
PIONEERS FOR COVERAGE:

Local Solutions for Insuring All Children in California



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Authors:

Liane Wong, Hilary Frazer, Len Finocchio, Theresa Winterbauer and Gretchen Schroeder

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EXECUTIVE SUMMARY

To achieve a healthier California, policymakers and the public must start by improving the health of the state's youngest and most vulnerable residents. Access to comprehensive and affordable health insurance coverage is an important precursor in determining the health of children, their families and the broader community. Uninsured children are half as likely as privately insured children to have well-child visits, office visits or hospitalizations. Children and youth require a protective and preventive system of health coverage—one that helps families anticipate and address needs on a preventive basis and coordinates services when problems arise.

Even with important recent gains in expanding public health coverage to the state's uninsured children, there are an estimated one million uninsured children under the age of 19. Approximately two-thirds of these children are eligible for the state's Medi-Cal or Healthy Families programs, and one-third are ineligible due to their immigration status (180,000 undocumented children) or because their family's income is too high to qualify for public programs (161,000 children with family incomes above 250% of the federal poverty level). Many of the state's uninsured children are in mixed status families that include both citizen and noncitizen members. With some children eligible and others ineligible for coverage within the same family, parents must choose between insuring only some of their children and leaving all of their children uninsured.

In addition, although employer-based coverage remains the predominant form of coverage for California's children, structural economic changes and four years of annual double-digit health care premium increases have eroded the affordability of employer-sponsored coverage, particularly for dependents. A recent study by the Health Research Educational Trust and the Henry J. Kaiser Family Foundation found that employee contributions towards family coverage had increased by 49 percent. These factors combined likely explain why about one in ten children still do not have access to health coverage.

California counties—which for more than two decades have had the primary responsibility for providing health care to uninsured residents—have responded by creating a nationally recognized model for expanding health coverage and creating systems change called the Children's Health Initiative (CHI). Santa Clara County launched the first CHI in 2001 with a diverse mix of public financing and private foundation support. CHIs have established a vision of health coverage for all children that are county residents.

Children's Health Initiatives are innovative programs designed to:

- Cultivate new public-private partnerships for children's coverage;
- Reform and streamline existing systems in the creation of a single "One Open Door" enrollment pathway;
- Create an affordable and comprehensive Healthy Kids gap coverage product; and
- Maximize and coordinate with existing public health coverage programs including the Medi-Cal and Healthy Families programs.

Through a broad and complex coalition-based effort, nine counties have implemented CHIs and at least another 20 localities are attempting to follow suit as of the release of this guidebook.

Why Have CHIs Taken Flight in Such Rough Conditions?

CHIs have taken flight in the face of seemingly insurmountable odds. Like other states, budget shortfalls in California have prompted a close re-examination of Medi-Cal in order to reduce future program costs. Thirty-four states this past year have dropped at least 500,000 children from Medicaid and/or SCHIP through restricted eligibility. Shortfalls at the state level have created similar fiscal constraints at the county level, with a number of counties cutting health, public safety, and a number of other programs to close budget gaps.

Yet interest in replicating the CHI vision and strategies has accelerated since 2001. There are a number of reasons for this unexpected trend. First, it is clear from the results and the testimony of those involved with CHIs that these programs are beneficial to families, local government agencies, providers, health plans, community-based organizations, and local policymakers. Second, CHIs are helping existing public programs work better and maximizing the return of the public's investment in them. Much like SCHIP's important spill-over effects for Medicaid programs nationally, the new Healthy Kids coverage programs appear to have had positive enrollment effects on Medi-Cal and Healthy Families locally. Finally, the local and state commissions funded through Proposition 10—the California Children and Families First Act of 1998—and several California-based foundations have committed significant transitional funding to the CHIs to keep the momentum going and allow time for statewide policy change to occur.

To date, CHIs have enrolled more than 50,000 children in their Healthy Kids programs and covered tens of thousands more children under the Medi-Cal and Healthy Families programs. The next generation of CHI innovators is cultivating new approaches that will reflect local conditions while also navigating the challenges encountered by the first generation of CHIs. Emerging approaches include the expansion of local public plans outside their service areas, partnership development with one or more commercial health plans, and coordination of multi-county Children's Health Initiatives.

Purposes of this Guidebook

This guidebook is designed to assist local and regional coalitions in designing and implementing CHIs to provide health coverage to low-income children in their communities. The guidebook's focus is to (1) address practical issues associated with CHI planning and implementation; and (2) to inform policymakers, legislators, and state and local leaders of successful approaches in expanding coverage to children through local innovation. It will also

be useful for health plans, providers, and vendors that want to know more about the scope of a CHI and intend to participate in local and regional CHI planning and implementation activities.

Drawing on the collective expertise offered by the Children’s Health Initiatives, this guidebook lays out the major design options and strategies that CHI architects must consider during planning and implementation. A four stage conceptual framework highlights the developmental steps to achieve an operational Children’s Health Initiative. Because of the dynamic environment in which these programs are being created, this guidebook will be updated through policy and issue briefings as these programs mature and new model variants are developed.

Policy and Practice Considerations

Together, the Children’s Health Initiatives are reshaping social policy and expectations that **all children are eligible for health insurance** – and shifting the burden of navigating many different programs from families to the “behind the scenes” eligibility systems created to support them. CHIs have demonstrated that localities can be creative and work to precipitate broad scale changes that benefit children, families and communities.

Yet each CHI faces financing and sustainability challenges that will only be resolved with state and federal policy change. Achieving affordable and sustainable health coverage for all California children will require specific changes driven by high level leadership, diverse financing, and joint state and local cooperation, including:

- **State and local simplification of eligibility standards and enrollment systems such as those pioneered through One Open Door and Express Lane Eligibility (ELE);**
- **Redirection of current spending on health care services and administrative savings from system simplifications to finance expanded children’s coverage statewide;**
- **Identifying and securing a mix of financing contributions from government, families, employers and providers to expand children’s coverage statewide;**
- **Developing approaches to coordinate with private employer coverage and ensure such approaches are well coordinated with public programs; and**
- **Forging long-term public-private partnerships across all areas of the health care system that serve children and families, with the shared goal of ensuring that all California children have affordable health insurance coverage and a medical home.**

California’s Children’s Health Initiatives exemplify the power of local communities in creating health policy change. Through their vision and action, the CHI pioneers will continue to inspire and innovate to create solutions for the state’s uninsured children and families.

1 | PIONEERS FOR COVERAGE: LOCAL SOLUTIONS FOR INSURING ALL CHILDREN IN CALIFORNIA

Introduction

A decade has passed since the last serious debate on reforming the nation's health care system. Continued growth in health care costs, a sputtering economy and increasing instability in health insurance coverage for a majority of working families and individuals have again prompted calls for action in 2004. Unlike the situation in 1994, however, the faces of the uninsured now transcend income strata, geography, race and ethnicity. Access to affordable health coverage has squarely hit home for all Americans.

In 2004, most states struggled to remain solvent and were often faced with the challenge of maintaining rather than expanding health coverage to vulnerable populations. Like most other states, California experienced three consecutive years of budget shortfalls and is struggling to keep its Medicaid and State Children's Health Insurance Program (SCHIP) programs affordable and accessible despite difficult budgetary times, greater demands for coverage, and increasing cost of services. Without increased revenues the State will need to make difficult decisions around benefits and eligibility to balance the budget in future years.

Like the rest of the nation, California also faces sizable challenges in stabilizing its private insurance markets and containing health care costs. As insurance premiums continue to increase, many employers have reduced their benefit packages or eliminated health insurance for workers and their dependents. A recent study by the Center for Studying Health System Change found that declines in employer-provided health coverage were pronounced for children younger than age 18 who had coverage through a parent's employer—dropping by nearly four percentage points to 59.5% in 2003 from 63.4% in 2001.¹ Data from 2003 indicate that California mirrors national trends in the declining affordability and availability of employer-based dependent coverage.²

Employer-based coverage, however, remains the predominant form of coverage for California's children, with 55% of children receiving coverage through a parent's employer.³ This percentage has been below the national average for a number of years, and relates to both the

higher percentage of uninsured children and the higher percentage of children enrolled in public coverage.

The good news is that the rate of uninsurance among California's children, which peaked in 1998 at 21%, has declined to approximately 12% largely as a result of public coverage expansions.⁴ These expansions in Medi-Cal and Healthy Families (California's implementation of SCHIP) have evolved over the years and cover as many as four million children at any one point in time.⁵ In spite of these gains, many of California's children – an estimated one million or 12% of children 0-18 years of age – remained uninsured in 2001.⁶ Approximately two-thirds (670,000) of these children are eligible for Medi-Cal and Healthy Families and one-third (350,000) are ineligible due to their immigration status or because their families' income is too high to qualify for existing programs.⁷ Many of the uninsured children are in mixed status families that include both citizen and immigrant members.⁸

According to 2002 Current Population Survey data, California is ranked first in the nation with the largest immigrant population at 28% of the total foreign-born population.⁹ California is also home to over 2.4 million, or 26%, of the total 9.3 million undocumented immigrants in the United States.¹⁰ One in two California children lives in a family where either the child or at least one parent is an immigrant.¹¹ Immigrant children are three times more likely to lack health insurance coverage than U.S. born children. This lower coverage rate is due both to reduced access to employer-based insurance for these children (less than 45% of children in immigrant families have access to employer-based insurance) and the absence for many children of qualifying documentation status for existing public programs.¹² Parental misunderstanding about eligibility requirements and the possible immigration consequences of seeking insurance for children also contribute to keeping eligible children uninsured.¹³

Until policymakers and the public prioritize and commit resources to providing affordable health coverage to all children, many children will continue to fall into the uninsured or underinsured gap. At the same time, the health care system will expend far more resources addressing the consequences of children's lack of insurance than the actual cost of providing health coverage for this 12% of all California's children. Real costs borne as a result of lack of insurance for children include costs for inappropriate treatment, lost parental work days, lost days in school, and numerous behavioral and developmental interventions over the course of a child's first eighteen years.¹⁴

Local Innovation and Momentum: Children's Health Initiatives Take Flight

For more than 20 years, California counties have assumed the primary responsibility for providing health care to the uninsured and underinsured. With the number of uninsured children hovering at or above one

million, local coalitions have stepped up to the challenge by creating a nationally recognized model for expanding health coverage and creating systems change for children and families called the Children's Health Initiative (CHI). Although the state's fiscal situation has directly affected local budgets, since 2000 localities have advanced innovative coverage solutions through their CHIs. Santa Clara County launched the first of these in January 2001 with core financial support from the County of Santa Clara and the City of San Jose, the local First 5 Commission, the local Medi-Cal managed care plan, and private foundations. Two community-based organizations, one labor-affiliated and one faith-based, played an essential organizing role in securing the funding and policy resolve to launch the program.¹⁵

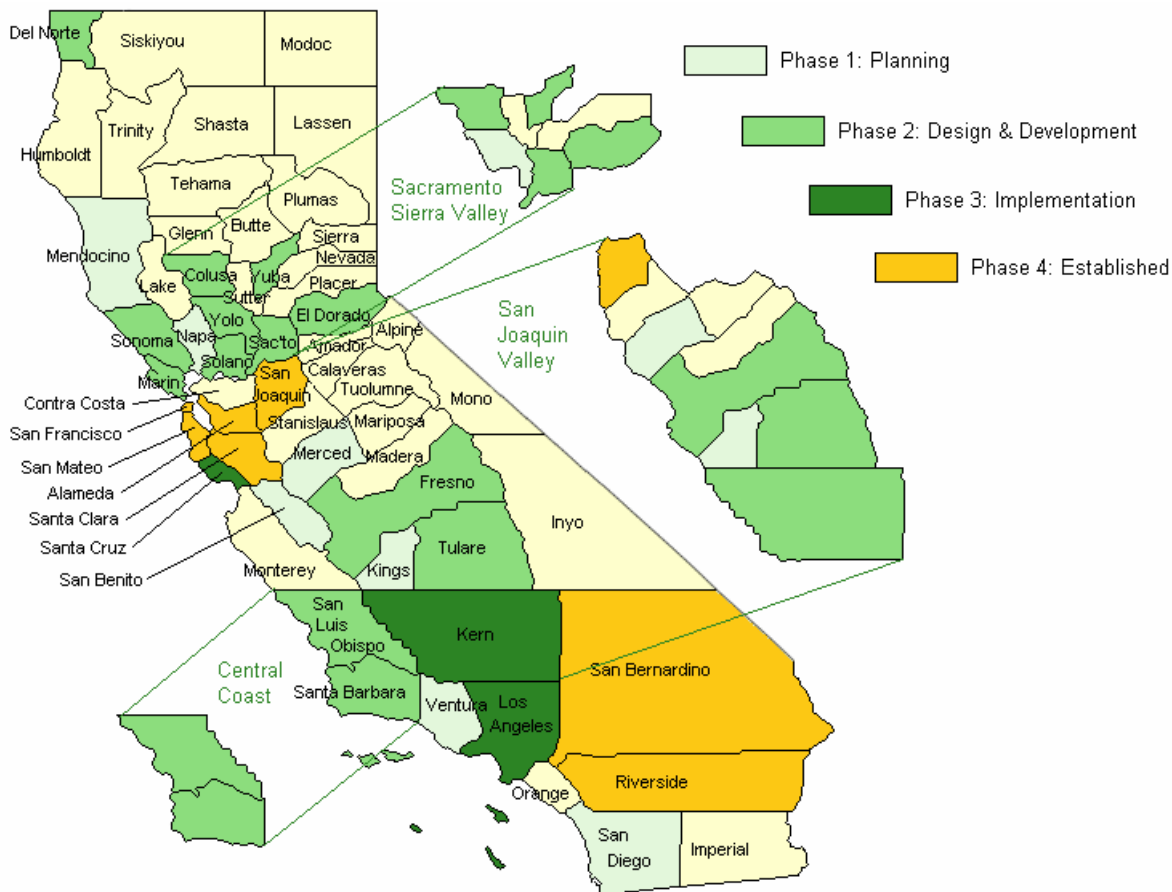
To some degree the structure, financing, and political dynamics have varied in each county with a CHI, but the vision, target population, and expansion products have been fairly similar in scope. The programs seek to reach all children living in families with incomes up to 300% of the federal poverty level (FPL), who do not qualify for existing public coverage.¹⁶ Through peer-to-peer support and external technical assistance, the CHI model has been pioneered in a total of nine counties and is under development in at least twenty others.¹⁷ While their circumstances and approaches differ, most CHIs share a bold vision of *health coverage for all children* and three key supporting strategies. These strategies include:

Cultivating New Public-Private Partnerships for Children's Coverage. Many CHIs have evolved as a shared responsibility across the public and private sectors, including various branches of local government, public and commercial health plans, hospitals, physicians, community clinics, educators, business, labor unions, faith-based organizations and philanthropy.

Creating a Single "One Open Door" Outreach and Enrollment Pathway. The CHI model has helped to facilitate the organizational transformation of several county social and human services agencies. Where once they focused primarily on enrolling families in Medi-Cal, in most counties with CHIs these public agencies now provide a single point of enrollment for multiple programs and benefits and strive to better meet the needs of the typical CHI "consumer"—families with children. As a result, agencies are implementing a single pathway, often called "One Open Door," for enrolling and retaining children in health care coverage. County staff and community-based assisters have been cross-trained to enroll families in *all* available public programs. In some counties, the One Open Door approach has been enhanced by a universal web-based application called One-e-App.¹⁸ The One-e-App streamlines an entire family's enrollment into multiple programs by electronically routing client information to multiple agencies through a single point of entry, making it much easier for families to apply for and receive confirmation of their children's enrollment across multiple public programs.

Creating a New and Comprehensive Healthy Kids Insurance Program. Generally the CHIs offer health coverage to children in families up to 300% FPL, filling the numerous age, income and eligibility gaps across all children's health insurance programs. The local CHIs have created a new coverage expansion called Healthy Kids, which typically mirrors the Healthy Families program. Healthy Kids provides a comprehensive scope of benefits (see Appendix F), and affordable premiums and cost-sharing for families (an average of \$4-\$6 per child per month) who are not eligible for Medi-Cal or Healthy Families and whose incomes are below 300% FPL. Each of the nine operational CHIs partners with their local public plan (or local initiative) or county organized health system to administer their Healthy Kids product, which serves as the designated health plan for Healthy Kids members.

Figure 1.1
Status of Children's Health Initiatives in California
October 2004



First Generation CHI Results

The first generation CHI pioneers have been tremendously successful in articulating a bold vision and leveraging multiple financing sources to support this vision. While some have had more success than others in securing financing and facilitating systems change, as a group these CHI pioneers have set a standard that other localities are now seeking to understand and emulate. In a relatively short period of time they have significantly increased the number of insured children in their areas and helped maximize health-related revenues to the counties.

To date, the nine operating Children's Health Initiatives have cumulatively enrolled more than 50,000 children in their Healthy Kids programs and covered tens of thousands more under Medi-Cal and Healthy Families.¹⁹ Researchers from Mathematica Policy Research found that in Santa Clara County the increase in Medi-Cal and Healthy Families enrollments was 28% higher over the initial two year period (2001-2002) than if the CHI had been absent.²⁰ This increase in enrollments brought an additional \$24.4 million in state and federal revenues into the county during the program's first two years of operation. In addition, three CHIs—Santa Clara, Alameda and San Francisco—were also important pioneers in the passage of AB495 in 2001. This legislation expands the state's SCHIP program by allowing counties to utilize their own local funds to draw down federal SCHIP funding for children in families between 250 and 300% of the federal poverty level.²¹

Although local budgets remain severely constrained, the momentum created by the first generation CHIs has been sustained through the commitment and investments of local First 5 Commissions, several large philanthropies, and First 5 California.²² Inspired by these pioneers, a second generation of innovators are currently working to develop CHIs across California, including regional collaborations in the Sacramento Sierra Valley region, the San Joaquin Valley region and along the Central Coast.

The Second Generation of CHI Innovators

Currently there are a number of counties and regions in the planning or early implementation stages of Children's Health Initiatives (for a complete explanation of the four stages of CHI development, see Chapter 3). This second generation will develop new approaches to coverage that reflect their environmental realities while navigating the challenges identified by the first generation of innovators. While there is an established base of learning that they can draw from, the second generation CHIs will in many ways craft new approaches that will bring their own set of implementation challenges. Several CHIs are in the early stages of creating new CHI variations, including partnering with a licensed commercial health plan, stimulating expansion of an existing public plan into a neighboring county, and creating multi-county CHI coalitions.

Commercial plan participation. The Healthy Kids Kern program located in the San Joaquin Valley is the first CHI to launch its Healthy Kids program in partnership with a licensed commercial health plan, Health Net of California. At least three other counties—Tulare, Sacramento and Fresno—are likely to develop variations of this approach in the coming twelve to eighteen months. This model is an important variant since 38 California counties do not currently have access to coverage through a local initiative or county organized health system. Unless the State’s Medi-Cal redesign process expands Medicaid managed care to some of these counties, expanding CHIs to include commercial health plans is a viable alternative for smaller rural counties seeking to provide coverage to uninsured children in their areas.

Public plan expansions. Two counties along the Central Coast are coordinating their planning and pre-implementation activities with a single public health plan, the Santa Barbara Regional Health Authority (SBRHA). As a result of CHI planning in San Luis Obispo, where SBRHA will administer the Healthy Kids product, conversations began in earnest with the SBRHA to also administer a Healthy Kids program in Santa Barbara County. Similar coordination may also occur in several counties in the North Bay region.

Multi-county purchasing and collaboration. Two counties in the San Joaquin Valley are coordinating in the planning and implementation of One-e-App, and five counties in the Sacramento Sierra Valley region are examining the feasibility of a regional Healthy Kids insurance product. A regional CHI model has the added benefits of insuring portability of coverage for families across county boundaries, increasing local coalitions’ purchasing power and creating administrative economies of scale. Joint planning and action also allows individual counties to share expertise and build a broader base of political and public support. Regionalization of CHIs in some areas may also facilitate small and rural county participation in expanding children’s coverage statewide, as smaller rural counties generally lack the infrastructure and provider capacity to fully implement a Children’s Health Initiative.

Establishing a Vision and Principles for Health Coverage for All Children in California

The time has come to learn from earlier attempts at reform and subsequent incremental expansions and develop policy solutions that are as bold in their approach as they are practical in their effect. As outlined by the Institute of Medicine’s Committee on the Consequences of Uninsurance, an important reform objective is to provide financial access to appropriate and effective health services – and financial access is best achieved when all Americans, and certainly all children, have affordable health insurance.²³

A working vision, put forth for consideration by the Institute for Health Policy Solutions and adapted from the American Academy of Pediat-

rics, the Institute of Medicine,²⁴ and a number of local stakeholder groups, states that:

“All children in California will have comprehensive health coverage and access to a medical home that enhances their health, well-being, and readiness to learn.”

Six core principles underlie this vision:

- (1) All children should have comprehensive health care coverage, regardless of income or immigration status.
- (2) Health care coverage should be affordable and sustainable for all children and families.
- (3) Health care coverage should be stable and continuous for all children and families.
- (4) All children should have a medical home.²⁵
- (5) Health care coverage affects children’s health and well-being and promotes access to high-quality care that is effective, efficient, safe, timely, family-centered, equitable and culturally and linguistically appropriate.
- (6) Improving children’s health through access to affordable health insurance will have positive long-term impacts on children’s readiness to learn and participation in learning environments.

These principles are grounded in a significant body of research documenting the costs and consequences of not providing health care coverage to children.²⁶ Health care coverage has been shown to greatly facilitate children’s access to care for acute and chronic illness, and essential primary and preventive care.²⁷ Furthermore, there is strong evidence that when children develop long-term relationships with a health care provider as a result of being insured, they will receive more accurate diagnoses, require fewer hospitalizations, and incur lower health care costs.²⁸

Improved access to timely and appropriate health care can improve children’s health status over time, which has important implications for their development and well-being as well as their families’ economic well-being. Ensuring the affordability and accessibility of insurance coverage reduces stress on parents and improves families’ quality of life by reducing the financial risks uninsured families face.²⁹ By improving children’s health and reducing families’ stress, a 2003 evaluation of California’s SCHIP program found that coverage had an important bearing on improving children’s school performance and readiness to learn.³⁰ It’s clear that providing health coverage to all children makes good sense on numerous levels – covering all children is good for our society, good for our economy, and it will help to ease the strain on our health care system by ensuring that parents seek and receive appropriate and timely care for their children.³¹ Getting children insured also sets an important expectation for parents that their children will have access to health care throughout childhood and adolescence, and this has crucial implications for children’s capacity to reach their full potential and thrive as adults.

How to Use this Guidebook

This guidebook is designed to assist local and regional coalitions in designing and implementing CHIs to provide health coverage to low-income children in their communities. As such, this resource focuses on practical issues associated with CHI planning and implementation. A secondary, but equally important goal is to inform policymakers, administrators, and state and local leaders of the successful approaches in expanding coverage to children through local innovation. In addition, health plans, providers, and administrative vendors that want to participate in local and regional CHIs may also find the guidebook's practical information helpful for their planning efforts.

The authors have drawn on the collective expertise offered by existing Children's Health Initiatives and the experience of providing technical assistance to a number of the operating and emerging programs. Although these experiences have informed the content, we readily acknowledge that there is no single right way to accomplish all of the design and implementation tasks associated with creating a CHI. Thus, although the necessary steps are discussed, readers should not conclude that a particular approach is required or that other approaches will not work. Each CHI must be tailored to local circumstances and conditions.

In addition, the information contained herein offers approaches that have been and will continue to be created in highly dynamic environments. This has made the task of synthesizing and updating CHI developments an ongoing and challenging endeavor. Our goal in developing the guidebook has been to lay out the major design options and decisions that architects of a CHI will need to consider. The guidebook is intended to provide sufficient information about the various options available to facilitate informed decision-making at each step of the process. As they continue to expand and refine their programs, updates on leading examples, lessons learned and in-depth profiles from CHIs will be available through the IHPS California Web Resource Center (www.ihps-ca.org).

Contents Overview

The relative ease with which a Children's Health Initiative can be started and operated depends on factors that vary by county and by region. Key enabling factors that have been present in the environments of operating CHIs are introduced and discussed in Chapter 2. Chapter 3 includes a general discussion of the CHI's evolution and presents a four stage conceptual framework along with a brief description of key activities in each stage. This chapter also provides options for creating an effective governance structure and securing the appropriate staffing and technical assistance resources.

Chapters 4 through 9 focus on core functional areas of the CHIs, including financing, program design, budgeting, outreach/enrollment/retention, plan and administrative vendor selection, and program evaluation. Chapter 10 provides a glimpse ahead at the policy and sustainability options in creating a seamless system of coverage for all children in California.

Finally, this guidebook includes a number of tools and resources for CHIs to utilize in the creation of their own expansions. Most of these resources have been “road tested” by and adapted from operational programs. Through their commitment and creativity, the CHI pioneers will continue to inspire new approaches that could prove informative to other local, state and federal programs seeking to provide health coverage for all children.

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22. Local First 5 Commissions were created through the passage of Proposition 10 in 1998. Proposition 10 dedicated revenues from taxes on cigarettes and other tobacco products to support early childhood development for children up to age five. There are 58 local commissions that receive 80 percent of the dedicated revenues, with the other 20 percent being allocated to the State Commission or First 5 California. For more information about Proposition 10 and the First 5 Commissions go to <http://www.cfc.ca.gov/>.
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30. See note 29.
31. The California Endowment. *Health Insurance Coverage for All Children: A Goal Within Reach*. Health...In Brief, Volume 3, Issue 2. Woodland Hills, CA: The California Endowment, June 2004.

2 | ESSENTIAL LEADERSHIP: CREATING A RECEPTIVE ENVIRONMENT

Local Leadership and Political Champions

For communities developing a Children’s Health Initiative, there is no substitute for strong local leadership. From the beginning, leaders who are willing to leverage their organizational and professional resources will be the most important drivers of institutional change, and political and public support. These strong leaders provide vision and generate essential community “buy-in,” conceptualize and implement strategies to streamline outreach and enrollment, raise local and statewide financial support, and increase provider interest in caring for newly insured children.

While many organizations are participating in expanding children’s coverage and access to a medical home, several have assumed central leadership roles. In Santa Clara County, the necessary leadership to guide and build the CHI came from four main organizations: the health and hospital system, the local public plan, a faith-based advocacy group, and a local labor organization. In addition, financial support from the county Board of Supervisors, the local public plan, the First 5 Commission, and several foundations was instrumental to the CHIs viability. Finally, a *San Jose Mercury News* editorial about why universal coverage for children is not only practical but a crucial civic priority provided additional community support.¹

In Santa Cruz County the CHI has been led by the First 5 Commission, the local health and human services agencies, the local public plan and a community foundation. In Los Angeles County the First 5 Commission, LA Care (the local public plan), the County Department of Health Services and a statewide foundation have played leadership roles. The health and human services agencies, local clinic consortium, a family advocacy organization and the First 5 Commission provided leadership in Sonoma County. In San Luis Obispo, the leadership has been shared by the First 5 Commission, directors of the public health and social services departments, local pediatricians, a local community foundation, a local insurance agent, and the medical director of the local California Children’s Services (CCS) program.

Established CHIs have had a multitude of “political champions” who play a crucial leadership role for the initiative both at the local and

Common CHI Leadership Roles

- Establish and communicate the CHI vision
- Provide leadership to the CHI steering committee and sub-committees
- Develop community support through a CHI coalition
- Inform and participate in statewide health policy development.
- Identify and recruit political champions
- Dedicate staff to support the CHI work plan
- Facilitate the institutional partnerships necessary to meet CHI objectives
- Galvanize organizational change that supports CHI objectives
- Solicit financial support

statewide levels. These champions may assume different roles for the initiative, but are generally considered the “ambassadors” or “rainmakers” of the initiative. Community leaders from many sectors have served in this role, including local public plan leadership, health and human services agency directors, chief medical officers and other physicians, members of county boards of supervisors, a county superintendent of schools, and leaders of faith-based organizations.

Political champions mobilize strong local commitment and community financial support for the initiative. They are particularly important for fundraising efforts. In addition, CHI champions will create or maintain close relationships with other potential political supporters within the county and sometimes advocate on behalf of the initiative at the state level. Perhaps most importantly, political champions elevate discussions of universal coverage for children beyond the traditional health care provider and advocacy communities.

Community Engagement and Support

Essential leadership must be supported by participation and input from organizations and community members whose missions and interests include the health, welfare and safety of children. Broad grassroots participation is the vehicle for educating community members about uninsured children and can be instrumental in motivating local organizations and leadership to invest in the CHI.

Community coalitions with diverse public and private stakeholder interests have been the foundation for critical input into and support for most CHIs. Coalition partners represent those organizations that will contribute to, and be affected by, any initiative seeking to address uninsured children. Coalition composition varies based upon community characteristics and must take into account those organizations that may yield significant influence, funding, or staffing resources.

Educating potential program champions and community stakeholders is an important step towards fostering community engagement and encouraging participation in the development of CHI principles and objectives. This educational process begins with a discussion of the number of uninsured children in the county and the financial, social and public health benefits of providing comprehensive health coverage for children. Stakeholders learn about strategies that have worked in other counties, particularly streamlining enrollment into Medi-Cal and Healthy Families and creating a new Healthy Kids coverage product. As the coalition comes together it creates an ideal environment for discussing needs and access issues, and the roles that different organizations can play in shaping and supporting the CHI. Perhaps more importantly, the coalition serves as a forum for designing local coverage solutions, including outreach and enrollment social service redesign, as well as for developing the political and public will to sustain the CHI.

It is important for the coalition to recognize this dual role of not only addressing the technical “how to” aspects of creating a coverage product for uninsured children, but also of engaging the community about why it is worthwhile to do so. The latter can be approached in a variety of ways, including town hall meetings, community forums, and presentations to specific community groups.

In general, framing the goals of the initiative in terms of institutional and community benefit is essential to obtaining the buy-in of key stakeholders. Increased enrollment in health insurance may also decrease emergency room use and uncompensated care, typically a priority goal for hospitals. Expanding insurance coverage also brings increased revenues to clinics, hospitals, dentists and physicians, certainly a shared goal for most community stakeholders.

The Role of Local Public Plans

For each of the first generation CHIs, the local public plans have played instrumental roles in the developmental leadership and on-going administration of their county’s initiative. These publicly organized and operated health plans are community-based organizations that specialize in serving Medi-Cal populations.² They are locally operated, mission-driven, and invest virtually all of their revenues in the local public plan provider community, keeping health care dollars in the communities they serve. Their local commitment has helped protect safety net providers in their communities, and thus they are natural stewards for programs like Healthy Kids. They are also often leaders in local health promotion and disease awareness efforts, and involve community members in their governing board structure. The plans’ connections with their communities have been instrumental in outreach and enrollment initiatives, ensuring appropriate utilization and ensuring enrollee retention during the annual eligibility renewal period.

In Santa Clara, San Francisco, Riverside and Los Angeles counties, the Local Initiative (LI) has played this role and the local County Organized Health System (COHS) has done the same in San Mateo and Santa Cruz counties. Table 2.1 below lists the CHI counties with a participating local public plan.

Health plans in first generation CHI counties have created Healthy Kids insurance products based on Healthy Families by modifying their existing Knox-Keene licenses. This approach has enabled them to use existing administrative infrastructure for Healthy Kids enrollment and information management, ensuring appropriate utilization and supporting annual renewal. This approach has also allowed LIs and COHSs to rely on their existing physician networks to serve newly enrolled children.

Stakeholders Typically Participating in CHI Coalitions

- Health Services Agency
- Public Health Departments
- Social/Human Services Agency
- Local Community Foundation
- First 5 Commissions
- Hospitals & Hospital Consortia
- Community Health Centers
- Health Plans (Local Public Plans and Commercial Plans)
- Community-Based Organizations
- County Office of Education
- School Districts
- Chambers of Commerce
- United Way
- Labor Organizations
- Migrant Education
- Advocacy Organizations
- Faith-Based Organizations
- Medical & Dental Societies
- Pediatricians & Family Physicians
- Child Care Centers

Table 2.1
Children’s Health Initiative by County Model of Medi-Cal
Managed Care

County	Medi-Cal Managed Care Model ³	Name of Local Initiative/County Organized Health System
Los Angeles	Two-Plan Model	L.A. Care Health Plan ⁴
Riverside	Two-Plan Model	Inland Empire Health Plan
San Francisco	Two-Plan Model	San Francisco Health Plan
San Joaquin	Two-Plan Model	Health Plan of San Joaquin
San Mateo	County Organized Health System	Health Plan of San Mateo
Santa Clara	Two-Plan Model	Santa Clara Family Health Plan
Santa Cruz	County Organized Health System	Central Coast Alliance for Health

Developing Provider Support

The momentum generated through the CHI leadership development and coalition building process must include as its foundation a positive relationship with community providers – physicians, dentists, vision and behavioral health providers, hospitals and clinics. While this relationship may already be established, particularly in counties with a local public plan, counties with less of a history of working with providers will need to work hard to reach out to them. Provider commitment to the CHI’s objectives will be crucial to its overall success and will increase provider participation in health plan networks. Known and respected providers should be included in CHI planning from its inception, particularly on the steering committee and working subcommittees.

Coalition partners can quickly identify a few providers who have the respect of their peers and who have the professional stature and commitment to serve as ambassadors on behalf of the CHI with the rest of the provider community. These providers, as well as key leadership from the local medical society, should be approached by CHI leaders and invited to join the planning efforts, as they will be valuable in developing program components that will maximize provider participation. Providers that should be represented include pediatricians, family practice physicians, pediatric mental health providers, dentists and pediatric specialists.

In San Luis Obispo County, for example, local pediatricians have been involved in the CHI leadership and planning from the outset and have been instrumental in gaining additional provider support. CHI leaders there have also met with all local pediatricians to solicit their input and the health plan partner has begun to enroll pediatricians in the provider network.

Similarly, provider engagement must also include community clinics and public hospitals that typically form the safety net already providing services to uninsured children and their families. While their issues and concerns with Medi-Cal, Healthy Families and managed care plans may differ from those of private physicians, their input is no less critical. Their participation and leadership will be essential to understanding current service utilization by children, developing successful outreach and enrollment strategies, and designing contracts with public and commercial health plans.

Focused proactive meetings with specific medical and dental providers can address possible reimbursement concerns about a new Healthy Kids insurance product. Moreover, a presentation to local hospitals and clinics about the economic benefits of increased insurance coverage may win their good will and financial support for the overall initiative.

With providers as firm coalition partners, CHI activities can move from defining a common purpose to outlining the program components and specific tasks necessary to achieve it. Over time, these tasks and activities generally are undertaken by an increasingly formalized and cohesive coalition.

1. Editorial: City Shouldn't Give Up on Kids' Health Insurance. *San Jose Mercury News*. June 15, 2000.

2. Hurley RE and Rice C. *An SOS for COHS: Preserving County Organized Health Systems*. San Anselmo, CA: Pacific Health Consulting Group, May 2004.

3. For more information about these and other managed care models, please visit the Medi-Cal Managed Care Division website at <http://www.dhs.ca.gov/mcs/mcmcd/html/Definitions.htm>.

4. LA Care Health Plan is not a local initiative or county organized health system per se. Rather, it is an umbrella consortium of several local public health plans in Los Angeles County that together make up the local initiative plan of the Two-Plan Model.

3 | CHI EVOLUTION, GOVERNANCE & STAFFING

CHI Evolution: The Four Stages of CHI Development

Over time local Children’s Health Initiatives transition from an informal group of stakeholders with common objectives to a coalition of aligned partners with formal policy decision-making and program oversight responsibilities. CHI evolution occurs across four developmental stages with the amount of time spent in each stage varying based on available financing, operational and systems capabilities and local conditions.

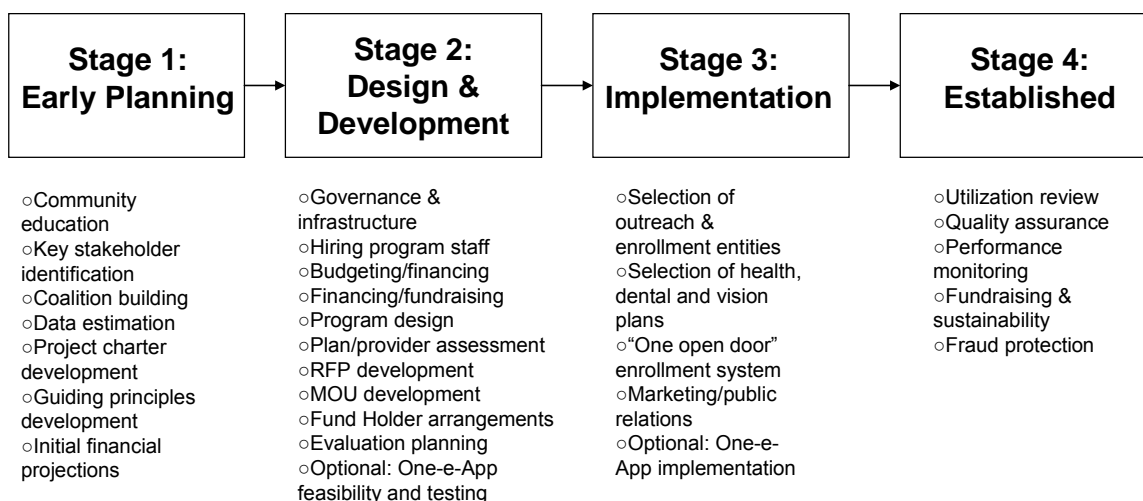
In general, while advancement through each of the four stages is sequentially ordered in the conceptual framework, some activities in the early stages may continue through subsequent CHI stages. For example, community education and coalition building are essential at each stage of a CHI’s development although the emphasis and specific activities undertaken will vary. In addition, while the framework shown in Figure 3.1 provides a general mapping of the CHI development process there is intrinsic variation across the nine CHIs. That is, CHIs may undertake certain activities earlier or later in their development than others. As of late 2004, second generation CHI counties fall within stages 1 through 3 but none are yet in Stage 4.

Stage 1: This stage consists of primary planning tasks and activities such as engaging the support of local leaders and providers, inviting stakeholder participation, building the coalition, and estimating the number of eligible children. As described in Chapter 2, activities related to the creation of a receptive environment begin and continue throughout this stage. The transition from stage 1 to stage 2 usually occurs once CHI stakeholders create and sign a project charter, or coalition partners agree to the initiative’s vision and guiding principles.

Stage 2: This stage addresses more detailed program design issues, beginning with governance and infrastructure development. It is during this stage that a CHI will embark on activities to create a governing board, recruit and hire program staff, develop an implementation workplan and timeline, establish fund holding arrangements, and establish agreement on organizational roles and responsibilities. Joint planning with the Social/Human Services Agency in the development of a single

enrollment pathway and cross-training staff within the agency and out in the community are essential activities in this stage. Other stage 2 activities include developing consensus on the scope of services and cost-sharing levels for the Healthy Kids program, developing budget and financial projections, designing outreach and enrollment strategies, and fundraising. CHI partners may also choose to conduct a feasibility assessment for the implementation of the One-e-App universal electronic application. Evaluation planning and design activities may also begin in this stage.

Figure 3.1
The Four Stages of a Children’s Health Initiative



If a local public plan partner is available, then discussions with plan leadership should begin in this stage. For CHIs without a local public plan partner, it is expected that Requests for Proposals (RFPs) for health, dental and vision plans would be developed and released. The CHI should expect that the process for selecting and negotiating with one or more plans will take a minimum of three months. Fundraising will also commence and remain a central activity throughout stages 3 and 4. Stage 2 usually comes to a close with the development of memoranda of understanding (MOUs) or other types of agreements executed between the CHI partners responsible for the program components identified in figures 3.2 and 3.3.

Stage 3: CHI coalitions begin the implementation activities of stage 3 after the planning, design and organizational activities have been addressed. A CHI is considered as entering the implementation stage when the outreach entities or contractors have been selected and trained. In addition, the selection and execution of contracts with health, dental, and vision plans for the Healthy Kids program should be finalized. Plans for media coverage and a community event to offi-

cially “launch” the Healthy Kids program will be underway. Ideally, a CHI would be ready to implement a universal application system simultaneous to the launch of the Healthy Kids program.

Stage 4: CHIs enter the fourth and final stage after twelve months of operations. CHIs in Stage 4 typically focus on fundraising to support current and future enrollment targets and assessing their effectiveness in reaching predetermined objectives, such as appropriate service utilization and Health Plan Employer Data and Information Set (HEDIS) quality measurement. Evaluators will collect data throughout stages 3 and 4 to assist the governing board in monitoring the performance of all contractors and to gauge the initiative’s success in meeting the goals specified in the project charter.

Organizational Involvement in Early Planning

Across many first generation CHIs, the initial group of primary stakeholders included the leadership from at least four organizations: the First 5 Commission, the Health Services Agency, the Human Services Agency, and the local public plan. The support of these organizations has proven critical. First, the local First 5 Commissions have played a lead role in providing the necessary anchor funding and guiding principles for Children’s Health Initiatives. The Health and Social Services Agencies are also essential coalition partners in their role providing health and public services to the target population. In fact, because the local Social or Human Services Agencies are responsible for enrolling children and families in Medi-Cal and assisting with Healthy Families enrollment they have proven to be operationally critical to enrolling children in the new Healthy Kids programs. Finally, the local public plans, because of their unique community mission, presence, and established linkages with local providers and community-based organizations, were early CHI catalysts and continue to provide core leadership and administration of the Healthy Kids insurance product for first generation CHIs.

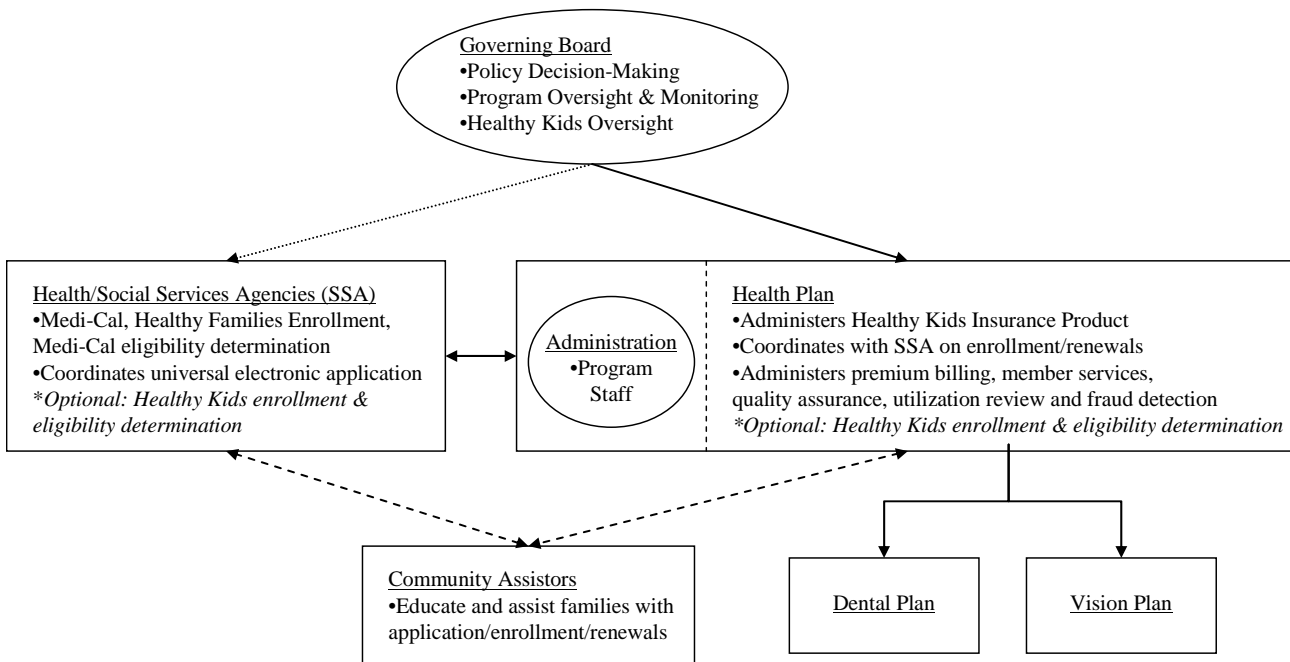
The early strategic planning phase—typically the first six to 12 months of CHI planning—is often led by a “charter” group of key decision-makers and conducted on a fairly informal basis. This group is often composed of at least two of the four key primary planning partners already discussed, but may also involve members of the Board of Supervisors, a provider champion, or an influential community leader. CHIs have typically adopted this strategy of limiting the size of the charter group to incubate the CHI and minimize opportunities for derailment early in the planning process. Over time, however, this committee may either transition or expand to a larger group of stakeholders for political and operational reasons. Eventually the CHI’s charter members must identify other essential community stakeholders to provide the hands-on leadership through each of the four stages and collaborate with the broader group of stakeholders.

The Importance of Sound Governance: Governing Board Roles and Responsibilities

Governance has become an important component of the Children’s Health Initiatives, and marks the emergence of the next generation of CHIs. Governance is the relationship between the CHI stakeholders, staff, and the governing board of a CHI. Each of these groups has different responsibilities. When the groups are able to communicate openly and independently, it is said that a CHI is exhibiting good governance.

Most CHIs transition to a more formal governance structure once the early planning process is complete. Generally, the governing boards of operating CHIs have been called steering or oversight committees. There are four primary reasons for creating a formal governance structure. First, members of the governing board will establish overall policy direction for the CHI, oversee project administration, and centralize accountability for the overall initiative. Second, the board will also be the primary entity under which financing for the CHI will be secured

Figure 3.2
CHI Organizational Roles and Relationships with a Local Public Plan Partner

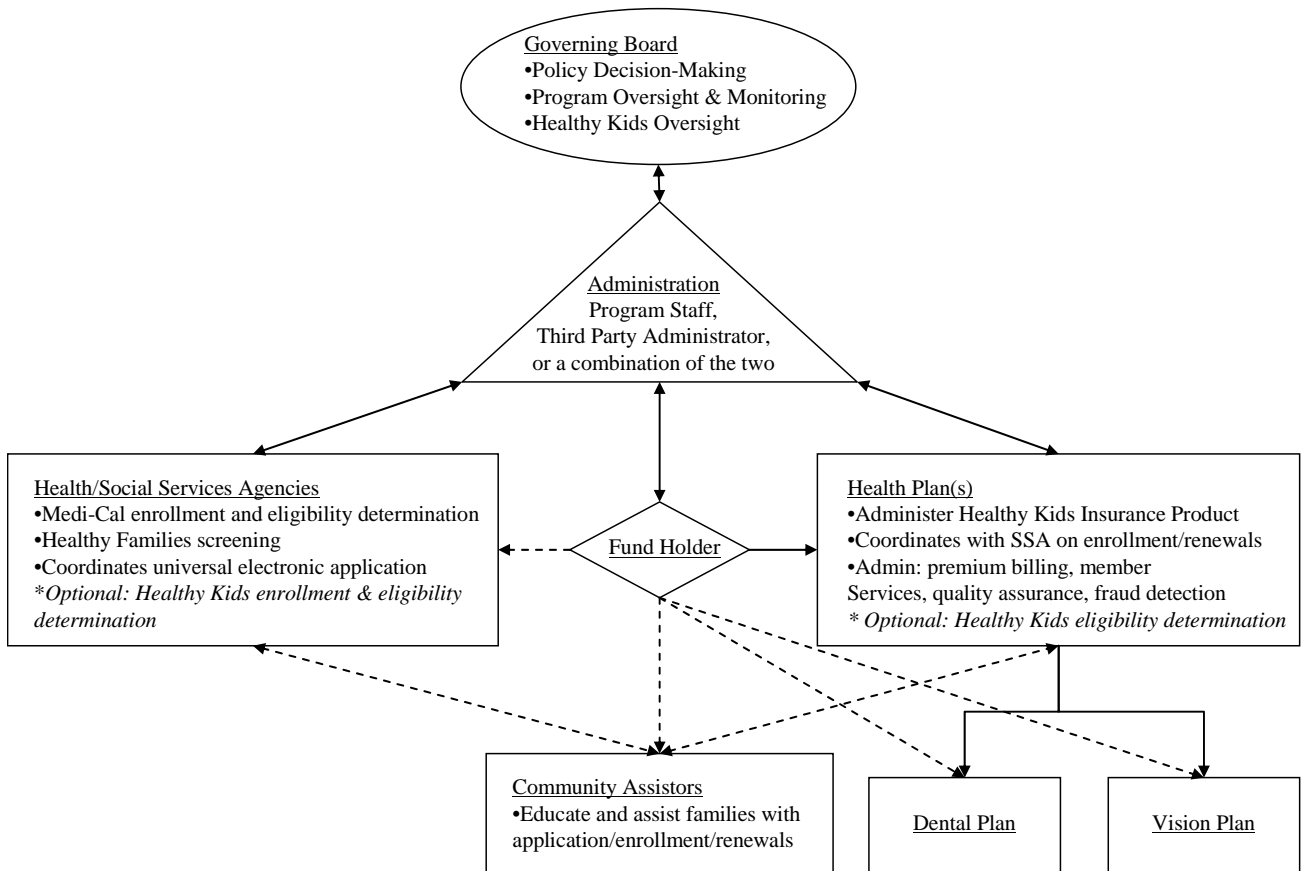


This figure illustrates the roles and relationships for most operational CHIs as of Fall 2004, which have a local public plan partner that functions as both the plan as well as the Healthy Kids program administrator. This approach requires an accountable plan partner that can largely assume the coordination and other administrative responsibilities for the Healthy Kids program.

and fundraising strategies are executed. Third, the governing board will be responsible for overseeing and monitoring the performance of the health, dental and vision plans, and presumably one or more participants on this body will contract with a health plan or plans to provide the Healthy Kids insurance product. Finally, this entity will need to direct staff and consultants hired to implement the initiative’s objectives and also assign responsibilities and tasks to the designated subcommittees.

The inclusion of influential leadership in the governance structure creates a level of accountability for decision-making that is critical to a

Figure 3.3
CHI Organizational Roles and Relationships with One or More Commercial Plan Partners



This figure illustrates the various roles and relationships likely to exist between a CHI governing board, Healthy Kids program administration activities, health plan contractor(s), the fund holder and local agencies for CHIs without a strong local public plan partner. In this scenario, the administrative/program staff component resides outside of the contracted plan(s) and assumes much of the oversight and coordination responsibility for the program. Dedicated program staff will be integral to this approach because of the high degree of coordination required. This approach may be seen in second generation CHIs pursuing a regional CHI and/or those contracting with commercial health plans.

program's ultimate launch and sustainability. Governing board participation reduces the possibility that an initiative will become mired in ongoing "processing and reporting" without progress toward actual implementation. The governing board should meet regularly to discuss such issues as the ongoing health and sustainability of the CHI, the plans and their performance, and the overall impacts of the program. If problems arise, it's the board's responsibility to address them before they become serious.

Without leaders setting an expectation for accountability within their organizations, facilitating inter-organizational collaboration, and working to raise the necessary financing, the CHI is likely to stall or never come to fruition. Most CHIs have designated clear organizational roles and responsibilities prior to program operationalization. They have created memorandums of understanding (MOU) to designate the responsibilities of key agencies for enrollment and eligibility determination, fund holding, provision of the Healthy Kids insurance product, outreach and administration (see Appendix C). Figures 3.2 and 3.3 depicts the inter-organizational relationships that some counties have formed.

Governing Board Composition

Governing board members are integral to the program's successful implementation. Thus, the board membership should be comprised of major funders, participating providers and other participants in a county-wide leadership role. All governing board members should have decision-making authority for their organization, or possess sufficient influence in the broader community in order to effect change. Board members should also be independent, and not in any way stand to personally benefit from the CHI or its activities.

Examples of local leaders and organizations participating in the stewardship of CHIs include: the local Board of Supervisors and their staff; Health and Human Services Agency leadership, hospital and health system leadership, community clinic leadership, pediatricians and private physicians, the local medical society, local philanthropy, education, and business. Community-based organizations, such as the labor-affiliated Working Partnerships USA (WPUSA) in Santa Clara County or the faith-based Fresno Metro Ministries in Fresno County, are also likely candidates for participation on the governing entity. A children and families advocacy group, such as the Family Action Network in Sonoma County, is another example of a likely community-based participant in overseeing and monitoring CHI activities. It is also highly advantageous to select members who will champion the CHI to local policymakers and other key stakeholders.

The model for emerging CHIs will likely change with regard to the health plans' involvement in the early stages of planning and governance when there is no publicly administered health plan. If a competitive bidding process is anticipated (see Chapter 8), then a conflict of

interest could arise in identifying one or more health plans to participate on the governing board. For this reason, boards should be broad and require potential conflict disclosure and processes by which board members can recuse themselves. Any insurance carrier that may ultimately compete for the Healthy Kids product may need to recuse itself from a CHI's governing board. However, health plans should be invited to participate in subcommittees where their input is essential to program design and improvement.

CHI governing board members in the operational CHI counties have had many affiliations, as indicated in Table 3.4.

Table 3.4
Potential Governing Board Members

Funders	Implementing Agencies	Partners
Board of Supervisors Local First 5 Commission Community and Other Foundations Hospitals Health Systems	Health Services Agency Social Services Agency Health Plans Clinics (community and county) Health Systems Community-based Organizations	Education Labor Faith-based organizations Physicians Medical Society Dental Society Hospitals Health Systems Child Care Providers Other Community-Based Organizations Business

The governing board is not the same as staff and does not have the same responsibilities. Staff may make day-to-day operational decisions, but major strategic issues require the board's participation and approval. A governing board should provide careful oversight of the CHI and draw on its members' expertise in areas such as outreach and enrollment, financing, quality improvement, plan performance monitoring and program evaluation.

An important balance to strike in designating members for the governing body is both the desire to be representative and the need to be able to make decisions effectively. The board should be equipped with an effective system to monitor staff and contracted plans and vendors. Board size generally varies between seven and fifteen voting members and generally only one member per organization sit on the board. Too large a board can be unwieldy, whereas too small a board doesn't allow for the variance of perspectives and skills that are required for sound governance. Although there may be strong political reasons to establish a large and fairly informal governing entity, generally this approach is not recommended. Decisions are generally made by consensus among board members, however, an odd number of participants allows for a tie-breaking vote if votes are split between governing board members.

However, as on most other dimensions, each CHI differs in number of coalition participants, level of health systems integration, and collaboration history—all of which may influence a CHI’s governance structure options. An informal governance structure has been adopted by the Santa Clara CHI because of the unique conditions in which the CHI operates: a well-integrated public health and hospital system, a relatively small group of key stakeholders, and a multi-year history in collaborating on children’s coverage issues. The Los Angeles CHI, which is relying on internal structure to provide functional, representative governance, exemplifies another CHI governance alternative. In contrast to Santa Clara and Los Angeles, San Mateo’s Board of Supervisors has formally passed a resolution naming the county’s oversight committee as the decision-making body for the CHI. San Mateo’s oversight committee members include the Health and Human Services Agencies, the First 5 Commission, the local public plan, the hospital consortium, a community foundation and the local labor council.

Subcommittee Composition and Structure

Most boards are divided into subcommittees, each of which focuses more directly on specific components of the CHI. Some of them, such as a governance committee, may be short term or optional. Most CHIs have at least three to four subcommittees. Subcommittees focus on specific task areas of the CHIs, including but not limited to financing, outreach/enrollment/retention, health plan and provider participation, marketing and communications, governance, and evaluation and performance monitoring (which may include quality and utilization review). Their focus is to research options and operationalize activities identified by the governing body. Examples of CHI subcommittees are included in Table 3.5.

Subcommittees typically meet on a bi-weekly or monthly basis depending on their charge, status of specific activities under their purview and the stage of the initiative. Throughout the early planning phase, for example, the outreach/enrollment/retention subcommittee may need to meet twice a month until the outreach plan has been completely formulated. In a similar vein, the program evaluation subcommittee may only meet once or twice in the early planning and design phases, but ramp up meetings once the CHI moves into actual implementation. CHI planners should exercise flexibility in setting forth meeting schedules and agendas for the subcommittees, as they are likely to change over the course of the initiative.

Developing a Project Charter and Implementation Timeline

CHIs have found that program momentum may slow after establishing a governing board due to a lack of clear consensus about program goals, activities and timelines. Several first generation CHIs have acted to avoid this by creating a charter document that defines the vision, princi-

Table 3.5
Sample CHI Subcommittee Functions

Subcommittee	Role/Function
Financing/Fundraising	<ul style="list-style-type: none"> • Determine core operating budgets and financial projections • Develop plan for financing the CHI from public, private and philanthropic sources • Meet with and/or make presentations to potential funders • Ensure program sustainability over the long term
Outreach, Enrollment & Retention	<ul style="list-style-type: none"> • Ensure program enrolls targeted eligibles • Ensure families learn how to use the program • Ensure enrollees stay enrolled as long as eligible • Make recommendations regarding eligibility criteria, application forms, required documentation • Examine outreach, enrollment and retention issues for Healthy Kids, Medi-Cal and Healthy Families
Health Plan Participation	<ul style="list-style-type: none"> • Draft and review RFP to select health, dental and vision plans to provide Healthy Kids coverage product • Evaluate submitted bids and provide recommendation to steering committee
Marketing/Community Relations	<ul style="list-style-type: none"> • Develop and recommend communication strategies, including messages and materials to reach various target groups, e.g., donors, community members, providers, policy leaders, community organizations, and low-income families with children • Help to broaden coalition membership and insure adequate communication to all community stakeholders
Program Evaluation	<ul style="list-style-type: none"> • Oversee and design the evaluation process • Design key research questions and components that will guide the evaluation • Develop RFP to solicit evaluation proposals • Select the evaluator • Review the evaluation’s progress • Conduct performance monitoring • Quality assurance and utilization review

ples and goals of the initiative. In some counties this document is called a project charter. This charter is a living document that defines the intent, scope, and breadth of the local children’s health initiative, and may change at the recommendation of the governing board as the initiative unfolds (see Appendix D). Other CHIs, such as Sonoma and San Luis Obispo, have agreed to a set of guiding principles for their programs.

The project charter or statement of principles serves as an “anchor” for the initiative over the course of its development and implementation. These documents set the framework under which individual organizations go back and secure the broader organizational buy-in and commitment of resources to the CHI. For CHIs where there may be some difficulty in achieving clear consensus on the breadth and scope of the initiative, the process for creating and adopting a charter document will assist in alleviating potential misunderstandings as the initiative moves

forward. In creating the project charter, it is recommended that the group realistically identify key challenges and opportunities in the initiative's implementation. The charter may also include a statement about participation in the governance structure, and a general timeline for program launch. The timeframe for actual implementation will vary based on the availability of resources and a provider for the Healthy Kids product, but the average time to implementation generally ranges between nine and eighteen months. A sample implementation plan is included in Appendix E.

Staffing and Technical Assistance Considerations

With the governing board in place and poised to begin Stage 1 tasks, leadership should carefully consider specific staffing and technical assistance needs. The work includes, but is not limited to, staffing committee meetings and community forums, developing numerous technical papers, preparing budgets and cost estimations, and managing contracting processes for outreach, health plan administration and other services. While the governing board members or staff from their respective organizations may take responsibility for some of this work, many CHIs have solicited expertise from outside technical consultants.

CHIs also vary in their decision to hire dedicated full time staff to the program. Ideally, funding can be secured through the key partners to hire a dedicated, full-time project manager for the initiative prior to commencement of subcommittee activities. This staff member can be housed in any of various organizations, including the Health or Human Services Agencies, the First 5 Commission, the health plan or a key community-based organization participating in the coalition. The decision of where full-time staff are located will depend on a number of factors, including the salary structure and benefits the fiscal agent would provide, and the extent to which the staff member would be accountable to both the fiscal agent and the governing board. A CHI project manager should understand the relationships between key participating entities and have the ability to facilitate inter-organizational relationships. S/he may also be asked to staff one or more subcommittees in addition to the governing board in order to provide a central linkage between all the committees.

The funding source or sources for CHI staff will depend on which organization has available resources or the flexibility to underwrite staff support. In the Santa Clara and San Mateo CHIs, the local public plan and the Health and Human Services Agencies provided full and part-time staffing for the CHI. Other CHIs, including San Francisco, San Joaquin, Riverside, Los Angeles and Santa Cruz relied heavily on staff from the local public plan. Several second generation CHIs have received grant support to cover the costs of dedicated full-time staff or consultation for their planning process. Finally, a combination of sources including a regional community foundation, the First 5 Com-

mission and the local United Way are supporting a full-time project director for the Sacramento Cover the Kids by 2006 initiative.

Because a range of technical issues will need to be addressed during stages 1 and 2, most CHIs have utilized the combined support of staff and outside consultation. The issues and topics requiring expert research, writing, and technical guidance include:

- *Estimates of uninsured children:* This addresses the scope of uninsured children in the county and/or region and to the degree possible, breaks down the estimates by demographic characteristics. These estimates not only serve as the basis for financial projections, but also serve as a rallying point for developing community support.
- *Budget projections:* This will be based on the estimated number of children for a Healthy Kids product, benefits selected, premium costs and other factors. The budget may also include estimating costs based on enrollment projections by month and by year. The projected premium costs for children covered by the Healthy Kids product may need to be modeled in advance by outside experts.
- *Financing sources:* Research will be needed into the various state and local financing sources that may be available to fund the CHI. This assessment would include a feasibility study of tapping into each potential source and the particular requirements associated with each source.
- *Health plan solicitation, evaluation and negotiation:* Covering children ineligible for Medi-Cal and Healthy Families with public or commercial health plans will require expert knowledge of the managed care environment, Request for Proposals (RFPs) development and review, health plan negotiation and contracting arrangements, and third party administrator (TPA) functions and contracting arrangements.
- *Local provider capacity:* Achieving the goal of improving children's access to care in the county or region will require sufficient provider capacity (physicians, specialists, dentists, clinics, hospitals, mental health providers) to serve them. This assessment often precedes the health plan contracting phase and utilizes both existing data and some additional interviews and surveys. This can also be addressed in the health plan RFP process.
- *Outreach, enrollment and retention infrastructure:* Creating a "One Open Door" outreach and enrollment system first requires an assessment of the existing infrastructure and all of its complexities. This may also include a feasibility study of implementing a One-e-App electronic enrollment system.

- *Legal and actuarial issues:* Legal issues may arise around governance, financing and fund holding, and contracting with health plans. In the case of First 5 Commissions, issues may arise relative to the 0-5 funding restrictions. It is also highly recommended that an independent actuarial valuation of the scope of services be included in the start-up budget for a CHI.

Each county with a CHI will address the staffing and technical assistance needs differently and a number of options should be considered. As discussed earlier in this chapter, CHI staff and external technical expertise may also be provided by local community-based organizations and the Health and Social Services Agencies. In Fresno County, for example, the staffing to the CHI coalition is provided by Fresno Metro Ministries, a community-based organization. In San Luis Obispo, dedicated CHI staff will be housed at no charge at the Human Services Agency. In several of the first generation CHIs, staff have been hired as part of the local public plan. In addition, local agencies and community-based organizations may also address some of the specific technical assistance needs discussed above. In particular, county counsel offices may play an important role in addressing legal issues around the use of First 5 funds, governance and contracting with commercial managed care plans.

Finally, the relationships between the governing board, staff members and consultants should be clearly identified and communicated prior to implementation. The various staffing and technical needs are likely to be identified in the implementation workplan, with specific activities or tasks assigned by expertise area. It should be expected, however, that certain responsibilities between staff and consultants will evolve over time as local technical expertise is developed.

4 | FINANCING

The Importance of Realistic Optimism

Financing is always the first major hurdle faced by start-up ventures, whether for-profit or not-for-profit. Like all new ventures, Healthy Kids programs have benefited from the creativity, vision, and determination of those who worked to get them financed. To date, nine CHIs have moved forward to operation through systematic planning, judicious goal setting, and realistic optimism. While their approaches have varied and their efforts have often met with resistance, at least initially, the message is clear: CHIs made up of committed organizations and influential community members can bridge the financing gap and create local coverage programs for children.

Financing Components

Essential CHI financing components and strategies are: 1) securing planning and anchor funds; 2) securing local funds; 3) securing external funds; 4) program staging to match financing with enrollment levels; and 5) developing long term sustainability. While all five components are essential, only the first four components are necessary for start-up. Sustainability secured through long term federal, state and local funding commitments is the fifth critical financing component.

Another key consideration that underlies each aspect of developing a viable financing plan is ensuring adequate funder diversity. CHIs have assembled a varied mix of funders. Table 4.1 lists the funding streams of the nine operational CHIs and their sources. The funder mix and the amounts they individually provide to the initiative are a result of each county's economic, political and organizational environment.

Planning and Anchor Funding

One major early role of CHI leaders and political champions is identifying and cultivating financial support for planning activities. A planning grant supports necessary staff and outside experts and also demonstrates that funders have found merit in the proposed planning activity. CHI planning grants have come from a variety of local sources including local First 5 Commissions and community and private foundations. San Mateo and Fresno CHIs also used Federal Healthy Communities Access Program (HCAP) grants to fund their planning activities. Organizations

participating in the CHI may also provide financial and in-kind staff support through each of the planning and implementation stages.

As planning progresses and the initial budget requirements of the CHI are projected, staff should develop a matrix of potential local and external public and private funding sources and explore the feasibility of accessing these sources within the community coalition. This matrix should also identify the main gatekeepers to local funding sources, such as tobacco settlement allocations, First 5 allocations, community foundation funding, hospital, and hospital district resources. This matrix serves as the key to identifying potential major anchor support for program implementation and operation. Receiving anchor funding helps CHIs encourage other probable funders to “come to the table” and contribute. CHIs have generally received anchor funding through the local First 5 Commissions to support their planning and implementation efforts and, in several cases, also to support several years of operation.

Table 4.1
Current Mix of Funding Sources for
Children’s Health Initiatives

	Statewide	Local
Public	<ul style="list-style-type: none"> • California Children & Families Commission (First 5 California) • AB 495 	<ul style="list-style-type: none"> • Local First 5 Commission • County General Fund • City General Fund • Hospital District • Plan Contributions • Master Tobacco Settlement Allocations
Private	<ul style="list-style-type: none"> • The David and Lucile Packard Foundation • The California Endowment • Blue Shield of California Foundation • California HealthCare Foundation 	<ul style="list-style-type: none"> • Community foundations • Corporations • Individuals

The funding assessment should evaluate the local dynamics and fiscal realities within the county to secure funding from several sources. If funding gatekeepers are not already participating on the governing board or coalition, meetings should be set up between them and the CHI leadership and/or political champions. Cultivating public support to ensure available funding should be made a priority throughout a CHIs development.

In the first generation CHI counties, local resources have been instrumental in CHI planning, infrastructure support and premium subsidies. In these counties local contributors have included local First 5 Commis-

sions, local initiatives and county organized health systems, Master Tobacco Settlement allocations, county and city general funds and local community foundations.

Often one local funder steps forward with a planning grant or anchor funding, thereby encouraging other funders and supporters to participate. These anchor funds have been provided by First 5 Commissions, local public plans and Boards of Supervisors.

Hospitals in the community may also prove a source of funding as in 2002 they incurred nearly \$330 million in uncompensated care statewide caring for children and youth.¹ Non-profit hospitals must provide “community benefits” to satisfy their tax-exemption status and must plan how best to spend those benefit resources with their community.² District hospitals, which are publicly owned, may have resources to support health insurance coverage for children in their service area. In San Mateo County, for example, two district hospitals have contributed significantly to the CHI.

Other local funders include community foundations, business, and philanthropies. California has also received some \$950 million dollars in Tobacco Settlement funds from the first installment in 2000 through 2002.³ Individual counties have used their allotments in a variety of ways, including health service provision. However, careful coalition building and strategic champion selection may enable a CHI to receive some of these funds.

Perhaps most importantly, the existence of committed local funding has helped leaders and political champions to solicit matching funds and other resources from outside the community. In some instances, local support may come in the form of in-kind leadership contributions, personnel time and technological expertise from public service agencies, and political commitment from CHI champions. It is the amassing of collective local resources—financial, in-kind and political—that demonstrate local commitment, build momentum and attract other sources of financial support.

Complementing Local Funding

Most CHI leaders have worked to balance local funding with a mix of state (both public and private) and federal resources. Four private foundations including The David and Lucile Packard Foundation, The California Endowment, the California HealthCare Foundation, and the Blue Shield of California Foundation have each made multi-million dollar investments in children’s coverage statewide. Individual county First 5 Commissions have also made children’s insurance coverage a priority. Cumulatively, local First 5 Commissions have invested over \$50 million annually to CHI planning and premium support for children under age six. Significant resources have also been allocated by the California Children and Families Commission (State First 5 Commission) through its Health Access for All Children program. Announced in

Medicaid Administrative Activities (MAA)

Federal resources are available to support the following activities:

- Planning:
 - Interagency coordination to improve delivery of Medi-Cal services (One-e-App contract, CBO outreach contracts, etc)
 - Planning to increase Medi-Cal system capacity (working with community partners to fill gaps in Medi-Cal services)
- Outreach for Medi-Cal:
 - Marketing the program by distributing flyers, informing families of program benefits, etc.
 - Making referrals to application sites
 - Referring children and families to Medi-Cal covered health services (well-baby visits, dentists, mental health counseling, etc.)
- Medi-Cal Enrollment:
 - Assisting with the Medi-Cal application process
 - Translating for the application process

early 2004, the Commission has made a four year, \$46.5 million investment to assist with premium subsidies for children birth to age five who are ineligible for Medi-Cal and Healthy Families and who are in families with incomes below 300% FPL.

Established CHIs have negotiated state funding support for Healthy Kids enrolled high-need children by working with the California Children's Services (CCS) program. Together they ensure that CCS-qualified children who are at risk for or who have serious, chronic and disabling physical conditions or diseases have their CCS-eligible services paid for by the program. That is, the CCS-eligible services required by these children are "carved out" of what their health plan is expected to provide, and the plan is not financially responsible for the costs of these CCS-covered services. This approach requires the health plan to have an MOU with the county CCS office that specifies this "carve out" for eligible Healthy Kids enrollees.⁴ Additionally, Healthy Kids eligibles will need to apply to a county CCS office and be accepted prior to being CCS-qualified.

The Child Health and Disability Prevention (CHDP) program is another state funded program that could pay the cost of CHDP services provided to eligible children enrolled in Healthy Kids. To date, there is no "carve-out" for CHDP program services. Counties should track CHDP services provided to CHDP-eligible children enrolled in Healthy Kids programs in the event that such a carve-out arrangement is negotiated in the future.

Federal funding through the Medicaid Administrative Activities (MAA) program may also play a role in Healthy Kids programs because of the links between outreach and enrollment provided to Medi-Cal and Healthy Families eligible children and Healthy Kids eligible children under a One Open Door approach to outreach, enrollment and retention activities (See Chapter 7 for more information on the One Open Door approach). MAA is a state-administered, federal cost reimbursement program for counties, community-based organizations and school districts involved in administering the Medi-Cal program. MAA reimbursements return to local Social Services Agencies as unrestricted dollars. Under the One Open Door approach, which screens Medi-Cal, Healthy Families and Healthy Kids eligibles, some of the costs associated with Medi-Cal eligibility screening can be reimbursed by MAA.

Federal funds may also support Healthy Kids programs through a unique local to federal matching opportunity known as AB 495. The program, administered by MRMIB, allows county agencies to transfer local funds to draw down unused federal State Children's Health Insurance Program (SCHIP) funds⁵ for children in families above the Healthy Families income threshold of 250% FPL and below 300% FPL but who would otherwise qualify for Healthy Families. For this reason, the program may provide matching funds for some portion of Healthy Kids eligible children in programs that go up to 300% FPL.

AB 495 is highlighted as an innovative national model, as federal SCHIP funds typically require a state fund match. Counties will have to put up their own matching funds to draw down the federal resources. Moreover, the source of local matching funds will be carefully scrutinized and cannot include any funds that may have originated from federal dollars (e.g., Medi-Cal, Medicare). Four pilot counties have received approval to implement these matching programs. Other counties are planning to apply to qualify for approval through the federal Centers for Medicare and Medicaid Services (CMS).

While all potential funding is critical, the AB 495 program is at best only a partial funding source for Healthy Kids programs. First, SCHIP dollars are time-limited and set to expire in 2007. Second, children supported by these funds must have legal immigration status. Given that Healthy Kids programs have largely enrolled undocumented children below 250% of FPL, these funds will support a small proportion of all children enrolling. Lastly, the federal application and reporting requirements are numerous and unless documentation status information is collected according to CMS guidelines, the process may discourage some potential Healthy Kids applicants from applying for the program.

Program Staging

Each of the established CHI counties initially raised sufficient funds for outreach and enrollment efforts, and to cover a majority of the total expected Healthy Kids enrollment. Given that marketing and outreach to Healthy Kids-eligible children takes time, financing the cost of premium subsidies can be staged over the first 12 to 18 months. Los Angeles County, for example, launched the CHI first for children 0-5 and then for 6-18 year olds nearly a year later. This staging allowed CHI leaders and political champions to systematically raise resources for the older population.

As in Los Angeles, launching with limited funding must be accompanied by aggressive sustainability and fundraising plans. Typically, multi-year funding (up to five years) may be more readily secured for the 0-5 population, and thus fundraising efforts will generally focus on 6-18 year olds. In addition, contingency plans, such as enrollment caps and waiting lists, should be outlined in the event that funds become limited. Unlike the Medi-Cal program, county Healthy Kids programs are not entitlement programs. This distinction ensures that CHIs can limit enrollment to match the available funding.

CHIs have been, and can be, launched with partial funding. With funding secured for essential program elements and a portion of the premium costs, the momentum created by a successful launch is invaluable in creating the goodwill necessary to raise additional resources. Furthermore, CHI planning should realistically stage launches and enrollment expansions to match immediately available and potential resources.

Considering Funder Restrictions

Potential funding may come with restrictions that affect the program design and how the resources are specifically used. First 5 funds, for example, are statutorily restricted to children under six years of age. If First 5 funds serve as the anchor grant, the initial program launch may be restricted to children under six. Los Angeles County launched their Healthy Kids program with this restriction in July 2003 and launched 6-18 enrollment nearly a year later. This age-specific restriction requires CHI leadership to find funding specifically for the 6-18 population. Moreover, CHIs with anchor funding from First 5 should be careful to ensure that the initiative's overall objectives remain broadly focused on all children birth to age 18. If funding for the 6-18 population is raised incrementally, the CHI leadership will have to address how to best use the funds incrementally. In other words, if funds are not sufficient to cover the entire 6-18 population, some choices for their use include: covering siblings of Healthy Kids enrollees under age 6; continuing Healthy Kids coverage for children after they turn 6; or covering a subset of eligible 6-18 year olds and keeping the remaining applicants on a waiting list.

Long-term Sustainability

The most important issue for all CHIs that have operationalized Healthy Kids programs is ensuring long term program sustainability. None of the CHIs has yet secured adequate long term financing. Healthy Kids programs are relying in large part on transitional or "bridge" funds while CHIs work to achieve long term sustainability.

After anchor funding has been secured, CHI leadership should develop and implement a plan to attract long-term funding from all available sources. Such a plan for program sustainability identifies all potential funding sources and addresses the political work necessary to secure them.

A number of CHIs have initiated their long term financing efforts by first obtaining anchor funding from Local First 5 Commissions to support planning and, later, to provide multiple year premium subsidies for children under age six. These and other anchor grants often come with a "challenge" to obtain matching funds from other funders. As a result, governing boards and political champions should develop a "matching funds strategy" to attract other comparable grants and commitments, particularly for the 6-18 population. Funders generally feel more comfortable supporting an initiative when another major funder, such as a First 5, has already made a multi-year financial commitment.

Cultivating potential long-term funders requires soliciting the support of the general public as well as the support of political representatives and other influential community leaders. This can be accomplished by successfully marketing the program's objectives, demonstrating the value of investing in children's coverage, and specifying the economic benefits to the community. Committed and potential funders may benefit from periodic reports on CHI enrollments, total secured funding to date, and the overall return on investment in children's coverage.

Fund Holder Options: Each CHI must address how to legally administer funds raised for the initiative and make payments to contactors, most notably the selected health plan and community-based organizations. Specifically, an identified organization will hold and manage funds directed to support the initiative. The chosen fund holder assumes responsibility for disbursing some or all of the funds, tax reporting, and fiscal monitoring of CHI projects.

Table 4.2
Fund Holding Arrangements for Established CHIs

County	Fund holder Type	Name of Fundholder
Alameda	Local Agency (Local Initiative Health Plan)	Alameda Alliance for Health
Los Angeles	501 (c)(3)	California Community Foundation (LA Care Health Plan directly invoices First 5)
Riverside	No fund holder arrangement	Inland Empire Health Plan invoices supporting entities directly
San Francisco	No fund holder arrangement	San Francisco Health Plan invoices S.F. Department of Public Health and First 5 directly
San Joaquin	Local Agency (First 5 of San Joaquin)	First 5 San Joaquin
San Mateo	Local Agency (San Mateo County Health Services Agency)	The Health Services Agency receives Healthy Kids funds from: (1) First 5 San Mateo (premium and non-premium expenses for children under age 6); (2) San Mateo County (matching funds for children aged 6-18); and (3) the Peninsula Community Foundation (private and health care district funds for children aged 6-18)
Santa Clara	501(c)(3)	Santa Clara Family Health Foundation holds private/corporate and individual funds; Santa Clara Family Health Plan directly receives tobacco settlement funds from the city of San Jose and Santa Clara County
Santa Cruz	Community Foundation	Community Foundation of Santa Cruz County (funds for kids age 6-18); Central Coast Alliance invoices First 5 Santa Cruz directly

Established CHIs have created various fund holding arrangements. The three main options are to contract with (1) a local community foundation; (2) a local agency; or (3) to establish a 501(c)(3) charitable organization to meet the fund holding responsibilities. Table 4.2 above shows the fund holding arrangement in established CHIs.

1. California Office of Statewide Health Planning and Development, Selected Hospital Annual Financial and Patient Discharge Data, 2002. This figure represents the cost-adjusted sum of charity, bad debt and county indigent program shortfalls, less subsidies and gifts for indigent care. To obtain the amount of uncompensated care attributable to children and youth 19 and under, the proportion of children from all discharges was applied to the total amount of uncompensated care. The hospitals included are comparable acute care hospitals and those excluded are Kaiser, specialty, psychiatric, state and federal hospitals. Kaiser hospitals are do not report certain financial data, including bad debt and charity care.

2. SB 697, passed in 1994, states that private not-for-profit hospitals "assume a social obligation to provide community benefits in the public interest" in exchange for their tax-exempt status." Therefore, under the community benefit legislation, a private not-for-profit hospital in California is required to: 1) conduct a community needs assessment every three years; and 2) develop a community benefit plan in consultation with the community.

3. Statehealthfacts.org. *Tobacco Settlement Funds, Cumulative Total To Date, SFY2000 through SFY2003*. 50 State Comparisons, Health Costs and Budgets, Kaiser Family Foundation State Health Facts website. Available online at <http://www.statehealthfacts.kff.org/>.

4. Typically, however, plan PCPs are still expected to coordinate the CCS-covered care required by CCS-qualified children.

5. For more information on AB 495 and the application process, please visit the MRMIB website at <http://www.mrmib.ca.gov/>.

5 | PROGRAM DESIGN

Core Coverage Objectives

To achieve the overall goal of affordable health insurance for all children, a local CHI focuses its financial and leadership capital in two main areas: 1) coordinated outreach and enrollment into Medi-Cal, Healthy Families and Healthy Kids programs; and 2) the development of a comprehensive health coverage program for children under 300% FPL who are ineligible for Medi-Cal and Healthy Families. This approach to insuring all low to moderate income children is built upon the following core coverage objectives:

Coverage objective 1

Coordinate outreach and enrollment structures and processes for subsidized insurance programs into a seamless system. This is also known as the “One Open Door” approach to outreach, enrollment and retention that is addressed in Chapter 7. Such coordination improves the ease with which families can navigate complex insurance programs and enroll all of their eligible children into comprehensive coverage. Central administrative coordination also allows counties to maximize enrollment in state and federally funded programs, bringing valuable resources into the county. With the development of a Healthy Kids product (discussed below), families will have coverage options for all of their children, regardless of immigration status.

Coverage objective 2

Develop a comprehensive Healthy Kids product for all children ineligible for Medi-Cal and Healthy Families. Counties with established CHIs have designed and developed comprehensive insurance products called Healthy Kids. This approach stands in contrast to the more typical fragmented approaches of providing episodic non-emergent care to children in emergency departments or in providing a more limited scope of services. Figure 5.1 below illustrates the continuum of alternatives for providing health services to the uninsured.

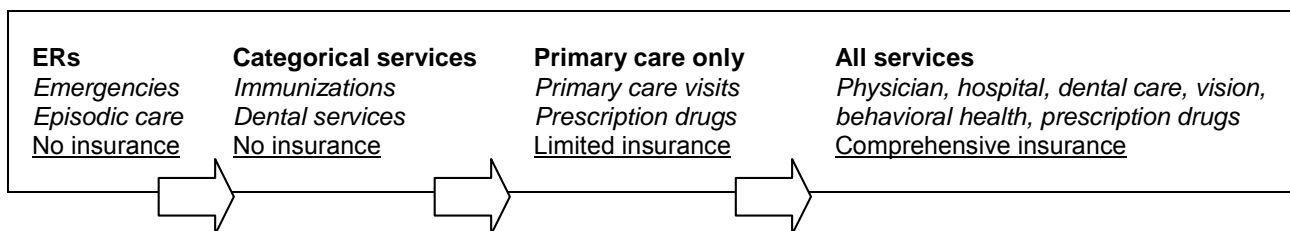
There is strong evidence supporting comprehensive coverage for children. Most notably, a comprehensive coverage product allows for a medical home where children’s care can be continuous and well coordinated. Some counties have decided to cover uninsured children by funding community clinics to provide primary care or by purchasing a lim-

ited scope benefit package from the California Kids Program.¹ While these are worthy options, current funding support for Children’s Health Initiatives focus on the development of comprehensive children’s coverage programs.

Coverage objective 3

The Healthy Kids product should mirror the Healthy Families program. In each of the nine operational CHIs, the Healthy Kids product is designed to mirror the Healthy Families program. This standardization has a number of important justifications. First, the Healthy Families-equivalent coverage provides comprehensive benefits, including professional services, preventive care, hospital services, prescription drugs and dental services (a more comprehensive list is shown in Appendix F). For many families, this would allow children access to the same set of services and providers even though they may receive coverage through different programs (for example, one child may be enrolled through Healthy Families or Medi-Cal and the other through Healthy Kids). The approach also has practical benefits since it allows Healthy Kids programs to build on the state’s existing coordination with the California Children’s Services program and leverages established Healthy Families and Medi-Cal provider networks.²

Figure 5.1
Continuum of Coverage Alternatives



Second, a standardized Healthy Kids product allows for easier program replication across counties and will be crucial to statewide policy development and adoption. As multiple counties address a CHI regionally, including the Sierra Sacramento Valley and Central Coast regions, a standardized program will be an imperative. With a common program across counties, statewide financing and adoption of expanded children’s coverage will be politically and administratively more viable.

Lastly, a standardized Healthy Kids product modeled after Healthy Families will be easier for health plans and providers to administer, thereby encouraging their participation. Healthy Kids plans will likely contract with the same plans and providers currently serving Healthy

Families enrollees in the county. In addition, families with children in Medi-Cal, Healthy Families and Healthy Kids will be able to enroll their children in the same health plan and the same provider network.

Coverage objective 4

Create and maintain standardized and comprehensive coverage, even if expansion to population groups needs to be staged over time. CHI leaders will grapple with the philosophical and operational issues about how to best move forward with limited resources. Some funding realities may force CHIs to limit program eligibility to specific subpopulations such as children 0-5 or to offer the Healthy Kids product to a limited number of eligibles and maintain a waiting list. Several CHIs grappling with funding limitations have decided to focus at least initially on children 0-5 years of age because of their vulnerability to preventable health problems and the greater likelihood of available local First 5 funds to support their coverage. See the text box about the Los Angeles CHI experience.

Los Angeles County Healthy Kids

In early 2003, First 5 LA initiated the Children's Health Initiative with a grant of some \$100 million over five years to provide coverage to all children 0-5 under 300% FPL. The goal was to launch a comprehensive Healthy Kids product on July 1, 2003. With the short timeline, it was not possible for the coalition to raise the necessary funding to cover the 6-18 population as well. Rather than wait until all funding could be raised, the Healthy Kids product was launched on July 1, 2003 for the children 0-5e and a specific subcommittee was established to raise the funds necessary to cover the 6-18 old population. Enrollment opened to the 6-18 population in May 2004.

If a Healthy Kids comprehensive coverage product cannot be provided to all children due to funding limitations, CHI leaders can consider various staging alternatives, including:

- *Comprehensive coverage for children 0-5 only:* Rather than delay the launch of a Healthy Kids product due to insufficient funds for all children, a program can launch if sufficient funds exist for the 0-5 population. CHI leaders will determine how best to use other funds from among the options below.
- *Comprehensive coverage for siblings of children 0-5 enrolled in Healthy Kids:* This option focuses on the family unit to ensure that all children in a family have comprehensive coverage. Siblings of children 0-5 would be identified during outreach and enrollment and simultaneously enrolled.
- *Comprehensive coverage for children turning 6 years old:* Limited funds could also be used to continue comprehensive coverage for children "aging out" or turning six, when the First 5 funding would no longer pay for their coverage. This option puts emphasis on the continuity of coverage over time and avoids the difficulties of removing a child from coverage.

Healthy Kids Program Design and Policy Decisions

Once the broad coverage principles have been addressed, the coalition will need to make a series of design and policy decisions before launching a Healthy Kids program. These program design decisions include eligibility criteria, hardship fund criteria, family premiums and cost-sharing. While the covered benefits under Healthy Kids are fairly consistent across the operational CHIs, program policies in these areas do differ. Below is a discussion of the main design considerations.

Eligibility

These Healthy Kids programs cover children and youth ages 0-18 in families with incomes up to 300% of the FPL who are ineligible for Medi-Cal and Healthy Families. There are two exceptions: San Mateo County has an upper family income threshold of 400% FPL and Riverside County's Healthy Kids program has a 250% FPL threshold. CHI leaders in San Mateo determined that the high cost of living in the county warranted a higher income threshold for their Healthy Kids program. In each county, children are eligible for Healthy Kids programs regardless of immigration status. In addition to income eligibility requirements, families must also show proof of county residency by providing documents such as utility bills, rental agreements, pay stubs, etc.

Family premiums and other cost-sharing

Families can make financial contributions to the Healthy Kids product in two ways, by paying a share of the monthly premium and through co-payments when their child or children receive services. CHI leaders may consider establishing cost-sharing levels based on a family's gross monthly income as in other public insurance programs. The Medi-Cal program, for example, does not collect premiums as these families are below 150% FPL. In the Healthy Families program where family incomes are higher, premiums range from \$4-\$9 per child per month, with a maximum of \$27 per family. Riverside and San Bernardino counties do not have a family premium but rather a one-time enrollment processing fee of \$5 to \$20 depending on the network selected. Table 5.2 below compares family premium contributions and co-payments in selected CHI counties.

Payment plans can also be structured to facilitate family participation. For example, premiums in most counties are paid quarterly rather than monthly. Discounts for pre-payment of a year's premium costs also encourages families' participation and ensures 12 months of continuous coverage. The Santa Clara, San Mateo and San Francisco CHIs have policies in place that provide three months of free coverage if the family pays the entire 12 months of coverage upon enrollment.

Annual eligibility renewal

Another significant program policy involves the stated enrollment period and the process for eligibility redetermination at the end of the cur-

Table 5.2
Family Premium Contributions and Co-Payments

	Santa Clara	Riverside	San Mateo	San Francisco
Family premium per child	\$4 – 6 Maximum \$12 – 18 per month per family	No premiums but an “enrollment processing fee” of \$5 or \$20 depending on plan selected.	\$4 <150% FPL \$6 151-250% FPL \$12 250-300% FPL \$20 300-400% FPL No maximum	\$4 Maximum \$12 per month per family
Co-payments	\$5 for some services including office visits and prescription drugs	\$5 co-payments for most services; \$10 for dental visits	\$5 for office visits and prescription drugs; preventive visits are free.	\$5 for some services including office visits
Payment schedule	Monthly	One time	Quarterly	Quarterly
Payment incentives	If first 9 months paid in advance, remaining three months are free.	Processing fee paid at time of enrollment	If first 9 months paid in advance, remaining three months are free	If first 9 months paid in advance, remaining three months are free

rent enrollment period. All Healthy Kids programs except Los Angeles currently offer coverage for a full twelve months, with renewal processing occurring on an annual basis. In Los Angeles, eligibility renewal is assessed in six-month intervals.

Twelve months of continuous coverage and successfully renewing coverage at the annual eligibility renewal period is known as “retention.” Recent reports have demonstrated that children lose their public insurance coverage for a number of avoidable reasons.³ CHIs can structure administrative processes to facilitate children’s retention in the Healthy Kids programs. For example, databases can be designed to send reminders to families well in advance of their renewal deadline and list the steps necessary to reapply. Families that do not respond can be contacted by phone as well. Renewal applications can also be pre-completed with information already known about the family such as income level, address and number of children.

Hardship funds

Santa Clara, San Mateo, San Francisco and Santa Cruz counties have hardship funds that will pay a family’s share of Healthy Kids premiums in the event of a demonstrated financial hardship. In Santa Clara County, hardship fund applications are automatically sent out to families with income under 150% FPL. Families can also apply for hardship funds either through the official application or through a letter. The Santa Clara Family Health Plan will call families if they miss a monthly premium payment to inform them of the hardship fund. After a second missed premium and a termination notice, more calls are made notifying the family of the hardship fund. In each case, families self-declare their income and existence of a hardship and their premiums are then subsidized for duration of enrollment period. To date, there are between

700 and 800 families in the Santa Clara County receiving hardship assistance. An example of a hardship fund policy and procedures is included in Appendix G.

Although the Tulare County CHI is still in the planning stages, one of their first accomplishments was to establish a similar hardship fund to support children currently enrolled in Healthy Families. Eligible children are identified by Certified Application Assistors and eligibility specialists and a completed hardship application is forwarded to United Way Tulare County for processing and payment to the Managed Risk Medical Insurance Board. Families self-declare income or document their hardship circumstances and premiums are then subsidized for the duration of the enrollment period. Once the Healthy Kids product is launched in Tulare County, the hardship fund will be available to these enrollees as well.

Enrollment caps and waiting lists

First 5 Commissions have generally provided funding to cover the cost of Healthy Kids premiums for eligible children 0-5. For the greater number of Healthy Kids eligible children 6-18, local CHI coalitions are struggling to raise enough local funding to cover all eligible children in the county. The difficulties faced in securing funding for older children has resulted in four of the operational CHIs to implement policies that cap enrollment for eligible children ages 6-18 in their Healthy Kids programs. Likewise, a number of the newly emerging CHIs are uncertain as to whether or not they will be able to secure adequate funding to launch their Healthy Kids programs for all eligible children 0-18.

The two strategies that CHIs have implemented to manage enrollment in their Healthy Kids programs have been enrollment caps and enrollment freezes. Enrollment caps maintain a certain level of enrollment

Table 5.3
County Healthy Kids Enrollment Caps and Waiting Lists
(as of October 2004)

County	Cap 0-5	Cap 6-18	Wait List for 6-18
Alameda	No new enrollment	No new enrollment	No
Santa Clara	No cap	10,000	Yes
San Francisco	No cap	No cap	No
Riverside	2,000	4,485	Yes
San Mateo	No cap	4,800	No
Los Angeles	15,000	No cap	No
San Bernardino	1,700	1,065	Yes
San Joaquin	750	1,000	Yes
Santa Cruz	804	725	No

and as children leave the program, new children are enrolled. All CHIs with enrollment caps in place have created waiting lists (see Appendix H for an example of waitlist policies and procedures). Enrollment freezes stop enrollment after a certain date. As children leave the program, new children are not enrolled until a target enrollment level is reached and enrollment is reopened.⁴

As of May 2004, four counties have capped enrollment in their Healthy Kids program. The high demand for these programs exceeds the amount of funds currently available, leaving counties with the difficult task of determining how to allocate limited resources. In general, the four CHIs have enrollment caps in place only for Healthy Kids eligible children 6-18. In almost all of the counties, funding for all children 0-5 has been available through the First 5 Commissions. Under these circumstances, families enrolling their children in CHIs are often faced with difficult choices. If they have children of different ages, they may be able to enroll a child under age 6 immediately into Healthy Kids, but they are required to put their children 6 years of age or older on the waiting list for the same insurance program. Table 5.3 above summarizes CHI caps and waitlists.

Coordination with other programs

Most established Healthy Kids insurance products have been able to “carve out” California Children’s Services (CCS) coverage.⁵ In other words, these Healthy Kids programs have been able to transfer financial and treatment responsibility for CCS conditions to the CCS program once a child has been determined CCS eligible. While the management of CCS children varies somewhat between CHI counties and the local public plans, the process of referring potentially eligible children generally follows a similar pathway. Typically, a provider identifies a potentially eligible child and refers him/her to the local CCS office for eligibility determination. The health plan may also educate physicians about screening for CCS conditions, facilitate the early identification process, and assist families with the necessary paperwork for applying. If determined eligible for CCS, a child typically remains enrolled in the Healthy Kids program but must receive treatment for the CCS eligible condition through the specialized network of CCS providers and specialty centers.

Minimizing “crowd-out”

This term refers to the phenomenon where the availability of publicly subsidized insurance premiums reduces enrollment in existing employer-sponsored coverage—public coverage “crowds out” the employer-sponsored coverage. This may occur for two main reasons. First, employers may drop existing dependent coverage knowing that the public coverage is available in the county for children. Alternatively, families may decline employer coverage for dependents because of high cost-sharing requirements, finding the publicly subsidized coverage more affordable.

Counties can consider eligibility restrictions or “firewalls” to help focus public coverage on those most in need of it and to discourage employers from dropping and workers from declining existing coverage. Established CHIs have endeavored to avoid substantial employer dependent coverage “crowd-out” in two main ways:

- *Sliding scale premium contributions:* As discussed earlier in this chapter, family premiums can be determined based on family income. No premiums or very low premiums for families who are income-eligible for Healthy Kids (i.e., 250% to 300% of poverty), may lead them not to take up dependent coverage offered by their employers. Families in this income bracket are more likely to be offered employer-sponsored dependent coverage with cost-sharing. Consequently, premiums for this income group may be set at a level that deters them from declining dependent coverage from their employers.
- *“Look-back” periods:* Similar to the Healthy Families program, applications for Healthy Kids coverage can require applicants to have been without employment-based health insurance for some period of time in order to qualify for public coverage (see Appendix L for an application example). The Healthy Families program has a “look back” period of three months, as do Los Angeles, Santa Clara and Santa Cruz counties. San Mateo has a six-month look back period because its Healthy Kids program extends to children in families with incomes up to 400% FPL.

Families above 300% FPL are more likely to have employer-based coverage but with increasing cost-sharing requirements. CHIs can consider making Healthy Kids coverage available to these families with higher cost-sharing requirements. This option may also include a employer contribution option, where employers and employees share the premium costs.

1. The California Kids (CalKids) Healthcare Foundation was founded by Blue Cross of California in 1992 to provide access to basic health services for uninsured children. It currently enrolls some 17,500 children between 2 and 18 years of age. For more information visit <http://www.californiakids.org/>. CalKids insurance, for a family premium of \$15 with co-payments, covers these benefits: Primary and preventive medical care; Prescription drugs; Vision care; Dental care; and Behavioral health care. Hospital inpatient services are not covered.

2. California Children’s Services (CCS) is a state-sponsored program that treats children with certain physical limitations and chronic health conditions or diseases.

3. Testa K, Mohamadi L, Horner D, Lazarus W, Richards J, and Finocchio L. *Children Falling Through the Health Insurance Cracks: Early Observations and Promising Strategies for Keeping Low-Income Children Covered by Medi-Cal and Healthy Families*. Oakland, CA: The 100% Campaign, January 2003. Also see the 100% Campaign materials at <http://www.100percentcampaign.org/resources/priorities/retention-main.htm>

4. For a more detailed discussion of enrollment caps and freezes in specific counties, please see the IHPS Issue Brief - *Local Experience with Healthy Kids Enrollment Caps* (June 1, 2004) - on the publications page of the IHPS Web Resource Center at <http://www.ihps-ca.org>.

5. The Inland Empire Health Plan’s Healthy Kids program in San Bernardino does not have a memorandum of understanding with the CCS program for the transfer and financial responsibility of eligible children.

6 | BUDGETING

Budget Considerations

Development of financial projections and a global budget for a Children’s Health Initiative is an ongoing, dynamic process. Fluidity of the budget process reflects the fluidity of county-level data estimates of uninsured children, the transitional nature of many CHI revenue sources, and the status of a county’s children’s coverage programs. CHI planners should expect to develop start-up and multi-year budgets under several different scenarios to account for these factors. Planners should assume that some scenarios will change because of changes in the external environment, including the amount of future statewide funding that may be available for Children’s Health Initiatives.

CHI planners need to keep the following in mind in developing practical financial projections. First, the annual rate of enrollment into the Healthy Kids program will vary by county. The actual “ramp up” of enrollment into the Healthy Kids program – the program that is entirely locally funded rather than a state/federally funded program like Medi-Cal or Healthy Families – is largely within the control of the CHI and those entities conducting in-reach and outreach activities. Consequently, the governing board and the coalition can calibrate their activities to enroll the number of children for which they have secured premium support. If enrollment surpasses expectations, children usually are placed on a waiting list. While this is not optimal, this approach insures that the program will not run up a deficit or cease to function due to a funding shortfall. Waiting lists also demonstrate a community’s level of need to policymakers and funders in actual numbers.

Second, each CHI also has options for “scaling” the scope of the initiative to the amount of financing secured. For example, if a CHI has secured funding for all uninsured ineligible children ages 0-5, but only a percentage of the funding needed to enroll those ages 6-18, program planners could develop policies to cover the older siblings of the 0-5 year olds enrolled through the CHI or set aside funding for children that would first age out of the program. This strategy involves creating program policies appropriate to the amount of funding secured by the program launch date. It is better to build the program to cover children as soon as possible rather than waiting to raise all the funding needed to

cover all the estimated uninsured children ages 0-18. This is probably a more likely scenario in smaller or more rural counties where resources and funding are scarce.

Third, program planners have the option of covering some portion of the target population in other coverage programs (such as California-Kids or Kaiser’s Child Health Plan) transitionally if only a small percentage of the total budget will be secured in the first year of operations. Agreements can be made with some programs to help secure full or partial funding to enroll or retain children in an existing program and then transition them to the Healthy Kids program once the necessary funding is secured.

In summary, CHI planners have a number of options and assumptions to consider and build into their budgeting process. Unlike other local programs, however, CHIs have a significant amount of control to build or “scale” their program based on available financing. The CHI governing board and staff should establish a regular process to assess the accuracy of budgetary assumptions by line-item and over time. In addition to allocation decisions across key program areas and activities, budgeting must also reflect the budgetary cycles and funder requirements associated with program planning activities, startup and maintenance of program operations.

Table 6.1
Sample CHI Budget Items

<p>Premium and enrollment costs</p> <ul style="list-style-type: none">• Insurance premiums• Hardship fund• Outreach, enrollment and retention<ul style="list-style-type: none">○ Eligibility determination staff○ Certified Application Assistors○ Training and materials○ Advertising and promotions• Optional: Universal application and information system development and implementation (One-e-App) <p>Planning and administrative costs</p> <ul style="list-style-type: none">• CHI personnel• Administration• Expert technical assistance:<ul style="list-style-type: none">○ Actuarial○ Legal○ Information technology specialists• Evaluation planning and implementation <p>Income and revenues</p> <ul style="list-style-type: none">• Planning and operating grants• Premium subsidy grants• Family premium contributions
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Global Budget Items

The global budget can be separated into three main areas. These areas are premium and enrollment costs, planning and administrative costs, and income and revenues.

Table 6.2
Generic Premium Cost Model

	<i>Per Member Per Month (PMPM)</i>
Physician Primary Care	\$ 19.00
Physician Specialty Care	\$ 12.00
Pharmacy	\$ 5.00
Hospital Inpatient	\$ 9.00
Hospital Outpatient	\$ 6.00
Other	\$ 7.00
<i>Total Medical</i>	\$ 58.00
Dental services	\$ 22-28.00
Vision services	\$ 2.00
Health Plan Administration (not outreach)	\$ 4.00
<i>Total Non-Medical</i>	\$ 28-34.00
Total Monthly Premium	\$ 86.00-92.00
Total Annual Premium	\$ 1,032-1,104.00

Source: Pacific Health Consulting Group, 2004

Premium and Enrollment Costs

Insurance premium costs, the largest portion of the budget, are typically based on an actuarial valuation of a comprehensive Healthy Families-like benefit package for comparable child populations. This is a critical component in establishing Healthy Kids premium rates on a per member per month (PMPM) basis. It is also normally appropriate that the actuarial valuation age-adjust the annual premium cost.

There are also a number of local factors, such as the availability of providers and prevailing contracting arrangements, that will affect premium rates on a county by county basis. The component of the PMPM with the greatest variance by CHI is dental services. The table above shows a generic premium cost model derived from Healthy Kids programs in several first generation CHIs.

There are two important caveats to consider in this budget model derived from Healthy Kids programs in counties with local initiatives (LI) and county organized health systems (COHS). First, the LIs and

COHSs contract with experienced actuarial firms in pricing a comprehensive health, dental, vision and behavioral health benefit package for low to moderate income child populations. The final Healthy Kids premiums have been consistent with local Healthy Families costs. Second, commercial health plans may have a slightly higher PMPM rate, as their administrative costs can be higher than LIs and COHSs, which have reduced their administrative cost allocations primarily to marginal costs for Healthy Kids.

A hardship fund may support both Healthy Families and Healthy Kids premiums (see Chapter 5 for a more detailed explanation of a hardship fund). Several counties have established hardship funds that pay the full Healthy Kids premiums for families experiencing temporary financial difficulties. Should a CHI decide to offer such family premium support, this would be reflected in the budget.

Each CHI will also develop or expand outreach, enrollment and retention activities for the Medi-Cal, Healthy Families and Healthy Kids programs. Budgeted costs for outreach, enrollment and retention will include community outreach workers, promotores, certified application assisters, and eligibility specialists. Marketing and public relations costs should also be budgeted as outreach and enrollment activities. Typical marketing and public relations expenses include Healthy Kids logo development, advertising on radio and in local print publications, CHI website development and promotional materials.

Several counties have also invested in an electronic application system to maximize children's and families' access to the full range of available public programs, including Healthy Kids. CHI planning should anticipate that the cost to test and implement One-e-App will vary by county based on the number of programs and interfaces required, the number of expected users and the desired workflow process.

Depending on the administrative capacity of the CHI organizational sponsor and the contractual relationship with the health plan, the budget may also include hardware and software to handle enrollment, utilization monitoring and retention. The One-e-App enrollment system may not be feasible in some counties and therefore other information systems may be required to track children's eligibility, enrollment and renewal status over time.

Planning and Administrative Costs

The budget will also include the costs of administrative personnel to coordinate the programmatic, organizational and technical aspects of the CHI. These personnel costs, and associated fringe benefits, will vary depending on the initiative and the degree to which participating organizations provide staff and other in-kind administrative support. Other related administrative costs include rent, postage, supplies, phone and other operating overhead items necessary to support the program.

Table 6.3
Sample Start-Up Budget

CHIs have also required outside expertise to develop actuarial valuations, financial projections, data estimates, policy analysis, information systems support and evaluation. Some CHIs have also contracted with fundraising experts to identify target markets and high yield fundraising strategies.

CHI Income and Revenues

Lastly, the budgeting process will also take into account income and revenues from planning and implementation grants, premium subsidy grants, and family premium contributions. As discussed in Chapter 4, CHIs have numerous sources of support that are often earmarked for specific initiative items.

Many CHIs receive initial start-up grants for planning, program design and implementation. These grants, often from statewide foundations or local First Commissions, might support personnel, meeting costs and technical assistance. Specific grants may also be available to support outreach, enrollment and retention activities, One-e-App feasibility and evaluation.

The premium costs will be the single largest line-item of the budget. Financial support to cover premium costs will come from several sources as funders may focus on specific populations. For example, premium support for children 0-5 may come from local First 5 Commissions. In addition, the California First 5 Commission will provide matching funds for 20% of 0- 5 premiums as long as certain programmatic conditions are met. Other private funders have programs to subsidize a portion of premiums for the children ages 6-18. Lastly, family premium contributions will also offset the total premium cost in the budget.

Budgeting Phases

Under direction from the steering committee, CHI staff and the finance subcommittee will develop two separate but inter-related budget components: 1) the “start-up” budget; and 2) a three-year global budget. The “start-up” budget includes the initiative planning phase, the costs of hiring and recruiting program staff, and initial outreach, eligibility, training and marketing activities. Table 6.3 illustrates a sample start-up budget and Table 6.4 provides a sample global three-year budget based on enrollment of 1,000 children each in years one, two and three, for a sample total enrollment of 3,000 children by year three.

Budget item	Pre-Launch (6 mo.*)
Outreach and enrollment initiatives - CBO contracts that include five Certified Application Assistants, outreach and enrollment objectives. Includes annual increase of 3%.	\$30,000
Training - Training of community-based CAAs and others to enroll children into Medi-Cal, Healthy Families and Healthy Kids.	\$5,000
Marketing & promotional materials - flyers, brochures, posters, radio spots to publicize CHI. Development of promotional materials.	\$10,000
Eligibility determination - 1 FTE eligibility specialist (including fringe benefits) and salary & fringe increases totaling 3%.	\$18,000
Administration - 1.5 FTE administrative personnel (including fringe benefits) and salary & fringe increases totaling 3%.	\$43,750
Operating overhead - Supplies, phone, postage, travel, rent, etc.	\$0
Technical assistance - consultants for data estimation, strategic planning, RFP development.	\$10,000
Evaluation - Grant subcontract for planning and first six months.	\$10,000
Sub-Total	\$126,750
One-e-App: IT staff, hardware, consultants	
Feasibility analysis	\$50,000
Implementation	\$450,000
One-e-App Sub-total	\$500,000
Total	\$626,750

**This sample budget reflects estimated expenses for a period of Six Months prior to launch.*

Table 6.4
Sample Three-Year Global Budget

Budget item	Year 1	Year 2	Year 3	Total Global Budget
Premiums - This covers 1,000 children in year 1, then 2,000 in year 2 and 3,000 in year 3. Assumes \$90 PMPM in year 1 with no rate increase in years 2 - 3.	\$1,080,000	\$2,160,000	\$3,240,000	\$6,480,000
Outreach and enrollment initiatives - CBO contracts that include five Certified Application Assistants, and additional county staff for outreach and enrollment activities. Includes annual increase of 3%.	\$400,000	\$412,000	\$424,360	\$1,236,360
Hardship Fund - Premium assistance for families demonstrating financial need.	\$10,000	\$10,000	\$10,000	\$30,000
Training - Training of community-based CAAs and others to enroll children into Medi-Cal, Healthy Families and Healthy Kids.	\$20,000	\$10,000	\$10,000	\$40,000
Marketing & promotional materials - flyers, brochures, posters, radio spots to publicize CHI. Logo, website and promotional materials.	\$100,000	\$100,000	\$100,000	\$300,000
Eligibility determination - 1 FTE eligibility specialist (including fringe benefits) and annual salary & fringe increases totaling 3%.	\$72,000	\$74,160	\$76,385	\$222,545
Administration - 1.5 FTE administrative personnel (including fringe benefits) and annual salary & fringe increases totaling 3%.	\$125,000	\$128,750	\$132,613	\$386,363
Operating overhead - Supplies, phone, postage, travel, rent, etc.	\$30,000	\$25,000	\$25,000	\$80,000
Technical assistance - consultants for data estimation, strategic planning, RFP development.	\$5,000	\$5,000	\$5,000	\$15,000
Evaluation - Grant subcontract for planning and conducting three-year performance monitoring.	\$150,000	\$150,000	\$150,000	\$450,000
Sub-Total	\$1,992,000	\$3,074,910	\$4,173,358	\$9,240,268
One-e-App: IT staff, hardware, consultants. Implementation, including program customization, development of system interfaces and documentation, and IT support.*	\$150,000	\$150,000	\$150,000	\$450,000
Total	\$2,142,000	\$3,224,910	\$4,323,358	\$9,690,268

*Note that implementation of One-e-App is optional, and the cost can vary greatly from one program to another, based on existing IT capacity and other local conditions. Implementation can be estimated to cost between \$450,000 and \$1,000,000, and annual maintenance between \$120,000 and \$200,000.

Key Budget Assumptions

There are several assumptions that pertain to the sample start-up and three-year global budgets.

Start up budget:

1. Start-up expenses are typically underwritten by a few CHI partners and foundations to help build local program momentum. Between \$100,000 to \$150,000 will be needed for start-up expenses, not including One-e-App feasibility and testing.
2. The estimated cost for One-e-App testing and implementation is between \$450,000 to \$1,000,000, depending on the complexity of implementation, systems interfaces required, number of users and desired workflow process.
3. The estimated timeframe for pre-launch activities is six to nine months.

Three year global budget:

1. Outreach, enrollment and retention activities will be coordinated between county staff and community CAAs. Achieving seamless coordination among county and non-county staff that serve the target population will maximize enrollments in the Medi-Cal and Healthy Families programs. Budget estimates include equal allocations for county staff and certified application assisters and/or community outreach workers.
2. The Healthy Kids product will mirror the comprehensive scope of services provided by the Healthy Families program. It is assumed that CHIs will be able to negotiate premiums that are within 5% of the prevailing Healthy Families rates within the county or region.
3. Premium estimates will remain fairly constant over the first three years of the program, even if program expansion to different population groups is phased in over time. A blended per member per month (PMPM) rate may be negotiated for all children 0-18 or a number of CHIs are moving towards tiered rating for 0-5 year-olds (the most expensive children, most of whom will qualify for Medi-Cal or Healthy Families), and then 6-18 year-olds based on actual claims experience.
4. A number of line-items are largely fixed costs, including marketing/promotional materials, outreach and enrollment, eligibility determination, administration, technical consultation, evaluation, and One-e-App feasibility and implementation. Premium costs will vary based on the actual number of children enrolled in years one, two and three.
5. The planning and administrative costs (CHI program staff, administration, and technical consultation) will vary by governance structure and the existing capacities of the program's organizational "home" or sponsor.

7 | CREATING ONE OPEN DOOR FOR OUTREACH, ENROLLMENT & RETENTION

One Open Door: Family-Centered Outreach and Enrollment

Outreach informs community members about available programs and other social services and is the starting point for Healthy Kids program success. Outreach workers, who are also referred to as community health advisors, family support workers, and in some cases Certified Application Assistors (CAAs), are the frontline messengers to communities about the availability of insurance for kids through the Healthy Kids, Medi-Cal and Healthy Families programs.

Several CHIs have adopted “One Open Door” conceptual re-thinking of outreach and enrollment activities to maximize family access to the full range of available health and other social service programs, including Healthy Kids. In these counties One Open Door has framed a careful restructuring of existing outreach, enrollment and retention efforts across health and social service agencies as well as community organizations. These CHIs have worked with their county agency and community partners to move from a traditional social service “silo” culture to one that offers coordinated and streamlined assistance. This coordinated outreach and enrollment assistance model allows families to access all available programs through a single contact at a range of social service venues and community settings rather than working through a confusing and time consuming labyrinth of programs and redundant processes in order to receive specialized application assistance for separate programs.

One Open Door is only possible through the adoption of extensive and sustained two-way communication by all partners. Further, this model of service provision is a profound culture change for program-oriented staff and generally requires significant retraining of outreach and enrollment personnel in agencies and community-based organizations. Some level of retraining and job change may be required across all organizations involved with outreach and enrollment activities including county eligibility workers, benefits analysts, CAAs and other community-based outreach staff.

One Open Door Conceptual Framework

Objectives:

- Increase access to health insurance and eligibility approval rates
- Decrease time between outreach and coverage initiation
- Increase retention of enrollees in coverage
- Increase appropriate utilization of health services

Principles:

- Adapt agency cultures and processes to encourage cross-agency collaboration and information sharing
- Re-engineer systems to maximize efficiencies and funding
- Reallocate existing resources and identify new ones to support principles and meet objectives
- Make processes family friendly

Methods:

- Develop transparent and consistent application assistance
- Deploy single application and streamlined screening and enrollment
- Apply an easily reproducible application process across different sites and modalities
- Provide comprehensive training of application assistants and eligibility workers
- Streamline steps and coordination across programs
- Rely on proven outreach and in-reach strategies
- Ensure ongoing contact with covered individuals

Areas of Investment:

- Co-location of eligibility workers and benefits analysts
- Cross-training and retraining to ensure seamless referrals across programs and agencies
- Automation/Integrated, online application system (e.g., One-e-App)
- Retention and renewal efforts

Outreach Planning

Once a county has committed to streamlining outreach and enrollment it can begin to map out its strategies for doing so as Santa Clara, San Mateo, Alameda and other CHIs have done.

Target population identification

Pressure to maximize limited outreach funding may force CHIs to make choices about what populations to target and how extensive an outreach strategy to pursue. Knowing the demographics of target outreach populations in your community, particularly child coverage gaps by family income level and ethnicity, is critical in stretching outreach funds to maximum effectiveness.

In general, CHI outreach and enrollment strategies focus on two distinct populations:

- Children eligible for but not enrolled in Medi-Cal or Healthy Families; and
- Children ineligible for public programs without access to affordable private insurance, including:
 - Children with immigration concerns; and
 - Children from families with income at or above 250% FPL.

While distinct, these two populations are not separate. Many of the children who are eligible for Medi-Cal and Healthy Families but not enrolled are the siblings of children who are ineligible for those programs due, in large part, to their immigration status.¹ This is a particularly important consideration since estimates suggest that roughly two-third's of California's uninsured children are eligible for Medi-Cal or Healthy Families.² Coordinated outreach strategies for Healthy Families, Medi-Cal and Healthy Kids should be particularly effective in capturing many of these previously uninsured eligible children. In these mixed status families, parents are more likely to follow through on enrolling eligible children in Medi-Cal and Healthy Families since their ineligible children are able to apply to the Healthy Kids program. However, even a carefully coordinated outreach approach for these families will only be effective if conducted in a culturally appropriate manner. Communicating effectively with families with immigration status concerns requires relying heavily on word-of-mouth and working through known and trusted sources and organizations such as community health centers, family resource centers, schools, and migrant education programs.

Family income level is another major consideration in creating effective outreach and enrollment messages and approaches since family income level is highly correlated with access to private insurance coverage.³ Families with annual incomes above 250% of the federal poverty level generally are more likely to have been privately insured at some time and more familiar and comfortable with commercial health insurance marketing. Outreach to this higher income population may require more mainstream publicity generating activities, working with insurance brokers and employers directly, and a more extensive marketing budget. Additionally, this population is less likely to be reached at traditional safety net institutions in the community such as community health centers and human or social services agencies.

Inventory of Existing Outreach Activities

In keeping with their One Open Door objectives, some CHIs have worked from the beginning of outreach planning to ensure coordination with existing programs for children and families. Most CHIs have chosen to invite representatives from all entities planning or operating outreach activities for Medi-Cal and Healthy Families as well as other public programs to an orientation on the purpose of the CHI and to intro-

duce the Healthy Kids program.⁴ These meetings generally have included directors of the health and social services agencies, community clinic directors, public hospital community outreach managers, and representatives of the school districts as well as any other CBOs involved with outreach, such as labor and faith-based organizations. Most CHIs have found these introductory meetings highly useful in initiating collaborative communication across entities, identifying commonalities of interest and providing a comprehensive inventory of all outreach activities to families that may be modified to include Healthy Kids program outreach and access to other available programs.

Outreach Collaboration in San Mateo County

San Mateo initiated its Healthy Kids outreach planning by inviting all stakeholders to a kick-off meeting, including the Health Services Agency, Human Services Agency, county contractors, all school districts in the county, the county's legal aid society, labor representatives and others. Since that initial meeting, all participants have contributed to the Healthy Kids program's outreach success: legal aid agencies helped craft messages on the public charge issue that could be distributed to the community; labor organizations held outreach fairs and documented the experiences of the uninsured that the CHI has used in its outreach and marketing efforts; school districts and community based organizations have formed partnerships to more efficiently enroll families identified through the Request for Information sheets sent out by the schools; and county contractors have worked together to identify specific target populations and the best strategies to reach these populations. Convening these groups in a collaborative format allowed San Mateo to develop a multi-faceted outreach plan through a variety of channels to create a truly comprehensive outreach strategy.

Outreach Strategies

The major strategies used to expand health coverage to uninsured children and families are in-reach, general community outreach, and school-based outreach. This section provides a brief overview of these strategies and specific ways in which CHIs have deployed them.⁵

In-Reach and Joint-Outstationing Activities

In-reach activities identify and enroll into public programs children whose families are seeking services at a range of locations, including hospitals, social services agency district offices, community health clinics and other community-based organizations, and WIC and Cal-WORKS sites. These venues are targeted both because of the likelihood that a person who is seeking services there either for themselves or for a family member is income-eligible for public programs and because many of these organizations are trusted by the communities they serve.

Community clinics are particularly common in-reach locales because those who seek care at clinics have an immediate health need or concern. Clinics and other safety net providers generally have made identifying uninsured clients a central component of their registration proc-

esses and rely on on-site eligibility workers. WIC and CalWORKS sites are also effective locations for in-reach since both programs work with low-income families whose children are likely to qualify for Medi-Cal, Healthy Families or Healthy Kids. Eligibility workers at these sites provide families with information on available health insurance programs and assist interested families in applying for coverage. Some CHIs have created “tell a friend” brochures or personalized business cards for their outstationed application assistants to share with the families they assist. These brochures and cards are frequently passed along by families to their friends and neighbors.

Community Outreach

Getting the word out about the availability of health insurance in a way that families will trust and act upon is often a challenge. Common community outreach strategies that can be customized for specific populations include:

Promotoras: This form of community outreach relies on trained community residents to communicate with their neighbors about opportunities for health insurance for children. Known in Spanish as “promotoras,” these outreach workers are important information resources for communities reluctant to seek assistance through in-reach venues and unlikely to either ask outreach workers they do not know about eligibility requirements or to share confidential information with them. Several CHIs have deployed trained promotoras to increase enrollment and improve retention in county Medi-Cal, Healthy Families and Healthy Kids programs.

Early Focus on Outreach in Tulare County

Tulare County plans to launch its Healthy Kids program in Summer 2005 but began outreach efforts in July 2004. The Tulare County CHI’s Outreach, Enrollment, Retention and Utilization (OER) subcommittee developed strategies, relying in part on information from focus groups of targeted parents, to increase outreach, enrollment and retention of children in existing health insurance programs and eventually into Healthy Kids. One of their strategies integrates CAAs into county WIC program sites to provide on-site one-on-one application assistance, case-management and education about insurance programs. The Tulare Health and Human Services Agency streamlines the process by designating a specially trained eligibility specialist to process all Medi-Cal applications coming from WIC program sites. A second outreach strategy will place these CAAs in schools, Healthy Start, Head Start, Foodlink sites and other high yield locations in the county. A third strategy is to develop a promotoras program for very rural communities that includes door-to-door outreach and appointment setting for sites in their community.

Community events: Special community events such as Cinco de Mayo and the Vietnamese New Year, and community health fairs are ideal venues for outreach workers to answer questions, dispel rumors about

seeking insurance coverage, and identify those interested in pursuing applications for existing public programs and the Healthy Kids program. Several CHIs launched their Healthy Kids program outreach efforts at community health fairs where families could learn more about Healthy Kids, Medi-Cal and Healthy Families, and set up appointments with application assistants or, in some cases, receive immediate application assistance.

Written materials: Flyers that provide easy to understand information about all available insurance programs, including the Healthy Kids program, in Spanish and English (and other languages if indicated by community demographics), and telephone contact information with the appropriate language competency are another useful component of community outreach efforts. Local stores, restaurants, churches, and libraries will usually be willing to post flyers and have additional copies available for those who request them. In addition to local outreach worker information or application locations, flyers should include a CHI call center number or hotline. One centralized number, either an 800 number or local number, offers families a consistent way to get more information, have their questions answered or find out where they can receive assistance in their community.

Santa Clara's School Outreach Efforts

Santa Clara's CHI has been able to maximize its outreach funding through a careful and sustained collaboration with Santa Clara County school districts and individual school partners. The CHI initially worked with all of the county's school districts to inform them of the initiative and to identify individual schools and districts to partner with in an ongoing outreach campaign. CHI partners worked with each school or school district individually to tailor education, outreach and enrollment efforts to meet its needs and resources. Activities included surveying parents about whether their children were insured, as well as application events, and presentations to school staff.⁶

For more information on school-based outreach efforts in California, please visit the Consumers' Union Healthy Kids, Healthy Schools website at <http://www.healthykidsproject.org>.

School-Based Outreach

School-based outreach targets families with age-eligible children effectively. Major school-based outreach components include: (1) Request for Information (RFIs) flyers and health insurance surveys that are sent home with children and ask parents about their interest in obtaining affordable coverage for their children and other school mailings; (2) school-based events such as Back to School nights and Enrollment Fairs at which parents receive information from outreach workers about the availability of Medi-Cal, Healthy Families and the Healthy Kids program and can express an interest in applying; and (3) school liaison

programs. A fourth school-based outreach program, Express Enrollment, has recently been piloted in some California school districts as well.

RFIs and Surveys: These flyers and health insurance surveys are often sent home with the National School Lunch Application or in back-to-school packets along with letters explaining the importance of vision and hearing screenings or other health-related topics. Completed forms can be sent back to the district or can go directly to the county. Some schools post information on available insurance programs in the school newsletter and have flyers available in school and health offices.

School events: Schools can easily provide information on insurance coverage programs to parents during the many events they host during the school year. Back to School Nights, typically held in the fall, are a good opportunity to hand out information and discuss the need for health insurance with individual families. Schools also host events specifically for the parents of young children that provide a wonderful opportunity to educate them about the importance of health insurance while they're also learning about the necessity of immunizations and health screenings prior to kindergarten registration.

School liaisons and other strategies: Some CHIs work through a designated school liaison on school-based outreach efforts. In most cases, the liaison will be a health coordinator or school nurse. Many school districts already are engaged in outreach activities for Medi-Cal and Healthy Families, primarily in schools with high rates of uninsured students, and their efforts can easily be expanded to include Healthy Kids program information as well. Many school districts already bill through Medi-Cal Administrative Activities (MAA) for their Medi-Cal outreach activities.

Piloting Express Lane Enrollment

A total of five California school districts implemented Express Lane Enrollment in 73 schools during the 2003-2004 school year: Alum Rock Union Elementary in Santa Clara County, Fresno Unified, Los Angeles Unified, Redwood City in San Mateo County, and San Diego Unified. Complete results are not yet available on the success of the program, however preliminary results indicate that parents are excited about the program; it has not had a negative impact on the school lunch program; and of the school lunch applications received in most districts, about half of the children or an even higher proportion are already enrolled in either Medi-Cal or Healthy Families.

For more information on Express Lane Enrollment, please visit the Express Lane Eligibility website at:
<http://www.childrenpartnership.org/expresslane/index.html>

Health-e-App And One-e-App

- Health-e-App is a web-based system that allows families working with trained assisters to apply for Medi-Cal and Healthy Families over the Internet and receive preliminary eligibility determination. Healthy Families applicants can also select providers and health, dental and vision plans.
- One-e-App is a web-based system that interfaces with Health-e-App and allows families to apply for multiple programs through a single application. One-e-App can screen for a range of programs including Medi-Cal, Healthy Families, Healthy Kids, Food Stamps, WIC, Express Lane Eligibility, CHDP, and AIM.

Express Lane Enrollment: Express Lane Enrollment allows National School Lunch Program (NSLP) eligibility to serve as a proxy for Medi-Cal eligibility and provides temporary presumptive eligibility for those children who are deemed Medi-Cal eligible based on their participation in NSLP. The rationale behind the approach is that any child who meets eligibility requirements for NSLP will most likely be eligible for Medi-Cal because of the similarity of eligibility requirements for the two programs. Express Lane Enrollment outreach through the NSLP may prove particularly attractive for CHIs that have embraced a One Open Door approach because the NSLP is open to all children who meet the income criteria regardless of their citizenship or immigration status.⁷ Thus, with the proper information intake occurring locally, those children who meet all NSLP criteria could be quickly identified for the Healthy Kids program, while those applicants eligible for Medi-Cal and Healthy Families could be identified and presumptively enrolled in those programs. At present, the full potential of this approach is not available but there is a significant amount of research and advocacy underway examining the necessary legal changes and confidentiality concerns of immigrant parents and guardians.^{8,9,10}

Eligibility Determination, Enrollment, and Retention

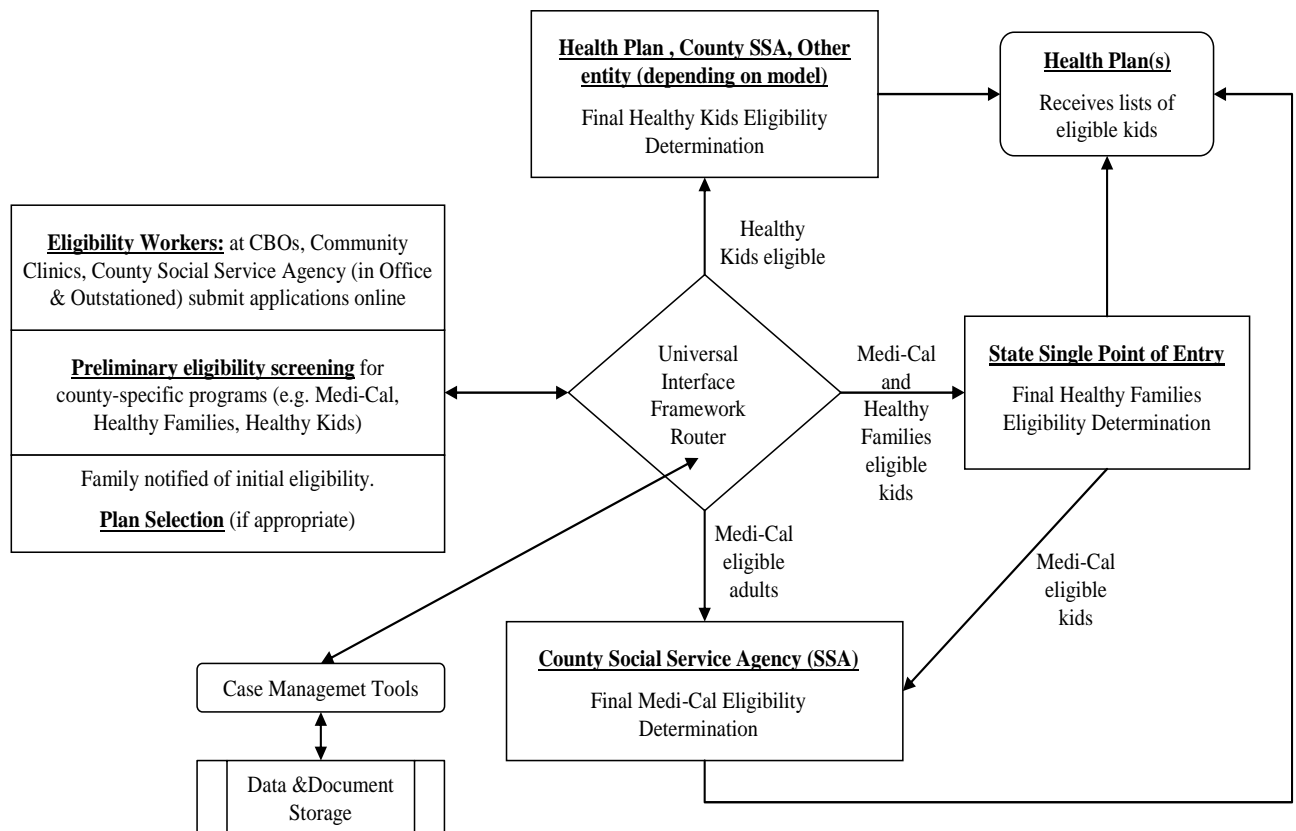
As part of developing a comprehensive strategy to enroll children in available programs, CHIs have focused on creating an enrollment process that conforms to One Open Door principles, is acceptable to all CHI partners, and maximizes available federal, state and local funding. While their operational approaches to eligibility determination and enrollment vary, all CHIs have developed processes that first funnel potential eligibles through careful Medi-Cal and Healthy Families screenings to ensure that only children ineligible for Medi-Cal and Healthy Families will be enrolled in the Healthy Kids program.

Training is an essential element in ensuring that screening and enrollment processes and eligibility determination for Healthy Kids program are undertaken in a consistent manner and that children who are eligible for Medi-Cal and Healthy Families are enrolled in those programs. Application assistors and eligibility specialists must be trained in the program details for all three programs, be able to steer families to the most appropriate program, and be able to fill out all program applications accurately to avoid delays in enrollment and denials.

Many counties have found that training efforts can also work to create a culture change among application assistors. CHIs have found that involving application assistors in the planning and implementation of new assessment and enrollment processes strengthens the program and eases job change-related discomfort. Asking assistors to identify problems they are experiencing with the new systems, potential solutions and ways to improve the families' enrollment experience often increases assistor satisfaction and commitment levels.

Establishing a quality assurance process also helps with early identification of flaws and programmatic inconsistencies. The David and Lucile Packard Foundation funded the County Outreach Retention and Enrollment (CORE) project to streamline enrollment and retention processes in children’s health insurance programs. Alameda, San Mateo, San Francisco, Merced, Stanislaus and Santa Cruz counties participate in the project and have relied on recognized quality improvement methods to strengthen the enrollment and retention processes within their control and to share information and best practices across counties.¹¹ The outcomes of this project have provided counties with improved practices resulting in increased enrollment and retention and reduced staff workloads. Additionally, Alameda County’s “No Wrong Door” pilot evolved out of their careful look at enrollment processes through CORE.

Figure 7.1
One-e-App Flow Diagram



Technological Advances

Applicants still have the option of mailing in paper applications or, working with a trained CAA or county agency employee, completing an electronic application (Health-e-App) that separately assesses their eligibility for the Medi-Cal and Healthy Families programs and electronically submits applications for the programs. The electronic Health-e-

App application has simplified and accelerated the eligibility determination process for applicants and those who assist them and has been a major improvement for those seeking entry into public programs. Some CHIs have overlaid a separate paper application process for the Healthy Kids program that is only completed if the applicant appears ineligible for Medi-Cal and Healthy Families. Others, including the San Mateo, Santa Clara, Alameda and Santa Cruz CHIs, have implemented or are in the process of implementing One-e-App.

Launching a Healthy Kids program creates an opportunity for integrating with the Medi-Cal and Healthy Families programs. This opportunity is fully realized through use of an integrated enrollment and eligibility determination process. IT planning and infrastructure considerations, and the decisions made by the CHI and its strategic partners, particularly the participating health plan and the Social Services Agency or Human Services Agency, are at the core of ensuring integrated enrollment and eligibility determination. One-e-App has been designed to interface with Health-e-App so that all those who apply using One-e-App are simultaneously assessed for eligibility for Medi-Cal for children, Healthy Families, and Healthy Kids. One-e-App can be customized to perform eligibility determination for additional public programs. One-e-App also creates a countywide database for tracking outreach and retention and provides other management tools as well. While the costs and complexity involved in developing a universal eligibility assessment system may require CHI counties to move forward slowly, the integration potential between the Medi-Cal, Healthy Families and Healthy Kids programs afforded by such an approach cannot be over-emphasized.

While the benefits of moving toward this approach are real and immediate with the program's launch, CHIs and their partners will need to be firmly committed to underwriting or seeking assistance in underwriting the costs of planning, hardware, local customization, and annual maintenance that are incurred in implementing the system. A CHI can expect to devote time to developing local requirements, working with strategic partners, and developing a detailed cost estimate for the project. Besides the obvious financial considerations, strategic partners may be concerned about what changes imposed on intake and eligibility determination procedures throughout the community may mean to their organization. These concerns may be particularly acute for the SSA where there may be concerns about the potential job assignment changes that will be required to support the new streamlined approach to eligibility assessment.

One-e-App offers the ability to track administrative, outreach and enrollment statistics with ease. Without such a system the CHI will need to rely on health plan databases for program tracking and monitoring information. Not all plans will have the necessary IT capacity to easily monitor and provide this information on a timely basis. For counties unlikely to be able to move toward developing an integrated enrollment

system, it will be important to focus on the data capture and reporting capabilities of their health plan partner.

In the absence of an integrated enrollment system, CHIs will need to rely on a series of manual and electronic eligibility intake and assessment processes to determine eligibility for the Medi-Cal, Healthy Families and Healthy Kids programs. Since some CHIs, at least in the short term, will not be in a position to implement One-e-App, it will be crucial to develop the most streamlined approach possible for sharing applicant information and ensuring that the necessary data linkages exist to facilitate eligibility determination and enrollment for Healthy Kids eligibles while also guaranteeing that any applicants who are eligible for Medi-Cal and Healthy Families are not incorrectly deemed eligible for Healthy Kids.

Implementing Healthy Kids and One-e-App in Santa Cruz

Santa Cruz decided to launch its Healthy Kids program and its use of One-e-App technology simultaneously after learning of Santa Clara and San Mateo's difficulties in converting from Healthy Kids paper applications to One-e-App. Rather than taking a sequential approach, Santa Cruz's pre-launch activities included customizing One-e-App software for its Healthy Kids program and training staff on its use.

To ensure the CAAs felt confident taking applications electronically, Santa Cruz County staff provided extensive pre-launch group and individual training on One-e-App, offering upwards of three trainings to the CAAs. Through their efforts, CAAs developed a high comfort level with One-e-App. All of Santa Cruz's CAAs now are confident about the process which requires them to fax a family's paper documentation into One-e-App and then work on the computer with the stored information to complete applications using One-e-App software.

When Santa Cruz went live in July 2004 all of its CAAs were completing online applications for families using the One-e-App technology. Santa Cruz CHI officials report that CAAs are pleased with the speed of the application process and report greater certainty that families are applying for the most appropriate program. Santa Cruz County's use of One-e-App has created a paperless application process for Medi-Cal, Healthy Families and its Healthy Kids program.¹² Santa Cruz implemented One-e-App in seven weeks from start to finish.

Any health plan that is already a Medi-Cal or Healthy Families contractor will have the systems capabilities to interface electronically with both the Medi-Cal and Healthy Families programs and their contracted intermediaries and receive eligibility information for new program enrollees. However, the linkages required to receive eligibility information for new Healthy Kids program enrollees may not exist.

If a CHI's Healthy Kids program eligibility determination will be done by the local social services or human services agency as it is being done in most operational CHI counties, then an electronic interface between the agency and the health plan is needed. If there is no existing electronic interface with the SSA, the CHI will have to work with the health plan and the SSA to create the linkage. It will be important to develop a link that easily communicates with the plan's information system. Creating this linkage may be a major technical hurdle of program implementation.¹³

Retention Strategies

Over time an operational Healthy Kids program's focus will change from outreach and eligibility determination to member retention. Renewal processes can dramatically and directly affect a program's retention rate. Programs should institute renewal policies and procedures that are both family friendly and easy to follow in order to retain eligibles in coverage. Most CHIs with effective retention strategies have incorporated the following principles into their renewal activities.

Renewal Simplicity

Make it easy and simple for families to renew. For example, mail out pre-filled renewal forms for parents to sign and return and include with every renewal form a local number to call and a site to visit if they need assistance with some aspect of renewal. This approach incorporates aspects of the simplification trend in renewal adopted by some state Medicaid and SCHIP programs.¹⁴

Built In Leniency

Design renewal and premium payment policies that give families some latitude in meeting deadlines. Start the renewal process early (three months before deadline) to give families time to respond. Create systems that contact parents when renewal forms have not returned by a certain date (prior to the renewal deadline) and plan to assist late-responding parents to help them retain their children's coverage.

Early and Frequent Communication

Determine what entity will take the lead for the renewal process and ensure that the entities performing outreach and enrollment activities are also involved. Contact families through different venues: mail out forms and reminder postcards; call families who have not returned renewal forms; and post flyers throughout the community with information on how and where to renew. If a CHI decides to collect information at renewal time, communicating what is needed to the families becomes incredibly important. Suggestions to create an effective mail-in renewal form include formatting the renewal form as a checklist where parents can check off all of the information they are required to submit; sending renewal forms home in a color envelope and printing the forms on color paper to attract attention; enclosing postage-paid, self-addressed envelopes in the renewal packet; and sending reminder postcards two weeks before and two weeks after the renewal forms are

Improving Service Utilization and Retention: The Role of the Santa Clara Call Center

In January 2003, Santa Clara Family Health Plan (SCFHP) implemented dedicated outgoing and incoming call centers into its Healthy Kids program to encourage appropriate health care service utilization and enrollee retention. Outgoing call center staff conduct call campaigns about proper utilization and remind families to return their children's renewal packets. Separate call center staff receive inbound Healthy Kids calls from the plan's 800 number.

Member Services contacts families immediately prior to their insurance becoming effective to verify and update contact information, assist families in choosing a doctor, inform families of premium payments and renewal process and to encourage them to go to a new member orientation. Call centers provide a good opportunity to answer a family's questions, assist them in accessing services and remind them of available resources.

At renewal time, SCFHP sends out two rounds of renewal packets, 75 and 45 days prior to a child's annual renewal date. Renewal forms are pre-filled with data currently in the Plan's Healthy Kids database, families just have to update this information. If families do not respond to those mailings or if they submit incomplete packets, the call center contacts the families during the month prior to the family's termination date. The first call is made 30 days prior to termination and if no response is received, another call is made two weeks before termination. During the final week before termination additional calls are made to families who have not yet responded encouraging them to go to an enrollment site and complete the renewal form. Call center staff are fluent in Spanish and Vietnamese and telephone interpreters are available for those who speak other languages.

mailed.¹⁵ Ensuring that families receive renewal forms that are language appropriate will expedite the renewal process and prevent children from being inadvertently disenrolled.

Frequency of renewal requirements also affects retention levels since more frequent renewals increase a child's chance of disenrolling through accident or oversight. Short renewal periods also increase a CHI's administrative burden. Most CHIs have opted for an annual renewal period for their Healthy Kids programs consistent with Medi-Cal and Healthy Families policy but at least one, Los Angeles, has selected a six-month renewal period.

Premium payments and the systems and policies set up around this issue will also have an impact on retention. Monthly premiums provide a consistent means of staying in touch with a family but also increase the chance that the family may not pay their premium and will disenroll. Having less frequent premium payments eases the burden on the families and promotes continuity of care as well as decreasing the administrative burden of the CHI in processing premiums. Some CHIs have set up incentives for families to pay their premiums in one lump sum with

offers of paying for the first three quarters of the year and receiving the fourth quarter for free. Making it easy for families to pay their premiums, by providing premium payment coupons, for example, will also help with retention rates. Establishing a hardship fund for families who are unable to pay their premiums and publicizing it will help to ensure continuous coverage for the most needy.

In addition to creating policies and procedures that assist the family in maintaining coverage, using the same One Open Door approach that was successful in outreach efforts can also work in member retention efforts. Ensuring that every application assistor can help families with the renewal and that all partnering groups – the social services agency, CBOs, schools – are kept up-to-date on the renewal process, policies and how to assist families in keeping their children covered is critical. The outreach strategies the CHI developed—in-reach, promotoras, joint outstationing of application assistors—can also be used to inform parents about the importance of renewing their child’s insurance and provide assistance with the renewal process. Because of their member-friendly approach, outreach workers who maintain communications with applicant families can play an important and cost-effective role in member retention. For example, through callbacks to enrolled eligibles outreach workers can: remind families to pay their premiums; make sure that children receive all appropriate preventive and age-appropriate diagnostic services; and provide a linkage to other information that eligibles may require, such as how to request a deferment on premium payments due to a change in job status.

A tracking system provides a CHI with critical information about why and when enrollments occur. Knowing what percentage of children disenrolled for avoidable reasons allows the CHI to take steps to better work with families to retain their children in coverage. Many operational CHIs track a variety of disenrollment categories on a monthly basis, including: age-outs, failure to pay premiums, moves out of county, change in income, and unable to contact. Outreach workers and application assistors may also be able to offer valuable insights into reasons for disenrollment and ways to increase retention.

1. Lessard G and Ku L. Gaps in Coverage for Children in Immigrant Families. *The Future of Children* (Spring 2003) 13(1): 101-115.

2. Brown ER, Ponce N, Rice T, and Lavarreda SA. *The State of Health Insurance in California: Findings from the 2001 California Health Interview Survey*. Los Angeles, CA: UCLA Center for Health Policy Research, June 2002, p. 46.

3. Brown ER. Trends in Health Insurance Coverage in California, 1989-1993. *Health Affairs* (Spring 1996) 15(1): 118-130.

4. As described in earlier chapters, these organizations also play important early and continuing roles in other CHI planning activities.

5. A more detailed and comprehensive discussion of these strategies will soon be available from the Consumer’s Union.

6. See the Santa Clara Family Health Plan's website at <http://www.scfhp.com>.
7. The Head Start program is similar to the NSLP in not requiring proof of legal status of applicants. Thus, it could be another valuable conduit to coverage for CHIs. However, additional adaptations and changes to current rules would be required before the benefits of Head Start express lane eligibility would be realized.
8. See The Children's Partnership's Express Lane Eligibility website at <http://www.childrenspartnership.org/expresslane/index.html>.
9. See Consumers Union's Healthy Kids, Healthy Schools website at <http://www.healthykidsproject.org>.
10. See the Center on Budget and Policy Priorities website at <http://www.cbpp.org>.
11. See the CORE: County Outreach Retention and Enrollment website at <http://www.coreproject.org>.
12. The process is only paperless once all the collected hard copy information is faxed into the system.
13. Alternatively, it may be possible for health plans to assume the role of determining program eligibility in counties in which the social services agency or human services agency is unwilling to become involved in eligibility screening for Healthy Kids.
14. Testa K, Mohamadi L, Horner D, Lazarus W, Richards J, and Finocchio L. *Children Falling Through the Health Insurance Cracks: Early Observations and Promising Strategies for Keeping Low-Income Children Covered by Medi-Cal and Healthy Families*. Oakland, CA: The 100% Campaign, January 2003.
15. Lake Snell Perry & Associates. *Retaining Eligible Children and Families in Medicaid and SCHIP: What We Know So Far*. Literature review conducted by LSPA for *Covering Kids & Families*, a national program of the Robert Wood Johnson Foundation, June 2003.

8 | PLAN & ADMINISTRATIVE VENDOR SELECTION

Selecting Accountable Plan Partners

Publicly administered and owned health plans such as local initiatives and county organized health systems are community-oriented organizations uniquely suited to operating CHI-created Healthy Kids programs. These plans are already invested in their local community's health and access to care, are generally at the center of most community health projects, initiatives, and campaigns, and are under the oversight of governing boards with specified local representation requirements.¹ These characteristics mean that local public plans are also more likely to participate in new ventures with real value for the community but with minimal or no profit potential, as long as the venture will not imperil their financial solvency. In contrast, while commercial health plans may be excellent community partners with a proven interest in a community's well-being, they are less likely to be able to enter into or to continue to operate a line of business that is unprofitable or insufficiently profitable over time.

Several of the second generation CHIs planning to launch Healthy Kids programs may be able to partner with a local public plan that is expanding its Healthy Families service area. These counties will have many of the favorable administrative start-up conditions of the operational CHIs.

CHIs unable to partner with local public plans will need to contract with a commercial plan or plans that have demonstrated a strong performance track record and a sound reputation in the local community. CHI governing boards will need to oversee the process for selecting a commercial plan partner or partners to provide the new Healthy Kids product. Fortunately, there are some inherent operational advantages for CHIs that partner with commercial plans. One of these advantages is that commercial plans will have in-house systems, capacity and experience to bill and collect family premiums. This capability means that commercial plans will also have the ability to engage in pro-active renewal processing.

In searching for a commercial plan partner or partners, CHI governing board members and staff should first identify which health plans contract with the Healthy Families and Medi-Cal programs since there are many practical reasons for partnering with Healthy Families and Medi-

Cal participating plans. However, CHIs should also investigate how a plan's public program participation is locally regarded as well as its track record according to state and federal assessment activities and reports.

As discussed previously, many Healthy Kids enrollees are undocumented or in mixed status families. These families generally have had limited interaction with a community's mainstream providers and will be most comfortable in a plan that includes familiar traditional and safety net providers. Since both Medi-Cal and Healthy Families participating health plans are contractually required to have provider networks that include traditional and safety net providers, they may increase a mixed status family's comfort level in accessing preventive as well as other types of services.

A third advantage of contracting with a health plan that participates in public programs is that it may enable children in mixed status families to establish a relationship with the same primary care provider. Plans that participate in public programs also offer provider continuity for children who may lose eligibility in one program and become enrolled in another. For example, a child from a family whose income surpasses the 250% FPL threshold for Healthy Families, but remains below the income cutoff for Healthy Kids, could continue to see the same provider after being disenrolled from Healthy Families and enrolled in Healthy Kids.

This ability to transfer a child between programs without changing providers is also a clear advantage from the health plan's and provider's perspective since it allows them to retain enrollees whose program eligibility changes, as well as decreases the likelihood of unnecessary health care expenditures or inadequate care management during periods of ineligibility. As a consequence, commercial plans that otherwise would be reluctant to take on a relatively small number of Healthy Kids enrollees (because of the organizational and administrative fixed costs associated with launching a new line of business) may be more inclined to contract with Healthy Kids enrollees if their costs may be offset through increased volume in their Healthy Families line of business.

The fourth advantage for CHIs to contract with participating Healthy Families and Medi-Cal plans is that these plans should already comply with guidelines set by the Centers for Medicare and Medicaid Services (CMS), the State's Health and Human Services Agency, the Managed Risk Medical Insurance Board, and the Department of Managed Health Care. In general, plans successfully meeting these compliance requirements should have the capacity to meet CHI-determined performance standards in delivering health care services to Healthy Kids subscribers. These standards would be set by the governing board and would likely focus on plans' performance on the Health Plan and Employer Data Information Set (HEDIS), the Consumer Assessment of Health Plan

Survey (CAHPS), and in some cases, National Committee for Quality Assurance (NCQA) certification.

A final reason to contract with health plans that have public program experience is that they generally already have the infrastructure and capacity to administer a Healthy Kids program. Plans that already participate in Medi-Cal, for example, are more likely to have an established system interface and protocols in place with the local Social or Human Services Agency to exchange data on enrollments and renewals. This interface could be expanded to include appropriate data exchange of Healthy Kids subscriber information as well.

While plans participating in public programs will already have some traditional and safety net providers in their networks, their networks may need to be further expanded to meet geographic or other types of requirements of Healthy Kids enrollees. CHIs should assess each plan's provider capacity prior to beginning conversations with prospective health plan contractors. This initial provider capacity assessment is also the time to ask different types of providers—in particular safety net providers—about their reimbursement and claims experience with each health plan; their answers will provide important information about children's access if enrolled in a specific health plan.

Soliciting, Evaluating and Negotiating with Accountable Health, Dental and Vision Plans

Once a CHI's potential health plan partners are identified and an initial provider capacity assessment is conducted, CHI governing board members will need to select the organization or organizations to lead health plan contracting for the Healthy Kids insurance product. This activity will require a well-established governing board with roles of key parties clearly defined (See Chapter 3). While the responsibilities for plan selection tasks can be divided in a variety of ways—among CHI staff, governing board members, external consultants or some combination thereof—it is strongly recommended that CHI board members and staff be an integral part of this process. Effective governance and program management hinge on a comprehensive understanding of the expectations and operations of the health plan and administrative contractors.

The governing board will also need to discuss and agree on specific arrangements for coordinating outreach between the health plan(s), the Social Services or Human Services Agency, and community-based organizations. Agreements between the health plan, the Social/Human Services Agency and those organizations already involved in outreach and enrollment will need to be made prior to the launch of the program. Certain program restrictions are already in place under Medi-Cal and Healthy Families for health plans to conduct outreach. An understanding of these restrictions will ensure that those in charge of coordinating outreach will craft program policies that work for the health plan and the community-based organizations engaged in outreach activities.

Preliminary steps to successfully negotiating and contracting with plan partners are (1) an identification or inventory of the full range of functions that may be performed by the health plan and (2) an evaluation of the advantages and disadvantages of performing various functions in-house versus through external contractors. There is no single “best” way to contract with commercial health, dental and vision plans, as individual county or regional conditions may often determine which approach is most appropriate. A major goal in soliciting a health plan or health plans to provide the Healthy Kids insurance product is to generate interest among a number of contractors. This goal is more likely to be met if a CHI uses a lengthier and more flexible process.

The RFP and RFI Processes

The CHI governing board will need to decide whether to issue a single Request for Proposal (RFP) for a health plan to manage the medical, dental, vision and behavioral health benefits for the CHI, or to issue separate RFPs for medical and behavioral health, dental, and vision care. By issuing a single RFP for a bundled benefit package, a CHI will streamline its responsibility in overseeing multiple contracts, but may limit flexibility in determining the price and terms for each set of benefits. In a bundled benefit scenario, the health plan will assume the financial risk for the entire per member per month (PMPM) premium. If the governing board chooses instead to issue separate RFPs, CHI staff will be required to manage multiple contractual arrangements but will have more flexibility in determining the terms of each contract. If the CHI has the staffing and administrative capacity for the second option, issuing separate RFPs ensures that specific attention can be paid to the scope of services and performance of each plan.

The health plan solicitation process can be conducted in various ways, including through issuance of Requests for Qualifications (RFQs) and/or issuance of RFPs.

An RFQ can:

- Notify health plans of the program’s purpose and intent. Health plans with an interest in administering a Healthy Kids program will need time to conduct their own strategic planning process, assess the compatibility of the business opportunity, and determine the extent to which their infrastructure will require modification to handle the new line of business.
- Solicit information on potential health plans and their level of interest in the program. For example, an RFQ can identify which plans are serving specific health care market segments and communities and in which geographic locales and zip codes.
- Establish an early communication link with the plans. Potentially interested plans may be more receptive if they are initially approached informally through an RFQ. It creates a more relaxed atmosphere within which a CHI selection team may explore competi-

bility with specific health plans and solicit valuable insights from plans that may not be sufficiently interested to respond to a more formal RFP process.

AN RFP can:

- Provide a more comprehensive set of qualifications with which to assess plan capability. A satisfactory RFP response will be a formal health plan bid and will contain a complete listing of plan capabilities and relevant relationships and business ventures. A full proposal will provide necessary regulatory health plan information such as licensure and solvency information; service area data; cultural and linguistic competency standards; willingness to comply with and relevant experience in meeting program parameters and contract language. Additionally, a responsive bid will include a premium quote for a specified set of services.

The RFQ and RFP processes can be combined. A combined approach can reduce the time frame within which to assess and select a plan partner but may be riskier for a CHI than a more protracted process. A shortened and more intensive process may reduce the pool of potential partners earlier in the process and thereby more greatly restrict a CHI's ability to negotiate on price and other considerations. Health plans are unlikely to provide premium bids until they fully understand program specifications and feel that they are both very interested in and very likely to be awarded the contract.

Crafting an Effective Multi-step Process

For the reasons stated above, CHIs should invest the time necessary to conduct a thoughtful multi-step process. These steps include:

- Establish an independent evaluation committee. Prior to sending out an RFP, the CHI governing board will need to designate an independent evaluation committee. This committee will need to decide how to operationalize the CHI's objectives into evaluation criteria. Clear, consistent and objective criteria for evaluation will simplify the proposal evaluation process.
- Issue the RFP, including an RFP questionnaire. The RFP questionnaire is designed to ensure that a health plan or plans have the management expertise to perform the functions required by the CHI, and that there are no organizational conflicts that may represent a conflict of interest. Most RFPs also ask health plans to name the individuals with primary responsibility for health plan activities associated with the CHI. See text box on this page.
- Designate a comment period and invite potential applicants to a bidders conference. RFP release should be followed by a clearly defined comment period. Plan to hold a bidder's conference at which RFP questions will be presented by potential bidders and

Topics to include in an RFP questionnaire

- Information about the health plans' ownership and management
- Approach to account management and identification of key individuals responsible for reporting to the CHI governing board and staff
- Financial information
- Nature and extent of current business in the county
- Provider network characteristics
- Experience performing necessary functions, such as:
 - Claims administration
 - Utilization management
 - Quality assurance
 - Referral management
 - Grievance resolution
 - Member services
 - Data analysis and reporting
- Sample of selected materials (for example, performance report formats, quality assurance, and provider profiling reports)

written or verbal answers can be given by the program sponsors either on-site or later after any needed additional research or analysis is conducted.

- Revise the RFP. Rely on information and questions received during the comment period and bidder's conference to refine the RFP.
- Issue the final RFP and request premium quotes. Based on input received from the health plans and others, the program sponsors can issue the final RFP, which will serve as the bid document for health plans. Health plans should respond to all RFP items by a specified date.
- Identify finalist plans using a formal bidder assessment process.
- Negotiate and sign contracts with the health plan(s). To the extent the CHI intends to be an aggressive purchaser, the final negotiations center around the organization's willingness to meet price, performance standards, and other criteria as defined by the CHI.

Assessing Provider Networks

A coverage program that focuses on wellness, preventive and primary care requires a strong primary care network. However, access to quality dental providers is another major area of need for Healthy Kids target populations. The RFP process should gather sufficient information about both medical and dental provider networks to comparatively assess each bidding plan's health and dental provider network strengths and gaps. RFPs should require plans to demonstrate linkages with safety net providers as well as private physicians and dentists with open and accessible practices. Specific RFP questions should include the total number of physicians and dentists by specialty with open practices, geographic distributions (by zip code), percent board certified, percent that have faced any formal sanctioning for practice irregularity or not meeting practice standards of care, and turnover rates.

Summary data tables will be critical components of both health and dental plans RFP responses. Requested summary tables should include distributions of primary care physicians, specialists and dentists by geographic region (zip codes) and listings of current enrollees by zip code. When compared, this summarized data should quickly provide reviewers with a sense of a health plan or dental plan's network strength and any gaps. Plans that respond by submitting provider directories should not be considered fully compliant with the data request since it will be more difficult for CHI staff to make plan to plan comparisons relying on directories. Additionally, directories are unlikely to be as current as data provided by the plans.

Assessing Quality Assurance and Management

A number of different topics fall under the category of quality assurance and quality improvement. Quality management activities are designed to:

- Support the provision of necessary care in a high-quality, efficient manner;
- Eliminate unnecessary and inappropriate care;
- Systematically assess the intermediate and final outcomes of care; and
- Promote consistency in medical practice.

Questions in this section of the RFP will cover the health plan's credentialing and recredentialing of network providers, development and use of practice parameters and clinical protocols, routine tracking of key indicators of quality for process and outcomes of care, and quality management program evaluation activities. An important quality consideration is the plan's data collection and reporting systems for quality assurance. The RFP should include questions about quality information management systems, including the ability to produce routine and customized reports. Most CHIs require that the administering plan comply with the audited clinical quality measures issued by the National Committee on Quality Assurance (NCQA) Health Plan Employer Data and Information Set (HEDIS), and age relevant HEDIS measures for children ages 0-18. Health plans have also been asked to comply with the most recent recommendations of the American Academy of Pediatrics (AAP) for preventive pediatric health care and the Recommended Childhood Immunizations Schedule/United States, adopted by the Advisory Committee on Immunization Practices (ACIP).

Assessing Health Plan Information Systems Capability

CHIs should carefully scrutinize the specific information systems (IS) capabilities and performance record of potential health plan partners prior to making a final partner selection. Data collection and the evaluation of health plan performance and outcomes are paramount to the CHI governing board's ability to be accountable to funders and coalition stakeholders. While this chapter lists a number of critical performance aspects to consider prior to plan selection, insufficient system capacity and too few skilled IS staff to manage system expansions or revisions will severely impede other aspects of plan performance. In determining plan systems capability, key performance areas to investigate include:

1. What are the plan's existing administrative function system capabilities and what types of data reporting and data exchange information does the plan's IS department manage on a regular basis?
2. Does the plan now do any premium collection? And if so, how does the plan propose to incorporate premium collection processes and ensure that they are technically supported?
3. What new functions will the plan need to add to its existing system functions to service the Healthy Kids line of business?

These issues are particularly critical to explore with plans with minimal public program experience. For while commercial plans are likely to have extensive premium collection experience and dedicated systems to support this business function, some plans may have less experience with providing the more extensive member service-related functional capabilities of plans that specialize and/or have long time experience with Medi-Cal and Healthy Families. Make sure to inquire about specific member service and related reporting and member assistance requirements for Healthy Kids that are not typically offered to commercial enrollees.

4. Does the plan have experience establishing a new line of business?

This is a critical area to explore with a potential contractor. There must be comfort in the plan staff's ability to troubleshoot information system start-up problems as they arise such as inability to receive critical new member-related information on a timely basis. Ask the plan to specify their process for identifying and resolving processing and information-exchange system problems. Furthermore, the process will be several orders of magnitude more involved if plans are expected to conduct eligibility determination for Healthy Kids program applicants. This systems area will need particular scrutiny and will require careful coordination with IS and other plan staff to ensure appropriate programming and staff training and careful implementation oversight.

5. Does the plan already have an electronic interface with the local Social Services Agency?

This is another critical IS capability area to explore with plans with minimal public program experience. Some of the Medi-Cal plans will already have an electronic link to the Social Services Agency through which information is already exchanged on a regular basis. However, plans without public program contracting experience are not likely to have the same existing interface capabilities. Creating these linkages will be technically challenging and require health plan IS staff to develop new system protocols and testing procedures.

Member Services

The governing board, staff and/or key subcommittee members will want to assess the capacity of the health plan to identify and directly address issues such as linguistic and cultural competency and access, consumer problems and the health plan's ability to respond to the CHI's concerns about member services.

The RFP questionnaire should elicit descriptions of the plan's formal and informal problem-identification and problem-solving processes. Other related items that might be included in a questionnaire are telephone response rates (for example, abandoned call rates and average wait time), customer service staffing levels (including customer or member services to member ratios) and staff qualifications.

RFP specifications should also clearly identify any particular CHI requirements for coordinating with consumer ombudsman activities. The division of labor between the CHI and the health plan for resolving consumer complaints should also be established prior to contracting. Other specifications may include requirements for tracking and reporting consumer complaints and their resolution.

Obtain Premium Valuation for Benefits

Once communications with the health plans are underway, the CHI may want the services of an actuarial consultant to determine a premium valuation for the proposed benefits package. Actuarial valuation of the benefits will enable the CHI to establish internal premium targets against which it can evaluate plan price proposals.

Financial Solvency

CHIs must assure that health plan bidders have sufficient resources and financial reserves to carry out the proposed programs. CHIs can rely on the Department of Managed Health Care and the Department of Insurance for assurances of financial integrity, because state licensure ensures that an HMO or insurer has met specified financial solvency requirements. However, it is also recommended that RFPs request a complete set of financial statements for at least the two preceding years.

Other Key Factors

Information about less tangible health plan characteristics can also be critical factors in the negotiating and contracting process. For example, a plan's willingness and ability to forge a satisfactory working relationship with the CHI governing board and staff may override concerns about the plan's capacity to provide certain functions (although if these are mandatory functions there should be an agreement about the plan's intent and timeline for increasing their capacity to provide these functions later on). With a solid working relationship, the CHI can work with the health plan to improve performance over time. Some suggested questions to better gauge these areas of compatibility include:

- Are you willing to incorporate specific quality and performance standards into a multi-year contract?
- Who do you think owns the data related to Healthy Kids members?

Making the Final Selection

The evaluation committee will develop and rely on a matrix of general evaluation criteria to score final proposal submissions. This matrix should include a scoring range by topic area or component to ensure comparability across committee members. Recommended evaluation criteria include:

- capacity to perform functions (short and long-term);
- quality of services;
- business philosophy and compatibility with CHI's objectives;
- experience;
- flexibility and responsiveness;

- willingness to financially partner;
- capacity/willingness to coordinate with other CHI partners;
- price and willingness to include competitive annual rate caps; and
- financial solvency.

It is important not to underestimate how time-consuming the selection process can be. Proposals are lengthy documents and the matrix and scoring process and range will assist evaluation committee members in comparing health plans (assuming there is more than one) on a number of qualitative and quantitative characteristics. This matrix and scoring process will also help identify gaps in information about individual plans and assist the committee in presenting a clear recommendation to the steering committee.

Final Contract Negotiations

Once health plans submit bids, the next step is to set up meetings with individual respondents. These meetings allow the evaluation committee to clarify any remaining issues and evaluate the more qualitative aspects of each proposal. Plan respondents generally find it helpful to receive some specific guidelines for their presentation before the meeting. For example, the evaluation committee may ask all finalists for a step-by-step accounting of how they intend to implement the program within a specific timeframe. Presentation guidelines also may address any specific concerns about a plan.

Face to face meetings are recommended as they offer the evaluation committee crucial insights into the health plans' philosophy, capabilities and credibility. Health plans' willingness and ability to work with the governing board, staff, Social Services Agencies, outreach contractors and administrative vendor can make or break a contracting relationship.

Responses to the proposals and meetings with finalist health plans can shed light on additional modifications to the model contract. Due to concerns discussed earlier in this chapter, it is recommended that the evaluation committee request a multi-year contract with caps for maximum annual rate increases. Most operating CHIs have settled on a blended PMPM rate for the 0-18 population, but several are moving toward a tiered rate approach with rates negotiated by age categories based on actual enrollments. Typically CHIs sit down with each health plan and negotiate price individually along with other items that vary from plan to plan.

The timeline for solicitation, negotiation, and contracting varies depending on whether the CHI is contracting with a qualified health plan or health plans versus working with a health plan that is not already in the market and a Medi-Cal and Healthy Families provider. In general, three months is the minimum period of time to allow and six months is usually adequate. Some parts of the process, including a health plan's

RFP response period, cannot be condensed beyond a certain minimum amount of time without compromising the number and quality of responses.

Soliciting and Evaluating Potential Administrative Vendors

Once the roles and responsibilities of CHI partners are clarified, it will be necessary to decide how core administrative functions will be handled. If the governing board has the option of contracting with a Medical and Healthy Families participating health plan, many of the administrative functions may also be contracted to the health plan within the prime contract. However, a CHI may choose to hire a third party administrator (TPA) to handle core administrative activities such as premium collection, member renewal, quality assurance and fraud detection.

Core administration tasks may require specialized skill and capacity. For the contracting entity that already possesses the administrative capacity to perform these functions, contracting out for these services can be more expensive and a waste of resources. Conversely, program sponsors with limited administrative capacity will benefit from contracting for these services with a third-party administrator or insurer.

A CHI may choose to implement either an RFP or RFI process for the reasons discussed earlier. Because administrative vendors vary widely in their capacities and relative strengths, it is recommended that clear selection criteria and an independent panel be established for vendor selection and negotiation. Administrative vendors typically need at least one month to respond to an RFP (depending on the size of the responding organization) but may respond more quickly to an RFI.

Following is a short list to use in evaluating potential vendors:

- Technical expertise and capacity;
- Flexibility and willingness to work with other contractors/parties;
- Track record and experience administering similar programs within and outside the state; and
- Cost.

The operational CHIs have chosen to contract with their health plan partner to provide the full scope of administrative services. As a result, this guidebook provides general information about the third party administration selection process rather than CHI-specific experience to date. More information may be forthcoming on this topic area as the next generation of CHIs transition from planning to implementation.

Advantages of Contracting Out for Administrative Services

- Setting up a CHI administrative system can be complex and time-consuming. A number of potential contractors already have systems that can be put into place with relative ease.
- Since potential contractors have already expended the capital costs of developing systems to administer a CHI, new CHIs can contract for services at the margin and not assume the costs of initial capitalization.
- Administrative systems are also expensive to maintain, and many contractors have had experience in improving and debugging systems over time.

1. Hurley RE and Rice C. *An SOS for COHS: Preserving County Organized Health Systems*. San Anselmo, CA: Pacific Health Consulting Group, May 2004

9 | EVALUATION

Evaluation Considerations and Options

There are three primary reasons for CHIs to evaluate their programs. First, most funding is “outcomes-based.” Over time funders will opt to support programs with tangible results and likely will withdraw or reduce funding for programs that have been unwilling or unable to demonstrate their value. Second, improvement based on performance assessment is a necessity for programs seeking to maximize their operational effectiveness within a given resource level. And third, evaluation results will be critical to the goal of creating a statewide program to guarantee insurance access for all of the state’s children by serving as the “proof” offered to legislators and other decision makers that insuring California’s kids is both possible and practical.¹

Audiences for CHI evaluations include program funders and those considering becoming funders, program administrators and staff, partner organizations, other CHIs and Healthy Kids programs, local government officials, and state and federal policymakers. Typically, these various audiences will want to know different types of information yielded by evaluation. Most funders and policymakers will be interested in outcomes, the potential for broader program replicability and expansion, and other policy implications. Program staff and partner organizations will be most interested in “best practices” type information for program improvement purposes. Other CHIs will look to Healthy Kids program evaluations to determine what they may incorporate or change in their own programs or how they may revise or refine their own evaluation efforts.

Evaluation can be a major undertaking that requires a significant proportion of a CHI program’s resources or it can be a more limited examination of specific performance-related or other program monitoring issues. Both the scope and types of evaluation activities a CHI undertakes can be scaled to meet objectives set by CHI funders and other interested or locally involved parties. Certain types of evaluation research will be too costly for CHIs to undertake without additional funding. Nonetheless, some level of evaluation activity is a necessity for every CHI – even those with limited funds.

Early Evaluation Planning is Essential

Evaluators spend a tremendous amount of time and effort assessing: (1) what program activities, objectives and impacts to evaluate; (2) the reliability of the various available data sets; and (3) how best to capture additional credible and consistent data with which to measure program impacts and conduct other types of analysis. In some situations, data collection may be prohibitively expensive. In others, quantifiable data may just not exist in a verifiable format. Evaluations become much more difficult to conduct when evaluation planning commences after program design and implementation have occurred and the opportunities to collect various types of “baseline” or pre-implementation data have disappeared. For this reason, evaluation planning should be incorporated into early program design and budgeting discussions.

During these early planning discussions CHIs should assess their interest in and ability to pay for an evaluation of their program. CHIs that opt to conduct their own program evaluations should know that there are real costs associated with performance monitoring and other targeted types of assessment. Depending on the number of services, encounters and other data tracked and the types of measurement used, performance monitoring may cost anywhere from \$50,000 to \$100,000 annually. Combined with other assessment components that a CHI may want to include, such as a small survey or focus groups, as well as a summative report and presentation on the findings, the total cost for an internally conducted assessment may end up costing between \$100,000 and \$200,000. The cost may be difficult to calculate with complete accuracy, however, because of reliance on staff.

It is important to ensure that what a CHI proposes in terms of evaluation design and data collection and analysis will meet the expectations of its partners and the requirements of its funders. Typically, the more rigorous and broad in scope an evaluation, the higher its costs and the greater the credibility of its findings. When it seems likely that funders or other parties will not be satisfied with what is being proposed, a CHI may want to consider other options such as being part of a collaborative research project that will enable it to share data collection and analysis costs with other CHIs or seeking additional funds with which to hire an experienced external evaluation team. For example, the Santa Cruz CHI plans to expand its internal Healthy Kids program monitoring activities by teaming with other CHIs to conduct a collaborative survey of enrollees. That broader survey effort will be informed by a smaller survey to be conducted by an outside survey group funded by the California Health Care Foundation.

What to Evaluate

Not all CHIs will either need or want a comprehensive program evaluation. Most comprehensive evaluations incorporate process and descriptive analyses and a range of quantitative data-based analyses. Compre-

hensive evaluations require both qualitative and quantitative data for use in a range of analyses. Data sources for Healthy Kids program evaluations may include: 1) stakeholder interviews and focus groups with parents of enrolled children, program administrators, health plan staff, contractors, providers, and others; 2) population, satisfaction, and health status surveys; and 3) health plan administrative data, hospital and any other uncompensated care data, Medi-Cal and Healthy Families program data, and outreach and enrollment contractor data. Typically, choices of analyses are driven by available data, the identified questions of interest, overall evaluation plan design, and available funds.

Three comprehensive Healthy Kids evaluations underway in Santa Clara, San Mateo and Los Angeles have been designed to address major research questions, including:^{2,3,4,5}

1. Has the introduction of a Healthy Kids program increased enrollment in other public programs for children?
 - Are children being enrolled into Medi-Cal and Healthy Families whose enrollment can be attributed to the Healthy Kids program?
 - Are more children from mixed status families being enrolled into the coverage for which they are eligible?

2. Do Healthy Kids programs have a measurable impact on enrollees and other populations?
 - Are children enrolled in the program better off than their uninsured counterparts in terms of access to care, use of health care, quality of care received, and health status?
 - Are there changes in the satisfaction levels of enrolled children and their parents?
 - What has been the program's impact on the safety net and other providers?
 - What has been the program's impact on uncompensated care costs?
 - Is there evidence of crowd-out?
 - Has the program altered local employer decisions about offering dependent coverage?

3. Do Healthy Kids/CHI program processes work as intended?
 - Are outreach and enrollment activities bringing children into all the programs for which they are eligible?
 - Are retention strategies working to keep eligible children in the program?
 - Which program processes can be improved?
 - Which program processes appear to be working well?
 - Is the provider network adequate to support the program?
 - Is the benefits structure adequate and appropriate?

Performance Monitoring

In addition to addressing these major research questions, the CHI evaluations underway in Santa Clara, San Mateo and Los Angeles conduct performance monitoring to identify specific ways that Healthy Kids programs can be improved. Performance monitoring tracks existing administrative and other performance-related data over time such as medical administrative data used for HEDIS reporting and can be done by participating plans or outside evaluators. Performance monitoring provides information about how well program enrollees are meeting access and quality benchmarks such as well child visits and immunizations. One drawback of relying on performance monitoring in the absence of other evaluation components is that monitoring will not provide information about why certain benchmarks are or not being met. However, thanks to the research contributions provided by large scale CHI evaluations it will be increasingly defensible and appropriate for CHIs to limit their Healthy Kids program assessments to performance monitoring and analysis of targeted systems change and access to care changes.⁶

CHI Evaluation Experience to Date

To date, the Santa Clara, San Mateo and Los Angeles CHIs have initiated major external evaluations of their Healthy Kids programs. Of note, all three of these CHIs received separate funds specifically for their evaluation efforts. Santa Clara's evaluation was funded by The David and Lucile Packard Foundation. San Mateo's evaluation was funded in part through its federal Community Access Program grant as well as through earmarked funds provided by each of its major program funders. First 5 LA and The California Endowment are funding Los Angeles' Healthy Kids program evaluation.

In contrast, Riverside and Santa Cruz have not applied for evaluation funding and are planning performance monitoring focused activities. Neither program anticipates hiring an outside evaluation team. The table below presents comparative data about the Healthy Kids program evaluations undertaken or planned by these five counties.

1. Summit on Cultivating Health Coverage for California's Children, Sacramento, CA. *Summit Findings Report: What Was Achieved and the Path Forward*. Los Angeles, CA: Community Health Councils, Inc., August 2004.

2. Oral communication with Will Nicholas, First 5 LA, September 13, 2004.

3. An overview of the Los Angeles Healthy Kids Initiative Evaluation presented to community stakeholders by the Urban Institute, University of Southern California, University of California at Los Angeles, Mathematica Policy Research, Inc., and Castillo and Associates, June 2, 2004.

4. Trenholm C. *Expanding Coverage for Children: The Santa Clara County Children's Health Initiative*. Trends in Insurance Coverage Issue Brief Number 3. Washington, DC: Mathematica Policy Research, Inc., June 2004.

Table 9.1
Side-by-Side Comparison of CHI Evaluations

	Santa Clara	San Mateo	Los Angeles	Santa Cruz	Riverside
Outside evaluation team	Yes	Yes	Yes	No (will hire outside survey group to conduct customer service survey)	No
Evaluation Funders	The David and Lucile Packard Foundation	Multiple public and private foundation grants	First 5 LA The California Endowment	Received \$10,000 grant from the California Healthcare Foundation	N/A
Estimated Cost	\$1.26 Million	\$1.25 Million	\$3.4 Million	Unknown with exception of \$10,000 grant for survey (most work will be done by staff)	Unknown (all work will be done by Inland Empire Health Plan staff)
Data	<ul style="list-style-type: none"> •Site visits •Case studies •Interviews •Focus Groups •Surveys •Enrollment Data for Medi-Cal, Healthy Families and Healthy Kids •Health plan data 	<ul style="list-style-type: none"> •Site visits •Case studies •Interviews •Focus Groups •Surveys •Enrollment Data for Medi-Cal, Healthy Families and Healthy Kids •Health plan data 	<ul style="list-style-type: none"> •Site visits •Case studies •Interviews •Focus Groups •Surveys •Enrollment data for Medi-cal, Healthy Families and Healthy Kids •Health Plan Data •Outreach and enrollment database of contacts 	<ul style="list-style-type: none"> •Survey •Demographic Data •Enrollment data •Claims/ Encounter data •HEDIS utilization measures 	<ul style="list-style-type: none"> •Claims/ Encounter data •HEDIS utilization measures
Duration	2 years, 10 months	5 years	4 years	Ongoing regular monitoring	Ongoing regular monitoring
Design Components	<ul style="list-style-type: none"> •Process analysis •Enrollment analysis •Impacts analysis 	<ul style="list-style-type: none"> •Process analysis •Enrollment analysis •Impacts analysis 	<ul style="list-style-type: none"> •Process analysis •Enrollment analysis •Impacts analysis •Performance monitoring 	<ul style="list-style-type: none"> •Performance monitoring 	<ul style="list-style-type: none"> •Performance monitoring
Study Population	Ages 0-18 living in families < 300% FPL ineligible for Medi-Cal and Healthy Families	Ages 0-18 living in families < 400% FPL ineligible for Medi-Cal and Healthy Families	Originally ages 0-5 but now expanded to include ages 6-18 living in families <300% FPL ineligible for Medi-Cal and Healthy Families	Ages 0-18 living in families < 300% FPL ineligible for Medi-Cal and Healthy Families	Ages 0-18 living in families <250% FPL ineligible for Medi-Cal and Healthy Families

5. Howell E, Hughes D, Stockdale H, and Kovac M. *Evaluation of the San Mateo County Children's Health Initiative: First Annual Report*. Washington, DC: Urban Institute, April 19, 2004.

6. Recent findings from CHI evaluations already underway have clearly identified the positive spillover effects of launching a Healthy Kids program and the effectiveness of outreach efforts in bringing uninsured children into coverage. See notes 4 and 5.

10 | POLICY AND SUSTAINABILITY: LOOKING AHEAD TO INSURING ALL CHILDREN IN CALIFORNIA

CHI Successes and Challenges

Looking across a number of key measures, Children’s Health Initiatives in California have been a success. To date, they have provided health insurance to over 50,000 children who otherwise were uninsured and without access to any form of coverage; sparked spillover enrollment of many more thousands of children in the state’s Medi-Cal and Healthy Families programs; and collectively have formed a broad-base of support for universal children’s coverage at the state and local levels. The CHIs have increased children’s access to essential preventive, primary and oral health care services, and it is expected that over time they will work to increase appropriate utilization of preventive services such as well-child visits, oral health screenings and examinations, vision and hearing screenings, and immunizations. Children’s Health Initiatives are collectively reshaping social policy and expectations that **all children are eligible for health insurance** – and shifting the burden of navigating many different programs away from families to “behind the scenes” eligibility systems and infrastructure support.

Yet CHIs face a number of issues related to financing and sustainability that will not be resolved until state and federal policy change is achieved. First generation CHIs have tapped a number of local revenue sources. Some are multi-year commitments, but most other revenue sources are time-limited or subject to annual renewal. Across first generation CHIs, most local First 5 Commissions have made multi-year commitments for children ages 0-5. State demographics however, indicate that the majority of uninsured children are between 6 and 18 years of age. This mismatch between available funding and need has forced a number of CHIs to institute waiting lists for eligible children.

Foundations and the First 5 Commissions have indicated that their investments in CHIs are on a time-limited and transitional basis. In addition, county budgets remain uncertain in the current fiscal climate while health care premium costs are projected to continue upward (although the annual increase should be lower for children relative to the general population). Indeed, the long-term financial prognosis for the Children’s Health Initiatives – because of their reliance on mostly local and private transitional funding for premium subsidies – is that they are not

sustainable without policy change that includes shared fiscal responsibility at the federal, state and local levels.

Outlook for the Future

California's Children's Health Initiatives are one example of how local communities can be a powerful impetus for policy change in the expansion of health insurance for children. Through innovation and coordination, these locally operated programs are serving as the engines for change in a time when coverage "reform" has often translated to resource or benefits reduction. Achieving health coverage for California's children will require high level leadership, diverse financing, and joint state and local cooperation. This joint state-local effort should embrace several goals in order to achieve affordable and sustainable coverage for all the state's children, including:

- Implement key changes at the state and local levels to greatly simplify eligibility standards and enrollment systems such as those pioneered through One Open Door and Express Lane Eligibility (see chapter 7 for further explanation);
- Redirect current spending on health care services and administrative savings from system simplifications to finance expanded children's coverage statewide;
- Identify and secure a mix of financing contributions from government, families, employers and providers to expand children's coverage statewide;
- Identify and develop approaches to coordinate with private employer coverage and ensure such approaches are well coordinated with public programs; and
- Develop long-term public-private partnerships across all areas of the health care system that serve children and families, with the shared goal of ensuring that all California children have health insurance and a medical home.

1. Simplify eligibility standards and enrollment systems: More of California's uninsured children could receive health coverage under the Medi-Cal and Healthy Families programs through the expansion, simplification and coordination of outreach and enrollment systems. An electronic enrollment system for all hospitals to automatically enroll newborn babies into Medi-Cal, as well as facilitate mechanisms for pregnant women to enroll their babies into Medi-Cal before birth could be developed with state support. Improvement and simplification of the current express lane eligibility (ELE) processes with the National School Lunch Program and the Food Stamp Program, as well as the expansion of ELE to other public programs would further efforts to

seamlessly enroll children into health coverage.¹ Support of dedicated health coordinators in school districts would help schools implement these and other health-related responsibilities.

In addition, some counties have streamlined the enrollment process through the One Open Door single enrollment pathway that allows families to apply once for coverage in multiple programs. This innovation has been greatly enhanced in several counties through the roll-out of a universal, web-based application system. Automatic enrollment in health coverage, patterned after compulsory immunizations to attend school, could be piloted at the county or city levels through coordination with hospitals, schools, clinics, child care facilities, and family resource centers.

2. Redirect current health care spending and administrative savings towards health coverage for all children: Current spending and administrative savings from several financing options could be redirected towards covering every child in California.² Many uninsured children who could enroll in expanded health coverage are likely to have received limited health care services that are paid by federal and state programs, such as emergency services, some preventive screenings, and immunizations. Current funding for these services could be redirected toward health coverage. Similarly, policies could be implemented that would generate savings in existing health care programs without reducing services and that would reinvest the savings towards coverage.

Economies of scale in outreach and administration could also be achieved if the patchwork of programs under the current system were to be made more efficient for families and the program staff that support and serve these families. If, for example, counties had the option to purchase Healthy Families coverage for their Healthy Kids eligible children, it would be more cost-effective than continuing to expand one county or region at a time, each with its own administrative and programmatic infrastructure.

Similarly, as more counties engage in planning and implementation, several CHIs have taken steps in expanding children's coverage using a multi-county or regional approach. Individual CHIs considering a regional approach would likely benefit from economies of scale in the areas of outreach, fundraising, administration and in the development of regional technology solutions. By joining their efforts, counties may also be able to enhance their purchasing power with plans and third party administrators. Regional purchasing will help counties stretch their dollars by enhancing their bargaining power through administrative streamlining.

3. Secure a diverse mix of public-private financing of health coverage for all children: The diverse funding partnerships that have been created at the county level could be replicated at the state level. A state-wide partnership between state and local governments, health plans,

providers, employers, families and philanthropic organizations would create a practical and cost-effective opportunity for pooling resources to provide a social good with long lasting health and economic benefits. As sustainability options are considered on a statewide basis, there may be important opportunities to translate some of these strategies from the local to the state level.

4. Ensure coordination between private employer coverage and public coverage expansions: Pragmatic approaches to coordinate with privately financed employer coverage are essential to the development of fiscally responsible policy to provide affordable health coverage for all children. Policymakers, foundations and local stakeholders will need to examine options for developing a broader, systemic policy approach that: (a) clearly identifies expectations and roles for employers without encouraging employers and families to drop existing contributions to family or children's coverage; and (b) harnesses financing and tax subsidies for employer and worker contributions to create affordable coverage options for families. As the community of employers is broad and diverse, it will also be important to partner with employers of varying sizes and industries in the development of these options.

A number of first and second generation CHIs are developing approaches to engage employers that are locally feasible but that may not be generalizable. Continuing to monitor and learn from these local efforts is critical to understanding how to best ensure long-term sustainability of a statewide approach. California should also learn from the experience in other states that have implemented programs to coordinate public and private coverage including Illinois, Rhode Island, and Pennsylvania.

5. Develop public-private partnerships across the health care system: A number of local Children's Health Initiatives have forged linkages between public and private sector stakeholders in financing and coordinating children's coverage. These partnerships can assume many forms, and may include developing approaches for public and commercial health plan participation and investment, developing coordinated systems of care between public and private providers, and bringing business and labor partners together under the broad banner of the Children's Health Initiatives. Adapting and transferring technological innovation from the private to the public sectors of the health care system to help facilitate a coordinated continuum of care for children and families is another possible area for further exploration.

Conclusion

This guidebook highlights the key steps that local coalitions have taken or will need to take in order to build their children's coverage programs. California now has the opportunity to build on local success and innovation and extend coverage in a broad and sustained manner.

A number of changes under consideration through the Medi-Cal Redesign and California Performance Review processes could affect the policies and strategies adopted by the state and localities.³ At the present time, state officials are deliberating on ways to reform the Medi-Cal program in order to reduce future program costs. It will take some time before the state and counties fully understand the implications of what emerges from this reform process. At the same time, the Governor has convened a commission to make recommendations on how to achieve state savings of \$32 million over five years through agency consolidation and modification of state business practices, including the potential restructuring of some state and county roles. As these major policy changes loom in the future, local leadership of the Children's Health Initiatives indicate that the effects of these reforms are complex, uncertain and difficult to predict over time.

On the other hand, the outcome of the state ballot referendum on SB 2—legislation passed in 2003 that would require large employers to provide health care coverage for their employees and dependents by January 2006 and medium employers to provide coverage for their employees by 2007 or pay into a state administered fund—could potentially create a renewed opportunity to craft policy options with the private sector towards statewide children's coverage.

California's Children's Health Initiatives are a large-scale experiment that could be parlayed to stimulate like innovation at the state level. Whether this local innovation will ultimately result in a statewide children's coverage program or will become a new state-local hybrid approach is unclear. Potential changes at the federal level could also have important implications for the timing and policy options pursued by the state and localities in expanding coverage. In the midst of these changes, local coverage solutions must continue to be tested and refined through the Children's Health Initiatives. If localities remain committed to creating a seamless system of coverage for all children, the breadth and depth of reforms needed across the state may indeed occur.

1. Horner DC, Morrow B, and Lazarus W. *Building an On-Ramp to Children's Health Coverage: A Report on California's Express Lane Eligibility Program, Express Lane Eligibility Issue Brief*. Washington, D.C. The Children's Partnership and The Henry J. Kaiser Commission on Medicaid and the Uninsured, September 2004.

2. Unpublished data from a forthcoming California Budget Project publication on financing options for children's coverage in California.

3. See the Department of Health and Human Services Medi-Cal Redesign website at www.medi-calredesign.org for more information about California's Medi-Cal Redesign process. For more information on the State's California Performance Review Process, see <http://cpr.ca.gov>.

GLOSSARY

Access – The ability to receive needed preventive, urgent and emergent health care services in a timely and medically appropriate manner. Most insurance programs, including the Medi-Cal and Healthy Families programs, have contractually specified access requirements that must be maintained by program providers.

Benefits Analyst (BA) – A county employee (typically with the Department of Social Services) who can determine eligibility for public programs, assist with applications and provide benefits.

California Children’s Services (CCS) – A statewide program that treats children with certain physical limitations and chronic health conditions or diseases. CCS can authorize and pay for specific medical services and equipment provided by CCS-approved specialists. The California Department of Health Services manages the CCS program. Larger counties operate their own CCS programs, while smaller counties share the operation of their program with state CCS regional offices in Sacramento, San Francisco, and Los Angeles. The program is funded with state, county and federal tax monies, along with some fees paid by parents.

Capitation – A method of payment in managed care in which a provider is prepaid a fixed amount per person enrolled in an individual plan. Based on a defined set of benefits, this fee is typically paid on a monthly basis regardless of the type of care delivered or the frequency with which a patient accesses services.

Certified Application Assisters (CAAs) – Trained individuals who operate out in the community to educate families about the availability of medical, dental, and other health insurance services offered by Medi-Cal, Healthy Families and other locally available insurance programs. CAAs also provide assistance with applying for programs.

Children’s Health Initiative (CHI) – Local or regional initiative to identify and enroll children in publicly available health insurance by integrating outreach, enrollment and retention processes and by creating a new insurance product called Healthy Kids that fills the gaps in existing public programs.

Coalition – The community-based organizations, hospitals, health plans, foundations, First 5 Commissions, government agencies, schools, clinics, advocates and others that have come together to form a local Children’s Health Initiative.

Community Health Advocate (CHA) – Trained individuals who provide support and health education to the community, and may assist with health program applications in some counties.

County Organized Health Systems (COHSs) – Quasi-governmental organizations that contract with the state Medi-Cal agency to become risk-assuming intermediaries and negotiate capitation rates for all Medi-Cal beneficiaries in a county. Each COHS administers a capitated, comprehensive, case-managed health care delivery system. There are five COHSs that cover Medi-Cal beneficiaries in eight counties: Monterey, Napa, Orange, Santa Cruz, San Mateo, Santa Barbara, Solano, and Yolo.

Coverage – Refers to a person’s enrollment in a private or public health insurance plan or program. The term is often used synonymously with “insurance” or “insured.”

Eligibility Workers (EWs) – Human services professionals who assist eligibles and beneficiaries with applying for, receiving and maintaining benefits from a range of public programs, including Medi-Cal, Healthy Families, WIC, and cash assistance programs.

Enrollment Assistant – A trained employee who assists families with applications for public programs.

Federal Poverty Level (FPL) – The Federal Poverty Guidelines, often referred to as the “Federal Poverty Level,” are issued each year in the *Federal Register* by the U.S. Department of Health and Human Services. The guidelines, a simplified version of the poverty thresholds used by the Census Bureau for statistical purposes, are used to determine financial eligibility for certain programs, including Medi-Cal, Healthy Families and Healthy Kids.

Health-e-App – A Web-based system that allows families working with trained assisters to apply for Medi-Cal and Healthy Families over the Internet and receive preliminary eligibility determination. Healthy Families applicants can also select providers and health, dental and vision plans.

Healthy Families Program (HFP) – California’s version of the State Children’s Health Insurance Program (SCHIP), Healthy Families provides health coverage to children in families with incomes between 100 and 250 percent of the FPL who do not qualify for Medi-Cal and do not have private insurance. Services covered are similar to those in the benefits package for California state employees and require payment of a monthly premium.

Healthy Kids – A new health insurance product for children in low-income families who are not eligible for Medi-Cal and Healthy Families. The target population for Healthy Kids is generally children who do not qualify for Medi-Cal or Healthy Families due to their immigration status or who are in the income range above HFP but below 300% FPL (\$56,550 for a family of four in 2004).

Local public plans – As we use the term in this guidebook it includes both county-organized health systems (COHSs) and public or local ini-

tiative plans (LIs) operating in Medi-Cal two-plan counties.

Medi-Cal Administrative Activities (MAA) program – A program administered by DHS which offers a way for Local Governmental Agencies (LGAs) and Local Educational Consortia (LECs) to obtain federal reimbursement for the cost of certain administrative activities necessary for the proper and efficient administration of the Medi-Cal program. MAA activities include Medi-Cal outreach; facilitating the Medi-Cal application; non-emergency, non-medical transportation of Medi-Cal eligibles to Medi-Cal covered services; contracting for Medi-Cal services; program planning and policy development; MAA coordination and claims administration; TCM coordination and claims administration; training; and general administration.

Medi-Cal for Children – California’s Medicaid program, funded jointly by the federal government and the state of California, covers eligible children who reside in families that meet specified income and eligibility requirements.

One-e-App – A Web-based system that interfaces with Health-e-App and allows families to apply for multiple programs through a single application. One-e-App can screen for a range of programs including Medi-Cal, Healthy Families, Healthy Kids, Food Stamps, WIC, Express Lane Eligibility, CHDP, and AIM.

Premium – Amount that must be paid every month to purchase health insurance.

Private health plans – As we use the term in this guidebook, private or “mainstream” plans are for-profit managed care entities with privately insured members that also bid to participate and agree to accept capitation rates for a county’s Medi-Cal beneficiaries.

Promotora – A trained community resident who informs the community about health insurance programs and access to services. Known in Spanish as “promotoras,” these outreach workers are important information resources for communities reluctant to seek assistance through in-reach venues and unlikely to either ask outreach workers they do not know about eligibility requirements or to share confidential information with them. Several CHIs have deployed trained promotoras to increase enrollment and improve retention in county Medi-Cal, Healthy Families and Healthy Kids programs.

Traditional and safety net providers – Current CHDP providers, except for clinical laboratories; community clinics, free clinics, rural health clinics and county owned and operated clinics; university teaching hospitals; children’s hospitals; county owned and operated general acute care hospitals; and any disproportionate share hospital.

Two-Plan Model – A Medi-Cal managed care model where Medi-Cal beneficiaries are enrolled into one of two managed care entities (one commercial plan and one public) within the county. The local initiatives (LIs) are operated or sponsored by a public entity such as a health authority or county-initiated organization and are required to contract with traditional and safety net providers at the same rates offered to other participating providers. Some counties have not established a public

plan and instead have contracts with two commercial plans. There are twelve Two-Plan counties in California: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare.