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The Importance of Realistic Optimism

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

Financing Components

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

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

Planning and Anchor Funding

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

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

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

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

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

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

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

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

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

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

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

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

Complementing Local Funding

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

Medicaid Administrative Activities (MAA)

Federal resources are available to support the following activities:

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

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

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

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

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

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

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

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

Program Staging

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

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

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

Considering Funder Restrictions

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

Long-term Sustainability

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

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

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

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

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

Table 4.2
Fund Holding Arrangements for Established CHIs

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

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

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

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

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

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

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