IHPS Innovation in Coverage and Access Forum
CHI Closed Session
November 16, 2005

Break out session: Local Control

Three main topics were brought up in the discussion about local control: The benefits of local control (vs. State control); general concerns about a statewide coverage program and how it would affect the local CHI; questions about what should be the steps of the CHI moving forward in order to ensure that CHIs have a voice in the discussion about a statewide program and to maintain their local programs while the state program is in its early stages of development.

Benefits of Local Control:

- The ability to advise the health plans on application and other processes
- The CHIs ability to be responsive to the community
- Trust (the ability to stay away from the image of being "government")
- Cost-effectiveness
- Community comfort with the CHI

Concerns about a statewide coverage program:

- How/ whether to start a local CHI with the Statewide effort moving forward
- Keeping the local flavor of the CHIs
- Possible strings attached to state funding
- CHI input regarding the statewide effort was not adequately solicited in the past
- Will a statewide program exclude some of the kids that are currently being covered?
- Implementation!! (not knowing what the plan will be)
- Statewide efforts affecting local CHI fundraising
    - Funders have a goal for statewide coverage
- Keeping covering kids separate from politics
- Meeting the diverse needs of the State
- How to address the local communities questions about the statewide initiative

Moving Forward:

- Need a new script placing CHIs in the context of the statewide picture and placing the statewide effort in the context of the local CHI

- Coordinated effort of the CHIs
    - CHIs have strength united
    - CHIs have strength in all of its partners and how they all communicate with the state on various levels

- What is the best method for CHIs to provide technical assistance to the statewide program?
    - CHIs can act as technical experts for the statewide program transition
    - Should convene an advisory committee of CHIs for the statewide program
    - Should organize around illuminating implementation issues
    - Would like an independent oversight committee over the statewide implementation

Break out session: Community Involvement

In this session the group discussed the ways CHIs are currently fostering community involvement but also touched on larger questions such as why are CHIs important to communities and why is community involvement important to the CHIs.

How is community involvement currently being fostered?

- Oversight or advisory committee
    - made up of community members
    - made up of CAAs and other stakeholders
- Contracts with CBOs
- Mayor declares "Healthy Kids Day"
- Healthy Kids appreciation dinner for CAAs, CBOs, and community providers
- Enrollment in the Health Plan office
- Telecenter
- No Wrong Door
- Outreach staff
- Outreach in schools and churches
    - Schools
        - Headstart
        - Promatoras
        - Information on Healthy Kids sent out with school registration
        - Request for Information forms sent out with school lunch applications
- Family Resource Centers (especially key in rural areas)
- Hosting and attending community events
- Partner with community clinics
    - Clinics mail out enrollment forms to cash payment patients

Ways to get more community involvement/ support:

- Get the County Board of Supervisors (BOS) support
- One-e-app is seen as a "bureaucracy buster" and has businesses interested

Why is community involvement important?

- Outreach, enrollment and retention
- Fundraising

What is the value of the CHI to the community?

- Providing health coverage
- Healthier kids

Challenges to getting community support:

- CHIs are not traditional charities
- Some BOS will not support the CHI
- Not having County Organized Health Plans

Lessons Learned:

- Families do not like only being able to enroll some of their kids in Healthy Kids (due to enrollment caps for 6-18)
- Do not publicize being "closed"; instead take children's names for the waitlist. It is bad publicity and people stop trying to enroll at all.

Break out session: Fundraising and Sustainability

This discussion focused on the challenges of fundraising and finding sustainable funding sources, as well as solutions the CHI's have found to overcome some of these financial challenges.

Biggest Issues/Challenges

- Messaging—how to make it about health *care,* not insurance
- Getting local community foundations involved in funding
- Creating the infrastructure in the CHI needed to do fundraising over time
- How to cover the cost of administration, given the funders requirements
- Fundraising for 6-18 year olds
- How to fundraise in the environment with the ballot initiative and potential state-wide legislation
- How to address the issue of the hospital initiative coming in June
- How to deal with the various issues among or within stakeholders (e.g. supervisors)
- How to get hospitals engaged?
- Is a statewide solution passes, their might be a perception that "we won", and then we will not get the actual funds for 4 years
- How to ensure longer term funding
- How to ensure sharing among CHIs (fundraising, consultants, communication plans, etc.)
- Foundations may be looking at funding new ideas (CHI-old idea)
- The issue and goal need to be framed better, (e.g. we want the child to have a "medical home")

Some Suggestions from the Group:

- Importance of getting stakeholders together, e.g., legislators, business community, local leaders, providers, etc.
- Need to make a sound economic case
- Find ways to find the emotional tie
- Show the business aspect, show the impact to Medi-Cal, make the overall case
- Have politicians make direct calls (e.g. Mayor of L.A)
- Document ways that this issue is linked to others (e.g. sick children don't go to school, etc.)
- Have sponsorship programs, e.g. businesses will sponsor kids, so you get businesses vested, then you can say "this is of value to the community"
- Have a funding plan that includes supervisors, First 5s, etc., this gives you a better chance of getting long term support
- Think about having a local community foundation, or a trust including corporations, individuals, etc.

- Allow a community foundation to be a fundholder, if they can promise a certain increase in funds
- Try to get the legislators to come together with the business leaders, and agree on common ground
- Hire a fundraising consultant
- Get health plan involvement—put them in the community foundation
- Have a regional "talking points" program to get the right messages across
- Train the steering committee on fundraising, include the United Way and physicians, get groups from industry together
- CHIs could share the names of consultants that have helped with fundraising
- Don't focus on "insurance"
- Educate the First 5s on how this is in their long term interest (having children with a medical home)
- Have IHPS convene a meeting with the CHIs and the First 5 Association Leadership
- Try to have people from hospitals on the steering committee, many hospitals have a community grant program, they want to show they are offering community benefit, show how funding the CHI does this
- Link the hospital board to the CHI
- Give the funders publicity-acknowledge them
- Create a win-win, think if it in terms of building collaboration, schools, hospitals, businesses
- Think of specific messages for hospitals (e.g. ER rates)
- Make sure you get a multi-year commitment
- Peer pressure approach
- Leverage funds from the source to get it from another, use press releases, publicize it
- Call on other CHIs to hook up hospital CEOs in one county with hospital CEOs in another
- Try to separate politics from the importance of covering kids, get the BOS and businesses together in a forum, help educate each other
- Gove potential funders the options of the way they fund (e.g. outright grants or match funds by a certain percentage, etc.)
- Compile real life stories, show how having coverage affects families "grab the community"-make a Video/DVD for the funders
- Target different industry groups based on what message works specifically for them
- One consultants advice "go for the big guys"—foundations, hospitals

Break out Sessions: Health Net

The discussion regarding Health Net focused on how each county is individually working with Health Net and their challenges, as well as how these counties that have a common health plan can work together to address common challenges.

CHI's Contracting with Health Net

- Kern
- Orange
- Tulare
- Fresno
- Healthy Kids, Healthy Future (Colusa, El Dorado, Sacramento, Yuba)

IT

- Enrollment data
- Multiple counties, sites
- TPA/One-e-App
- Meet with foundations re: OEA
- HealthNet
- Common systems for CHI's

Premium collection

- Kern – HealthNet
- Fresno – CHC initial, Health Net other
- Tulare – CHI w/ premium assistance

Charity Contribution

- Fresno – Premium Price, van
- Tulare – N/A AB495 issue
- Kern – Premium assistance, admin, 50 lives, infrastructure

Start-up and staffing

- Sufficient staffing?
- Overextended?
- Diminishing services?
- Non-insurance aspects
- Marketing
- Premium collection
- Medi-cal is prize
- Provider claims processing
- Provider relations
- Corporate vision – corporate FP and community benefit

Future Communication

- Health Net Caucus
- Meet more frequently
- (urgency) In Person
- distill implementation issues
- frame issues for ballot initiative and/or legislation
- Regional Meetings
- Connect to other meetings:
- ITUP in February
- Step-by-Step
- More time to talk
- Conference Calls
- Share tools
- Site visits
- Agenda ideas solicited in advance
- Who to contact on specific issues (i.e. resource guide to CHI contact people)
- Meet with state partners

<u>Break Out Session: Size: Small & Rural</u>

The Small and Rural Counties discussion focused on the challenges of being small and rural as well how they could work together to meet these challenges (such as regionalization).

Critical Mass

- Number of kids, admin, no central organization, multiple agencies, multi-task, limited staff response
- Funding - mix and match
- Full-time staffing lacking
- CAAs not focused on OERU, multi-tasking
- Administrative Home
- Need combined MC/HF/HK (joint application, joint CAA's)
- Sometimes one coordinator, many part-time CAA's
- Training and continuing education – CAA
- CAA coalition
- Funding
- Regional Networks – infrastructure

Regionalizing (Rural coalition or Regional Coalition)
Possible topics to regionalize around

- Health Plan (number of lives)
- Provider network (specialists)
- OERU

- Application process (potential)
- Fundraising
- Local is local
- State/regional opportunities
- Migrating families
- Distance – 5 hours in Northern CA
- Distinct provider network

Size vs Rural

- FQHC – ambivalence and indifference to CHI
- Hospital – on board, but have not put in funds
- Lack of experience

<u>Challenges for Rural and Health Net Counties</u>

Financing and Financial Reality/Sustainability

- 6-18
- 0-5
- Admin
- OERU

Community engagement

- Media
- Momentum
- BOS
- Undocumented Kids
- Local flavor
- Value-added

Retain local flavor in the statewide plan

Retention, tracking and data

Break out Session: Retention

Participants in both retention discussions agreed that enrollment retention success is multifactorial. Participants concurred that some critical elements are within a single organization's control while others are the result of successful collaboration with other entities. Participants shared their experiences and discussed specific elements that appear to contribute to high retention levels and operational and other barriers to retaining enrollees.

Tools/Opportunities for Assessing and Improving Retention

- Good tracking systems; having a centralized data collection approach
- Case management of enrollees through out the year
- Making welcome calls to new enrollees and other ongoing communications with enrollees on a scheduled basis to encourage utilization; consider scheduling first office visit during welcome call
- Training outreach workers and others who interact with applicants and new enrollees specifically about how to communicate and outreach to mixed status families
- Offering hardship funding of family premiums
- Building and retaining a good relationship with Medi-Cal eligibility and other key organizations
- On all calls with enrollees take the opportunity to update contact information, phone number, and back up number
- Use pre-populated postcards to do annual eligibility renewals
- Set expectations about enrollment retention early – at time of initial application
- Work closely with schools – get an applicant's school name and have schools make follow up contacts
- Develop reminder kits for enrollees (e.g. document holder kits; reminder magnets; change of address forms)
- Have a multi-step approach to communicating with enrollees about annual renewal requirement (e.g. 60 day advance of termination – send out a phone blast to enrollees letting them know the renewal packet is coming; 45 days in advance send out a postcard; 2 weeks prior to termination place personal phone calls to enrollees)
- Work with providers to encourage them to remind enrollees about renewal when they utilize services
- Experiment with email addresses as a way to track down enrollees "lost" during the year
- Consider forming a program integration workgroup to develop an integrated retention plan with roles specified for plan staff and contractors and providers
- Offer enrollee incentives for making appointments

Challenges to Retention

- The considerable variation across organizations in how they measure retention; should there be standardization in retention measurements?
- Lack of data centralization
- Low levels of enrollee literacy reduce effectiveness of mailed enrollment renewals and other mailed communications – hence the need for using prepopulated renewal forms in combination with phone call reminders
- Lack of accountability for some organizations critical to renewal e.g. CAA performance; Need incentives to maximize CAA performance and tie incentives to renewal
- Provider unwillingness to be part of retention team
- Retention is contingent on high staffing levels – may need to hire more people to make phone calls and conduct case management during the year
- Mobile population issues
- Lack of integration and team mentality among all entities and people necessary to retain enrollees