program. In the EPO, “enhanced” rates are also the norm—Blue Cross pays its providers its standard commercial fee schedule, which is considerably higher than that of Medi-Cal. Blue Cross told us this schedule was needed in order to recruit an adequate provider panel in rural counties. The preponderance of *Healthy Families* participating dental plans pay providers on a fee-for-service basis.

Healthy Families and Medi-Cal differ in the way that providers are paid for delivering vaccines to children. Medi-Cal participates in the Vaccines For Children program(VFC), a federally-funded, state-operated vaccine supply program that provides participating physicians

with free vaccines to immunize children of parents who are unable to afford the cost for the vaccine. Federal law, however, dictates that *Healthy Families* cannot incorporate the VFC program, thus federal officials had no choice but to deny MRMIB’s original request that *Healthy Families* incorporate VFC coverage. Instead, providers are reimbursed directly by the health plans for administering immunizations to *Healthy Families* enrollees at zero cost to the enrollee. Pediatricians have proposed a bill to create a VCF look-alike for *Healthy Families*, but this proposal is currently stuck in fiscal committee as a result of fears among state legislators that the state’s cost will be greater than the current system.

C. EXPERIENCES AND LESSONS LEARNED

The key informants we interviewed, including state program administrators, health plan officials, staff of community-based organizations, even child advocates, generally praised the strength of the *Healthy Families* service delivery system and described children’s access to care as “quite good.” Furthermore, there was typically agreement among these informants that access to care under *Healthy Families* was somewhat better than under Medi-Cal. (“We don’t hear the same level of complaints from *Healthy Families* enrollees as we do from Medi-Cal enrollees, with regard to access,” stated one Los Angeles-based advocate.) This relative strength was attributed to various factors, including that *Healthy Families* operates HMO systems in more counties than Medi-Cal (43 versus 22), and that the program offered families more choices of plans in those counties where both *Healthy Families* and Medi-Cal had managed care arrangements. In particular, informants believed that the EPO system in rural counties was more effective than Medi-Cal’s fee-for-service system in providing enrollees with access to primary care, in particular due to its organized and identifiable network of physicians who accept *Healthy Families* patients. Provider participation problems under Medi-Cal, especially in more rural parts of the state, persist in making it difficult for some families to find providers willing to accept Medi-Cal payments.

An additional reason why *Healthy Families* access was praised relative to that of Medi-Cal was the fact that the program contracts with Blue Cross, Blue Shield, Kaiser and HealthNet—4 of the 5 largest health plans in California—across the entire state. Once again, given these plans’ very large networks, and strong brand identities, *Healthy Families* enrollees signing up with any of these organizations tend to find themselves having many options to choose from in terms of primary and specialty care physicians. (Over 60 percent of enrollees are in those “commercial” plans).

Furthermore, two specific policies embodied in *Healthy Families* contracting rules were also seen as fostering low-income families' access to traditional safety net providers, well experienced in serving vulnerable populations. First, MRMIB awards the "Community Provider Plan" designation to the plan in each county that can demonstrate the largest number of contracts with FQHCs, disproportionate share hospitals, and other essential community providers. In turn, the program extends a discounted premium to families that choose to enroll with the Community Provider Plan. This policy has created a strong incentive for health plans to contract with safety net providers in hopes that they can gain an edge over other plans with whom they compete. Second, MRMIB's contracts stipulate that health plans must demonstrate that they can extend to enrollees an adequate network of culturally competent and appropriate providers. This, too, has resulted in health plans seeking out contractual arrangements with providers that traditionally serve ethnic populations, such as FQHCs.

Overall, key informants also believed that California's move to managed care had had a positive and beneficial effect on children's access to care; this was seen as true for Medi-Cal vis-a-vis its traditional fee-for-service systems, and seemed also to be true with *Healthy Families*. In one county we visited, administrators from the "local initiative" Inland Empire Health Plan (IEHP) described how, prior to managed care, 250 physicians served a Medicaid population of nearly 500,000 in San Bernadino and Riverside Counties. With the creation of the Two Plan Model, however, IEHP aggressively recruited providers and built a network of 800 primary care doctors. Today, these officials report, the only persistent access problems they see are in remote desert towns like Barstow.

A great deal of excitement and praise was directed toward the success of the Rural Health Demonstration Project. Health plans and their local networks have eagerly pursued that additional funding, and the models they have created were widely praised for their ability to extend services to needy families. We visited a FQHC in a remote corner of Kern County where telemedicine has been used to provide specialty care consultations to children with disabilities. These "real time" video and audio conferences with experts from UCLA Medical Center and other facilities in southern California were described as extremely effective, and their obvious strength was that they saved vulnerable families from having to travel several hours to large, unfamiliar cities.

Perceptions of children's access to dental care were oddly mixed, however. On one hand, there is strong evidence that *Healthy Families* enrollees are obtaining high levels of dental services. Anecdotally, we often heard that dental coverage was "a real draw" for the program among working families, and utilization data indicate that roughly 90 percent of children in

Healthy Families are receiving dental services in their first year on the program, nearly double the anticipated rate. This figure suggests that there was significant pent-up demand for dental care among low-income families, and that the vast majority of families have succeeded in obtaining some dental services.

When asked to identify any “trouble spots” with the program, key informants most often pointed to problems with dental access. “There just aren’t enough dentists to meet children’s needs,” and “...we hear from a lot of families that say they can’t find a dentist,” were comments we heard, primarily from advocates. One FQHC official in rural Humboldt County did report that she believed dental access to be stronger under Medi-Cal in her region compared with *Healthy Families*. MRMIB officials acknowledged that perhaps, despite their best efforts, demand for dental care still exceeds the supply of dentists willing to provide it. But they also felt that “advocates may be using *Healthy Families* as a platform for publicizing broader dental access problems across the state and not those specifically tied to our program.” On paper, *Healthy Families*, indeed, has fewer dentists on its rolls than Medi-Cal—6,000 compared to 10,000. However, MRMIB and Delta Dental officials were quick to point out that this network of 6,000 was in place to serve a program with 400,000 children, whereas only 1,500 of Medi-Cal’s 10,000 dentists actively participate in the program and have to serve 6 million children.

We also heard of some problems related to the delivery of behavioral health services (“...the system simply does not have sufficient capacity for children,”), specialty care (“...we lack sufficient pediatric subspecialists in the areas of orthopedics, neurology, and otolaryngology, among others,”) and the lack of a Vaccines for Children-like (VFC) model under *Healthy Families*. On this latter point, pediatricians were especially vocal in their dislike of the fact that *Healthy Families* did not participate in the VFC program, leaving pediatricians to purchase vaccines on their own. Payments for immunizations, they believed, fell far short of the costs they were incurring in purchasing and administering vaccines.

Many informants we interviewed were also dissatisfied with the operations of the CCS and SED carve outs. The fact that very few children were being referred into CCS and SED suggested that adequate systems for identifying children with qualifying conditions were not in place, they reported. Furthermore, most providers and health plan officials described serious coordination problems resulting from the carve-outs. “The carve-outs fracture care for families and children,” said one plan official; and providers were often described as being “caught in the middle” when it came to disputes over who was responsible for paying for services—the health plan or the CCS or SED programs. Health plans were mixed in their opinions over whether the design should be changed—managers of the Kern County Health Plan said “...we’d rather just

treat the kids here, within our network....as long as we are paid for it;” while officials from other plans admitted that the carve out gave them a direct incentive to refer some of their highest cost enrollees to another system. Legislative staff, however, remained in favor of maintaining the set up and working to improve the status quo—”I’m still more comfortable with CSHCN receiving care through CCS than I would be with them getting care from HMOs,” said one staffer.

Utilization rates among *Healthy Families* enrollees were described as lower than those of Medi-Cal. Informants were unable to explain this pattern with any certainty, not knowing whether it was a function of the differences of the ways *Healthy Families* and Medi-Cal provide care, or the result of variations between enrollee characteristics. Advocates and others suggested the lower utilization was a reflection of the fact that the program served families of higher socioeconomic status and higher education whose children were probably somewhat healthier; staff of community-based organizations feared that it was more a reflection of families’ unfamiliarity with insurance and how to obtain care through managed care systems; while providers and health plan administrators suspected that the rates might be explained by the ethnic mix of enrollees and that Hispanic families might be reluctant to seek care unless their children were sick. This was identified as an issue that clearly required closer study.

During our interviews, fees surfaced as by far the most controversial topic related to service delivery and access. While health plans were generally satisfied with the capitation rates they were receiving—low per capita utilization translated to a positive bottom line for these organizations—physicians were very outspoken in their dissatisfaction with how *Healthy Families* had been implemented. One group of pediatricians with whom we spoke felt strongly that MRMIB, and its contracting health plans, had relied far too heavily on Medi-Cal’s rate structure for setting *Healthy Families* reimbursement. These rates, among the lowest in the nation,²² were described as the “wrong place to start” when establishing rates for the new program. Physicians were especially frustrated by the fact that MRMIB and other state officials had “sold” them on *Healthy Families* by promising that the program would be modeled after private insurance, “...but then they turn around and pay us like it’s Medi-Cal!” There was a sense among these providers that they were also being taken advantage of by health plans—”...well if they’re doing so well under *Healthy Families*, they need to turn around and send some of the money our way!” As further evidence that the environment in California had become

²²Stephen Norton and Stephen Zuckerman. “Trends in Medicaid Physician Fees, 1993-1998.” *Health Affairs*, Vol. 19, No. 4. Bethesda, MD: Project Hope, July/August 2000.

distinctly unfriendly to doctors, the pediatricians pointed to the recent survey by the California Medical Association which found, among other things, that over 40 percent of physicians in the state planned to leave patient care in the next three years (either by moving out of state, retiring, or changing professions).²³ These doctors reported that the widely held view among providers was that Medi-Cal and *Healthy Families* were “the same program,” and that “...with enrollees from these two programs becoming a larger and larger share of our patient load, it will simply become unaffordable for many of us to continue practicing.” “This puts us in a terrible position. Of course we’re going to participate in *Healthy Families* and Medi-Cal, we’re pediatricians! But it is unfair to ask us to lose money on each and every encounter,” was how the former president of the state chapter of the American Academy of Pediatrics summed things up.

Dissatisfaction with rates and fees was not the sole concern of physicians, however. Of note, dental plans were reported as having taken “a big hit” during the first round of *Healthy Families* contracts, given enrollees’ very high rates of utilization and the fact that the plans are paid on a capitated basis. Similarly, FQHC officials reported that they, too, are losing ground under SCHIP. “The fees we receive from health plans under *Healthy Families* don’t come close to the cost-based reimbursement we’ve traditionally received from Medi-Cal.” Indeed, one center director went so far as to say that they made more money when these families were uninsured—“Before SCHIP, these uninsured families usually paid us sliding scale fees. Well, those fees are higher than the rates we receive under *Healthy Families*!”

In future years, state officials will need to carefully monitor the impact of reimbursement rates and practices on provider participation and, by extension, access-to-care.

²³“And Then There Were None: 2001 Physician Survey Results.” *California Physician*. California Medical Association, Summer 2001.

VIII. COST SHARING

A. POLICY DEVELOPMENT

Driven by the desire that *Healthy Families* resemble a commercial product, the inclusion of cost sharing in the program was an early decision in California. It was believed by the Governor and legislators alike that cost sharing would help promote ownership and responsible utilization among families with enrolled children. In addition, the success of the state's Access for Infants and Mothers (AIM) program—which includes a premium equal to 2 percent of family income—indicated that enrollees are comfortable with and are willing to make a small contribution toward their health care costs. In addition, some policy makers identified stigma as a barrier when families receive free care in a program like Medi-Cal.

In their contracts with the state, health plans were obliged to charge all enrollees a premium. As described above, plans receiving designation as “Community Provider Plans” are permitted to offer a discounted premium to enrollees, with the notion that this would give these plans a competitive advantage. Originally, the state had wanted health plans to compete on enrollee cost sharing, even to the extent of allowing them to go beyond Title XXI cost sharing requirements, thinking it would create incentives for plans to lower their price. HCFA disagreed, however, stating it might lead families to incorrectly perceive higher priced plans as superior. At another point, MRMIB had wanted to pattern *Healthy Families* cost sharing after that of CalPERS, but it quickly became apparent that such a design would not comply with federal limits on cost sharing. In the end, HCFA accepted the state's plan to impose nominal premiums and copayments in a way that was designed to be “as consumer friendly and as state of the art as possible.”

B. POLICY AND PROGRAM CHARACTERISTICS

In a relatively simple categorization of premium amounts shown on Table 6, families with incomes below 150 percent of poverty pay a contribution per child per month of either \$4 (when enrolled with a CPP), or \$7 (when enrolled with non-CPP plans), to a maximum of \$14 per family per month. Above 150 percent of poverty, families pay monthly premiums equaling \$6 per child (for CPP enrollees) and \$9 per child (in non-CPP plans), up to a maximum of \$27

per family per month. Copayments are set at \$5 per visit for all services except prenatal, well baby, well child and immunization services and inpatient care. Furthermore, families are

TABLE 6: COST-SHARING POLICIES

Policy	SCHIP
Enrollment fee	No
Premiums by family income ^a	Yes
< 150% FPL	\$4-\$7 monthly per family up to a \$14 limit per family ^b
151-250% FPL	\$6-\$9 monthly per family up to a \$27 limit per family ^b
Consequences for non-payment of premiums	Yes
Disenrollment	Yes, after a 60-day grace period
Black-out period	Yes, for six months (exceptions apply)
Copayments ^a	Yes
All enrollees	\$5 for all services except prenatal, well baby, well child and immunization and inpatient care services up to a \$250 annual limit (excluding vision and dental).
Deductibles	No

SOURCE: State of California. State Child Health Plan under Title XXI of the Social Security Act: California's *Healthy Families* program. November 18, 1997 Website
http://www.dhs.cahwnet.gov/org/Director/healthy_families/stplan.pdf

NOTE: SCHIP=State Children's Health Insurance Program (Title XXI)

^aAmerican Indians and Alaskan Native children who meet the eligibility criteria for *Healthy Families* and provide acceptable documentation of their status are exempted.

^bThe lower premium is for the Community Provider Plan (CPP)

protected from paying more than \$250 per benefit year in total cost sharing, excluding vision and dental.²⁴

For all families, the first premium payment is required with the application form as a condition of eligibility. Every month, parents are sent a billing statement as a reminder that their premium is due on the 20th day of the month of coverage. If a premium is not paid on time, a child will not be disenrolled until 60 days have passed. But, if the child is disenrolled for non-payment of premiums, they are not allowed back into *Healthy Families* for six months.²⁵

To facilitate premium payment from the second month onward, a number of options are available to families:

- Enrollees may pay their premiums at any Rite Aid—a very prominent drugstore chain in California—across the state;
- Parents who pay three months worth of premiums at one time get the fourth month free; and
- In a “third party” system, the state allows persons or entities - termed “Family Contribution Sponsors” - to pay a families’ annual premium in a lump sum for the first year of enrollment. “Family contribution sponsors” must register with the MRMIB for each family sponsored, and families receiving this benefit must submit a Family Contribution Sponsorship Form along with their initial application

Collection of copayments is the responsibility of participating providers. From our interviews with health plans, we learned that some health plans reduce their fees to providers by the copayment amounts. Others do not, however, with the intent of giving providers a strong financial incentive to collect these fees (which constitute a bonus, of sorts, on top of normal fees). Finally, families are responsible for tracking their total out-of-pocket costs under *Healthy Families*, collecting receipts via the “shoebox method.”

²⁴American Indians and Alaskan Native children who meet the eligibility criteria *Healthy Families* and provide acceptable documentation of their status are exempted from cost sharing.

²⁵There are exceptions to this six month wait: if the parent has suffered illness and could not work for two or more weeks or lost their job, the child qualifies for no-cost Medi-Cal.

C. EXPERIENCES AND LESSONS LEARNED

Cost sharing under *Healthy Families* was widely described as “very affordable.” We heard no reports from local outreach or enrollment staff that premiums were deterring families from enrolling, nor did we hear that copayments were deterring utilization.²⁶ Some informants even commented that they believed cost sharing was too low under the program. For example, officials from two health plans remarked that copayments, especially for inappropriate emergency room use, should be higher to promote proper utilization. State officials, while accepting that “the jury is still out on whether cost sharing is too low or too high,” noted some irritation with federal limits on families’ out-of-pocket costs seeing them as “...taking away one of our cost-containment options.” State public health staff and advocates, however, made clear that they are “...always concerned about the affordability of premiums, no matter how low.”

Advocates were unclear about the perceived benefits of cost sharing as a means of “promoting ownership” and “giving pride” to families. All our other informants, however, were certain of the benefits of this aspect of cost sharing. Many local application assistants reported that parents say they would actually rather pay to stay in *Healthy Families* than have their children transferred to Medi-Cal, though it is unclear whether this implies that parents actually like to bear some of the cost of their health care, or that paying was simply preferable to entering Medi-Cal.

The impact of premiums on disenrollment was unclear, however. State data do not provide detailed insight into the various reasons why families disenroll from the program. The code labeled “nonpayment of premiums” serves as a “catch all” reporting category that may include families who stopped paying their premiums for any of a number of reasons, including moving out of the state, enrolling in private insurance, becoming dissatisfied with *Healthy Families* coverage, or after concluding that premiums are unaffordable. Therefore, even though data indicate that one-third of all disenrollment is due to nonpayment of premiums, this figure does not shed light onto the question of whether families find the program’s premiums affordable or not.

Logistical hurdles surrounding the process of paying premiums appear to present a more tangible problem, however. According to local staff with experience in assisting families with applications, parents are often confused by the requirement to submit a premium to a program for

²⁶Forty-nine families of the 140,000 families with children enrolled in 1999/2000 met the \$250 limit. There were 107 children in these 49 families, and there were a total of 250,000 children in the 140,000 families.

which they have not yet been determined eligible. Furthermore, problems associated with getting refunds of premiums when children are found ineligible for *Healthy Families* are well known, perhaps discouraging parents from submitting payments with the initial application. Problems such as these have led many informants, including officials at EDS, to conclude that the program would better serve clients if premiums were not required with the initial application, but rather after families are enrolled.

IX. FAMILY COVERAGE AND EMPLOYER SUBSIDY ARRANGEMENTS

State officials in California have long been interested in extending SCHIP coverage to the parents of child enrollees. This interest has been based in several theories—that offering coverage to parents would lead to more successful rates of enrollment among eligible children; and that enrolling entire families into care would result in more and more appropriate utilization of care. Early on, MRMIB officials also realized that even if they were to enroll every eligible child into coverage, they would never be able to spend the state’s entire allotment of federal funds; an artifact of the original federal allocation formula that was based on what were perceived as inflated estimates uninsured children who are *Healthy Families* eligible. (State officials reported that more uninsured children are Medi-Cal eligible and undocumented than the estimates suggested.) However, HCFA’s clear policy during the first two years following the creation of Title XXI was that it did not want to grant waivers to the program. Rather, the agency preferred to have states gain experience implementing the programs as Congress originally intended before allowing for experimentation.

This all changed in July 2000, when “family coverage” expansions were included among the demonstration projects for which states could seek waivers under Section 1115 of the Social Security Act. Specifically, in a letter to state officials, HCFA indicated that states could request waivers if they could clearly demonstrate that they had conducted aggressive outreach and adopted a large number of policies aimed at facilitating child enrollment into Medicaid and SCHIP, as long as the costs of covering children and parents did not exceed the state’s SCHIP allotment.

In anticipation of HCFA’s guidance, the California legislature had already passed a bill identifying the basic structure for *Healthy Families*’ expansion of coverage to parents. From this bill, a waiver request was developed asking that authority be granted to cover parents of *Healthy Families* enrollees with incomes between 100 and 200 percent of poverty, as well as parents with incomes below 100 percent of poverty who do not qualify for Medi-Cal because of excess assets. To the dismay of some staff in the state legislature, there was a three-month delay in submitting the waiver to HCFA—it went in December 2000—and its approval was subsequently delayed.

Despite the delay, there was at the time of our site visit a general feeling among key informants that the waiver would eventually be granted, and virtually all expressed excitement at

the prospect.²⁷ These informants believe that offering parental coverage will lead to higher rates of enrollment among eligible children, and better utilization of services once coverage is achieved. However, they also expressed caution over expected further complications in the application process that will result from adding parents. Many pointed to the fact that Medi-Cal still requires an assets test for parents indicating that that will cause further problems with referrals between the two programs. Others saw the need to bring the upper income threshold for parents in line with that of children by raising it to 250 percent or risk causing families significant confusion.

The only opposition to extending coverage to parents came from the American Academy of Pediatrics and the pediatricians it represents who believe that expansions to parents should not be granted until the program is functioning properly for children, preferring instead that unspent federal funds be used to increase rates.

²⁷In November 2001, Governor Davis asked the legislature to delay the parental coverage expansion to July 2003. In January 2002, however, CMS approved California's waiver request. The legislature will consider the governor's request as part of the spring/summer 2002 budget deliverables.

X. FINANCING

Details of California’s spending and funding allotments are provided in Table 7. The state annually receives the largest allotment in the country of which it has spent just 25 percent. According to state and legislative informants, the underspending is a result of two factors. First, the CPS estimate on which the allocations were based appeared to overestimate the number of SCHIP-eligible children residing in the state, while underestimating that many of these children were likely eligible for Medi-Cal. Second, MRMIB officials report that they have experienced lower per capita expenditures under SCHIP, so even strong recent enrollment has not translated into rapidly escalating spending.

The state share of *Healthy Families* funding—34 percent—has so far been sourced from general revenue funds, not the state’s tobacco settlement. There were no concerns voiced by any of the informants we interviewed that funding would decline at the state level, owing to the political popularity of *Healthy Families*. Both the Governor and legislature are active and outspoken in their support for the program and, if anything, would like more money spent on outreach. Most recently, Governor Davis included language in the state budget committing the state to ongoing full funding for children under *Healthy Families*, symbolically creating a virtual entitlement to coverage. Still, the recent economic uncertainties and the change of the federal administration were reported by some informants to be a cause of concern for program funding into the future.

TABLE 7: SCHIP ALLOTMENTS AND EXPENDITURES, IN MILLIONS, 1998-2000

FFY	Federal Allotment	Expenditures	Expenditures as Percentage of Allotment for the Year	Percentage of Year’s Allotment Spent by End of FFY 2000	Redistributed Amount
1998	\$854.6	\$2.0	0%	30%	
1999	\$850.6	\$67.7	8%		
2000	\$765.5	\$194.3	25%		0

SOURCE: Centers for Medicare and Medicaid Services (CMS), Memo from Center for Medicaid and State Operations to State, January 25, 2000; Federal Register Notice, May 24, 2000; Kenney et al., *Three Years into SCHIP: What States Are and Are Not Spending*. Urban Institute: September 2000.

NOTE: SCHIP=State Children’s Health Insurance Program (Title XXI); FFY=federal fiscal year.

XI. OVERARCHING LESSONS LEARNED

California's *Healthy Families* program can be considered a success from a number of perspectives. The program, after a slow start, has established itself as a relatively well-known and positively regarded insurance product, a factor that has helped it enroll the second largest number of low-income children in the nation—over 475,750 at the time of the site visit, and 500,000 as of December 2001. *Healthy Families* has developed a managed care delivery system that is typically described as succeeding in extending broad access to program enrollees. State officials at MRMIB—the quasi-governmental agency responsible for administering *Healthy Families*—were praised by many informants for their creative and flexible management styles and, in partnership with Medi-Cal officials, appear to have developed a team approach to coordinating the operations of these two large programs. Politically, the program is very popular and, as a result, the future outlook for ongoing funding and support is bright.

Beyond these broad positive observations, we can report on other, more specific lessons that have been learned by state and local officials regarding the factors and program strategies that promote, or inhibit, the successful implementation of a child health insurance program. These lessons are summarized below.

- ***While the creation of a separate program under Title XXI was necessary given political and environmental factors, the choice has resulted in both positive and negative long-term consequences.*** There was little chance that California would pursue a large Medicaid expansion under Title XXI; political resistance to a broader entitlement, disdain among providers, and strong consumer resistance combined to lead policymakers to conclude that a Medicaid expansion, alone, would not succeed in significantly reducing uninsurance among low-income children. Yet the creation of a separate program, modeled after private insurance, has resulted in a system that seems mostly better, but in some ways worse, than the one that preceded it:
 - In isolation, the *Healthy Families* program has succeeded in many of the ways its designers intended—strong political and public support has emerged, simplified enrollment and positive outreach have spurred strong enrollment, and expansive provider networks appear to offer good access to care.
 - Furthermore, under *Healthy Families*, policymakers have designed and tested innovations—in the areas of outreach, enrollment, and service delivery—and the success of these efforts has led to a critical “spill over” onto Medi-Cal. The program has seized the opportunities provided by SCHIP to adopt sweeping reforms to its eligibility policies and enrollment processes, and has spearheaded

the first-of-its-kind outreach campaign targeting both SCHIP and Medi-Cal-eligible children.

- However, the establishment of a program so overtly distinct from Medi-Cal has, in some ways, led to serious challenges in coordinating their operations. With *Healthy Families*, the “brand new kid on the block,” apparently very popular with families with uninsured children, Medi-Cal has been all the more challenged in its efforts to reinvent its image, gain political support, and overcome the long-standing negative opinions and fears that have plagued the formerly welfare-linked program. Even the Democratic Governor, while praised for his staunch support of *Healthy Families*, is subtly criticized for not fully “getting behind” Medi-Cal. Practically speaking, this dichotomy of perceptions has made it extremely difficult for state officials to holistically market “health insurance,” while severely undercutting their ability to smoothly “screen and enroll” children across the two programs.

Overall, however, we found a general consensus among key informants that positive progress was occurring. Medi-Cal simplification and an emerging cultural shift among local departments of social services seemed to be both spurring improved enrollment and a reduction in enrollment-related stigma. The INS clarification of “public charge” was also reported to be “taking hold” in the Hispanic community and enrollment of children of immigrant parents seems to be improving. If these trends continue, and if a more unified and consistent approach to positively marketing the two programs as one can take place, it seems increasingly possible for California to achieve its broader goal of insuring all low-income children.

- ***Investing in local-level outreach, and extending community-based organizations both the resources and the authority to design campaigns that are tailored to local needs, are apparently, an effective means of attracting new enrollees.*** Initially, California focused the majority of its outreach dollars on mass marketing and advertising to raise public awareness of *Healthy Families*. Over time, however, the state’s emphasis—both philosophically and fiscally—has significantly shifted to supporting local level efforts. Through its Certified Application Assistance program, Outreach Contracts, Medi-Cal 1931(b) funds, and its new School-Based Outreach initiative, California has directed millions of dollars to community collaboratives and organizations to support outreach and application assistance in schools, health systems, county programs, churches, businesses, and ethnic communities, among others. Trusted and credible community members, spreading the word about health insurance, are universally considered as having been successful in reaching and enrolling not only “hard to reach” populations but also “mainstream” families that simply may not have otherwise taken the time to sign up their children. The considerable flexibility that has been extended these groups is also described as having fostered great “ownership,” “buy in,” and “commitment” among outreach staff.
- ***Certified Application Assistance and Outreach Contracts offer two alternative, but complementary models for supporting local outreach and enrollment efforts.*** California implemented two very different initiatives to achieve, fundamentally, the same purpose—enrolling families. With the CAA program, the state set up a “finders

fee” arrangement, paying local individuals and organizations retroactively for every child they enrolled in *Healthy Families* or Medi-Cal. With Outreach Contracts, the state provided “seed money” to enable local organizations to hire staff and otherwise create the capacity to provide application assistance. With three years of experience to reflect on, state officials have not concluded that one approach is more effective than the other. Rather, they have observed that the different funding mechanisms work equally well for different types of local groups. The CAA approach tended to not work for busy, understaffed CBOs who were attempting to layer application assistance on top of staff’s normal duties and responsibilities; existing staff didn’t have time to perform this complex, time-consuming new function, and retroactive reimbursement did not permit these groups to “staff up” with new employees to carry out the activity. (For these groups, monies in the form of Outreach Contracts worked much better, allowing groups to hire new staff to assist families with completing applications.) In contrast, CAA funding worked well for high volume providers who already had staff who worked to identify sources of insurance for their clients (such as FQHCs), and also for networks of individuals who chose to “make it their job” to seek out and enroll children. In fact, this accounts for the far higher volume of children enrolled by CAAs compared with Outreach Contractors. The higher volume of their enrollment “business” made it feasible to rely on retroactive payments.

- ***Contracting with mainstream managed dental organizations appears to have opened the doors to improved access to dental care.*** As it built its delivery system for *Healthy Families*, MRMIB focused considerable attention on developing a dental network that would match its health network in terms of structure and breadth. Rejecting Medi-Cal’s state administered fee-for-service approach, MRMIB pursued capitated contracts with well-known managed dental organizations (such as Delta Dental) as a strategy to gain better access to a provider pool that has often balked at serving low-income families. The move appears to have paid off—a relatively large network of over 6,000 dentists is now available through the 5 dental plans under contract with the program, and a reported 90 percent of enrollees have received dental care during the first year of their coverage.
- ***Healthy Families has established a strong service delivery system that appears to be supporting good access to care. But payment arrangements appear to be undermining provider commitment to the program, resulting in some uncertainties about access in the future.*** By most counts, the access picture under *Healthy Families* seems quite positive. At least in part because MRMIB has contracted with the largest, best-known plans in the state, enrollees’ appear to have access to very large networks of mainstream providers. Furthermore, we heard great praise of MRMIB’s efforts to foster improved access in rural areas and for underserved populations through its Rural Demonstration/Special Populations grants. However, we also heard of growing frustration among providers participating in the program. These physicians complained that rates under *Healthy Families* are insufficient and similar, in fact, to the low fees that make Medi-Cal a unpopular program with some providers. The lack of the Vaccines for Children program in *Healthy Families* was also a source of rate-related unpopularity with pediatricians. Health plans reported however, that rates the rates they pay physicians are reasonable; indeed, most cited paying “enhanced” Medicaid fee schedules. While we had little sense that provider issues were reaching crisis proportions or that effects on access were imminent, this

situation seems to merit close monitoring by state officials. The lack of a clear explanation for the perceived relatively low rate of utilization among *Healthy Families* enrollees (compared to Medi-Cal) also seems to deserve closer attention.

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APPENDIX A
KEY INFORMANTS

APPENDIX A —KEY INFORMANTS

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