

MAXIMIZING MEDI-CAL: SONOMA'S EFFORTS TO EXPAND HEALTH COVERAGE

Daniel C. Kim*

EXECUTIVE SUMMARY

In this paper, new policies and practices that Sonoma County's Medi-Cal program has adopted are reviewed in light of welfare reform. Specifically, this paper explains how Sonoma has (1) simplified its Medi-Cal re-enrollment process for discontinued CalWORKs clients and (2) increased its collaboration with other health programs and organizations through its involvement in the county's Children's Health Insurance Collaborative. The paper then assesses how these new policies and practices might be adapted to San Francisco's Medi-Cal program. In addition, the author identifies potential performance measures to help monitor and evaluate Medi-Cal's efforts to maximize health coverage and improve customer service.

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INTRODUCTION

For my BASSC internship, I wanted to find out what other counties were doing to expand Medi-Cal coverage. Specifically, I wanted to find out what was being done to:

1. Maximize health coverage for all low-income and needy individuals.
2. Reduce net county costs associated with safety net health-related services.
3. Improve customer service for those enrolling in Medi-Cal.

To this end, I wanted to study how Sonoma County operates its Medi-Cal program. In particular, I wanted to find out how Sonoma conducts its outreach efforts and ensures that CalWORKs discontinued cases continued to receive Medi-Cal. I also hoped to identify which of Sonoma's practices might be applicable to San Francisco and make recommendations to our own Medi-Cal program.

METHOD AND APPROACH

Before visiting Sonoma, I first met with management and staff from the San Francisco Medi-Cal program. Wanda Jung, the San Francisco Medi-Cal program manager, and her management team explained the basics of the Medi-Cal program, including the procedures for initial intake and carrying cases. They also described what San Francisco was doing in terms of expanding Medi-

Cal outreach and improving customer service for Medi-Cal clients.

In Sonoma County, I spent three days in the Medi-Cal program with Debbie Kelly, Sonoma's Medi-Cal program manager. As my facilitator, Debbie graciously explained the basics of Sonoma's Medi-Cal program, walked me through Sonoma's Medi-Cal intake and carrying procedures, provided reading materials¹, and connected me with other management and staff within Sonoma's Human Services Department. I also met with Kim Seamans, who explained some of the intricacies of the Medi-Cal program, and Felisa Pinson, who showed me how to review and determine the Medi-Cal eligibility of all discontinued CalWORKs cases.

My report begins with a brief overview of the Medi-Cal program, followed by the factors that have changed Medi-Cal over the past several years. This is followed by a description of Sonoma's efforts to expand Medi-Cal coverage and the implications for San Francisco's Medi-Cal program. I conclude with a list of proposed performance measures that may help the Medi-Cal program monitor the effectiveness of its efforts to expand Medi-Cal coverage and improve customer service.

WHAT IS MEDI-CAL?

In 1965, Congress created the Medicaid program as a way of providing health coverage to people receiving welfare. Following federal guidelines, California

¹I highly recommend *The Guide to Medi-Cal Programs: A Description of Medi-Cal Programs, Aid Codes, and Eligibility Groups*, written by Claudia Page and Susan Ruiz for the Medi-Cal Policy Institute. I found this primer to Medi-Cal to be both informative and readable.

then created Medi-Cal, its own Medicaid program. Although eligibility requirements for Medi-Cal programs vary amongst states, each Medicaid program generally provides health coverage for the following types of persons:

- Aged, blind, or disabled (SSI-linked)
- Families with children facing deprivation (AFDC-linked)
- Children or pregnant women
- Individuals with specific health care needs

In California, each of the 58 counties is responsible for administering Medi-Cal. To this end, counties are responsible for enrollment, ongoing maintenance and management of records, and case review to redetermine eligibility.

WHAT HAS CHANGED MEDI-CAL?

In recent years, the Medi-Cal program has seen a sea of changes on the federal, state, and local levels. These changes have made the Medi-Cal program more complex and difficult to administer, while also making the need for Medi-Cal coverage all the more pressing.

- **Time-limited Eligibility Reduced Medi-Cal Health Coverage.** Prior to welfare reform, the Medi-Cal program was linked to the federal Assistance for Families with Dependent Children (AFDC) program, which was an entitlement program that offered welfare benefits to families meeting the requirements of “deprivation”. As long as these families received AFDC benefits, they were continuously enrolled in Medi-Cal. In 1996, however, welfare reform abolished AFDC and replaced it with the Temporary Assistance for Needy Families (TANF) program (otherwise known as CalWORKs in California). CalWORKs, unlike

AFDC, offers welfare benefits for a limited period of time. Now that Medi-Cal is linked with CalWORKs, those formerly AFDC clients who are now enrolled in TANF will receive Medi-Cal coverage for only as long as they remain eligible for the time-limited CalWORKs program.

- **New Medi-Cal Programs and Other Related Health Programs Were Created.** Welfare reform also introduced new Medi-Cal programs, including the 1931b program, and made changes to other programs, such as Transitional Medi-Cal (TMC). These new or revised Medi-Cal programs, with their different terms of health coverage and eligibility requirements, have made Medi-Cal eligibility determination more difficult and time-consuming. At the same time, several new, non-Medi-Cal programs have been initiated over the past few years. These new programs, which include the state-funded Healthy Families initiative and Cash Assistance Program for Immigrants (CAPI), along with the privately sponsored programs by Blue Cross and Kaiser, offer health coverage to low income families and children ineligible for Medi-Cal. Nevertheless, efforts to enroll eligible children and adults into these new programs have been slow, and there are still fewer eligibles enrolled than not.
- **San Francisco’s Demographics Have Changed.** In San Francisco, an increasing number of our Medi-Cal eligible population has limited English proficiency. Although DHS offers some information and services in different languages (i.e. Spanish, Russian, Cantonese, Mandarin, Vietnamese, Cambodian, etc.), large segments of our client populations continue to lack adequate access to Medi-Cal and other health-related programs.

- **County Health Care Costs Have Skyrocketed.** Meanwhile, despite the expansion of Medi-Cal eligibility and other options for subsidized health coverage, county costs associated with healthcare continue to skyrocket. With federal and state reimbursement rates lagging behind the increasing cost of health care services, the San Francisco Department of Public Health anticipates a \$10 million general fund shortfall in fiscal year 1999–2000—this despite an increase of \$20 million general fund monies over the prior year. Given this shortfall, the need to expand Medi-Cal coverage has become ever more pressing.

SONOMA'S MEDI-CAL PROGRAM

Sonoma has taken a number of measures to expand health coverage for low-income families. For the purposes of this report, I focus on two areas: how Sonoma (1) expands health coverage for discontinued CalWORKs clients and (2) collaborates with other agencies. In addition, I also propose some performance measures, which I developed based on my research and discussions with Sonoma's Medi-Cal staff.

EXPAND HEALTH COVERAGE FOR DISCONTINUED CALWORKS CLIENTS

In efforts to increase health coverage for discontinued CalWORKs clients, Sonoma has instituted a pilot project to simplify the re-enrollment process for discontinued clients.

Before the pilot project, all discontinued CalWORKs cases were assigned to aid code 38 (Edwards), which provides discontinued clients a

30 day grace period to re-enroll for Medi-Cal coverage. This grace period allows discontinued clients time to complete and submit their Medi-Cal application to the Medi-Cal program, which then re-determines the clients' eligibility for Medi-Cal coverage. Discontinued clients who failed to submit their Medi-Cal application lose their Medi-Cal coverage after 30 days.

With the implementation of the pilot project, different procedures were developed for three different types of discontinued CalWORKs cases: (1) cases ineligible for continuing benefits², (2) cases discontinued due to earnings, and (3) all other discontinued cases.

- **Cases ineligible for continuing benefits.** SonomaWorks employment specialists (ES) continued to assign these cases to Edwards, since these cases by definition were ineligible for Medi-Cal coverage.

- **Cases discontinued due to earnings.** SonomaWORKs ESs now assigned these cases to Medi-Cal TMC. The Medi-Cal TMC program offers clients who discontinue due to earnings up to 24 months of Medi-Cal coverage. The first 12 months covers all family members, while the second 12 months only covers adults in the family (although children can usually qualify for other Medi-Cal programs during this period). By automatically enrolling these clients into TMC, Sonoma was able to prevent any break in health coverage for these clients.

In some cases, however, clients discontinued due to earnings may be eligible for the 1931b Medi-Cal program. The 1931b program is preferred over TMC because it offers the same level of

²Clients ineligible for continuing benefits include: 001 death, 003 client request, 004 failure to cooperate, 044 resident of a non-medical public institution, 048 out of state/loss of residence, 098 whereabouts unknown, and 038/019/073/096 determined ineligible.

health coverage without TMC's time limits. Therefore, in order to ensure that all 1931b eligible cases receive 1931b instead of TMC coverage, a Medi-Cal eligibility worker (EW) is assigned to the SonomaWORKs post assessment unit to review all discontinued cases before they are closed out. This Medi-Cal EW makes the final determination of health coverage for all cases discontinued due to earnings.

- **All other discontinued CalWORKs cases.** The Medi-Cal EW stationed at SonomaWORKs also reviews all other discontinued cases. That is, before closing out a non-income discontinuance, the SonomaWORKs ES must give the case file to the Medi-Cal EW. The Medi-Cal EW then reviews the case file to determine what Medi-Cal coverage the discontinued client should receive. This Medi-Cal EW usually turns around these cases within a few days so the SonomaWORKs ES can promptly close out the case.

Prior to this pilot project, fewer than 25 percent of their discontinued CalWORKs clients were re-enrolling for Medi-Cal coverage. Now, with the implementation of this pilot project, about 75 percent of discontinued CalWORKs clients are enrolled in TMC or 1931b (see Figure 1).

Implications for San Francisco

In San Francisco, Medi-Cal workers review all CalWORKs cases that are discontinued due to earnings. As a result, San Francisco has also been able to increase the number of discontinued CalWORKs clients re-enrolled for Medi-Cal coverage. But unlike Sonoma, San Francisco does not house its Medi-Cal staff with its CalWORKs staff. Rather, all discontinued cases are transferred from the CalWORKs employment specialists to the Medi-Cal program for further review.

Transferring cases, however, may increase the time it takes to process discontinuances. Therefore, in order to expedite processing of discontinued clients, San Francisco should consider co-locating Medi-Cal staff with CalWORKs employment specialists. By specializing in discontinued cases and co-locating with employment specialists, these Medi-Cal staff can help expedite processing and promote knowledge sharing between the Medi-Cal and CalWORKs programs.

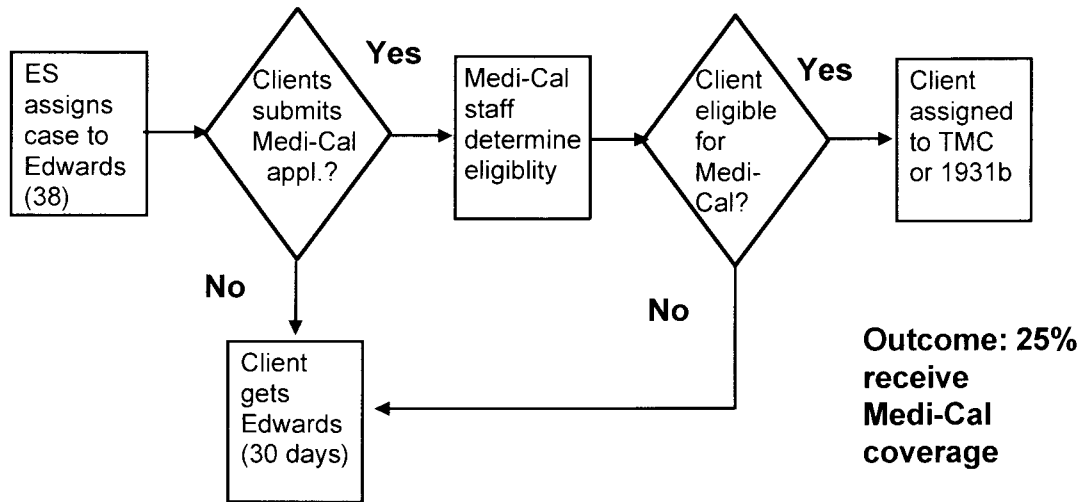
In addition, I recommend that San Francisco consider eventually co-locating Food Stamp workers with the CalWORKs program. Like the co-located Medi-Cal workers, these food stamp workers would specialize on discontinued CalWORKs cases, but also serve as a resource to CalWORKs employment specialists on other food stamp-related issues.

One of the major challenges to co-location will be the lack of space in our CalWORKs offices. Currently, most of San Francisco's CalWORKs staff are located in the 170 Otis office, which offers cramped quarters for existing staff, let alone additional staff. Accordingly, co-locating Medi-Cal and Food Stamps in 170 Otis may not be feasible at this time. But in the future, as the CalWORKs program begins to decentralize its staff to neighborhood locations, DHS should consider adding a Medi-Cal and Food Stamp worker to each CalWORKs unit.

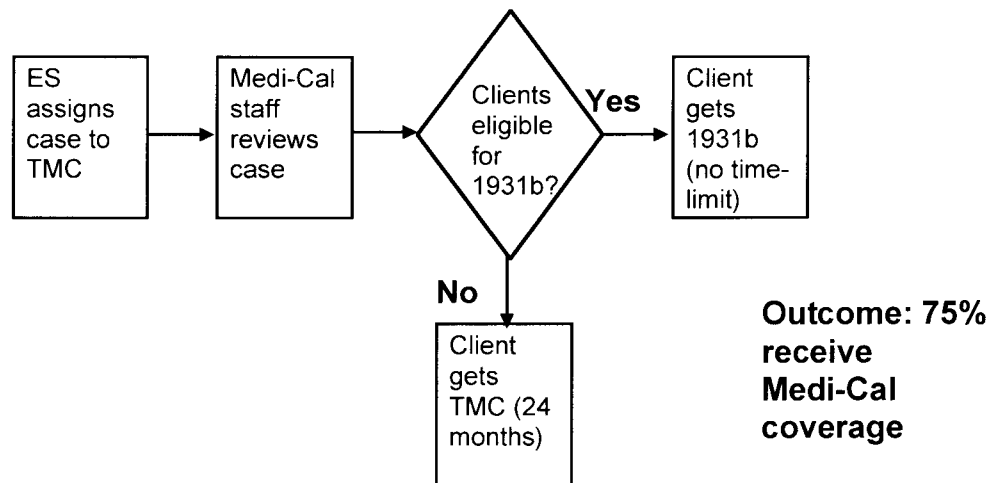
Another challenge will be the question of supervision—that is, who should the Medi-Cal or Food Stamps worker report to? In this case, I recommend a joint reporting structure in which the co-located Medi-Cal or Food Stamps workers report to their CalWORKs (unit) supervisor and their Medi-Cal or Food Stamps (program) supervisor. These two supervisors would then confer and jointly produce the worker's annual evaluation.

Figure 1
Old and New Procedures for Enrolling CalWORKs Clients Discontinued Due to Earning

Old Procedure



New Procedure



COLLABORATE WITH OTHER AGENCIES

Sonoma County has formed the Children's Health Insurance Collaborative (CHIC), which is comprised of management from the Medi-Cal program, various programs within the County Health Department (Maternal Child Health, Child Health and Disability Prevention, California Children Services), Kaiser, Blue Cross, the Women Infants and Children program, and several representatives from private, non-profit health clinics.

CHIC meets on a monthly basis and offers each organization the opportunity to inform, review, and learn about new policies, procedures, and practices related to children's health insurance. At the meeting I attended, several clinics discussed their outreach efforts, identified opportunities to collaborate, and solicited input from the other group members. For example, one organization informed the other CHIC members that it had begun conducting outreach efforts at schools. The Medi-Cal representative also noted that AB 1735 (Thomas) would promote efforts to conduct health-related outreach through school lunch programs. In the course of this discussion, one CHIC member volunteered to contact the Santa Rosa school district to see if they could work together on promoting health-related outreach at the schools.

Implications for San Francisco

San Francisco has its own collaborative comprised of staff from both the Medi-Cal program and the Department of Public Health, as well as representatives from various health organizations within the county. I recommend that San Francisco's Medi-Cal program continue to develop ties with these organizations and jointly develop strategies to expand health coverage for low income families and single

adults. In addition, I recommend that the Medi-Cal program establish formal ties with the San Francisco Unified School District (SFUSD). For example, with SFUSD's help, the Medi-Cal program could target its outreach efforts to families of students eligible for SFUSD's school lunch program.

To facilitate this collaboration with SFUSD, the Medi-Cal program may want to identify what resources or data SFUSD could provide to help improve our outreach efforts. Medi-Cal should also coordinate efforts with the San Francisco Department of Children Youth and Families (DCYF), which provides funding for school-based clinics. By working in conjunction with DCYF, Medi-Cal can leverage existing resources within San Francisco schools and thereby prevent the duplication of effort.

To make the collaboration between SFUSD and DCYF mutually beneficial, Medi-Cal could establish health fairs during open houses at targeted schools, provide additional funding to the school-based clinics, or offer free vaccinations or other materials which could be paid for by using Medi-Cal 1931(b) outreach monies.

IMPLEMENT PERFORMANCE MEASURES

During my internship, I spoke to Medi-Cal management and staff in both San Francisco and Sonoma. As a result of these conversations, I compiled and drafted the following goals for the Medi-Cal program:

- Maximize health coverage for all low-income and needy families and single adults
- Improve customer service for those enrolling in Medi-Cal

- Reduce net county costs associated with safety net health-related services
- Prevent fiscal abuse by ensuring that only those eligible for Medi-Cal are enrolled into the program

In order to determine whether these program goals are being met, the Medi-Cal program should consider developing performance measures tied to each of these program goals. In Sonoma County, the CHIC has implemented some performance measures, and the Medi-Cal program currently monitors caseload statistics. But the Medi-Cal program has not yet implemented performance measures at the program level. Fortunately for me, I had the opportunity to work together with Kim Seamans, Sonoma's Medi-Cal analyst, to draft some performance measures to cover the first two goals of maximizing health coverage and improving customer service. These performance measures are identified below.

1. Maximize health coverage for all low-income and individuals. By enrolling more low-income and needy San Franciscans into Medi-Cal and other subsidized health and nutrition programs, DHS will not only improve the health and well-being of its clients, but also help reduce the cost of indigent healthcare, which is subsidized by county general fund monies.

In order to identify which clients are being underserved and whether or not targeted outreach efforts are successful, the Medi-Cal program could collect, sort, and review the following data:

- Number of new and total Medi-Cal enrollments by program type (1931b, TMC, Edwards, IHSS, SSI/SSP, Foster Care, CalWORKs, etc.)
- Number and percentage of new and total Medi-Cal enrollments by client type (i.e. ethnicity, age, etc.)

Furthermore, in order to determine whether or not we have expanded health coverage for low-income and needy San Franciscans, we could measure:

- Number and percentage of new and total indigents successfully enrolled into SSI/Medi-Cal by DHS or SSI Advocacy Unit staff
- Number and percentage of new and total CalWORKs discontinuances enrolled into Medi-Cal TMC or 1931b programs
- Number and percentage of referrals who are subsequently enrolled into WIC, Healthy Families, California Kids, CHDP, CCS, etc.

2. Improve customer service for those enrolling in Medi-Cal.

The Medi-Cal program can assess its customer service by measuring how promptly and accurately staff are processing Medi-Cal applications. To this end, the program could measure:

- Average time (i.e. working days) it takes to notify client that they are/aren't eligible for Medi-Cal.
- Number of cases reviewed by (by intake and carrying worker)
- Number of cases completed by (by intake and carrying worker)
- Percentage of cases reviewed that are completed (by intake and carrying worker)
- Number of failure to provide notices that are issued (by intake worker)
- Number of pending or overdue cases (by intake worker)
- Number of incomplete redetermination reports (by carrying worker)

Implications for San Francisco

In order to determine whether DHS's efforts to increase health coverage for low-income and needy

San Franciscans have been successful, I recommend that the Medi-Cal program develop performance measures, track and monitor these measures, and evaluate trends with Medi-Cal management and staff on a monthly basis and with Executive Management on a quarterly basis.

The major challenge to implementing performance measures will be staff resistance. Medi-Cal staff may feel threatened by the idea of these measurements. Therefore, in order to minimize this resistance, I recommend that these performance measures be aggregated to measure the overall effectiveness of Medi-Cal units and not individual Medi-Cal workers.

CONCLUSION

The Medi-Cal program has undergone significant changes over the past several years. But these changes have also resulted in a number of new opportunities for the Department to expand health coverage, collaborate with other health providers and agencies, and improve customer service. As net county costs associated with public health continue to increase, counties will look increasingly to their Medi-Cal programs to expand outreach efforts and increase Medi-Cal enrollments. In order to meet these needs, County Medi-Cal programs will need to streamline their procedures to make them more customer-friendly and develop performance measures to ensure that their goals are being met.