SOUTHERN AREA CONSORTIUM OF HUMAN SERVICES

Medi-CAL Outreach:
Literature Review

Anita Harbert, Ph.D.
Director, SDSU School of Social Work
Principal Investigator

Donald Dudley, MSW
Director, Academy for Professional Excellence
Co-Principal Investigator

Prepared by:
Carrie Gibson, BA

November 2006

SACHS is a program of the
***Academy for Professional Excellence* at**
San Diego State University School of Social Work.
6505 Alvarado Road, Suite 107 / San Diego, CA 92120
http://theacademy.sdsu.edu

INTRODUCTION

At SACHS' August 2006 Annual Planning Meeting, the SACHS Members requested that a literature review be completed on the best-practices for conducting Medi-CAL outreach and to increase the coverage for those eligible for Medi-CAL. The following is a summary of five reports exploring the best-practices for conducting Medi-CAL outreach. A review of this literature reveals that there are two main steps that can be taken to increase the coverage for those eligible for Medi-CAL: simplify and automate.

Simplification: Chimento, Forbes, Menges, Theisen and Pande (2003) report that simplification would help persons already eligible for Medi-Cal by making it easier for them to obtain coverage, maintain coverage, and retain savings and other assets. It would make low income persons eligible who were not previously eligible. County eligibility workers would be able to handle larger caseloads and processes applications faster.

Overton (2006) provides examples of simplification including eliminating quarterly documentation requirements in favor of a 12-month continuous eligibility for children in Medi-Cal would help keep children from dropping out. Another example of simplification is of the "no wrong door policy" where a family can enroll in several programs at many community locations. A further example is from San Bernardino County which created materials and provided clear, easy-to-follow steps, which significantly improved the rate of return for renewal packets and will soon be implemented county-wide. Four counties also send Medi-Cal clients personalized renewal forms with known information already filled in, which has improved renewal rates and reduced clerical errors.

Automation: Atlas, Chimento, and Shukla (2001) conducted a study of the Health-e-App pilot in San Diego County. They found that with the use of this automation program applicants expressed heightened confidence in the automated process, specifically citing the real-time preliminary determination feature as beneficial; staff that processed applications and determined eligibility all expressed support for the automated application; the use of the automated system lowered the total time between application submission and final eligibility determination; and the system produced highly reliable, real-time preliminary eligibility determinations.

Atlas, B., Chimento, L., Shukla, P. (2001). Business Case Analysis of Health-e-App. The Lewin Group. Available from: http://www.chcf.org/documents/policy/HealtheAppBCA.pdf

Chimento, L., Forbes, M., Menges, J., Theisen, A., Pande, N. (2003). Simplifying Medi-Cal Enrollment: Opportunities and Challenges in Tight Fiscal Times. The Lewin Group and the Medi-Cal Policy Institute. Available from: http://www.chcf.org/documents/policy/MediCalSimpIssueBrief.pdf

Chimento, L., Jee, J., Shulka, P. (2004). How Policy Changes Impact Enrollment: A Look at Three County Efforts. The Lewin Group. Available from: http://www.chcf.org/documents/policy/PolicyChangesImpact.pdf

J. Darnell, H.S. Lee, J. Murdock. (1999). Medicaid and Welfare Reform: States' Use of the $500 Million Federal Fund. Kaiser Commission on Medicaid and the Uninsured. **http://www.kff.org/medicaid/2176-index.cfm**

Overton, L. (2006). Simplify, Automate, and Follow the Leader: Lessons on Expanding Health Coverage for Children. California HealthCare Foundation. Available from: http://www.chcf.org/documents/policy/SimplifyAutomateAndFollowTheLeaderIB.pdf

Atlas, B., Chimento, L., Shukla, P. (2001). Business Case Analysis of Health-e-App. The Lewin Group. Available from: http://www.chcf.org/documents/policy/HealtheAppBCA.pdf

This independent business case analysis outlines the key benefits of Health-e-App, the Internet-based application developed to simplify and expedite enrollment in Healthy Families and Medi-Cal for children and pregnant women. The analysis of the Health-e-App pilot- a four week test in 2001 in San Diego County- was conducted by the Lewin Group, a national health care consulting firm. (Note: the Health-e-App software is the base upon which One-e-App was developed. A similar independent business case analysis of the One-e-App pilot will be published later this year.)

Health-e-App's performance was compared to the current paper process to gauge the following:

- Users' satisfaction with the application experience
- Efficiencies for state and county agencies, the Certified Application Assistants (CAAs) and potential program beneficiaries
- Changes in accuracy and completeness of applications received
- Implementation issues to consider for countywide or statewide roll-out of the automated application

Key Findings:

1. User Satisfaction
    - Applicants viewed the automated process favorably.
    - Applicants expressed heightened confidence in the automated process, specifically citing the real-time preliminary determination feature as beneficial.
    - CAAs preferred the automated system to the paper system because they felt it was more credible and efficient and it made them feel more effective when serving clients.
    - Staff that processed applications and determined eligibility all expressed support for the automated application.
2. Time and labor efficiencies
    - Time spent by applicants and CAAs to complete an application at the enrollment site decreased during the pilot period
    - For Health Families applicants, Health-e-App is projected to perform as well, or better than the paper process assuming key modifications are completed.
    - For Medi-Cal applications, Health-e-App lowered the total time between application submission and final eligibility determination-

efficiency gains that are mainly attributable to elimination of mail time at several different points in the process.

3. Data Quality and Related Improvements
    - During the pilot, Health-e-App's features substantially reduced the number of errors in critical fields, such as date of birth, and provided a safeguard against losing applications at different transfer points in the processing.
    - Health-e-App produced highly reliable, real-time preliminary eligibility determinations.

Suggestions for development (in addition to several modifications underway at the time of writing):

- Enhance CAA training for programmatic issues such as documentation requirements and benefit options.
- Devise methods for real-time technical assistance for CAAs.
- Reconcile differences in information/documentation sought by the state and county for application completion and processing (i.e. date of birth).
- Make the electronic image files containing applicants' supporting documentation less fragmented and more readily accessible to agency staff.
- Develop methods to facilitate submission and tracking of premium payments, and consider changes to current policies with regard to the initial Healthy Families premium payments.

Chimento, L., Forbes, M., Menges, J., Theisen, A., Pande, N. (2003). Simplifying Medi-Cal Enrollment: Opportunities and Challenges in Tight Fiscal Times. The Lewin Group and the Medi-Cal Policy Institute. Available from: http://www.chcf.org/documents/policy/MediCalSimpIssueBrief.pdf

Some 820,000 people may be eligible for Medi-Cal but are currently uninsured. Surveys have found that the complexity of the enrollment process is a primary barrier to enrollment.

The California HealthCare Foundation commissioned The Lewin Group to assess the cost implications, enrollment impacts, and policy considerations of several strategies for simplifying the Medi-Cal enrollment process for the 1931(b) Only population. Many aspects of the Medi-Cal enrollment process cannot be easily simplified, but there are some aspects regarding eligibility standards and documentation requirements that could. Simplification would help persons already eligible for Medi-Cal by making it easier for them to obtain coverage, maintain coverage and retain savings and other assets. It would make low income persons eligible who were not previously eligible. County eligibility workers would be able to handle larger caseloads and process applications faster.

In this study, five simplification options are assessed in depth. These are options that would eliminate or simplify the assets test and streamline documentation requirements. Each of the options examined would increase program enrollment and reduce program administrative costs. The strategies would also increase the flow of federal dollars into the state at a time when state and local resources are shrinking.

1. Allowing self-certification of income
2. Allowing self-certification of assets
3. Allowing self-certification of assets and income
4. Eliminating the assets test for the 1931(b) Only group
5. Changing the assets methodology to count only liquid assets

Potential cost and enrollment impacts from the above options:

- Self-certification of assets would increase enrollment among persons already eligible for the Medi-Cal program and reduce administrative costs, while also providing a net savings to the state
- Other options would also increase program enrollment and reduce administrative costs
- All five options modeled would results in modest impacts on total program enrollment and costs

The study concludes that the Medi-Cal program is complex for many reasons, but that California does have flexibility in determining eligibility standards and documentation requirements. As counties face budget shortfalls, simplification strategies that reduce the costs of program administration while improving enrollment are important to explore. As eligibility workers experience rising caseloads, the administrative advantages of eligibility simplifications may be particularly important to consider.

Chimento, L., Jee, J., Shulka, P. (2004). How Policy Changes Impact Enrollment: A Look at Three County Efforts. The Lewin Group. Available from: http://www.chcf.org/documents/policy/PolicyChangesImpact.pdf

Three California counties—Alameda, San Mateo, and Santa Clara—have gone beyond state requirements, not only in expanding eligibility for coverage, but also in creating a more seamless process for enrollment in county programs, Medi-Cal, and Healthy Families. This report explores the policy, operational, and other considerations of implementing partnerships among county agencies, health plans, and other community stakeholders to change and improve the process for enrolling families into public health care programs.

I. Alameda County

a. SCHIP Project: a 2001 collaboration between the county's health care agency (HCSA) and social services agency (SSA) to increase public health insurance enrollment, retention and utilization.
   i. Enhancements to the existing outreach and enrollment process:
      1. conducted 10 community-wide enrollment events
      2. used computer-based application on laptops to increase timeliness, efficiency and accuracy
      3. developed marketing materials
      4. created a call center to provide information about enrollment events
      5. Co-located Medi-Cal eligibility technicians and Healthy Families certified application assistants at enrollment events
   ii. Results:
      1. Higher rate of Medi-Cal eligibility approval
      2. increased enrollment in Medi-Cal and Healthy Families
      3. Increased collaboration and communication between HCSA and SSA

b. No "Wrong Door" Pilot: a 2002 extension of the SCHIP project, to further the policy and operational recommendations of the project: increase access and approval rates for health insurance and public assistance programs, improve efficiency of application processing, and increase retention.
   i. During the pilot:
      1. Medi-Cal and Healthy Families determinations were run concurrently with 3 Social Services and 2 HCSA eligibility workers serving as Social Services application assistants (SSAAs).
      2. The SSAA conducted an initial assessment and assisted in filling out the appropriate application. If pre-screened for Medi-Cal, the client would meet with a Social Services eligibility technician to complete the

application. If ineligible for Medi-Cal, the application would be completed and forwarded to the appropriate program.

3. Similar to SCHIP, enrollment events were held.

ii. Results:

1. In 9 months following implementation, more than 2,400 individuals were screened and county offices participating in the pilot expanded to 5. Two additional satellite sites opened in December, 2003.

II. San Mateo County

a. <u>One-Stop Model</u>: single enrollment locations unveiled between 1995 and 1996 where clients could access a broad range of public services. In 2002, HSA and the Health Services Agency implemented similar strategies to create a more seamless enrollment process and maximize enrollment in Medi-Cal and Health Families, working collaboratively to conduct outreach and enrollment events throughout the county.

i. Strategies:

1. Created a new application assistant position (CHAs) to complete applications for Medi-Cal, Healthy Families and the Section 17000 program in clinic sites.
2. CHAs were co-located with HAS benefits analysts at clinic sites, community family resource centers and staff enrollment events.
3. Doubled the number of outstationed benefits analysts from 7 to 14.

b. <u>Children's Health Initiative</u>: the Healthy Kids program is the cornerstone of this 2003 initiative.

i. Eligibility for Health Kids is conducted using the one-stop HAS-Health method of enrollment

ii. All CHAs and HAS benefits analysts can assist families in completing applications for any form of health coverage in the county

iii. Now implementing the Health-e-App automated system.

III. Santa Clara County

a. <u>Children's Health Initiative</u>: a partnership between the Social Services Agency (SSA), Health and Hospital Systems (HHS), the Santa Clara Family Health Plan (SCFHP) and other community-based organizations launched in 2001. The goals are to educate families about use of their health benefits, improve enrollment and retention, and create a single point of access to their three programs: Medi-Cal, Healthy Families, and Healthy Kids.

i. Strategies:

1. Cross-trained eligibility workers and CAAs

2. In settings where staff were co-located, processes were jointly developed to facilitate workflow and eliminate duplication of services.
3. Representatives from all programs participated in public forums to increase their visibility
4. County agency staff engaged in joint trainings and launched a campaign to shift the public's perception of their agencies from unwelcoming to welcoming

ii. Results:

1. More than 76,000 eligible children applied for health insurance through the CHI.

IV. Lessons Learned

a. Strong Leadership Drove Initiative Development- champions of the initiatives brought stakeholders to the table, gaining their support and commitment
b. Intra-county collaboration made the initiatives viable- agencies benefited from each others efforts. Collaboration became the norm.
c. Broad stakeholder support was crucial to the success of the initiatives- involvement began early and secured ongoing support.
d. County stakeholders acknowledged the financial interdependencies that exist between each county's organizations; and- partners realized that their upfront financial commitments brought them closer to their goals and would ultimately benefit their county's overall fiscal situation.
e. A common set of actions helped to build and strengthen the initiatives' underlying foundations- action steps were often taken concurrently and required the participation of each initiative partner.

J. Darnell, H.S. Lee, J. Murdock. (1999). Medicaid and Welfare Reform: States' Use of the $500 Million Federal Fund. Kaiser Commission on Medicaid and the Uninsured. **http://www.kff.org/medicaid/2176-index.cfm**

This report reviews how states have responded to the $500 million federal fund that was created by the federal welfare reform legislation in 1996 to help states maintain Medicaid coverage for individuals affected by welfare reform. State Medicaid officials were asked whether they have drawn down federal funds from the $500 million fund; to describe the factors that influenced their decision; and what activities they are supporting with the additional federal monies. This summary highlights how states used outreach money for children's health programs.

- Eligibility Systems Changes
  - 26 of 40 states participating in the study reported making eligibility systems-related changes
  - This activity often was viewed as the most important activity and was frequently the first activity undertaken by the state
- Developing and Disseminating Outreach Materials
  - 19 states reported developing and/or disseminating new publications to targeted people (people who may be eligible for Medicaid under Section 1931).
- Training
  - 18 states reported conducting training activities to various subjects, including eligibility workers, outstationed eligibility workers, providers, and the community.
  - Wisconsin had one of the most extensive training efforts, providing to training to all of the subjects mentioned above, as well as staff from advocacy agencies, WIC sites, public health agencies, churches, homeless shelters and food pantries.
- Outreach Activities
  - Most states reported that they are coordinating their Medicaid outreach activities with the CHIP outreach activities.
  - Three states have contracted with a private vendor to conduct outreach activities.
- Outstationing Medicaid Eligibility Workers
  - 14 states reported outstationing activities
- Local Community Activities
  - Examples: Medicaid community activities coordinated with CHIP activities; contracting with minority organizations to conduct outreach;

working with advocacy organizations; working with the community to target hard-to-reach groups

- Public Service Announcements
  - 13 states use PSAs including radio, public transportation, billboards and posters.
- Educational Activities
  - Examples: working with community-based organizations, developing brochures, hiring outreach workers, developing PSAs, and offering a toll-free number on public benefits programs.
- Designing New Medicaid Eligibility Forms
  - 7 states designed new eligibility forms
- Identifying At-Risk Individuals (people who are vulnerable to losing Medicaid eligibility as a result of the TANF provisions)
- Hiring New Medicaid Eligibility Workers
  - Only 3 states did this
  - The time-limited nature of the funding was cited occasionally as a reason why this activity was not used more commonly.

Overton, L. (2006). Simplify, Automate, and Follow the Leader: Lessons on Expanding Health Coverage for Children. California HealthCare Foundation. Available from: http://www.chcf.org/documents/policy/SimplifyAutomateAndFollowTheLeaderIB.pdf

California has learned a great deal in recent years about how to provide health insurance for children. The state has significantly expanded enrollment in Medi-Cal and Healthy Families, and many counties have developed Children's Health Initiatives (CHIs) to cover children ineligible for state programs. As a result, the number of uninsured children in California has fallen by nearly one-fifth during the last five years. While there is substantial popular support for continuing to expand coverage until all children in California have insurance, nearly one million remain uninsured. This issue brief synthesizes key lessons from successful initiatives, as well as from reforms that have been identified but not yet implemented.

I. Simplify
   a. Simplify state and federal policies on eligibility.
      - Example: Expand Medi-Cal eligibility to some children who also qualify for Health Families
      - A benefit already observed: eliminating quarterly documentation requirements in favor of a 12-month continuous eligibility for children in Medi-Cal helped keep children from dropping coverage and reduced administrative burden
   b. Streamline the application, enrollment and renewal process
      - Example: many counties have adopted a "no wrong door" policy, where families can enroll in several programs at many community locations
   c. Reach out, redesign the paperwork, and provide assistance
      - Example: San Bernardino County created materials that provided clear, easy-to-follow steps, which significantly improved the rate of return for renewal packets and will be implemented county-wide.
      - Simplify forms
        - Example: 4 counties send Medi-Cal clients personalized renewal forms with known information already filled in, which has improved renewal rates and reduced clerical errors.

II. Automate

a. Improve enrollment efficiency with electronic applications
b. Integrate state and county data systems, taking older technology into account
    - Example: Alameda and San Mateo Counties are now piloting an electronic interface to route applications bi-directionally between One-e-App, the county welfare system (CalWIN), the county's indigent care system, the Single Point of Entry (SPE) and in San Mateo, the Healthy Kids Program.
c. Use technologies that provide automatic real-time connection to key enrollment databases
    - Example: CHDP Gateway uses a direct connection to the state's mainframe database for Medi-Cal (MEDS)
d. Move toward online enrollment
    - A few other states offer online enrollment and in Pennsylvania, 50% of online applications are received after business hours.
    - For 06-07, California has authorized funds to make Medi-Cal and Healthy Families accessible through Health-e-App and will soon begin studying the requirements for an online approach.
e. Policy should keep pace with technology, and vice versa
    - Example: Health-e-App prompted a new policy to permit electronic signatures and premium payments.
f. Foster political will for a statewide technology strategy
    - Leadership, vision and a willingness to tackle concerns voiced by labor, county welfare directors, advocates, vendors and others is required if modernization of enrollment is to become a reality.
g. Examples of Eligibility and Automation in California:
    i. A Single Point of Entry (SPE) to the statewide database of applicants and a joint application for Medi-Cal and Health Families
    ii. Health-e-App- a web based option for workers to submit joint applications electronically to the SPE
    iii. The CHDP Gateway- a fast electronic means of determining eligibility and enrolling children temporarily
    iv. Express Lane Eligibility (ELE) pilots- designed to automatically identify eligible children through their enrollment in the School Lunch Program
    v. One-e-App- a "front-end" electronic application that bridges several programs and services

III. Follow the Leaders
a. Work Together

- Successful Initiatives are coalitions that span the public and private sectors

b. Deliver the right message to the right people in the right places at the right time
c. Create inspiring goals and realistic plans to achieve them
    - Solano County achieved a 98% enrollment rate by creating excitement among the schools, care providers, aid workers and families about covering all the county's children
d. Take a customer service approach to health plan enrollment
    - Positive interaction with clients makes a difference in enrollment and retention.

IV. Obstacles to Overcome
a. Families' perceptions and experiences with the program are important factors (being treated with respect, having providers that speak their language)
b. Supply of providers that accept public health insurance
c. Transportation for families in remote or rural areas
d. Need more funding