

## All Children Have Health Coverage

# OUTCOME ONE

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## Using This Guide: A Note to Building Healthy Communities Coalition Leaders

### Purpose

Each of the Building Healthy Communities *Outcome Resource Guides* is intended to provide a deeper understanding of the background and context for each outcome, a sampling of promising practices and strategies that will contribute to achieving each outcome, and additional tools and resources that can help local leaders plan for improving the health of their communities. These guides were written specifically to assist local leaders and planners in the 14 communities participating in the Building Healthy Communities program of The California Endowment.

### Strategies and Promising Practices

The strategies and practices described in each guide are intended to provide options and spark new ideas for local planners. These lists and examples do not represent all known strategies and policy directions in the field. Rather, they represent an overall direction that, based on the evidence at hand, show promise for contributing to a comprehensive approach to improving health in California communities.

### Indicators of Success

These indicators are examples of ways to measure changes in this outcome. The appropriate indicator to use as a part of measuring progress, either as a part of an evaluation or a performance monitoring plan, will depend on the targeted changes and strategies that are selected either as part of a Place's work plan or part measuring a grantee's performance.

### Contributing to the knowledge base

These guides constitute the beginning of a TCE library of resources that will grow over the next 10 years based on the experiences of BHC communities, as well as on emerging evidence for promising policies and practices in the field as a whole. Community residents, local leaders as well as researchers and scholars are invited to add to this foundation as new tools, strategies, experience and evidence emerge. Please contact TCE at [www.calendow.org](http://www.calendow.org).

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**Outcome One: All Children Have Health Coverage****I. Background**

A top priority for California in the national health reform debates is that everyone has access to high-quality, affordable health insurance, especially the 6.4 million uninsured Californians. Children have a large stake in this debate. The California Endowment believes that ensuring all California children have high-quality, affordable health care coverage is the most practical first step toward achieving universal coverage. By taking this step California can at once reduce the number of uninsured, address the health needs of our children and their families, set the tone for implementation of health reform, and lower health costs in the future as healthy children become healthy adults. This in short is the focus of Outcome One.

**Why an Outcome on Children's Coverage?**

**Californians feel strongly that children's health coverage is a priority for the State.**

Starting with children's coverage is a feasible, achievable, and popular strategy, particularly when we are already investing over 90% of the public and private resources necessary to complete this important job.

- "Main Street" coalitions in a majority of the state's 58 counties have made children's health a priority and are working together to improve health services broadly.
- Nearly 80% of voters support the idea of health insurance for all children, consistent with the levels seen over the last couple of years. Specifically, four out of five voters (79%) favor children's coverage, with three out of five voters (60%) strongly supportive of it. Few voters are opposed to it (15%) or are undecided (6%).
- Insuring all children draws bipartisan support as well as backing from voters throughout the state: 89% of Democrats, 83% of Independents, and 66% of Republicans want to ensure all children have health insurance. Support is strong throughout the state – 79% in Los Angeles County, 84% in San Diego and in the Bay Area, and 76% in the Sacramento area of the Central Valley and in suburban Los Angeles, which includes Orange County and the Inland Empire.

**Children's health coverage will lower costs in the long term.**

Improving the health of California's children will result in healthy adults for the future. This is the only approach to cost containment that will both lower costs AND improve the health of Californians.

- Data show that children with health insurance are healthier. National studies demonstrate that children with insurance coverage are more likely to have access to a usual source of care, well-child care, immunizations, prescription medications, appropriate care for asthma, and basic dental services. They receive more timely diagnosis of serious health conditions, experience fewer avoidable hospitalizations, have improved asthma outcomes, and miss fewer days of school.<sup>1</sup> California-specific research demonstrates that enrollment in Healthy Kids programs (local insurance for children not eligible for Medi-Cal or Healthy Families) is associated with an increased use of medical and dental care, improved health status, and fewer school days missed. Enrolled children also experience dramatic improvements in having a usual source of care, receiving a recent medical visit, and dramatically lower levels of unmet medical needs when compared to uninsured children. In addition, parents of

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children with coverage reported far more confidence that they could obtain care for their children than uninsured children.<sup>2,3</sup>

It is estimated that the Healthy Kids programs statewide may have helped prevent as many as 1,000 hospitalizations a year by treating health conditions such as asthma earlier on an outpatient basis before they escalated and required hospitalization. If available in all California counties, USC researchers estimate that Healthy Kids could prevent an additional 4,300 hospitalizations annually, at a savings of an estimated \$24.3 million per year.<sup>4</sup>

- Healthier children make better learners, and become healthy, active, and productive adults, which lowers health insurance premiums down the road.
- In short, children’s health insurance is smart social, health, and economic policy.

### Children’s health coverage can unite a broad array of interests across the state.

- Teachers, small business leaders, parents, faith leaders, doctors, elected officials, community leaders, and health care providers are all actively engaged in children’s health.
- These stakeholders are united behind a “roadmap for reform” that starts with health insurance coverage by 2011, and leads to an agenda that converges around prevention, detection, and development. All California’s children will benefit immediately and California will benefit in the long run.

## The Roadmap for Children’s Health Coverage

### A. Expand health coverage to all children in California.

Evaluation results demonstrate that Medi-Cal and Healthy Families enrollment reach maximum levels only when coverage is expanded to all children and enrollment procedures are simplified. A study of the Santa Clara Children’s Health Initiative (CHI) showed more than a 25% increase in Medi-Cal and Healthy Families enrollment with the CHI than would have been expected without the CHI. The added enrollment resulted in increased state and federal spending in Santa Clara County by an estimated \$24.4 million during the initiative’s first two years.<sup>5</sup>

### B. Improve systems and policies to ensure that children get enrolled and stay enrolled.

Web-based technology, re-engineering of local social services staff, and simple forms can eliminate barriers to coverage and retention; lower administrative costs for the state; increase cultural and linguistic competence.

### C. Increase points of access for children by using coverage to provide preventive health care and health promotion services (inclusive of physical, dental, mental, and vision).

Using coverage to expand School-based Health Services at the elementary, junior, and senior high school levels can improve preventive services, provide access to behavioral health services, and encourage healthy lifestyles. Coverage provides the sustainable funding required to realize this expansion.

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**D. Reduce the burden of chronic health conditions through coverage of prevention strategies.**

Coverage can aid efforts to reduce obesity, improve asthma care, and increase behavioral health through school-based health centers, after-school programs, improvements in school nutrition and physical activity, and changes to environments where kids live and play.

**II. Brief Overview of Children's Coverage in California****Short History of Children's Health Coverage in California**

The health care system for low-income and vulnerable children in California is characterized by a complex combination of multiple large and small programs, some of which are designed to provide comprehensive (or nearly comprehensive) insurance, while others provide or finance particular services, usually for a specific health condition or population. This multitude of programs is governed by different eligibility standards, different reimbursement rules and amounts, different benefit structures, and different administrative systems. As a result, many families face difficulties knowing how to obtain services; in other cases, children fall through the gaps because they don't fit the particular eligibility criteria for particular programs. Thus, despite the many programs and services in California, many children remain unserved because family income, immigration status, health status, level of need, and often, where a child lives, determine eligibility for and access to coverage and services.

This patchwork of direct services and insurance programs evolved over time. Beginning with the enactment of the Social Security Act of 1935, which established the Title V program, states are provided with funds to offer limited health services for select groups of children, such as those with disabilities and those at risk of neonatal death, and for the provision of specific services such as immunizations.<sup>6</sup> The current patchwork is also the legacy of incremental efforts to provide funding to specific providers who serve low-income populations such as hospitals, which serve a disproportionate share of Medicaid patients (DSH), and federally qualified health centers (FQHC).<sup>7</sup>

More comprehensive insurance was introduced in 1964 with the advent of the Medicaid program (Medi-Cal in California) as part of the War on Poverty. Initially, Medicaid was an adjunct of the welfare programs, focusing on women and children in poverty. To be eligible for Medicaid, a child had to be linked to a welfare program known as Aid to Families with Dependent Children (AFDC), which meant having an absent parent ("deprivation") and very low income. In 1984, Medicaid was "de-linked" from the welfare programs and eligibility was expanded to all children whose families met certain expanded income guidelines.

From the ashes of President Clinton's failed national health reform effort in 1994 arose the drive to provide health insurance coverage for all children. Congress passed the Children's Health Insurance Program (CHIP) in 1997, which provided federal funding for state expansion of children's coverage. Rather than expanding Medi-Cal, California chose to create a new program called Healthy Families, which relied upon private and public health plans to provide coverage to the newly expanded population of children in families up to 250% of the federal poverty level (FPL) (currently \$55,125

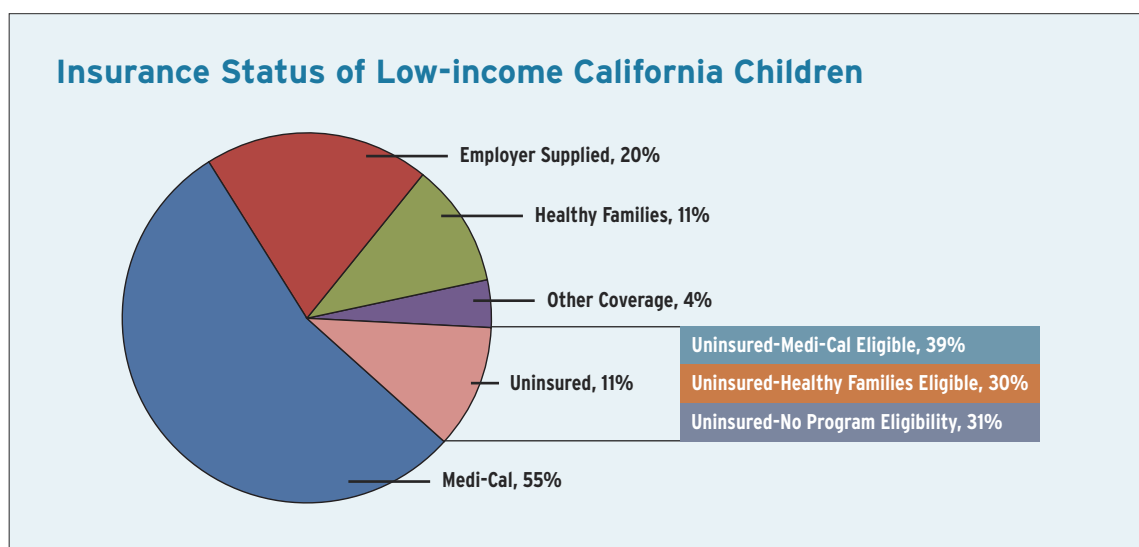
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for a family of four)<sup>8</sup>. Congress re-authorized CHIP in 2009 and allowed states to expand their eligibility limits to additional children. California has not expanded its program<sup>9</sup> and, in fact, has contemplated reducing the number of eligible children as part of its solutions to the budget deficit.

### Current State of Children’s Health Coverage

Overall, most California children (55%) still receive their health insurance through their parents’ employers. Medi-Cal covers more than one quarter of California children (26%) and Healthy Families covers 7% of children, while an additional 5% have privately purchased coverage. Approximately 6%, or 683,000 children, are uninsured statewide.

The distribution of health insurance differs dramatically for children in low-income families. For children in families with incomes up to twice the federal poverty level (\$44,100 for a family of four), only 20% have employer-based coverage, over half (55%) are covered by Medi-Cal, and 11% by Healthy Families. 11% of low-income children are uninsured.



### Outreach and Enrollment

A large proportion of the currently uninsured children are eligible for, but not enrolled in, Medi-Cal and Healthy Families. Of the low-income uninsured children (under 200% FPL), seven out of ten are eligible for, but not enrolled in Medi-Cal (39%) or Healthy Families (30%). The remaining children (31%) are not eligible for any public program, most likely due to their immigration status. For this reason, reaching uninsured children requires efforts to both enroll children who are eligible in existing programs and to create opportunities for those who are ineligible.

### Retention

Keeping children on health insurance is also a major challenge. Studies show that children need stable, continuous health insurance to get the full benefit of health care. Children with stable

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coverage are more likely to have a usual source of care and less likely to have unmet medical needs than either children with unstable, on-and-off coverage or uninsured children. Continuous coverage enables children to regularly access preventive care, while coverage with gaps leads to interruption of care, in the form of unfilled prescriptions and delayed or missed appointments. Importantly, children with unstable coverage are similar to children with no coverage at all in the benefits they receive from health care.<sup>10</sup>

Medi-Cal and Healthy Families both have poor retention rates – by the end of 21 months only approximately 50% of enrollees remain on the programs. Over one in three (35%) Medi-Cal children who have been dropped from the program are re-enrolled in the program within one year. The costs of this “churning” are considerable, both in medical costs for the families and the State,<sup>11</sup> and also in administrative costs associated with application processing.<sup>12</sup>

### Children’s Health Initiatives – A Local Solution to a Statewide Problem

Efforts to expand coverage to those uninsured children who were not eligible for Medi-Cal and Healthy Families began in earnest in the late 1990s. These were primarily children who lived in families above 250% FPL and undocumented children who were not eligible for federally funded programs. The California Endowment (TCE) funded five pilot projects to provide coverage to undocumented children. Soon thereafter, a local effort in Santa Clara County created the first Children’s Health Initiative (CHI) and enrolled the first children in a local plan called Healthy Kids in 2001. The focus of the Santa Clara program was to actively enroll eligible children in public programs and to create a new insurance product for children under 300% FPL who did not qualify for public programs.<sup>13</sup>

There are now CHI coalitions in 29 California counties.<sup>14</sup> The CHIs take a three-pronged approach to increasing coverage and seeking universal coverage among children:

- Coordinate enrollment of all children in available programs (e.g., Medi-Cal, Healthy Families, Kaiser Child Health Plan, CalKids, etc.).
- Create a new coverage program (Healthy Kids) for those children not eligible for existing programs.
- Increase retention and utilization of health coverage. There are currently approximately 66,000 children enrolled in Healthy Kids programs statewide.

With funding patched together from local resources, statewide and local foundations, health plans, providers, state and local First 5 Commissions, the CHIs are interim steps toward universal coverage for all children until there is a statewide coverage program. Originally seen as a policy effort to support the state’s effort to create a state-funded program, the children’s coverage movement gained early momentum and clear support from key state and local policymakers. Yet, this attempt to assist the state in finding the appropriate funding mechanisms has proved illusory.

California has current opportunities to expand coverage to more children with federal matching funds, but has not chosen to do so.<sup>15</sup> While ongoing advocacy continues to have a state policy for coverage for all California children, local communities have mechanisms to ensure that all their

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children have access to comprehensive health coverage and care. This resource guide provides key information to help community leaders map out a strategy to enroll all eligible children in existing programs, while creating new coverage programs to fill in the gaps.

**TABLE 1 Community Resources for Health Coverage for All Children**

	TCE PLACE	COUNTY	CHILDREN'S HEALTH INITIATIVE	KAISER CHILD HEALTH PLAN	CAL KIDS	MEDI-CAL LOCAL PLAN	ONE-E-APP
1.	City Heights	San Diego		Closed to new enrollment	Yes		
2.	Coachella	Riverside	Yes	Closed to new enrollment	Yes	Yes	
3.	Central Santa Ana	Orange	Yes	Closed to new enrollment	Yes	Yes	Yes
4.	Central Long Beach	LA	Yes	Closed to new enrollment		Yes	Yes
5.	Boyle Heights	LA	Yes	Closed to new enrollment		Yes	Yes
6.	So. Figueroa/ Vermont-Manchester	LA	Yes	Closed to new enrollment		Yes	Yes
7.	So. Kern County	Kern	Yes	Closed to new enrollment		Yes	
8.	Central/W. Fresno	Fresno	Yes	Open		Yes*	Yes
9.	Merced	Merced	Yes	Not available	Yes	Yes	
10.	East Salinas	Monterey		Not available	Yes	Yes	
11.	East Oakland	Alameda		Open		Yes	Yes
12.	Richmond	Contra Costa		Open		Yes	Yes
13.	So. Sacramento	Sacramento	Yes	Open			
14.	Del Norte	Del Norte	Yes (no Healthy Kids)	Not available	Yes		

\* In the process of formation.

### III. Promising Strategies and Practices

#### A. Ensure Access to Comprehensive Coverage

Comprehensive coverage is a necessary component of ensuring that children have access to a full range of integrated services with a consistent set of providers. Coverage should include all aspects of a child’s health needs – medical, dental, mental health, and vision. It should also have cost-sharing provisions that encourage parents to appropriately use early preventive services and minimize the use of non-essential emergency departments.

Having a “health home” is important to make certain that a child is with a provider that knows his or her health history, provides preventive and primary care, coordinates other health needs, and generally ensures that a child is healthy.<sup>16</sup>



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Both Medi-Cal and Healthy Families offer comprehensive benefits. The Medi-Cal scope of benefits is somewhat broader than Healthy Families in that it covers a wider range of treatment services under its Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) components.

Healthy Families' benefits are similar to most comprehensive commercial plans. There are no premiums or co-payments for children enrolled in Medi-Cal; Healthy Families co-payments are minimal and premiums are low.

In addition to comprehensive medical care, children need ongoing access to dental, vision, and mental health services. Dental coverage and early utilization are essential since childhood caries is the most common childhood disease – among five- to seventeen-year-olds, dental caries is more than five times as common as asthma. Dental insurance increases access to routine care and reduces the prevalence of untreated decay, but California children are three times as likely to be uninsured for dental care as for medical care. Vision coverage is also important to enable children to have early eye care, which is essential to learning and growth.

Mental health coverage is more complicated. While mental health services are covered under regular Medi-Cal for services provided by medical practitioners, comprehensive mental health services for serious conditions are covered by county Medi-Cal mental health managed care systems. They may also be covered by other programs offered by schools and regional centers for those with developmental disabilities. Mental Health coverage under Healthy Families is covered by the health plan, which generally contracts with a mental health plan to coordinate care with a network of mental health providers.

For those children who are not eligible for Medi-Cal or Healthy Families, the Healthy Kids programs sponsored by the CHIs have benefit structures that mirror Healthy Families and often have the same health plans and provider networks. The Kaiser Child Health Plan also has a scope of benefits that is similar to Healthy Families. The CalKids program offers a full range of primary care, but does not cover hospitalizations.

**Where to start:** Working with your local Children's Health Initiative (CHI) is the logical place to start to develop a coverage program. **Table 1** page 6 will let you know if there is one in your county. Contact information may be found at [www.cchi4kids.org](http://www.cchi4kids.org). For those counties without a CHI, you might consider organizing one using the toolkit listed in the Resources section.

### 1. Maximize Federal and State Funding

It is clear that low-income communities lack all the internal resources to provide coverage to all children. For this reason, it is important to maximize the use of outside funding, most significantly, federal and state funding. The simplest way to

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shift local costs to the federal and state governments is to enroll all eligible children in Medi-Cal and Healthy Families. Since these programs are fully funded by the state and federal government, payments to local providers for children enrolled in these programs – clinics, doctors, and hospitals – replace local resources that are being spent for uninsured children by providers, parents, nonprofit agencies, and donors.

Additional funding may be available through grants for providers who care for the low-income populations such as community health centers and public hospitals. Funding opportunities for outreach, enrollment, and retention are discussed below.

California may also draw down more federal funds if it enacts certain options that were made available in the reauthorization of the Children Health Insurance Program in early 2009. California may extend its Healthy Families program to cover 300% FPL. It may also draw down federal funds to cover legal immigrant children who previously were not eligible for federal support during the first five years of residence in this country. Extending Healthy Families to 300% FPL would require a one-third match by the state. However, extending coverage to legal immigrant children would save the state funds since they are already covered by the State without federal financial participation.

**Where to start:** Working with statewide advocates (listed in **Appendix A**) can help you learn about advocacy opportunities at the state and federal level on increasing funding for coverage in your area. With the enactment of CHIPRA (**see box below**), there are many additional opportunities to draw down federal funds, but the State has not implemented those provisions. Advocacy at the state level is necessary. Enrolling more children into Medi-Cal and Healthy Families means that care for local children will be paid for by federal and state funds, rather than by local funds.

**Children’s Health Insurance Program Reauthorization Act (CHIPRA) Opportunities**

The recently enacted federal Children’s Health Insurance Program Reauthorization Act (CHIPRA) gave states additional options for expanding and improving their children’s coverage programs with substantial federal funding. California has yet to take advantage of these opportunities, but continued policy advocacy could lead to statewide change.

Local coalitions can take an active role in ensuring that California maximizes the opportunities afforded by CHIPRA. Coverage for all children is a proven way to maximize enrollment into programs with federal financial participation, reduce hospitalizations of uninsured children, improve access to care, and have children miss fewer days of school. The critical issues on which local coalitions can make concerted efforts at the state level include:

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- **Expansion of Healthy Families to 300% of the FPL** – The locally funded Healthy Kids programs already cover children up to 300% FPL, and with the availability of federal funds for these children, California would continue its efforts toward universal coverage for children. In addition, the new federal and state funding would free up some Healthy Kids funds in order to cover other ineligible children. The Legislature and Governor need to be urged to adopt this expansion.
- **Coverage for legal immigrant children** – Local coalitions can advocate for California to draw down matching federal funds for children who are currently being covered with state-only funds. The state savings could be retained for children’s coverage or OERU expansion.
- **Dental “wrap-around” coverage for children with medical, but no dental, coverage** – California children are three times more likely to have no dental coverage than to have no medical coverage. CHIPRA enables the state to provide dental-only coverage to Healthy Families children. CHIs can advocate that the state adopt the CHIPRA option and ensure that Healthy Families coverage meets CHIPRA requirements.
- **Outreach, enrollment, retention, and utilization** – Local coalitions can pursue aggressive outreach and enrollment to maximize the bonus payments available to California, and advocate for the adoption of OERU programs such as Express Lane Eligibility. In addition, coalitions can advocate for adoption of the simplified citizenship verification processes to ease enrollment.
- Continued advocacy for coverage for all children as a proven way to maximize enrollment into programs with federal financial participation, reduce hospitalizations of uninsured children, improve access to care, and have children miss fewer days of school.

**2. Eliminate Families’ Financial Barriers Related to Premiums and Services (Co-Payments)**

The actual cost of a child’s care to a family takes many forms. For insurance such as Healthy Families, there is a monthly premium that a parent pays for the child’s coverage. Parents must also contribute a co-payment to the provider at the time of service or when a prescription is filled. There are additional costs for services and drugs that are not covered, including over-the-counter medications. For the uninsured, there are provider fees, including sliding scale fees, or perhaps out-of-pocket costs while trying to qualify for a program. Other “hidden” costs include time off from work for appointments or illness, and travel costs associated with obtaining care. All of these costs must be taken into account when designing community health coverage.

While there is an inclination to save program costs by imposing significant cost-sharing in the form of premiums and co-payments for services and prescriptions, a persuasive body of research has shown that low-income populations can be adversely affected by cost-sharing. Co-payments have a significant effect on utilization, and they do not discriminate well between necessary and unnecessary care. The cost of delayed care often outweighs the costs of early primary care.

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Meanwhile, the use of emergency departments for routine care is a significant issue. Ways to reduce the inappropriate use of emergency services include parent education, extended hours, and easier access to primary providers and co-locating urgent care clinics with emergency departments. Of course, providing comprehensive coverage for health needs will also act to encourage early use of primary care and reduce the use of urgent care.

**B. Establish “Gap” Programs for Uninsured, Ineligible Children**

For children who do not meet the eligibility requirements for full-scope coverage under programs such as Medi-Cal or Healthy Families, there are several options for ensuring that they receive health care.

**1. Temporary or Limited Scope Coverage**

*For uninsured children with health needs, there are several options for coverage:* Children Health and Disability Prevention Program (CHDP) screening and preventive services are available to all low-income children, regardless of immigration status. Under the CHDP Gateway program, children who are receiving these preventive services can obtain full-scope Medi-Cal coverage for a short period, while applying for Medi-Cal. Eligibility continues during the month of the original service through the next month to allow for the filing of an application. If the application is denied due to ineligibility for Medi-Cal, further Gateway eligibility is not available. If no application is filed during the presumptive eligibility period, the Gateway process may be repeated at a later time. CHDP Gateway is processed through CHDP providers.

A child may also be eligible for Medi-Cal, limited to services related to an emergency medical condition, regardless of immigration status. These limited-scope services may be provided by any Medi-Cal provider, provided they meet the standards of treatment for an emergency medical condition. Applications are processed through the local county department of social services. California Children’s Services may cover some or all of a children’s care for serious medical conditions. Applications are processed through local county health departments. Other services such as immunizations and family planning may also be available through the county or community clinics.

**2. Coverage through a Local Plan Such As Healthy Kids**

The primary model that has been pursued in California in the past ten years for uninsured children has been the creation of local coalitions, generally known as Children’s Health Initiatives (CHIs). As discussed above, the CHIs have worked to enroll and retain children in available public programs as well as to create local coverage products for ineligible children.

Most of the communities in the Building Healthy Communities initiative have Children’s Health Initiatives that should be active partners in the planning process.<sup>17</sup>

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Funding constraints have limited the ability of these programs to meet the needs of all uninsured children in a county, and the major state foundations that have been providing subsidies for older children on a limited basis will be ceasing such funding in late 2010. Funds for younger children, ages zero through five, will continue to be available through local First 5 Commissions in most CHI counties. To provide coverage for the older children, other sources of funds must be found through county contributions, hospitals and hospital districts, local health plans, and fundraising.

For those communities that do not have CHIs at the current time, there are toolkits that are available that provide a roadmap for the steps of creating a CHI. Formation of a coalition, solicitation of a health plan, and seeking funding are some of the issues that are covered.<sup>18</sup> Most counties created CHIs with the assistance of technical assistance consultants.

### **3. Establishing a Health Home at Safety Net Institutions Such As Community Health Centers**

If it is not possible to enroll children into a temporary or comprehensive coverage program, linkages with community safety net institutions can be created to ensure that children have access to quality, continuous care. In many cases, these children are already patients of the safety net through the CHDP or other programs. In addition, their siblings or parents may be eligible for Medi-Cal and Healthy Families and are also patients at the health centers.

Federally qualified community health centers (FQHCs) receive federal grant funds to serve the uninsured, including children, and may not turn any patient away due to lack of funds. County clinics may have similar policies to provide care to the uninsured. FQHCs can be found through an online guide sponsored by the California Primary Care Association.<sup>19</sup>

Many communities have found that having community health clinics as active partners in their local health coverage coalitions has facilitated the process of establishing health homes for uninsured children. At times grant funds are available to supplement other sources, but often the clinics will see the patients as part of the mission to serve the uninsured and seek reimbursement from available state and federal programs.

#### **C. Focus on Enrollment and Retention**

Outreach and enrollment efforts are conducted by many different sectors – county social services departments, community-based organizations, CHIs, health clinics, school districts, and other coalitions. These organizations use a variety of strategies for reaching and enrolling children – media campaigns, “in-reach” through providers, school-based efforts, community events, and case management by community workers. Technology assists in enrollment efforts through programs such as One-e-App. The most promising strategies are discussed in more detail on the next page.

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Community advocates have reported many challenges to success for enrollment and retention. They have also developed many strategies to overcome these challenges. Among the barriers to successful enrollment and retention are:

- a confusing array of programs with differing eligibility standards, services, plans, and providers
- a complicated enrollment and re-enrollment process
- a lack of understanding by parents of the need for continuous coverage
- minimal public funding to assist families with enrollment and re-enrollment

**Successful strategies to overcome these barriers include:<sup>20</sup>**

1. **Community coalitions** to raise awareness of the need for health coverage, to assist parents in obtaining coverage under existing programs, and to provide coverage for children who are ineligible for public coverage.

The past ten years have taught that community coalitions are essential to ensuring that children have health coverage. The most successful coalitions bring together schools, clinics, and other medical providers, local health plans, county social services agencies, community advocates, philanthropies, and local government leaders. These coalitions can help coordinate current activities, identify problems and gaps, and develop new programs.

2. A “**no wrong door**” approach to enrollment that helps parents to enroll their children in health coverage through whatever way they enter the system (e.g., health clinic, school, social service department, nonprofit agency, etc.).

To overcome the maze of programs that parents confront when trying to obtain care and coverage for their children, successful coalitions have found that allowing for the enrollment of children through many different gateways improves the success of enrollment activities. Rather than having a parent visit multiple offices for different programs, a “no wrong door” approach allows for multiple agencies that come in contact with children to assist in enrollment in multiple programs. Electronic enrollment systems such as One-e-App (discussed below) can facilitate enrollment in many different programs through one application interview. These systems can be developed and implemented locally using existing resources.

3. Trained **Certified Application Assistors** to work with parents to enroll children in health coverage and to keep children covered in linguistically and culturally appropriate ways.

With the myriad of programs and application processes, trained community assistors have been invaluable in navigating program applications. These assistors are often housed in community-based agencies and can be qualified as “certified application assistors” (CAAs) by the state agency that administers the Healthy Families program.<sup>21</sup> As members of the community, the CAAs often have the same cultural background as the parents and speak the same language. Core training of many advocates and specialized training for CAAs ensure that they are knowledgeable and current with program policies and procedures and can assist on more complicated cases.

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4. Use of **technological enhancements** to facilitate enrollment in the correct program and assist with re-enrollment.

Health-e-App is an Internet-based application used to simplify and expedite the enrollment processes for Medi-Cal and Healthy Families for children and pregnant women. It allows the application, signature, and supporting documents to be transferred electronically from a local enrollment site through the “Single Point of Entry” to the appropriate state or county agency for processing and eligibility determination. Using Health-e-App also minimizes mistakes caused by illegible handwriting on paper applications and leaves little room for error. Health-e-App is available statewide at no cost for use by CAAs and individuals, and CAAs can monitor the status of client applications.<sup>22</sup>

As an enhancement to Health-e-App, a number of counties have adopted One-e-App, which uses enhanced emerging technology to assist in the processing of applications for multiple programs. One-e-App is a Web-based system for connecting families with a range of publicly funded health and social service programs. This one-stop approach improves the efficiency and user-friendliness of the application process for families seeking health coverage. The application uses an interactive interview approach to help simplify data collection and entry, and helps to improve the quality and completeness of applications. It allows for real-time selection of a provider and a health plan, and real-time submission of applications for final eligibility determination.

One-e-App is used by CAAs, health clinics, caseworkers, and program administrators in a number of California counties, including Orange, Los Angeles, Fresno, and Alameda. More modules such as Express Lane Eligibility are being tested in a number of sites.<sup>23</sup> One-e-App has been implemented on a county-by-county basis in willing communities.

Other counties have also developed local databases to assist in enrollment and re-enrollment of children. These databases are often used with one particular coverage program such as Healthy Kids, but may also do some basic analysis of eligibility for other coverage programs such as Medi-Cal and Healthy Families. A local database is being used in Sacramento for its Healthy Kids program.

5. Use of **“Express Lane Eligibility,”** whereby children who are already enrolled in one program such as free/reduced price school lunch or WIC, are enrolled in Medi-Cal or Healthy Families.<sup>24</sup>

Express Lane Enrollment in California is an optional program that enables school districts to streamline and expedite the Medi-Cal enrollment process for uninsured children who receive free school meals through the school lunch program. It also provides a linkage to Healthy Families.<sup>25</sup>

CHIPRA further authorizes Medicaid and SCHIP agencies to borrow specific eligibility findings from other public need-based programs such as the National School Lunch Program (NSLP), Food Stamps, and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), rather than having to re-gather and re-analyze data according to their own rules.

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WIC is another great partner for identifying and enrolling uninsured children into existing programs. Since over 60% of California newborns receive WIC through 650 local centers, WIC provides a valuable opportunity for reaching parents of young children.<sup>26</sup>

Express Lane Enrollment can be implemented locally under existing regulations; its expansion will require some statewide advocacy.

6. **“In-Reach”** to children and parents where they are already receiving services such as health clinics or schools.

Reaching children and their parents at medical providers such as community health clinics is another effective strategy for identifying uninsured children and assisting them with enrollment. Intake workers at the clinics can identify uninsured children and assist their parents with enrollment or refer them to a CAA. When coupled with One-e-App, enrollment processes are streamlined. Clinics also have a financial incentive for enrolling children in programs since their sliding scale funds are limited and they receive favorable reimbursement from Medi-Cal.<sup>27</sup> In one CHI, over two-thirds of applications for the Healthy Kids program came through clinics.<sup>28</sup> In-reach programs can be established locally by working directly with the local community clinics and other service delivery sites.

7. **Retaining children** in their coverage program through case management and ease of re-enrollment.

Most programs require parents to undergo a periodic review of eligibility to maintain coverage. This is a critical time in enrollment where many children fall off the program if the proper forms are not completed.

To improve retention in programs, communities have included retention efforts with their outreach and enrollment efforts. The most successful strategies for keeping children in programs include educating parents about the importance of health coverage, helping children stay connected with medical providers, and simplifying the re-enrollment process. Continuous contact and case management with trained CAAs and CHI outreach workers have also proved effective. Other strategies that have helped in retaining children on coverage are reminder notices and postcards, follow-up calls from application assistors, and pre-populated re-enrollment forms, which enable a parent to just sign and return the form. Also, parents are much more likely to keep their coverage if they are actually using it for their children.

8. **Maximizing funding** for outreach and enrollments through partnerships with First 5s and billing for “Medi-Cal Administrative Activities.”

Community agencies have found multiple sources for financing their outreach and enrollment activities. Many local First 5 commissions have funded efforts to enroll and retain young children in health coverage programs, as have other philanthropies. The State has at times provided funding for outreach and enrollment efforts through grants to local coalitions and payments to certified application assistors (CAAs) for completed applications. Establishing relationships with your local First 5 Commission is the first step in developing a partnership.



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In addition, federal matching funds are available to fund certain activities related to Medi-Cal Administrative Activities (MAA). These MAA activities include:

- Medi-Cal outreach
- Facilitating the Medi-Cal application
- Non-emergency, non-medical transportation of Medi-Cal-eligible individuals to Medi-Cal services
- Contracting for Medi-Cal services
- Program planning and policy development
- MAA coordination and claims administration

The MAA Program offers a way for local government agencies and local educational agencies to obtain federal reimbursement for the cost of certain administrative activities necessary for the proper and efficient administration of the Medi-Cal program. The local agencies are generally the county health departments, school districts, and county departments of education. Community-based organizations may receive reimbursement for MAA activities by working through the government agencies and schools and fulfilling certain contract and documentation requirements.<sup>29</sup> Counties and school districts have designated personnel to assist in obtaining MAA reimbursement.

Additional efforts can be made to restore the outreach and enrollment funding that has been cut by the State in recent years. By working with the advocacy organizations listed in **Appendix A**, local coalitions can be part of statewide advocacy efforts.

#### D. Link with County, Regional, State, and National Policy Efforts

In developing children's coverage programs, California communities can rely on the assistance and support of many community and statewide institutions that have already developed programs. Children Health Initiatives<sup>30</sup> or children outreach and enrollment coalitions already exist in many California counties, and every county has a local First 5 Commission to serve children ages zero through five. Every county also has safety net clinics, most of which are designated "federally qualified health centers," whose mission is to serve low-income and uninsured individuals. Many schools have school health centers and can establish them.<sup>31</sup>

In addition to local resources, communities should ally with statewide policy groups which advocate for children's coverage. Three major children's advocacy organizations: Children Now, The Children's Partnership, and Children's Defense Fund, have formed the 100% Campaign<sup>32</sup> to promote health coverage for all children. Other health advocacy and research groups include PICO California,<sup>33</sup> Health Access,<sup>34</sup> Covering Kids and Families,<sup>35</sup> and California Budget Project.<sup>36</sup>

## IV. Measures of Progress

### How do we measure progress in ensuring that all children have health coverage?

A basic indicator is *the percentage of children enrolled in comprehensive coverage*. While national and statewide surveys can provide a general idea of the percentage of children that have health coverage, obtaining local data is more difficult. The extent of enrollment in programs such as Medi-Cal, Healthy Families, and Healthy Kids can be obtained from various agencies.

However, estimating the number of uninsured children is much more difficult on a local level. One possible way to get an estimate of uninsured children is to work with the county social services department to determine how many children are enrolled in restricted-scope Medi-Cal in your geographic area. Another possibility is to work with the local clinics to see how many of their patients have no insurance. These data will show how many children in the health system do not have comprehensive coverage, but will not account for children who do not seek care at these clinics or access the health system at all. Some schools also keep track of insurance status on their emergency contact information, and pre-school programs such as Head Start collect information on insurance status.

The next indicator of interest is *the percentage of children that retain health coverage*. If children have enrolled through a local certified application assistor or through a local electronic enrollment system such as One-e-App, their retention in programs can be tracked. Otherwise, the data collected in determining the percentage of children enrolled in comprehensive coverage will need to be tracked on an annual basis.

To determine if *children are receiving the health care that they need*, there are national measures that are known as HEDIS indicators. These indicators are routinely tracked by health plans according to national standards. They include measures such as well-child examinations and immunizations. One difficulty in using HEDIS measures on a local level is that the strict data protocols require a sufficient number of enrolled children in each category (e.g., children under age 12) to have statistically reliable results. The local Medi-Cal health plans may be able to assist in collecting this data.

Parents have been a good source of information on the health of their children. Surveys that were used in evaluating the Healthy Kids programs included questions about *changes in children's health, ease of access to all care, and satisfaction with care*.<sup>37</sup>

The *use of technology to enroll and retain children* can be measured by utilizing technologies such as One-e-App or a local database used for enrolling children.

The *existence of an active and effective coalition on children's health coverage* is a strong indicator of a community's commitment to universal coverage and its ability to succeed in reaching this goal.

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In conclusion, comprehensive health coverage is essential to ensuring the health of all children and facilitating their access to health services. While most of California's low-income children are eligible for health coverage through Medi-Cal and Healthy Families, many are not enrolled. Communities have developed an array of strategies to enroll children in these programs and make sure that they stay enrolled. For those children who are not eligible for Medi-Cal and Healthy Families, California communities have created local coverage programs and linked with safety net providers to guarantee that all children have a health home.

## V. Additional Resources

### Data

California Healthcare Foundation: *Children's Health Coverage Facts and Figures*. November 2009 – This report provides an overview of trends in children's coverage and insurance programs in California. <http://www.chcf.org/topics/view.cfm?itemid=122730>

California Health Interview Survey (CHIS): *AskCHIS* – An on-line tool that enables users to quickly search for health statistics by county, region, and state. <http://chis.ucla.edu/main/default.asp>

California Department of Health Services: *Medi-Cal Data* – Contains links to reports and files on Medi-Cal enrollments and fee-for-service utilization. <http://www.dhcs.ca.gov/dataandstats/statistics/Pages/MCSSHomePage.aspx>

Managed Risk Medical Insurance Board (MRMIB): *Healthy Families Program and Statistical Reports* – Provides a variety of reports on enrollment, retention, and utilization in Healthy Families. <http://www.mrmib.ca.gov/MRMIB/Reports.html>

### Children's Health Initiatives

California Children's Health Initiatives (CCHI) – Membership organization of all Children's Health Initiatives in California. Website has resource material and contact information. [www.cchi4kids.org](http://www.cchi4kids.org)

Institute for Health Policy Solutions (IHPS): "Pioneers for Coverage: Local Solutions for Insuring All Children in California." *CHI Guidebook*. October 2004 – A step-by-step guidebook for establishing a Children's Health Initiative. [http://ihps.ca.org/technicalassistance/chi\\_guidecheck.html](http://ihps.ca.org/technicalassistance/chi_guidecheck.html)

Institute for Health Policy Solutions (IHPS): "Checklist for Counties Pursuing a Children's Health Initiative." March 2004 – A checklist for counties that are establishing a Children's Health Initiative. [http://ihps-ca.org/publications/\\_pdfs/FinalChecklist\\_1104.pdf](http://ihps-ca.org/publications/_pdfs/FinalChecklist_1104.pdf)

### Providers

California Primary Care Association (CPCA): *Find a Clinic* – California Primary Care Association database for locating a community clinic in your area. <http://cpca.org/resources/findclinic/index.cfm>

School Health Centers – Website of California School Health Centers Association. <http://www.schoolhealthcenters.org/>

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**Outreach and Enrollment Strategies**

Community Health Councils, Inc. (CHC): *Covering Kids and Families* – Here you can access the following publications on outreach, enrollment, retention, and utilization (OERU): “Outreach, Enrollment, Retention & Utilization – Strategies for Health Care Coverage: Operationalizing the Policy Framework – Policies and Practices from Ten California Children’s Health Initiatives.” August 2008. “Policy Framework for Outreach, Enrollment, Retention and Utilization for Health Care Coverage in California.” May 2006. “The Path to Accessing Health Coverage: Outreach, Enrollment, Retention and Utilization.” January 2006. <http://www.chc-inc.org/chcKids.cfm>

Cousineau, Michael, et al. “Use of Outreach and Enrollment Strategies in California.” Health Access Data Assistance Center (SHADAC). January 2009. <http://www.shadac.org/publications/use-outreach-and-enrollment-strategies-in-california>

Ha, Stephanie, et al. “Increasing Enrollment and Retention in Children’s Health Insurance Statewide Programs through Trained Assistors.” The California Endowment (TCE). January 2006. [http://www.calendow.org/uploadedFiles/nhf\\_policy\\_report\\_full.pdf](http://www.calendow.org/uploadedFiles/nhf_policy_report_full.pdf)

Healthy Families Program: Health-e-App (HeA) – The state agency website, offering an enrollment tool for using Health-e-App. [http://www.healthyfamilies.ca.gov/EEs\\_CAAs/Health-e-App.aspx](http://www.healthyfamilies.ca.gov/EEs_CAAs/Health-e-App.aspx)

The Center to Promote HealthCare Access: One-e-App enrollment tool – Website provides information on One-e-App and how to enroll. <http://www.oneeapp.org>

The Children’s Partnership: *E-Enrollment and Express Lane Eligibility* – Background on electronic enrollment and the use of other programs to establish eligibility for health programs. [http://www.childrenspartnership.org//AM/Template.cfm?Section=Express\\_Lane\\_Eligibility1&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=148&ContentID=12069](http://www.childrenspartnership.org//AM/Template.cfm?Section=Express_Lane_Eligibility1&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=148&ContentID=12069)

The Children’s Partnership: *Express Enrollment in California: How It Works* – Background on an optional program that allows school districts to streamline and expedite the Medi-Cal (California’s Medicaid program) enrollment process for uninsured children who receive free school meals through the National School Lunch Program. [http://www.childrenspartnership.org/Content/NavigationMenu/Programs/EHealthAgendaforChildren/ExpressLaneEligibility/StateActivityReport/How\\_It\\_Works.htm](http://www.childrenspartnership.org/Content/NavigationMenu/Programs/EHealthAgendaforChildren/ExpressLaneEligibility/StateActivityReport/How_It_Works.htm)

Jacobson, Wendy, et al. “Closing Health Insurance Gaps for Families: WIC Can Make It Happen.” The Children’s Partnership with California WIC Association. May 2003 – A report on using the Supplemental Nutrition Program for Women, Infants, and Children (WIC) as an entryway to health coverage. [http://calwic.org/docs/reports/TCP-WIC\\_report.pdf](http://calwic.org/docs/reports/TCP-WIC_report.pdf)

Community Health Councils, Inc. (CHC): *Toolkit* – Toolkit covers Outreach, Enrollment, Retention and Utilization (OERU) strategies for healthcare coverage. <http://www.chcinc.org/userimages/OERU%20Toolkit.pdf>

County-Based Medi-Cal Administrative Activities (CMAA) – Offers background on potential eligibility for MAA reimbursement for outreach and enrollment activities. <http://www.dhcs.ca.gov/provgovpart/Pages/CMAA.aspx>

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### Advocacy and Policy Organizations

100% Percent Campaign – A California coalition of The Children's Partnership, Children Now, and Children's Defense Fund. <http://www.100percentcampaign.org/>

Health Access California – A California health access advocacy organization. <http://health-access.org/>

Community Health Councils, Inc. (CHC) – The lead agency for the Covering Kids and Families Statewide Coalition. <http://www.chc-inc.org/chcKids.cfm>

California Budget Project (CBP) – A budget policy research organization focusing on low-income and working families. <http://cbp.org/>

PICO California – The statewide collaborative network of faith-based community organizations. <http://www.picocalifornia.org/Files/MFH.English.pdf>

### Evaluation

Mathematica Policy Research, Inc. – The survey instrument in the evaluation of the Santa Clara CHI is available at: <http://www.mathematica-mpr.com/publications/PDFs/santaclara-app.pdf>

### Coverage Programs

Medi-Cal – <http://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-CalEligibility.aspx>

Healthy Families (HFP) – <http://mrmib.ca.gov/MRMIB/HFP.shtml>

California Children's Services (CCS) – <http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx>

Child Health and Disability Prevention Program (CHDP) – <http://www.dhcs.ca.gov/services/chdp/Pages/default.aspx>

Family PACT – <http://www.cdph.ca.gov/programs/FamilyPact/Pages/default.aspx>

California Children's Health Initiatives (CCHI) – Healthy Kids - <http://www.cchi4kids.org>

Kaiser Permanente Child Health Plan – <https://info.kp.org/childhealthplan/index.html>

CaliforniaKids – <http://www.californiakids.org/aboutframe.html>

## Appendix A

### California Children’s Coverage Programs – A Primer

**Medi-Cal** – The largest coverage program for low-income children is Medi-Cal. This jointly funded federal-state program provides for a very broad range of care at participating providers – community health centers, private doctors, public and private hospitals, and other types of providers. In most California counties Medi-Cal children must be enrolled in a managed care plan (public and/or private) and choose a primary medical provider. (More specific information on your county is contained in **Table 1** on page 6.) Dental services for most children are provided through the Denti-Cal program, which is administered by Delta Dental of California. Enrollment in dental coverage is automatic with Medi-Cal enrollment. Mental health services are covered through individual county Medi-Cal mental health plans.

Applications for Medi-Cal can be completed many different ways and eligibility is determined by the county social services department. Eligibility depends on the age of the child: for newborns until age one – 200% FPL; for children ages one through five – 133% FPL; for children ages six through nineteen – 100% FPL. Children must be citizens or legal residents to receive the full scope of services; undocumented children are eligible for a limited scope of emergency-related services.<sup>38</sup>

**Healthy Families** – Many children in families where the income exceeds the Medi-Cal eligibility limit are eligible for another federal-state program called Healthy Families. Healthy Families provides medical, dental, vision, and some mental health coverage through private and public health plans which contract with a network of providers. The Healthy Families plans operate much like private insurance plans and have established monthly premiums and co-payments due at the time of appointments. Families pay \$4-\$17 monthly premiums per child with a maximum of \$51 per family. Healthy Families covers children in families up to 250% FPL. Children must be citizens or legal residents to be eligible for the program; undocumented children are not eligible for any services.<sup>39</sup>

**Other Public Programs** – There is a range of other public programs that covers lower-income children.

The **Child Health and Disability Prevention Program (CHDP)** provides routine screening and preventive care for low-income California children up to 200% FPL, regardless of immigration status. For those children who are eligible for full-scope Medi-Cal, a wide range of additional services is covered. Services are accessed through CHDP providers that are credentialed through the local county health departments. CHDP also provides a “gateway,” which provides for full-scope Medi-Cal coverage for a period of up to 60 days, while applying for Medi-Cal.<sup>40</sup>

**California Children’s Services (CCS)** provides coverage for specified serious medical conditions for children in families up to \$40,000 in annual income. Applications are processed through the local county health departments.<sup>41</sup>

**Family Planning, Access, Care, and Treatment (Family PACT)** provides no-cost family planning services to low-income men and women (under 200% FPL), including teens.<sup>42</sup> Applications are completed at all approved providers. There is no immigration eligibility requirement for Family PACT.

**Other Private Programs** – To help fill in the gaps in health coverage for low-income California children and their families, a number of initiatives have been developed in recent years.

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**Healthy Kids** – Children’s Health Initiatives (CHIs) in 25 counties offer enrollment in a Healthy Kids plan to the extent funding is available. Similar to Healthy Families coverage, children are covered for medical, hospital, dental, vision, and mental health services. Income eligibility limits are set at 300% FPL (400% FPL in San Mateo County). Benefits are provided by several local health plans (Medi-Cal local initiatives and county-organized health systems) as well as one commercial health plan (Health Net). Healthy Kids programs charge families modest premiums as well as co-pays. Funding for CHIs is from local private and public sources and is very limited. Most programs have waiting lists for children, particularly those ages six through eighteen. Up to 85% of children enrolled in Healthy Kids are very low-income and would have been eligible for Medi-Cal if they had appropriate immigration status.<sup>43</sup>

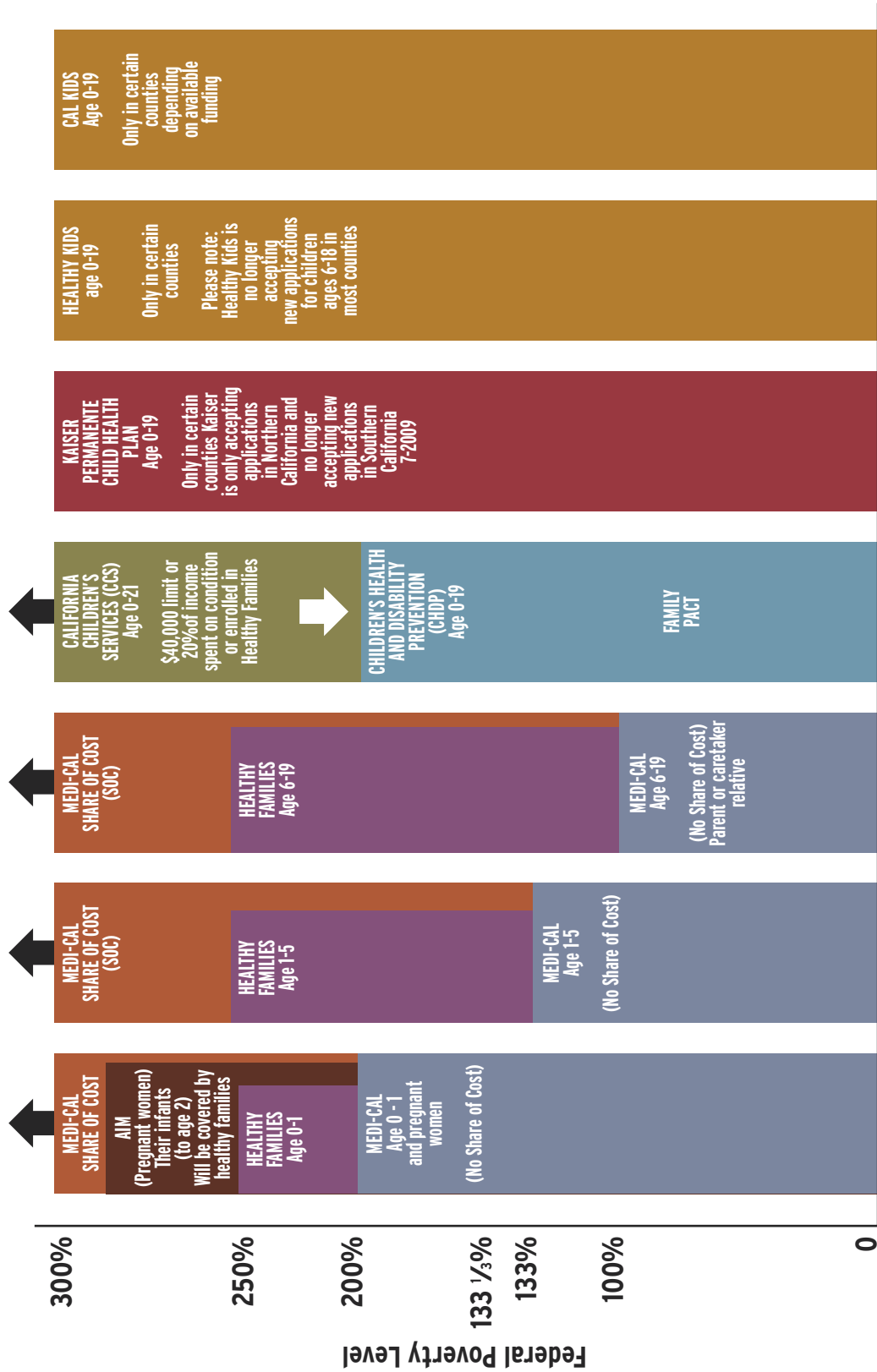
The **Kaiser Permanente Child Health Plan (KPCHP)** provides a full scope of services, including medical, mental health, dental, and vision care to children up to 300% FPL who are not eligible for Medi-Cal or Healthy Families. Most CHIs enroll children in KPCHP when slots are available in the area and a family is willing to be enrolled. KPCHP continues to enroll in northern California, but the program is at capacity in the southern California region. (See Appendix B<sup>44</sup>)

**California Kids (CalKids)** is an independent non-profit organization that provides preventive and primary health care coverage to approximately 7,100 low-income children ages two through eighteen. The program is subsidized primarily by foundations and local funding sources. CalKids provides outpatient medical, dental, and vision services, with the notable exception that inpatient services are not covered. Currently, coverage costs approximately \$468 per child, per year.<sup>45</sup>

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Appendix B

Children's Health Coverage – Income Guidelines



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### Glossary of Acronyms

- AFDC** Aid to Families with Dependent Children. A discontinued welfare program that was replaced by the California Work Opportunities and Responsibility to Kids program, more commonly known as CalWORKS.
- CAA** Certified Application Assistor to assist in applying for Healthy Families and Medi-Cal.
- CHDP** Children’s Health Disability Prevention program – the California program that implements the federal EPSDT requirement for Medi-Cal.
- CHI** Children’s Health Initiative.
- CHIP** The federal Children’s Health Insurance Program (formerly known as SCHIP – State Children’s Health Insurance Program). The California CHIP program is Healthy Families.
- CHIPRA** Children’s Health Insurance Program Reauthorization Act of 2009.
- DSH** Disproportionate Share Hospital which serves high numbers of uninsured and Medi-Cal patients and is eligible for supplemental funding.
- EPSDT** Early and Periodic Screening, Diagnosis, and Treatment – a federally mandated component of Medi-Cal. In California, the EPSDT program is called the Children’s Health Disability Prevention Program (CHDP).
- FPL** Federal Poverty Level – established annually by the federal government and used in determining income eligibility for many programs.

**TABLE 2 2009 Federal Poverty Levels**

FAMILY SIZE	FEDERAL POVERTY LEVEL (FPL)	133% FPL	150% FPL	250% FPL	300% FPL
1	\$10,830	\$14,404	\$16,245	\$27,075	\$32,490
2	\$14,570	\$19,378	\$21,855	\$36,425	\$43,710
3	\$18,310	\$24,352	\$27,465	\$45,775	\$54,930
4	\$22,050	\$29,327	\$33,075	\$55,125	\$66,150
5	\$25,790	\$34,301	\$38,685	\$64,475	\$77,370
6	\$29,530	\$39,275	\$44,295	\$73,825	\$88,590
7	\$33,270	\$44,249	\$49,905	\$83,175	\$99,810
8	\$37,010	\$49,223	\$55,515	\$92,525	\$111,030

- FQHC** Federally Qualified Health Center – a special designation for non-profit, community governed primary care clinics which receive enhanced Medi-Cal reimbursement and federal grants. FQHC “look-alikes” receive enhanced reimbursements, but do not receive federal grants.
- HEDIS** Healthcare Effectiveness Data and Information Set – performance measures for health plans established by the National Committee for Quality Assurance.
- MAA** Medi-Cal Administrative Activities – non-medical services provided to Medi-Cal patients that can be matched with federal funding.
- OERU** Outreach, Enrollment, Retention, and Utilization.
- USC** University of Southern California.

## Endnotes

- 1 "America's Uninsured Crisis: Consequences for Health and Health Care." *Institute of Medicine*. 23 February 2009. <http://www.iom.edu/en/Reports/2009/Americas-Uninsured-Crisis-Consequences-for-Health-and-Health-Care.aspx>
- 2 Trenholm, Christopher, et al. "Three Independent Evaluations of Healthy Kids Programs Find Dramatic Gains in Well-Being of Children and Families." November 2007. [http://www.cchi4kids.org/docs/Packard\\_Healthy\\_Kids\\_compilation\\_study.pdf](http://www.cchi4kids.org/docs/Packard_Healthy_Kids_compilation_study.pdf)
- 3 Howell, Embry and Trenholm, Christopher, "Santa Clara County Children's Health Initiative Improves Children's Health." March 2007. [http://www.cchi4kids.org/docs/Santa\\_Clara\\_study.pdf](http://www.cchi4kids.org/docs/Santa_Clara_study.pdf)
- 4 Cousineau, Michael R, et al. "Preventable Hospitalizations Among Children in California Counties After Child Health Insurance Expansion Initiatives." *Medical Care*, Vol. 46, No. 2. February 2008. [http://journals.lww.com/lwwmedicalcare/Abstract/2008/02000/Preventable\\_Hospitalizations\\_Among\\_Children\\_in.7.aspx](http://journals.lww.com/lwwmedicalcare/Abstract/2008/02000/Preventable_Hospitalizations_Among_Children_in.7.aspx). Also, see [http://www.cchi4kids.org/docs/Preventable\\_Hospitalizations\\_Final\\_Brief%20\\_12-07.pdf](http://www.cchi4kids.org/docs/Preventable_Hospitalizations_Final_Brief%20_12-07.pdf)
- 5 Trenholm, Christopher. "Expanding Coverage for Children: The Santa Clara County Children's Health Initiative." April 2005. <http://www.mathematica-mpr.com/health/chi.asp>
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- 7 See "California Children's Coverage Programs – A Primer," attached as Appendix A.
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- 9 Diring, Joel, and Wunsch, Bobbie. "California's Local Children's Coverage Efforts and New Federal and State Legislation: Opportunities for Advancing Children's Coverage." May 2009. [http://www.calendow.org/uploadedFiles/Publications/By\\_Topic/Access/Childrens\\_Coverage/TCE\\_OppToAdvChildCoverageMay2009.pdf](http://www.calendow.org/uploadedFiles/Publications/By_Topic/Access/Childrens_Coverage/TCE_OppToAdvChildCoverageMay2009.pdf)
- 10 Fairbrother, Gerry, and Schuchter, Joseph. "Stability and Churning in Medi-Cal and Healthy Families." March 2008. <http://www.calendow.org/uploadedFiles/Stability%20%20Churning%20Report.pdf>
- 11 Ibid.
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- 13 Stevens, Gregory, D., et al. "Children's Health Initiatives in California: The Experiences of Local Coalitions Pursuing Universal Coverage for Children. *American Journal of Public Health*, 97, No. 4, April 2007: 738-743. [www.ajph.org](http://www.ajph.org)
- 14 To get contact information for CHIs, visit [www.cchi4kids.org](http://www.cchi4kids.org)
- 15 See CHIPRA Opportunities on page 8.
- 16 See Resource Guide for Outcome Two for more information on health homes.
- 17 To get contact information for local CHIs, visit [www.cchi4kids.org](http://www.cchi4kids.org)
- 18 "Checklist for Counties Pursuing a Children's Health Initiative." *Institute for Health Policy Solutions*. March 2004. [http://ihps-ca.org/publications/\\_pdfs/FinalChecklist\\_1104.pdf](http://ihps-ca.org/publications/_pdfs/FinalChecklist_1104.pdf)  
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- 19 "Find a Clinic." California Primary Care Association (CPCA). <http://cpca.org/resources/findclinic/index.cfm>
- 20 Resources on successful outreach strategies are found in several publications produced by Covering Kids and Families. <http://www.chc-inc.org/chcKids.cfm>  
 "Outreach, Enrollment, Retention & Utilization – Strategies for Health Care Coverage: Operationalizing the Policy Framework – Policies and Practices from Ten California Children's Health Initiatives." August 2008.  
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