Summit Proceedings

ENSURING Health Coverage of the Publicly INSURED

Proceedings of a Summit on
Strategies for Increasing Enrollment and Retention in California's Medi-Cal and Healthy Families Programs

September 16, 1998

Sponsored by

The California Association of Public Hospitals and Health Systems
Local Health Plans of California
County Welfare Directors Association of California
California Association of Health Insuring Organizations

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September 16, 1998
Clarion Hotel
San Francisco

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Acknowledgments

On September 16, 1998, the California Association of Public Hospitals (CAPH), Local Health Plans of California (LHPC), the County Welfare Directors Association of California (CWDA) and the California Association of Health Insuring Organizations (CAHIO) sponsored a one-day summit entitled “Ensuring Health Coverage of the Publicly Insured: Strategies for Increasing Enrollment and Retention in California’s Medi-Cal and Healthy Families Programs.”

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This report was written and prepared by Sandy Sullivan of the California Association of Public Hospitals and Health Systems (CAPH), based on notes taken by staff during the summit. The contents are intended to reflect as accurately as possible the spirit of the presentations, views and opinions expressed throughout the day’s proceedings. CAPH takes sole responsibility for any mistakes, misquotes or misinterpretations.

Questions regarding this report may be directed to Sandy Sullivan at 510/649-7650.

Please feel free to copy and distribute this report!

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EXECUTIVE SUMMARY

Much attention has recently been focused on the number of uninsured children in California and in the nation. Concerned parties have also noted that many of the 1.7 million uninsured children in California are eligible for existing health insurance programs. For example, approximately 668,000 uninsured California children are eligible for Medi-Cal, and an additional 400,000 are eligible for the new Healthy Families program. But these children and their families often face formidable barriers to obtaining and retaining health care benefits: long and complicated application procedures, administrative barriers, fears related to their immigration status, or misunderstanding of the benefits that are available to them. Public agencies, including county health systems, county social service departments, and public health plans, are key to the enrollment and retention processes, and, as such, have tremendous potential to minimize some of these barriers both by implementing changes in policies and practices at the local level, and by advocating for more sensible eligibility and enrollment policies at the state level.

The purpose of the Enrollment and Retention Summit was to highlight innovative approaches to informing, enrolling and retaining individuals eligible for the Medi-Cal and Healthy Families programs. Another goal was to spotlight effective partnerships between local agencies, to discuss how these partnerships have come about, and to foster new collaborative efforts among participating organizations. The summit served as a first step to disseminate information about the creative ideas and instructive experiences that some counties have developed. The final goal was to identify policy changes that would assist enrollment and retention efforts.

This report summarizes each session of the summit in a consistent and user-friendly format. *Summary of Panel Presentations* provides a thorough but concise description of the information provided by each panelist. *Innovative Approaches and Lessons Learned* provides a quick way to review the points which may be most relevant to agencies in other counties who are implementing similar efforts. The *Policy Options* section highlights barriers or opportunities that can best be addressed by state or local advocacy efforts. Some of these issues may be promising areas for joint advocacy by the sponsoring organizations or for further research. Finally, the *Supporting Materials* section references materials distributed by summit presenters that may be useful to agencies in other counties and provides contacts to obtain these materials.

Major Policy Concerns Raised and Lessons Learned at the Summit. Certain overarching themes emerged over and over again during the course of the summit. These are summarized below and could serve as the basis for further efforts at the local and state levels.

- **The Healthy Families/Medi-Cal application must be simplified.** Every panel noted that the length and complexity of the joint Healthy Families/Medi-Cal application was a major barrier to enrolling eligible individuals in these programs. The Department of Health Services has recently appointed a Work Group on simplifying the application, and a number of summit attendees are already serving on or providing input to this Work Group. DHS has

committed to reduce the Healthy Families application from 12 to three pages and the Medi-Cal application from ten to five pages.

- **Eligibility requirements must be simplified.** Eligibility for public health insurance programs is extremely complex, which means that determining eligibility can take a long time and a great deal of documentation. Many of these complexities turn on questions related to an applicant's immigration status. Immigration-related concerns impact approximately two-thirds of all eligible beneficiaries in Los Angeles. The state can take a number of steps to simplify eligibility requirements, such as granting eligibility to legal immigrants who entered the country after July 16, 1996. Such simplifications would also aid in shortening the application.

- **Confidentiality issues must be addressed.** Collaborative efforts between social services agencies, health services agencies and local health plans are often hampered by laws and regulations concerning client confidentiality. While these regulations are important to protect the privacy of public assistance beneficiaries, it appears that their interpretation is not always clear. It may be possible to protect client privacy while sharing certain information that would promote health care coverage. It would be worthwhile to review and clarify the state confidentiality requirements to determine whether state-level reforms are needed to assist the eligibility process.

- **Medi-Cal stigma must be addressed.** Many participants noted that families are highly reluctant to sign up for Medi-Cal due to stigma, and concerns were raised that the Healthy Families program may suffer from identification with the Medi-Cal program. In Connecticut, the Medicaid and Children's Health Insurance Programs have been combined under a single name. Families simply apply for the Husky Program and do not need to concern themselves with the distinction between Medicaid or CHIP. They may not even be aware that the Husky Program encompasses Medicaid.

- **The Medi-Cal Program should provide children with twelve months' continuous eligibility, just as the Healthy Families program does.** Much of the Summit focused on retention of benefits—how to ensure that families stay on Medi-Cal once they are determined to be eligible. The Medi-Cal program could eliminate this difficulty by providing children with twelve months' of continuous eligibility, thereby doing away with the need for families to handle additional paperwork throughout the course of the year. Furthermore, twelve months of continuous eligibility would provide the continuity of care that is essential to protecting children's health. Because Healthy Families beneficiaries receive twelve months' continuous eligibility, this important policy change would also reduce the confusion caused by differences between the two programs.

- **Differences between Medi-Cal and Healthy Families eligibility requirements should be minimized.** Due to the difference in income requirements for children of different ages, many families have one or more children eligible for Medi-Cal, and one or more children eligible for Healthy Families. This adds greatly to the confusion associated

with these programs. Medi-Cal beneficiaries should be given one year's continuous eligibility just as Healthy Families beneficiaries currently receive, and Healthy Families beneficiaries should be able to use income deductions similar to those allowed by the Medi-Cal program.

- **Application assistance training needs improvement.** Many participants felt that the training for application assistors did not effectively prepare the assistors to fill out the applications. A significant percentage of all applications filled out by application assistors have had errors. Participants suggested allowing assistors to take the training twice and offering the training in Spanish. Kim Belshé, Director of the Department of Health Services, has recently announced an initiative to implement Spanish-language training, and to increase the application assistance fee to $50.

- **The "public charge" issue must be addressed.** At the time of the summit, the state of California and other concerned groups had not yet received clear direction from the federal Immigration and Naturalization Service about whether and how utilization of Medi-Cal and Healthy Families benefits would impact immigrants' "public charge" status. Confusion and fear about this issue has prevented many families from applying for Medi-Cal or the Healthy Families program.

- **Eligibility workers and application assistors must be well informed about both programs.** While the Healthy Families and Medi-Cal programs have a joint application, eligibility workers and application assistors are generally prepared to help with one program or the other. For example, many individuals ask about the Healthy Families program when they are in the social services office. In many cases these people are simply referred to the Healthy Families toll-free line, although 17% of all Healthy Families applicants (60 percent of all ineligible applicants) are rejected because their income qualifies them for Medi-Cal.

- **Eligibility workers are more effective when they specialize in Medi-Cal.** Currently, most eligibility workers must handle both the CalWORKS and the Medi-Cal aspects of a client's benefits. Both programs can be very complex and it is difficult for one worker to master both. Establishing caseworkers that are dedicated to Medi-Cal enables them to develop expertise in the eligibility requirements for various Medi-Cal programs, including Transitional Medi-Cal. Such efforts may also be helpful in reducing the stigma associated with the Medi-Cal eligibility process.

- **Direct communication between staff at partnering agencies is key to implementing successful collaborations.** A direct phone line between the Health Plan of San Joaquin and the San Joaquin County Human Services Agency; interagency staff meetings to develop a Transitional Medi-Cal flyer in Alameda County; partnerships between DSS eligibility workers and Health and Hospital System financial counselors in Santa Clara County; and monthly meetings at the Ventura County Health Services Agency to review specific Medi-Cal eligibility cases have all had concrete results in terms of enrolling and retaining beneficiaries.

- **Organizational culture at county agencies must change.** Historically, the role of eligibility staff has been to screen individuals *out* of public assistance programs, including Medi-Cal. With the advent of welfare reform, it has become more and more important to focus on screening individuals *in* to these programs as a way of enhancing their efforts toward self-sufficiency. This new role will require a change in organizational culture within county agencies.

Helping Families Negotiate the Medi-Cal and Healthy Families Enrollment Processes: Strategic Points for Intervention

Panelists: **Kathryn Dresslar,** Senior Policy Advocate, Children's Advocacy Institute
Patricia Freeman, Senior Health Policy Associate, Children Now

SUMMARY OF PRESENTATIONS

Goals of this Panel: To describe the enrollment processes for the Medi-Cal and Healthy Families programs and identify the points in these processes where families are most likely to encounter barriers. Panelists identified key opportunities during the process to ensure that beneficiaries obtain and retain benefits.

Patricia Freeman reviewed some statistics on California's uninsured children, particularly those who are Medi-Cal eligible. Ms. Freeman pointed out that the largest portion of uninsured children is currently eligible for the Medi-Cal program rather than the Healthy Families program. She warned of a danger to Medi-Cal outreach potentially posed by the Healthy Families program, which is being marketed as private insurance for working families. This may stigmatize Medi-Cal as a "second-tier" program.

Ms. Freeman then discussed a number of key opportunities to ensure beneficiaries enroll and retain their eligibility. For purposes of Transitional Medi-Cal, beneficiaries must be informed of this program before they leave the Medi-Cal system. Another important opportunity occurs when a child loses Medi-Cal eligibility because she reaches her first or sixth birthday. These children's parents can be contacted and urged to apply for the Healthy Families program.

Also, it is important to "catch" people when they are already in the welfare office for another reason. Currently, many people come in to the welfare office and ask about the Healthy Families program, and are referred to the toll-free hotline. Many of these people are probably eligible for Medi-Cal rather than Healthy Families, but no one evaluates their eligibility while they are in the Medi-Cal office. Application assistors can also encourage Healthy Families applicants to check the box on the application which authorizes EDS to forward appropriate applications to Medi-Cal. Finally, if the family is completing only the joint application form, county workers and application assistors can help them determine whether the adult family members might be eligible for Medi-Cal.

Ms. Freeman noted that she had received clarification from DHS the prior day that eligibility workers will receive compensation from the state for completing the enrollment process even if the child turns out to be eligible for the Healthy Families program, because establishing eligibility for Healthy Families involves ruling out eligibility for Medi-Cal. An all-county letter on this subject will be forthcoming.

Ms. Freeman also noted that applications received by the Managed Risk Medical Insurance Board (MRMIB) which were completed by the family without an application assistor had a very

high error rate. She also noted that of 4,000 children found ineligible for the Healthy Families program, 60 percent of these were ineligible because they were eligible for Medi-Cal.

Kathryn Dresslar raised a number of concerns about the implementation of the Healthy Families program, including exclusion from the Vaccines For Children program, premiums and copayments, the six-month disenrollment for failure to pay premiums, and the fact that legal immigrant children arriving in the United States after August 22, 1996 are not eligible. Nevertheless, children's advocacy organizations feel that the Healthy Families program does have great potential to benefit currently uninsured children. Ms. Dresslar expressed concerns about public health insurance programs' link to the federal poverty level, pointing out that California has the highest rent of any state in the country and that the federal poverty level might not be an appropriate measure for Californians. She also noted that the depth of poverty has increased, particularly among single parents.

Ms. Dresslar pointed out that the application-assistance training does not currently provide sufficient preparation for helping with the joint application and suggested that application assistors should be able to complete the training twice. Luis Pardo, Outreach Coordinator from Alameda County, noted that the application-assistance training should also be offered in languages other than English. Ms. Dresslar noted that staffs at community-based organizations feel overwhelmed by the enrollment task, which historically has not been their role.

INNOVATIVE APPROACHES AND LESSONS LEARNED

- Given the high percentage of Healthy Families applications that are turned down due to Medi-Cal eligibility, it is crucial that county welfare departments take the opportunity to evaluate Medi-Cal eligibility when someone asks for information about the Healthy Families program. It is not enough to give out the toll-free hotline number to these individuals.

- Los Angeles County is using the joint mail-in application form for families as well as for children. They add any additional documentation needed for the family from the regular Medi-Cal application form.

- Health plans and Medi-Cal workers may wish to identify "triggers" for children who will experience age-related changes in their eligibility status, so that a child no longer eligible for Medi-Cal can be signed up for the Healthy Families program. For example, a child whose family earns between 100 and 133 percent of the federal poverty level will lose Medi-Cal eligibility upon reaching age six, at which time s/he will become eligible for Healthy Families.

POLICY OPTIONS AND FURTHER ACTION

- The upcoming legislative session may provide opportunities to expand and simplify eligibility requirements in numerous ways.

- Children on Medi-Cal should be provided with one year of continuous eligibility just as Healthy Families enrollees are.

- The check-box which indicates that the Healthy Families application may be forwarded to the Department of Social Services for Medi-Cal consideration should be removed, and applications which appear to be Medi-Cal eligible should automatically be sent to DSS. Failing this, the presumption should be that the application can be sent for Medi-Cal eligibility review, with the check-box used only by those families who specifically request that their application NOT be sent to Medi-Cal.

- A unified enrollment contractor for both Medi-Cal and the Healthy Families program might eliminate many application barriers.

- Application assistance training should be strengthened, individuals should be allowed to take the training more than once, and training should be provided in languages other than English, particularly Spanish.

- Participation in school lunch programs may serve as a proxy for Healthy Families or Medi-Cal eligibility. Thus outreach efforts may be effectively targeted at children in these programs. The state of Washington is currently undertaking such an effort.

- The application must be simplified, and careful consideration should be given to creating a "program-blind" application, as Connecticut has done, so that applicants do not have to choose a program.

Interagency Collaboration: Alameda County Case Study

Moderator: **Crystal Hayling,** Director, Medi-Cal Policy Institute

Panelists: **Emmie Hill,** Division Director, Alameda County Department of Social Services
Irene Ibarra, CEO, Alameda Alliance for Health
Dave Kears, Director, Alameda County Health Care Services Agency

SUMMARY OF PRESENTATIONS

Goal of this Panel: In order to assist as many eligible individuals as possible to obtain public health insurance benefits, it is imperative that different county agencies work together. This panel describes the challenges, barriers and successes encountered by Alameda County in the course of its collaborative efforts, which are described below, followed by a description of each panel member's participation in these efforts.

Collaborative Efforts in Alameda County

Interagency Children's Policy Council. Founded in 1993, the mission of the ICPC is to facilitate interagency collaboration in order to promote the well-being of children. Participating agencies include the Department of Social Services, the Health Care Services Agency, courts, special education, probation, schools and a number of community-based nonprofit organizations.

The ICPC's collaborative process involves community agencies who help identify problems that the member agencies can address. For example, many pregnant women have no source of child care when they go to the hospital to deliver their babies; thus, ICPC agencies locate CBOs that can provide child care while mothers delivered their babies. Also, Alameda County has many grandparents raising children alone. The ICPC developed a single location to deliver a variety of services for grandparents raising children.

More recently, the ICPC has taken a leadership role in collaborative outreach efforts for enrolling children in insurance programs, establishing an Outreach Implementation Committee and hiring a full time Medi-Cal and Healthy Families Outreach Coordinator.

Transitional Medi-Cal (TCM). In 1996, HCSA, the Alameda Alliance for Health, Blue Cross and the Alameda Health Consortium (a coalition of community clinics) jointly approached Roger Lum, Director of the Social Services Agency, to express concern that clients who were discontinued from cash benefits were not aware of the TMC program. These agencies set up a small work group with representatives from each department to assess and solve the problem. The group reviewed the Notices of Action sent to CalWORKS participants and discovered that information about TMC was either buried or very confusing. The group also interviewed eligibility staff to determine their knowledge of the TMC program.

After these investigations, the group decided to take three concrete steps. They developed a colorful flyer advertising TMC, to be included in all CalWORKS termination notices; they

developed a flow chart describing TMC for the use of eligibility workers, plans and other organizations assisting clients; and they developed new training packets addressing TMC for eligibility workers.

Panel Presentations: How Did They Make It Work?

Crystal Hayling opened by noting that effective interagency efforts require collaboration, and not merely cooperation. She invited each of the three panelists to give a brief overview of his or her agency's efforts to collaborate with the other agencies to enroll and retain individuals in public health insurance programs.

Irene Ibarra noted that the Alameda Alliance for Health began operating in January 1996. In December of 1996 Alameda County "fully converted," or began directing all AFDC-related Medi-Cal beneficiaries into one of the county's two Medi-Cal managed care plans. By December of 1996, the Alliance had already realized that the number of managed care eligibles in Alameda County would be lower than the State had originally projected. Thus, the Alliance intensified its commitment to enroll and retain those individuals who are eligible for Medi-Cal.

The Alliance formed a Retention Planning Work Group, including staff involved in membership services, health education, community relations and marketing. The group determined that there are five primary reasons why members lose Medi-Cal eligibility. These reasons include: 1) the member goes "on hold" due to failure to submit necessary documentation; 2) the member turns 18 years old; 3) the member transitions from cash assistance and becomes eligible for Transitional Medi-Cal; 4) the member voluntarily disenrolls from the plan, or is mandatorily disenrolled; 5) a newborn, who is automatically eligible for the month of birth and the following month, completes this period of eligibility.

It became clear that the group would need an understanding of the extremely complex eligibility system in order to be effective. Thus, the Work Group reached out to the Alameda Department of Social Services for education in this area. They focused their retention efforts on Transitional Medi-Cal. A major issue in this regard was **confidentiality**—in other words, to protect client privacy, the Department of Social Services cannot release certain kinds of information to the health plans. In May of 1998, the Health Care Services Agency and representatives of organized labor joined the partnership efforts between the Alliance and DSS. This work group continues to meet on an ad hoc basis once a month and may propose a waiver to eliminate the requirement that Transitional Medi-Cal clients turn in the CA-7 income information form.

Ms. Ibarra discussed two specific examples of the Alliance's collaborative efforts with DSS. First, the Alliance developed the brightly colored TMC flyer, mentioned above, which is included with all CalWORKS termination notices. While planning for this flyer was a joint effort with the other interested agencies, the Alliance actually created the flyer and collected funds from the other agencies in order to cover the costs. The flyer is much more eye catching than a traditional DSS termination letter.

Secondly, the Alliance sends birthday cards to all beneficiaries turning 18 years old, notifying them that they can keep their Medi-Cal coverage for another year. This effort requires cooperation with DSS. The Alliance periodically sends DSS a list of 18 year olds on hold. DSS reviews the list and provides a response, within confidentiality limits, as to the status of each applicant. Specifically, DSS verifies and/or corrects hold status, noting if the individual has moved out of county or entered a different assistance program. The Alliance has received a very strong telephone response from these 18-year-olds, although the health plan can only inform callers of the availability of this coverage. Beneficiaries are then directed to the Department of Social Services for enrollment.

Ms. Ibarra also noted that Medi-Cal retention strategies are fully integrated into their Healthy Families marketing efforts. The Alliance identifies members who were discontinued from Medi-Cal for increased earnings and offers them the opportunity to enroll in the Healthy Families program.

Dave Kears noted that in the early 1990s, agencies including Health Care Services, Social Services, the courts, Probation, the County Administrative Office, schools, neighborhood associations and community provider organizations came together to develop a county-wide approach to children and youth services. Since the collaborative effort began during a fiscally challenging period, these agencies realized that they could not base their reform on new funds. Rather, they needed to move from current categorical spending to a collaborative approach using existing funds. Several board members are personally involved in these collaborative efforts, and the board as a whole is supportive of them.

Calling collaboration an "unnatural act between nonconsenting adults," Mr. Kears noted that working together means giving up control, requires commitment, must involve key players including the support of the county Board of Supervisors, and needs projects with results. Some collaborative projects are not successful, but the important thing is to move on from these projects and try something new until results are achieved.

Mr. Kears noted that support for simplification of eligibility requirements and regulations from the legislature and the administration is the single most important factor in helping to enroll more people in health care programs.

Emmie Hill briefly reviewed the many collaborative partnerships in which the Department of Social Services has participated. In 1988, DSS began the Outreach Program, which placed intake eligibility technicians in community health centers. In 1994, the agency participated in the creation of the Interagency Children's Policy Council. In 1996, DSS developed a district component to their outreach in community health centers, assigning six district eligibility workers to track applications accepted in these clinics. And in 1997 and 1998, collaborative efforts intensified, to include the Transitional Medi-Cal initiatives, placement of outreach staff from a number of agencies in community-based organizations, and the development of cross-department multi-service teams for assistance in care services.

Ms. Hill noted that it was very exciting to see that all of the agencies participated and collaborated to develop the TMC flyer, and that all agencies paid their share. This project was important to the Board of Supervisors, and thus department heads were able to divert some envelope-stuffers to handle the TMC flyers. Alameda County also involved organized labor in the efforts, since the initiative involved non-standard hours for eligibility workers.

As further steps to improve TMC retention, DSS consolidated all TMC cases into one building, in one unit, where they now telephone all discontinued clients. They also offered $20 Lucky and Safeway gift certificates to clients returning their TMC applications. (These efforts, and their results, are described in more detail in the Breakout C summary.) Future plans include focus groups to determine the reasons for poor response to the TMC opportunity, developing posters, and creating an easier way to obtain necessary income information.

Ms. Hill noted that the main barrier to these efforts was the agencies' lack of knowledge of each other. The various participants were not familiar with other agencies' rules, regulations and funding mechanisms. They were able to overcome this barrier through communication and the joint efforts to create a shared mission and priorities and to achieve results. The time and energy invested in this process ultimately resulted in mutual trust.

Audience discussion. Tony Rodgers, CEO of L.A. Care Health Plan, noted that his plan's efforts to telephone members "on hold" were extremely successful. When the Alameda County Department of Social Services contacted beneficiaries to request that they return their CA-7 forms, they had the opposite experience; beneficiaries were fearful of the welfare office. However, when the Alameda Alliance staff called, beneficiaries were much more receptive. It appears that health plans have greater success than social service departments in reaching out to beneficiaries; however, confidentiality issues do arise.

INNOVATIVE APPROACHES AND LESSONS LEARNED

- All panelists agreed that money was essential for successful collaboration. You cannot ask people to do more work without more money.
- Staff must see that the work matters, and that if one thing fails, the agencies will try something else. Dave Kears stressed the importance of having at least some "wins."
- Board of Supervisors' support and pressure for collaboration was key.
- During collaborative meetings, each agency needs to have people at the table who are willing and able to make decisions about policy, money, staff allocation, etc.
- One or two individuals in each organization must "somehow catch on" to the importance of these efforts and invest themselves in the work.

- Efforts of staff in the partnering agencies are key. For example, Irene Ibarra really relied on DSS staff to educate her own staff about eligibility procedures.

- It can take many meetings to produce a concrete product such as the TMC flyer, particularly since eligibility for public health insurance is so highly regulated.

- Public health insurance beneficiaries are generally much more responsive to outreach efforts by their health plan than efforts by the social services agency, so collaboration between the health plan and social services on outreach can be very beneficial.

- It is important for agency leaders to speak up when they feel another agency is not pulling its weight. Panelists stressed that their long relationship allowed them to "yell at each other" when necessary and to keep their focus on results.

POLICY OPTIONS AND FURTHER ACTION

- **Confidentiality:** Panelists stressed the problems raised by confidentiality regulations in reaching out to individuals who are in danger of losing their benefits. Confidentiality regulations may need to be reevaluated at the state level; however, these regulations are implemented at the local level.

- **Outstationing eligibility workers at health plans:** This was mentioned as a potential enrollment strategy. Further investigation would be necessary to determine the feasibility of this approach under various managed care models, such as the Two-Plan Model.

- **CA-7 Waiver:** Alameda is exploring a waiver so that applicants for Transitional Medi-Cal will no longer need to use the CA-7 form to provide the necessary income information. Since a very large portion of clients fail to turn in their CA-7 forms, Alameda's potential experiment with obtaining the income information in other ways may be instructive for other counties.

SUPPORTING MATERIALS

Transitional Medi-Cal Flyer for inclusion with termination notices. Contact: Irene Ibarra, 510/895-4532.

Birthday cards for 18-year-old Medi-Cal beneficiaries. Contact: Irene Ibarra, 510/895-4532.

Alameda County's Transitional Medi-Cal Flow-Chart. Contact: Emmie Hill, 510/639-1087.

"Healthy Families Outreach Concept: Interagency Children's Policy Council of Alameda County." Contact: Dave Kears, 510/618-3452.

Reaching Out to Prospective Enrollees

Panelists: **Jacque Wolfram,** Manager, Solano Kids Insurance Program (SKIP)
Angie Medina, Director, Children's Health Outreach Initiative, Los Angeles County Department of Health Services
Sheryl Spiller, Division Chief, Medi-Cal and Food Stamp Division, Los Angeles County Department of Public Social Services
Leona Butler, CEO, Santa Clara Family Health Plan

SUMMARY OF PRESENTATIONS

Goal of this Panel: Local agencies have developed numerous innovative strategies to find and enroll children in public insurance programs. This panel described comprehensive outreach programs in three California counties.

Jacque Wolfram began by describing the Solano Kids Insurance Program (SKIP), which is sponsored by the Solano Coalition for Better Health and the California Healthcare Foundation. The SKIP program is a focused, centralized resource to market public health insurance programs to eligible children. They have filed a marketing plan for reimbursement from the Medi-Cal Administrative Activities fund.

SKIP employs program representatives who have an enrollment goal of 800 children per year. Each representative has a geographic area to cover. A critical strategy has been the addition of a bilingual representative. Solano County provides a dedicated eligibility worker for the joint application who can assist enrollees identified by SKIP workers.

The program creates awareness through flyers and other materials in addition to those created by the state. SKIP staff make a special point of **accessibility**—they will go out and meet people "anywhere." They have pursued a highly successful school-based strategy, in which they make contacts with high school principals or coaches who refer children to SKIP. SKIP has also responded to the recent RFA for federal outreach funds. Some of these funds will be distributed to CBOs with focused outreach strategies.

In terms of retention, SKIP is exploring financial incentives for compliance with paperwork requirements, such as providing a $5 certificate for returning the CA-7 form, in conjunction with quarterly telephone calls to members reminding them about this requirement. They will also provide $5 gift certificates to local retailers and to members who refer other applicants. Research has indicated that health plan member satisfaction increases dramatically when the member has early contact with the provider; this early contact may also help to avert inappropriate emergency-room use. Thus, SKIP plans to implement a program of education about how to use a health plan. Finally, SKIP encourages Healthy Families members to pay for their first three months with their application, to receive the fourth month free and to guarantee four months' retention.

Angie Medina and Sheryl Spiller made a joint presentation regarding their efforts in Los Angeles County, where there are an estimated 700,000 uninsured children. Approximately 300,000 of these children are eligible for Medi-Cal, and over 200,000 are eligible for the Healthy Families program. In August 1997, the Los Angeles County Board of Supervisors declared 1998 the "Year of Healthy Children" and directed the Department of Public and Social Services (DPSS) to work with the Los Angeles County Department of Health Services (LAC-DHS) to increase Medi-Cal enrollment by 100,000 and increase CHDP visits by 35% within two years. As a result of this directive, DHS created the Children's Health Outreach Initiative. The Outreach Initiative focuses on all available children's health programs: Medi-Cal, Healthy Families, CHDP, California Kids, and Kaiser Cares for Kids.

Under the umbrella of the Outreach Initiative, Angie and Sheryl jointly chair **The Medi-Cal Health Access Work Group,** which grew out of an existing welfare reform work group. This group includes about 40 community-based organizations, and most county departments that work with kids. Major participants include Legal Aid, the Los Angeles City Children's Commission, the Los Angeles County Office of Education, L.A. Care Health Plan, MALDEF and the National Health Foundation. The Medi-Cal Health Access Work Group has four sub-groups, focusing on barriers, training/communications, form simplification, and CHDP.

The Outreach Initiative cooperates with **The Children's Health Access and Medical Program (CHAMP),** a school-based enrollment program administered by the National Health Foundation. Under the auspices of CHAMP, Lynn Kersey of Maternal and Child Health Access has developed a training program for volunteers that addresses all the various children's health programs, including Medi-Cal, Healthy Families, CHDP, etc. These volunteers will be placed in schools to enroll children.

Kaiser Permanente is also donating staff to conduct focus groups with individuals who are eligible for Medi-Cal but not enrolled and individuals who have just signed up for Medi-Cal. The focus groups address barriers to enrollment. After the focus groups are completed they will issue a report on their findings.

Leona Butler described the efforts of the Santa Clara Family Health Plan to build bridges with the community with a focus on enrollment into public health insurance programs. The health plan sponsored a one-day meeting during the summer of 1998, which brought together county agencies, CBOs and faith-based organizations, to develop collaborative enrollment strategies.

These outreach efforts have resulted in a number of ongoing collaborative projects. The Center for Employment Training is now training CalWORKS recipients as outreach workers to help enroll people in public insurance programs. The county public health department holds a monthly outreach meeting including the health and hospital system, social services, community clinics, CBOs, schools, mental health, alcohol and drug agencies. A local youth group hangs door knockers about the availability of children's health insurance, and a local food bank is distributing food bags with notices on the bags.

Ms. Butler also strongly encouraged counties to develop relationships with the business community. She noted that Santa Clara Family Health Plan has cosponsored some very successful events with the Hispanic Chamber of Commerce to provide children's entertainment and information about the Healthy Families program.

INNOVATIVE APPROACHES AND LESSONS LEARNED

- Jacque Wolfram noted that the productivity of eligibility workers improves dramatically when they are able to **focus** on finding and enrolling eligible individuals, rather than being diverted by paperwork. She recommends providing eligibility workers with blocks of paperwork-free time, even if they are not 100% focused on enrollment, as are the SKIP program representatives.

- Jacque Wolfram noted that SKIP's relationship with other county agencies is crucial to the success of the program, particularly the direct links with eligibility workers at the social services agency.

- Sheryl Spiller noted that LA County agencies are open to the fact that their organizations have been part of the problem, and they want to now be part of the solution. This acknowledgment goes a long way toward facilitating collaboration between different agencies. Collaborative relationships can succeed when everyone has the same goals, even where there is a history of lack of cooperation.

- Collaborative action with a large group of organizations is time-consuming.

- Ms. Spiller noted that they are endeavoring to change the culture within DPSS so that staff try to **screen in** eligible families, rather than **screen them out**.

- **Medi-Cal stigma** hampers the efforts of SKIP program representatives and others attempting to enroll children and families.

- The SKIP program is exploring the use of financial incentives to encourage people to retain their public health insurance benefits.

POLICY OPTIONS AND FURTHER ACTION

- **Delays in processing Healthy Families applications requires corrective action:** At the time of the summit EDS was six weeks behind in processing Healthy Families applications. These backlogs were also causing problems for CHDP providers attempting to obtain reimbursement for follow-up treatment provided to children under the CHDP program, since children must be enrolled in Healthy Families within 30 days in order for the provider to receive reimbursement. There are also backlogs at some social services departments due to the success of outreach efforts.

- **Immigration fears:** Ms. Spiller noted that LA County estimates that **two-thirds** of the eligible population is affected by fears surrounding their immigration status. Leona Butler noted that the "public charge" issue is not yet resolved and that the final INS regulations are still pending.

- **Simplifying the application:** In Los Angeles County, the task force on simplification has found that they can replace 3 pages of the application dealing with immigration status with 3 questions. All of the other information in this section is collected with the required accompanying documentation. As a member of the DHS Work Group on simplifying the application, and of the Healthy Families Advisory Committee, Leona Butler encouraged people to pass on ideas on simplifying the application to DHS.

- **Using one name for both programs:** In Connecticut, there is a single application for both Medicaid and CHIP. The difference is invisible to the applicant; both are called the "Husky Program." The family simply provides relevant income information and the state determines share of cost and other elements depending on whether the family fits under Medicaid or CHIP eligibility requirements.

SUPPORTING MATERIALS

Santa Clara Family Health Plan flyers about the Healthy Families program. Contact: Leona Butler, 408/260-4490.

Afternoon Breakout Session A
Bolstering Our Reinforcements: Maximizing the Effectiveness of Outstationed Eligibility Workers

Moderator: **Barbara Masters,** Vice President, California Association of Public Hospitals and Health Systems

Panelists: **Marilyn Cornier,** Manager, Valley Community Outreach Services, Santa Clara Valley Health and Hospital System
Julia Takeda, Director, Child Medi-Cal Enrollment Project, Los Angeles Department of Public Social Services
Liz Strand, Medi-Cal Program Manager, San Francisco County Department of Human Services

SUMMARY OF PRESENTATIONS

Goal of this Session: Panelists in this session focused on creative and proven ways outstationed eligibility workers have increased productivity, improved collaboration, and stretched the boundaries of the eligibility worker's traditional role.

Marilyn Cornier discussed the Medi-Cal Outreach Pilot Project jointly developed by the Santa Clara County Health and Hospital System and the Santa Clara County Social Services Agency.

History and Content of Program. In 1997, the Santa Clara County Social Services Agency released a study showing that of 4,000 Medi-Cal recipients dropped within a single month, 75 percent of these individuals were dropped because of missing forms or no-shows. Were it not for this loss of contact, some of these individuals might have been retained on Medi-Cal.

In response, the Social Services Agency and the Santa Clara Valley Health and Hospital System created a joint task force to address decreased Medi-Cal enrollment. The Santa Clara County Board of Supervisors approved $300,000 for a six-month pilot project, involving the Santa Clara Valley Health and Hospital System, ambulatory care, community health services, public health, and social services. The project outstationed four financial counselors in four county clinics which already had outstationed eligibility workers. One of the workers also spent time in one non-county, non-profit clinic with strong ties to the county health system. These financial counselors are bicultural, bilingual patient advocates who begin the eligibility process and serve as a link to the eligibility worker in the clinic or in the district office.

The program also employs four bicultural, bilingual outreach workers who pursue a number of activities in the community. Each month the supervisors of the outstationed eligibility workers in the clinics fax to the Outreach Project a list of Medi-Cal beneficiaries who are in danger of losing their benefits, generally because they failed to show up for an appointment or are missing forms. The outreach workers then make home visits to these families. They can help the families fill out forms and refer them to eligibility workers. Each outreach worker has a cell phone so

that s/he can call the district office on the spot to find out the status of an application. The outreach workers also make presentations at community events and build liaisons with community-based organizations for referrals. Financial counselors also refer individuals with Medi-Cal eligibility problems to outreach workers, particularly if they were getting Medi-Cal through a district social services office rather than the clinic. The project has done a lot of data tracking to determine where referrals are coming from, demographics of the applicants and outcomes of the application.

Challenges. Ms. Cornier noted that it is difficult to measure the number of eligible families who are not responding to outreach efforts due to concerns about the public charge issue and Proposition 187. She noted that coordination with other agencies is difficult, especially in a six-month timeframe, but it was necessary, and ultimately very helpful. Prior to the Outreach Project, the county clinics had a financial counselor system that didn't seem to work. It appears that supporting the financial counselors with outreach workers is critical.

Results. The program has shown very significant accomplishments. Prior to the program, Medi-Cal had a 60 percent Medi-Cal denial rate. After six months, the denial rate was 26 percent. Based on this difference, the Project estimates that the county recovered an additional $854,000 in Medi-Cal revenues.

Future Plans. The county has received a First Things First grant from the California Healthcare Foundation and the Packard Foundation. The eighteen-month, $225,000 grant will expand the financial counselor program to a number of community clinics that are not county operated, and the county will also station eligibility workers in these clinics. The additional financial counselors are expected to increase the need for outreach workers to visit people in their homes, and the public health department will be donating 12 of their outreach workers for this effort, at 30 percent of their time. The program hopes to become permanent as of this fall, and to expand outstation social services workers at community-based organizations.

Ms. Cornier would also like to focus more on retention, expanding the program's data base, follow-up phone calls to clients and a tickler system to remind clients to send in forms to maintain their eligibility.

Julia Takeda discussed the Child Medi-Cal Enrollment Project (CMEP) at the Los Angeles County Department of Public Social Services.

History and Content of Program. A year ago, the Children's Planning Council estimated that 300,000 Los Angeles County children are eligible for, but not enrolled in Medi-Cal. The Los Angeles County Board of Supervisors passed a resolution declaring 1998 the Year of Healthy Children and directed the Department of Public Social Services to work with the Department of Health Services to enroll 100,000 children by September of 1999.

DPSS brought together Medi-Cal stakeholders and created the CMEP. The CMEP was approved on February 3, 1998, and received 45 experienced Medi-Cal workers. These workers were placed at about 50 sites, primarily schools. Today, this number has expanded to 85 workers

covering 112 sites, including CBOs, clinics and churches. They also send eligibility workers out on evenings and weekends.

Challenges. CMEP workers noted that when visiting health fairs, no one would visit the CMEP booth—they only went to the booths with food and giveaways. Accordingly, the program developed a number of gifts, including fans, Rolodex cards, "pass it on" cards, rulers and bookmarks. The county is also developing a user-friendly guide to all of the health care assistance programs in the county, broken down by age group.

Barbara Masters asked how the CMEP worked out relationships with the outstation sites such as churches, and what the eligibility workers do at these sites. Ms. Takeda noted that since the governing board of the CMEP includes about 40 public and private agencies, the word is out regarding efforts to outstation eligibility workers. CMEP also advertises in the newspaper, at school meetings and at church services, and agencies contact them daily asking to participate. After an agency calls, CMEP staff go to the agency and evaluate the space, making sure there is a room to conduct an interview, a phone, and a fax machine. The eligibility worker will be stationed there full time if the site can generate 51 applications per month. With fewer applications, the worker will be stationed there part time. If the site can only bring in a few applicants, the worker will make an appointment and go to the site to take those applications.

Future Plans. In October and November, DPSS will stage a Medi-Cal kickoff. Ms. Takeda noted that the CMEP eligibility workers are already "pumped up" to enroll children, but other workers are not, so the kickoff is intended to energize the workers with training materials and giveaways.

Results. The program has been successful. In seven months, they have enrolled 18,000 children through CMEP, while the countywide effort has enrolled over 27,000 children. The program hopes to expand from 112 to 200 sites by the end of the year.

Ms. Takeda ended by noting that the project is changing the image of the county welfare office. Eligibility workers are now out in the community, and people are much more comfortable with them. CMEP has also strengthened DPSS' relationship with other county departments, such as the Department of Health Services.

Liz Strand explained that San Francisco County has a number of Medi-Cal initiatives on the drawing board and has several outstation sites.

History and Content of Program. The San Francisco Department of Public Health has a perinatal unit whose workers do outreach at public health clinics, Planned Parenthood, the Teenage Parenting Project, and San Francisco General Hospital. The Social Services Department also has a unit that handles Medi-Cal applications from the hospital council group.

The Social Services Department has developed a streamlined application process with the San Francisco clinic consortium. Staff at these clinics have received training from the Department of Social Services; they help patients fill out the necessary documents and send them to Social

Services with a special referral form. The referral form tells the eligibility worker that this application is expedited and that much of the work has been done already. A similar expedited process is in place at the sensitive services clinic at Balboa High School; all of these applications are sent to a specialized eligibility worker. Other outstation sites include Laguna Honda Hospital, a Job Corps site on Treasure Island and the Veterans Administration.

Each outstation site has a liaison who works for the site. This staff member does a preliminary screening, assists the client with the MC 210 form, explains to the client what to expect during the application process and what documents she will need to bring. The liaison also tries to clarify that s/he is not the eligibility worker, and that someone else will be calling the applicant to complete the process. This process helps to assure that the eligibility workers will have potentially eligible clients to interview.

Challenges. San Francisco County is currently focusing on CalWORKS, turning eligibility workers into employment specialists, and thus the Medi-Cal division has lost one-third of their staff, both workers and supervisors. Also, due to the cost of living, many families have left San Francisco because they can't afford to live there anymore. In outstation sites with liaison workers, there is some friction given that two organizations with different staffs and chains of command are engaged in the eligibility process, but the parties do meet to smooth out any differences that occur.

Future Plans. The department plans to develop a retention function, focusing some workers on cases in danger of losing their benefits due to noncompliance with paperwork requirements. These workers will follow up with phone calls and home visits. A coalition including the San Francisco Health Plan, Blue Cross, the clinic consortium, Health Access, the Chinatown Group, and the Mission Neighborhood Center will apply for the recently issued RFA for federal outreach funds.

Audience Discussion. Shahnaz Nikpay, CEO of San Francisco Health Plan, asked the panel whether there is a cap on the number of eligibility workers a county can employ. In general, there is no cap, but counties must show that their caseload justifies the number of eligibility workers before they obtain reimbursement. The county must put the money up front, so the county does run a financial risk if additional eligibility workers do not bring in additional applications.

Barbara Masters asked whether other counties are doing anything unique and special with their eligibility workers. Sandy Baldwin noted that some district offices in Contra Costa County are remaining open until 7:00 p.m. one night a week, for all services. In addition, Contra Costa County will sometimes send workers into the community, particularly to faith-based organizations, on Saturdays. These enrollment opportunities are advertised through churches, the Child Care Council, nail salons, laundromats, and any place where potential clients might see the flyers developed by DSS staff. The county has experienced a very good response to the evening hours. As the nontraditional hours are voluntary for the workers, the union has not raised concerns about these new efforts.

Healthy Families Program Coordination. Barbara Masters asked each panel member to comment on how the eligibility workers interface with the Healthy Families application process. Julia Takeda noted that Los Angeles has received 2000 of the joint Medi-Cal/Healthy Families program applications, and has set up a special station of ten eligibility workers to handle these applications. Outstationed eligibility workers take the applicant through the Medi-Cal application process first; if there is a share-of-cost, they help families with the Healthy Families program application and advise people to mail in the application.

Marilyn Cornier noted that every person in her outreach division has been certified to assist with the Healthy Families program application, and the outreach division mails the applications. However, in the clinics, they do not use the joint application. Since the eligibility worker is located in the clinic, they use the traditional Medi-Cal application.

Liz Strand noted that when mail-in applications are received, they are handed out to eligibility workers. Originally, this was done by language, but they are getting so many Cantonese applications that the Cantonese speaking eligibility workers cannot handle all of them. Another San Francisco staffer noted that for a while, they received "funny green applications" from the Healthy Families program, and they sent them back to Sacramento. Later, EDS informed them that these applications were for people who had been rejected for the Healthy Families program because they were eligible for Medi-Cal.

Cultural Change. Barbara Masters asked how the panelists are working to create culture change within their organizations, in order to encourage "screening in" rather than "screening out." Julia Takeda noted that cultural change is difficult, and her department has approached this primarily through training. She noted that their denial rate is going down. Marilyn Cornier noted that the outreach program has made it easier to collaborate and communicate with the eligibility workers. Once a month, the staff in a particular clinic, including eligibility workers and financial counselors, sit down to brainstorm about ways to improve their services. For example, in a recent meeting the eligibility workers suggested dividing up the packet of materials received by the client, to make it less intimidating. She believes the communication within the clinics has helped foster a pro-client attitude.

Liz Strand noted that Medi-Cal has always been the public assistance program that has focused most on screening in and least focused on screening out. San Francisco County is working program by program to instill a customer-service-oriented mentality. They are seeking resources inside and outside the department to encourage an ethos of service excellence to clients and between county departments, since other departments can often hold up the eligibility process.

INNOVATIVE APPROACHES AND LESSONS LEARNED

- Using your eligibility workers creatively can have **significant** results in terms of retention and money saved.

- Working together, outreach workers and financial counselors seem to have far greater success than either working alone.

- “Giveaways” or souvenirs gain people’s attention at outreach events.

- Evening and weekend hours for eligibility workers seem to receive a good response.

- Sending eligibility workers out into the community can help change the image of the county welfare department and make it more human and accessible.

POLICY INITIATIVES AND FURTHER ACTION

- Simplifying the application would drastically increase the productivity of all eligibility efforts.

- Changing the organizational culture is important—agencies that administer public benefit programs must see their job as helping people obtain benefits, not just screening people out. At the same time, other county agencies must foster a culture that encourages them to effectively support eligibility agencies.

SUPPORTING MATERIALS

Valley Community Outreach Services pamphlet. Contact: Marilyn Cornier, 408/885-4670.

Healthy Families program referral to Application Assistance Center. Contact: Marilyn Cornier, 408/885-4670.

Child Medi-Cal Enrollment Project marketing materials and program overview. Contact: Julia Takeda, 626/854-4935.

Afternoon Breakout Session B
Streamlining the Bureaucracy: Helping Families Navigate Across Systems

Moderator: **Wendy Jameson,** Senior Health Policy Specialist, California Association of Public Hospitals and Health Systems

Panelists: **Rasheda Rahmaan,** Eligibility Field Representative, Health Plan of San Joaquin
Linda Silva, Policy and Procedures Coordinator, San Joaquin County Human Services Agency
Sheryl L. Spiller, Division Chief, Medi-Cal and Food Stamp Division, Los Angeles County Department of Public Social Services
Katheryn Frugé-Browder, Member Services Director, L.A. Care Health Plan
Stephen Lehman, Marketing and Health Promotions Specialist, Ventura County Public Health Department

SUMMARY OF PRESENTATIONS

Goal of this Session: Enrolling in and staying on Medi-Cal can prove a difficult challenge, particularly for families who must navigate across a range of health and human services systems for assistance with eligibility paperwork. This panel highlighted local strategies to prevent people from losing their eligibility, to assist Medi-Cal beneficiaries "on hold" to retain Medi-Cal benefits, and to assist families in navigating between the Medi-Cal and Healthy Families programs, given that many families will have children eligible for different programs.

Wendy Jameson stated that two common themes throughout the summit have been confidentiality and interagency collaboration. She added that enrolling and staying on Medi-Cal is a great challenge to families, especially those with children of different ages and different eligibility statuses.

Rasheda Rahmaan and Linda Silva explained collaborative strategies developed by the Health Plan of San Joaquin (HPSJ) and the San Joaquin County Human Services Agency (HSA) to assist beneficiaries on hold to maintain their benefits. Ms. Rahmaan stressed that the foundation of this effort for HPSJ was the very early development of a pro-customer service attitude. Ms. Rahmaan will assist HPSJ members with the eligibility process regardless of the problem, and will, if necessary, accompany the member to the HSA. This attitude also helped the Health Plan approach and develop a close working relationship with the county HSA.

Health Plan staff knew that in order to develop a collaborative relationship with eligibility workers, it was important to focus on ways to help them get their jobs done, rather than to appear to be requiring more work. Accordingly, health plan staff developed policies and procedures to make work less cumbersome, and they provided an evaluation form to eligibility workers asking them how the Health Plan could make their jobs easier.

The two agencies learned the importance of keeping communication lines open at all times between the agencies on behalf of beneficiaries. To facilitate this communication, the Health Plan of San Joaquin stationed member education staff at the HSA to answer member questions and to provide ongoing member education at the HSA. The plan also installed a telephone line at the HSA that rings directly into the HPSJ office in order to answer questions posed by members or eligibility workers. This telephone also has language specific lines.

HPSJ staff worked closely with the HSA to develop and implement educational and other outreach activities for beneficiaries. The interagency relationship also resulted in training sessions for both Human Services and Health Plan staff.

Sheryl Spiller and Katheryn Frugé-Browder explained the collaborative processes they have developed to reduce the number of Medi-Cal beneficiaries suspended or terminated from Medi-Cal because of failure to return the CA-7 form.

Ms. Frugé-Browder noted that L.A. Care Health Plan, the Local Initiative in Los Angeles County, now has approximately 580,000 members. Of these, approximately 24,000-27,000 are "on-hold," 15.3 percent of whom are eventually returned to active status. The reason that most people are put on hold is that they do not complete their monthly and quarterly status reports. Approximately 15-20,000 additional members are disenrolled each month due to loss of eligibility.

To address this turnover, L.A. Care established an eligibility unit in the summer of 1998. This unit will eventually have four full time equivalent staff members. The unit sends letters to members who are on-hold, contacts members by telephone if possible, assists members who call L.A. Care with eligibility problems, and conducts outreach activities. L.A. Care and DPSS staff meet monthly to address any issues that are identified in the course of these enrollment and retention efforts.

Staff from DPSS and from L.A. Care have regular meetings with the county-wide Medi-Cal Health Access Workgroup, which is working to understand barriers to Medi-Cal enrollment and retention. The L.A. Care eligibility unit staff is receiving the same training Public Social Services eligibility workers receive. DPSS provides a tape-to-tape comparison of L.A. Care members and Medi-Cal participants, which allows L.A. Care to know when redeterminations are due. Thus, L.A. Care can contact these members and remind them to turn in their CA-7 forms. DPSS has provided a liaison to the L.A. Care eligibility unit to assist in problem solving. Finally, DPSS has implemented an eligibility supervisor review of 100% of eligibility redetermination-related terminations, to verify appropriateness of the action taken.

L.A. Care and DPSS have had significant success with these efforts. The health plan can quantify results in terms of an increased number of members released from on-hold status, decreased number of members placed on-hold to begin with, lower disenrollment due to loss of eligibility, improved demographic information on members, and decreased operating costs. In addition to assuring health coverage for families that otherwise would have lost coverage, L.A. Care has clearly saved money through these efforts. In terms of system change, DPSS is working with the

state to revise the quarterly status report to make it easier to complete. They are also advocating for the state to drop the status report requirement entirely.

Stephen Lehman spoke on behalf of Ventura County Public Health Department, a division of the county Health Care Agency, which outstations 20 Medi-Cal eligibility workers at Ventura County Medical Center, VCMC clinics, ambulatory care clinics, mental health sites, alcohol and drug sites, and selected private clinics. Ventura County has found that the outstationed eligibility workers resulted in a 143 percent increase in applications received for the population served in the provider sites; 43 percent faster processing of these applications; and a 150 percent increase in productivity of the staff involved in eligibility processing for county medical system clients.

Ventura County Medical Center has made a very significant commitment to training all staff who come into contact with patients about eligibility for Medi-Cal, including registration, medical and billing staff. Furthermore, the Ventura County Health Care Agency holds monthly meetings that bring together many different individuals who interact with patients: the eligibility workers, business/finance staff, doctors, DSS, admitting staff, and utilization review staff. Patient accounting brings a list of pending eligibility cases and all staff review difficult cases. The HCA staff is not allowed to look at hard copy DSS files on a particular patient. However, they can receive information within those files about the status of the patient's eligibility application. At the meetings, DSS staff bring the hard files and share what information they are permitted to share.

This information can help expedite the eligibility process. For example, the doctors may know something about the diagnosis that will help identify a potential eligibility category (e.g., disability). The monthly meeting helps everyone communicate changes in eligibility rules, which change frequently. Sometimes DSS learns of changes first, while sometimes HCA knows about them first. The meeting also helps identify services that are no longer covered by Medi-Cal. Business office staff may report that a particular treatment is now being denied, because they receive the denied TAR's.

HCA has also received access to the Department of Social Services' electronic eligibility files, the Welfare Information System (WIS). This system contains non-confidential information about each patient's eligibility status.

INNOVATIVE APPROACHES AND LESSONS LEARNED

- In general, outstationing eligibility workers can produce dramatic increases in productivity and enrollment of Medi-Cal-eligible patients in county health systems.
- Well-thought-out collaboration between health plan staff and eligibility workers can help reduce, rather than increase, the workload on the eligibility workers. If a collaborative relationship with eligibility workers is pursued on this basis, there are many possibilities for helping beneficiaries navigate the eligibility system.

- A direct phone line between the Human Services Agency and the Health Plan of San Joaquin, to help answer member and eligibility worker questions, has been invaluable.

- The establishment of a special eligibility unit at L.A. Care Health Plan has been very successful, and much of this success is due to the very concrete support of the Department of Public Social Services.

- Comparison of Medi-Cal enrollment tapes with health plan member data allows health plans to call their members at their recertification time.

- Every staff member who interacts with patients can provide valuable information to help move the eligibility process forward. Bringing staff together to discuss difficult cases allows for important information sharing. Furthermore, training staff in various functions can increase an organization's overall awareness of the need to sign up eligible members for public health insurance whenever possible.

POLICY OPTIONS AND FURTHER ACTION

- Advocate for a streamlined quarterly status report and, ultimately, for elimination of the status report requirement altogether.

- Provide twelve months' continuous eligibility for children enrolled in Medi-Cal, just as is currently available for Healthy Families beneficiaries. This would eliminate the entire issue of maintaining eligibility for the twelve month time period.

- The state should put enrollees' phone numbers on the MEDS tapes, so that health plans can more easily contact their members.

- A waiver statement should be added to the Medi-Cal managed care enrollment form that enrollees would check if they do not want the health plan and the social services agency to share information. If the enrollee did not check this box, then the agencies could communicate important information to help the enrollee maintain benefits.

- County health systems can improve their enrollment and retention efforts with access to the social service department's Welfare Information System.

SUPPORTING MATERIALS

Health Care Decision Chart (to help determine which program a child may be eligible for.) Contact: Sheryl Spiller, 562/908-8544.

MEDS Quick Reference and Aid Codes Master Chart. Contact: Linda Silva, 209/468-1067.

Sample letter to "on-hold" plan member. Contact: Rasheda Rahmaan, 209/939-3500.

Procedures for Processing Members Off Hold. Contact: Rasheda Rahmaan, 209/939-3500.

Afternoon Breakout Session C
Smooth Transitions: Helping Families Maintain Health Coverage When Cash Benefits End

Moderator: **Valerie Lewis,** Program Manager, Medi-Cal Policy Institute

Panelists: **Marlene Ratner,** Unit Manager, Medi-Cal Eligibility Branch, California Department of Health Services
Ingrid Aguirre Happoldt, Policy Analyst, Medi-Cal Policy Institute
Linda Monroe, SAWS Consultant, Medi-Cal Eligibility Branch, Department of Health Services
Emmie Hill, Division Director, Alameda County Department of Social Services

SUMMARY OF PRESENTATIONS

Goal of this Panel: This panel provided an overview of the statewide changes being implemented in the Transitional Medi-Cal program and in the new Section 1931(b) program, both of which provide Medi-Cal coverage to families losing their cash benefits. Panelists discussed local efforts to increase utilization of Transitional Medi-Cal and addressed issues related to Medi-Cal aid code 38, the temporary aid code for all AFDC-linked Medi-Cal beneficiaries who lose cash benefits.

Marlene Ratner provided an overview of the programs under which Medi-Cal beneficiaries may retain their benefits when they lose cash assistance. Specifically, she discussed Transitional Medi-Cal and the new Section 1931(b) program.

Transitional Medi-Cal is an existing program that allows Medi-Cal beneficiaries to keep benefits without a share of cost when they lose cash benefits for one of three reasons: a) they get a job; b) their income rises; c) they lose the ability to disregard certain forms of income. TMC is available in two six-month segments. It is easy to obtain the first six months of benefits, **as long as the beneficiary turns in the final CA-7 and notifies the welfare office that she is losing cash assistance.** To be eligible for the first six months of TMC, individuals must be enrolled in Medi-Cal for three months; they must have a child; and they must be employed.

For the second six months of TMC, there is an income cap. Gross earnings minus child care costs cannot exceed 185 percent of the federal poverty level. Also, the individual must have participated in TMC for the first six months.

In January of 1998, there were 57,000 individuals statewide enrolled in the first six months of Transitional Medi-Cal, and 23,000 enrolled in the second six months. This is only about 10 percent of all people who lost cash benefits. Ms. Ratner stressed that they do not currently know what percentage of these people are actually eligible for TMC. Many of the people who lose cash benefits may immediately get them back, for example, and thus be ineligible for TMC. It is also possible that families don't know about TMC, feel it is unnecessary because their children

are healthy, or want nothing to do with Social Services. The Department of Health Services is developing a survey to determine why people are not enrolling in TMC.

Section 1931(b). The state is also in the process of developing regulations for a new eligibility category mandated by the federal welfare reform legislation. Section 1931(b) of the Personal Responsibility and Work Opportunity Act (PRWORA) states that anyone who would have been eligible for AFDC under the income and other requirements in effect as of July 16, 1996, will continue to be eligible for Medi-Cal regardless of whether he or she can receive cash benefits under TANF. These regulations are expected to be completed in January of 1999. Until then, the Department of Health Services has instructed county social services departments not to terminate anyone from Medi-Cal when they lose their cash benefits, but to hold them on Medi-Cal in aid code 38. Thus, since January 1998, the number of beneficiaries in aid code 38 has increased dramatically. Counties will need to evaluate these beneficiaries for Section 1931(b), and for Transitional Medi-Cal, once the regulations are issued in January 1999.

Future Plans. On November 1, the Department of Health Services will conduct a phone survey of all beneficiaries leaving Medi-Cal in Orange County during the month of September, to try and determine why people are not signing up for TMC. This survey is described in more detail in Linda Monroe's presentation below. DHS will be implementing a toll-free line later this fall which will provide information about TMC in ten languages. DHS has also developed a flyer with information about Transitional Medi-Cal and a brief application; once finalized, this flyer will be incorporated into all CalWORKS termination notices, as required by the recent budget legislation. The state also has enacted a second year of Transitional Medi-Cal, funded only by the state, for individuals over age 19 with income below 185 percent of the federal poverty level. This program is expected to begin late in 1998.

Ingrid Aguirre Happoldt described the efforts of the Medi-Cal Policy Institute to understand the reasons for the very low enrollment in Transitional Medi-Cal. The Institute brought together a number of knowledgeable parties, including state policymakers, professionals from county social services agencies, local health plan representatives, the Legislative Analyst's Office, and academic researchers. They have focused on three areas that might improve Transitional Medi-Cal participation: communication to consumers, communication between the state and the counties, and communication between the state Department of Social Services and the State Department of Health Services.

To ensure continued coverage, it is essential to prevent people from losing their Medi-Cal benefits in the first place. For example, it is difficult, but very important, to encourage beneficiaries to fill out their final CA-7 form when leaving cash aid in order to trigger the Transitional Medi-Cal enrollment process.

Ms. Aguirre Happoldt noted that although eligibility workers are already overworked, they are absolutely vital to the retention process. The work group has discussed ways to assist the eligibility workers, such as development of a "cheat sheet" about Transitional Medi-Cal. Alameda County has already developed a TMC flow chart, and a subgroup of the Transitional Medi-Cal work group is working to develop a "cheat sheet" for use statewide.

Ms. Aguirre Happoldt reported that the Southern Institute on Children and Families in Georgia has developed some excellent materials on programs available to people who are losing cash benefits. These materials are colorful, straightforward, and discuss all the various assistance programs (Medicaid, child care, etc.) in one flyer. To obtain a copy of these flyers, call SICF at 803/779-2607.

There are research efforts underway to study the reasons for low enrollment in Transitional Medi-Cal. Researchers at California State University at Northridge have developed a survey instrument for focus groups and telephone surveys of TMC eligible individuals. Also, the Urban Institute will be looking at California and several other states regarding the impact of welfare reform on health care.

Linda Monroe, who is on loan to the state Department of Health Services from her long-term position at Orange County's Department of Social Services, discussed Orange County's efforts to maintain individuals on Medi-Cal after they leave cash aid. Orange County has always had specialized workers for Medi-Cal and TMC. Prior to February 1997, every cash case that was terminated was "touched" by one of these workers. The county sent out a modified application form to these clients, who had to fill it out and return it. Under these circumstances, Orange County had a 25 percent return rate (significantly better than the 10 percent statewide enrollment figure). Without the form, Orange County had no information on the beneficiary's new circumstances and no authority to keep the family on Medi-Cal. Furthermore, the county got no administrative money to cover their efforts to reach the 75 percent of terminated cases who did not return their forms.

In February 1997, Orange County implemented a pilot program, in which they pulled out all of the information they had on every terminated cash case. Often, there was enough information about the family in the file to establish Medi-Cal eligibility. If there was not enough information, a worker would call the family and try to obtain the necessary information. If the family was not reachable, then the county would send the mailing with the modified application form—and they still got a 25 percent response rate for the people who received the mailing. However, **overall** retention into Transitional Medi-Cal increased from 25 to 65 percent.

At this point, these efforts to retain people on Transitional Medi-Cal are on hold, pending completion of the Section 1931(b) regulations. However, on November 1, the state will conduct a survey of every client discontinued from CalWORKS cash benefits in Orange County to find out why they are not "taking them up" on the offer of Transitional Medi-Cal. A contractor will attempt to reach clients first by telephone, and then by mail. The survey will continue until March, and the state plans to publish a report on the results of this survey in May. In order to enhance response, CalOPTIMA, Orange County's county organized health system, will supply a ten-minute long-distance phone card to each participant. The phone card will have a recorded message providing information about Transitional Medi-Cal. Clients who participate in a follow-up survey three months later will receive an additional phone card.

Emmie Hill discussed Alameda County's Transitional Medi-Cal work group. This effort brought together representatives from Social Services, organized labor, the Alameda Alliance for Health, the Alameda Health Consortium, Blue Cross, and the Health Care Services Agency. The group undertook a number of strategies to increase Transitional Medi-Cal enrollment.

First, Alameda County consolidated all TMC cases and staff into one location in the county. They developed a TMC flow chart and revised the TMC training packets. They trained their staff to better recognize potential TMC clients and to obtain coverage for these clients. And they worked with the Alameda Alliance for Health to develop the flyer that was distributed during the morning session.

Alameda County also undertook efforts to call discontinued CalWORKS clients and encourage them to sign up for TMC, with disappointing results. These efforts were made between May and July of 1998. Staff was able to contact only about 8 percent of all clients, and received only 7 CA-7 forms out of 698 clients during the period. This was true despite attempts to reach people at various times (including evenings) and the offer of a $20 gift certificate for groceries from Lucky or Safeway for all those returning their forms. Ms. Hill hypothesized that the low response reflects a general mistrust of the Social Services Department. Interestingly, Los Angeles County has apparently had more success when contacting potential TMC clients. Los Angeles County has a goal of contacting every cash termination case to discuss continued health care benefits.

At this time, the department is holding all discontinued cases in the Edwards category (e.g., aid code 38), pending the release of the Section 1931(b) regulations. The number of Edwards cases has climbed from 1,500 in January to 6,000 in June, and the county expects to have 20,000 cases to review when the Section 1931 program is implemented. The Department of Social Services is very concerned about the need to review all of these cases. At the end of September, they will submit their implementation plan to the Board of Supervisors. The state will allow up to a year for this re-evaluation; however, the county will not be administratively funded for aid code 38 until they re-evaluate all the hold cases. The county is also hiring an outside contractor to conduct a focus group on the reasons why people are not signing up for TMC.

An audience participant suggested developing a mechanism to study what will happen to people after two years of TMC (e.g., will they be insured through work?). Ms. Aguirre Happoldt noted that the state has tried to look at this in conjunction with its application for a waiver for two years of TMC. The state wanted to show cost-neutrality, i.e., that an additional year of TMC might result in enough people obtaining employer-based insurance to cover the cost of the additional year.

INNOVATIVE APPROACHES AND LESSONS LEARNED

- The most important step in retaining eligible families on Transitional Medi-Cal is getting them to return their final CA-7 form to the social services department when cash benefits are terminated. Families may be unaware that they need to do this, or unwilling to have further

interactions with the social services department, unless the TMC program is explained to them and they are encouraged to complete the paperwork.

- Information from a closed CalWORKS case can often be sufficient to establish TMC eligibility without additional documentation from the family.

- Efforts to call potential TMC eligibles and explain the program have increased retention in the TMC program in Los Angeles, Orange and Alameda Counties.

- However, in Alameda County, these efforts were more successful when conducted by the Alameda Alliance for Health than when conducted by the Department of Social Services. Clients may be less willing to respond to phone calls from a social services worker than from another source, such as their health plan.

POLICY OPTIONS AND FURTHER ACTIONS

- Monitor the development and implementation of the Section 1931(b) regulations.

- Advocate for more informative and user-friendly materials about assistance programs for families losing cash benefits, such as those produced by the Southern Institute on Children and Families.

- Monitor the results of various research and outreach initiatives currently being developed, such as the toll-free hotline and the TMC flyer in CalWORKS termination notices.

- Share useful county initiatives, such as a TMC cheat sheet for eligibility workers, so that these may be used in other counties.

- Health plans and county social service departments should communicate with each other regarding plans for evaluating the aid code 38 cases after the implementation of the Section 1931(b) regulations. Health plans may be able to assist DSS in encouraging clients to provide the appropriate documentation to retain their benefits.

- After the TMC program has been implemented again, develop a mechanism to study whether TMC is helping families transition to other forms of health insurance.

SUPPORTING MATERIALS

Report to the Alameda County Board of Supervisors on Transitional Medi-Cal and Other Medi-Cal Programs. Contact Emmie Hill, 510/639-1087.

Draft Transitional Medi-Cal flyer and application form (to be included in all cash benefit termination notices per the 1998 budget legislation). Contact: Marlene Ratner, 916/657-0715.

DHS Transitional Medi-Cal Flow-Chart. Contact: Marlene Ratner, 916/657-0715.

"Orange County Transitional Medi-Cal Efforts." Contact: Linda Monroe, 909/280-0688.

Medi-Cal Policy Institute *Medi-Cal Facts* primer on Transitional Medi-Cal. Contact: Ingrid Aguirre Happoldt, 510/238-1040.

See also Alameda County Interagency Collaboration Panel for more TMC materials.