The Children's Partnership

ISSUE BRIEF

California's Express Enrollment Program

Lessons from the Medi-Cal/School Lunch Pilot Program—And Suggested Next Steps in Making Enrollment Gateways Efficient and Effective

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For More Information

- Visit www.expresslaneinfo.org for additional information on Express Enrollment in California, in addition to efforts in other states.

- For copies of this report, call (310) 260-1220, e-mail frontdoor@childrenspartnership.org, or visit www.expresslaneinfo.org/ELE/Report/EEIssueBrief.

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EXECUTIVE SUMMARY

In 2003 California implemented an Express Enrollment (EE) pilot program to enroll eligible, uninsured children into health insurance through school lunch. Now that the pilot phase is over, it is important to summarize observations about what can be learned from this experiment and to define the next phase of promising work. First, EE was the right experiment to try—it focused on where the greatest numbers of uninsured children are (over half of California's uninsured children receive school lunch), and it secured several enrollment-related streamlining advances in state policy, including presumptive eligibility and self-declaration of income.

Moreover, the first phase of EE worked well. It identified thousands of children as uninsured. If the results from the less than 1% of school districts implementing EE during the pilot phase were achieved statewide in all school districts, 200,000 to 500,000 uninsured children would be reached. That amounts to up to two in every three uninsured child in California and includes some of those hardest to reach. In addition, EE streamlined the initial coverage process for the identified uninsured children. It provided them with temporary coverage (68% of those applying), and as a result essential health care services, until their continuing eligibility could be verified.

The second phase did not work so efficiently. Even though 40% of children receiving temporary coverage were ultimately enrolled in Medi-Cal (full scope, share-of-cost or restricted), the numbers were smaller than had been hoped. In addition, when the children enrolled in restricted Medi-Cal are eliminated only 26% of children enrolled in temporary coverage were enrolled in Medi-Cal. The rate also decreased substantially when comparing enrollment to total number of applications received.

This was due in part to a two-step process that required the collection of information after the initial application and through which many children were lost. In addition, inadequate computer capability and data systems meant that 38% to 48% of applicant children already in Medi-Cal or Healthy Families were not discovered until after a labor-intensive process, which taxed county eligibility systems.

The pilots were deliberately designed to test on a small scale what worked and what problems needed to be corrected. The conclusions from this bold experiment provide valuable lessons that can be applied more broadly to current and future state efforts to use public programs to enroll uninsured children into health coverage, commonly called "gateways". The bottom line: if the capacity of gateways to identify uninsured children can be joined with modernized enrollment procedures and policies, there is the potential to enroll large numbers of uninsured children far more efficiently and effectively. Seven critical elements to a successful system follow.

1. Technology to Screen for Insured Children

EE requires significant time and resources to screen out applicant children who are already enrolled in Medi-Cal or Healthy Families. A successful enrollment system must immediately and automatically cull out these children.

2. Temporary Coverage Until Determination

Under EE, the initial school lunch application (with additions) is a Medi-Cal application. This allows children to receive temporary Medi-Cal until further information is collected to verify eligibility. At the same time, counties are still required to meet federal application processing rules. An effective enrollment system should implement this policy to ensure families and counties have adequate time, within federal rules, to complete the process.

3. Information Collected in One-Step

A two-step process was created for EE because of concerns that requesting too much information up-front would negatively impact school lunch, which has a simpler application process. Although EE has a streamlined follow-up process, the number of families replying to the second request is low. A gateway must balance the advantages of increased health coverage enrollments obtained through one step against the potential impact to a program.

4. Simpler Documentation Requirements

EE allows the school lunch application to serve as Medi-Cal documentation of income and residency. This is a critical enrollment policy that saves school districts and counties time and associated costs.

5. Inclusion of Healthy Families and County Programs

EE focuses primarily on Medi-Cal enrollment rather than finding coverage for children in any available program. An enrollment gateway system should process all applications received for Medi-Cal, Healthy Families, and county programs. This would ensure that all children identified as uninsured are matched up with health coverage.

6. Financing Mechanisms

One of the difficulties with expanding EE is the limited resources that schools have to implement a program. A successful gateway system should ensure that there are funding resources available.

7. Federal Flexibility

A truly effective enrollment policy would deem a child eligible for health coverage based on eligibility in a public program. Federal flexibility for this type of policy should be explored further.

The EE lessons provide a blueprint for creating effective enrollment systems through other public programs. These lessons are currently being applied to policy in California as legislation and a ballot measure are pursued to insure all children. The Children's Partnership is committed to assisting in these and other efforts.

INTRODUCTION

In 2003 California began an experiment to enroll eligible, uninsured children into health insurance through other public program gateways, specifically school lunch. The purpose of these efforts was twofold: (1) Find uninsured children who are eligible for Medi-Cal and Healthy Families through other public programs, building upon the fact that a majority of uninsured children are already enrolled in these programs; and (2) Utilize the information families submit to the other programs to make the Medi-Cal and Healthy Families enrollment process more efficient.

This Issue Brief provides an update on this effort, called Express Enrollment (EE). Specifically, it reviews the pilot program implemented within school districts and counties, describing activities to date and the program's overall effectiveness. The conclusions from this bold experiment are included. In addition, this brief applies the valuable lessons from EE to current and future state efforts to use public programs to enroll uninsured children into health coverage, commonly called "gateways."

The Children's Partnership (TCP) received funding from The California Endowment and the Blue Shield of California Foundation to provide technical assistance to school districts to implement Express Enrollment. In addition, TCP assisted in the development of Express Enrollment state policy, including revisions to the school lunch application and other forms. This report is based on our experiences with the program, in addition to input obtained from stakeholders and the participating school districts. The data in the report was obtained from the formal three-year evaluation conducted by University of Southern California, Division of Community Health.[1]

PROMISE OF EXPRESS ENROLLMENT

Since the creation of Healthy Families in 1997, significant state and local resources have been dedicated toward finding and enrolling uninsured children eligible for Medi-Cal and Healthy Families. Activities included payments to application assistors, toll-free numbers, local outreach events, and media. However, 779,000 children in California remain uninsured, 429,000 (or 55%) whom are eligible for Medi-Cal or Healthy Families.[2] Enrollment continues to be hampered by difficult enrollment practices.[3]

In October 2001 the Legislature passed AB 59, authored by Senator Cedillo and sponsored by Los Angeles Unified School District and County Welfare Directors Association. The intent of the bill's author, sponsors and supporters was to utilize the school lunch program as a gateway for identifying uninsured children and use the eligibility information already available to provide the children with immediate and ongoing Medi-Cal coverage. The legislation focused on using the National School Lunch Program to meet these

goals because of its connection to schools and possible high yield: *56% of California's uninsured children are in families that participate in school lunch.*[4]

The resulting Express Enrollment (EE) program allows children eligible for free school meals through the school lunch program to apply for Medi-Cal at the same time they complete a school lunch application. Children determined by the school to be income-eligible for Medi-Cal receive temporary coverage (under federal rules called presumptive eligibility). The county uses information on the school lunch application and an additional follow-up form to complete a Medi-Cal eligibility determination. The applications for those children ultimately determined eligible for Healthy Families or a local/county program are transferred appropriately.

EE began as an optional program for school districts starting in 2003. The program was deliberately planned as a pilot so that it could be tried on a small scale. Enabling legislation made the program optional for school districts, and implementation funding was not provided by the state.[5] Foundation funding, primarily The California Endowment, supported EE as a pilot program in select school districts and counties across the state. In 2005-06, 10 school districts in nine counties implemented EE in a total of 115 schools.[6] The school districts represent less than 1% of all schools in California.

BUILDING EXPRESS ENROLLMENT

The creation of Express Enrollment (EE) was accomplished through a state work group consisting of state officials from the Departments of Health Services (DHS) and Education (CDE), advocates, and implementing school districts and counties. EE required the implementation of the following new state procedures and policies.

School Lunch Express Enrollment Application

School districts participating in EE must revise their school lunch applications. The school lunch application must include information required to make a presumptive Medi-Cal determination and to obtain parental or guardian consent for sharing the information on the application with Medi-Cal.

To ensure limited changes to the application, the State agreed upon minimum federal and state requirements for making a presumptive Medi-Cal determination. CDE approved these changes to the school lunch application so long as they were marked optional for school lunch. The State determined that only the following additions were required:

- Family Relationship: school lunch uses household income for eligibility but Medi-Cal counts certain family members and income.
- Date of Birth: many schools already collect a child's birth date, but it is not a school lunch requirement for eligibility.
- Child's Income: school lunch asks for as part of the total household income, but Medi-Cal needs the child's income as a separate figure.
- Income/Household Size for a Child in Public Programs: children enrolled in programs, like food stamps, are income-eligible for free school lunch and do not submit income information, which is required for Medi-Cal.
- Parental Signature: the parent or guardian must provide consent and signature under penalty of perjury for each child applying.

Presumptive Eligibility

The presumptive eligibility determination is made by the school district. Under federal law they serve as the "qualifying entity." To make the determination, schools must calculate a child's eligibility based upon the income and household information provided on the school lunch application. Once the presumptive determination is made, the school district has five working days to transfer the application to the county social services department so that the child can be placed into coverage and sent a benefits card. The county has five working days to enroll an eligible child.

The presumptive eligibility period continues until a final determination is made. However, processing time must still continue within federal rules. The policy of ongoing presumptive eligibility required that federal authorities accept the revised school lunch application as the start of a Medi-Cal application, not simply an application for presumptive eligibility.[7] State officials and advocates believed it was critical that children not have interrupted coverage during the enrollment

process. At the same time, it was considered essential to keep additions to the school lunch application to a minimum by not seeking certain Medi-Cal eligibility information, such as the child's social security number. CMS confirmed that the minimum information sought via the school lunch application was acceptable to count as a Medi-Cal application, as long as the application sought the parent's signature under penalty of perjury.

Medi-Cal Enrollment Procedures

The county social services department is responsible for making the final Medi-Cal eligibility determination. A supplemental form and cover letter (MC 368) notifies the family of a child's status and collects additional information required, in lieu of other state forms (namely, MC 219-Rights and Responsibilities, MC 13-Immigration Status, and DHS 6155-Other Health Coverage).

EE accepts the self-declared income as stated on the school lunch application and thus does not require income or residency documentation, as is required of the regular Medi-Cal application. Documentation is only required if there is a discrepancy or the family wants to apply Medi-Cal deductions, like child care costs, to their income. Noncitizens are also required to present immigration documents per federal law. (In 2006, federal rules now require citizens to also provide citizenship documentation.)

Starting in 2005-06, children who return the MC 368 who are not eligible for full scope Medi-Cal (because of income or immigration status) are transferred to Healthy Families or an available local or county program. Healthy Families accepts the school lunch application with the county's determination so that families do not have to complete another application.

THE PILOT PROGRAM

Seven of ten implementing school districts received foundation grants from The California Endowment and the Blue Shield of California Foundation to pilot Express Enrollment (EE) through the 2005-06 school year.[8] The California Endowment also developed an EE initiative to support the State's development of the program. The following section focuses on the data from these pilot programs. The school districts have either two or three full years of experience, depending on their implementation date. The school districts were chosen based on geography, students eligible for free school lunch, and interest in the project. (See Table 1.)

Table 1. Pilot Program School Districts

School District	Foundation Support	Region	Year	Schools	Free-Lunch Eligible
Fresno Unified	California Endowment	Central Valley	2003/04	2	764
			2004/05	16	3,560
			2005/06	32	5,733
Los Angeles Unified	California Endowment	Southern	2003/04	19	6,180
			2004/05	5	5,956
			2005/06	11	12,533
Redwood City Unified (San Mateo)	California Endowment	Northern	2003/04	22	3,669
			2004/05	22	3,517
			2005/06	3	776
San Diego City Schools	California Endowment	Southern	2003/04	9	1,186
			2004/05	12	3,732
			2005/06	15	4,619
Lucia Mar (San Luis Obispo)	Blue Shield Foundation	Central Valley	2004/05	16	3,696
			2005/06	16	3,357
Laytonville (Mendocino)	Blue Shield Foundation	Northern	2004/05	6	247
			2005/06	6	220
Point Arena (Mendocino)	Blue Shield Foundation	Northern	2004/05	2	278
			2005/06	2	236

Source: Communications with pilot sites/ USC Division of Community Health

To understand EE's impact, the University of Southern California Division of Community Health (USC) conducted a three-year cluster evaluation in the school districts participating in the pilot project. The final evaluation report, compiling data on

enrollments, utilization, and client satisfaction, was released in conjunction with this report.[9] This brief uses the evaluation data collected by USC although the data analysis reflects solely the views of The Children's Partnership (TCP) and is not representative of the views of the evaluators. The analysis is supplemented with interviews with staff in the school districts and counties conducted by TCP through site visits and regular contact.

School Activities

The pilot school districts process the majority of the school lunch applications at the start of the school year. Outreach efforts for obtaining completed applications include posters, brochures, in-person assistance, and presentations. Once applications are received, the school district makes the school lunch determination and forwards the application to EE staff.[10] EE staff makes an income determination for presumptive Medi-Cal and transfers the applications to the county department of social services.

Four of the school districts process the applications manually. However, Fresno, San Diego, and Redwood City utilize One-e-App technology developed and funded by the California Healthcare Foundation and The California Endowment. One-e-App is a Web-based system that electronically screens and enrolls families in public health insurance programs using a single application. One-e-App has been enhanced to include EE, enabling a school district to enter the school lunch/Medi-Cal data into an electronic format. The system can calculate eligibility for EE, generate notices to families, and allow for transfer of the information electronically to the county.

Program Results

The USC Division of Community Health evaluation reports that over the length of the pilot program almost 11,500 (4,956 in Year 1, 3,017 in Year 2, and 3,515 in Year 3) free school lunch applicants submitted applications with Medi-Cal consent. Their data further shows that EE did not adversely affect school lunch participation and, in some cases, may have increased it. This was an important finding since concerns were initially expressed about whether a connection with Medi-Cal, a more complicated program that seeks immigration information, would impact school lunch participation.

In each year of implementation, participating schools in the pilot reported an increase in the number of school lunch applications received from the prior year. In the first two years the increase in the schools was as high or higher as the increase across the school districts and statewide. In the third year the increase in the pilot schools (5%) was smaller than the increase district wide but higher than statewide.

County departments of social services processed close to 7,000 applications for Medi-Cal over the three years of the pilot. The counties also received almost 5,500 applications (44% of all applications received) for children who were already enrolled into Medi-Cal or Healthy Families. Of the applications for those who were not already enrolled in Medi-Cal and Healthy Families, about 4,700 (68%) received temporary Medi-Cal benefits.[11] (Table 2 provides the breakdown of the applications processed by the county by each pilot year.)

Table 2. EE Applications Processed by Counties

Year	Applications Received at County	% Already in Medi-Cal or Healthy Families	Express Enrolled		Medi-Cal Enrolled (% of Express Enrolled)*	
			% of Apps. Received	*% of Children Without Medi-Cal*	All Programs (Full Scope, Share-of-Cost, Restricted)	Full Scope or Share-of-Cost
2003-04	5,599	48%	32%	61%	51%	28%
2004-05	3,092	44%	41%	72%	35%	24%
2005-06	3,689	38%	45%	74%	33%	25%
Total	12,380	44%	38%	68%	40%	26%

Source: USC Division of Community Health **Share-of-cost and restricted applications are forwarded to Healthy Families and an available county, as appropriate. No data is available on status of those applications.*

Around 1,900 applicants were enrolled into ongoing Medi-Cal.[12] Ongoing Medi-Cal includes children enrolled in full scope, share-of-cost or restricted Medi-Cal.[13] This represents 40% of the children who received temporary coverage. Those applicants who were enrolled in full scope or share-of-cost only represent 26% of the children who received temporary coverage. Starting in 2005-06 children eligible for share-of-cost or restricted Medi-Cal are transferred to Healthy Families or an available local/county program, as appropriate. Data on the transferred children is not available at this time.

The remaining children were denied coverage, predominantly due to failure of the families to return the MC 368 follow-up form.

Pilot and Family Feedback

Overall, school districts that have implemented Express Enrollment feel positive about their experience with the program. School districts believe that Express Enrollment brings a positive message to schools, one that stresses the importance of health insurance. In addition, there is a general sense that the children reached are those typically not served.

However, the low numbers of children enrolled into coverage was troubling for the school districts and counties, especially in relation to the effort of work involved. Counties were particularly concerned about the resources they have devoted to EE, including the time needed to manually screen out those children already enrolled in Medi-Cal or Healthy Families, in comparison to the low number of children enrolled.

Anecdotal family feedback shows that those families who do participate in the program are pleased with the process. Comments have ranged from disbelief that it is so easy to excitement about getting a Medi-Cal card in the mail so quickly. Families are also accessing services during the presumptive eligibility period. In the first two years of the pilot, about 20% of children receiving temporary coverage used services, including clinical, pharmacy, lab/x-ray and specialist care, during the presumptive period.[14]

EFFECTIVENESS OF EXPRESS ENROLLMENT

To determine the effectiveness of Express Enrollment (EE), this report evaluates the program's goals: to use the school lunch program to identify uninsured children; to enroll children into temporary and ongoing Medi-Cal; and to streamline enrollment. Since EE was implemented in less than 1% of school districts in the state, the overall number results are limited. To appreciate EE's potential, the analysis also attempts to present the results in the context of a statewide execution.

Is the School Lunch Program a Fruitful Gateway for Uninsured Children?

The school lunch program is a good avenue for reaching uninsured children. In addition, EE has the potential to identify uninsured children, although not all uninsured children in school lunch will utilize the program.

The Urban Institute estimates that 19% of low-income children in California families who participate in school lunch are uninsured.[15] With a school lunch participation rate in California of 2.6 million children, this equates to nearly half a million uninsured children participating in school lunch.

How successful was EE in identifying these uninsured children? The number of children in the pilot sites who returned the school lunch application asking for Medi-Cal varied by year. In Year 1, 42% of free school lunch-eligible children submitted applications with Medi-Cal consent. In Year 2, the rate dropped to 14% and in Year 3 to 13%. The rate of return depended on a number of factors, including a school's insurance rate and outreach activities. In addition, the target population decreases in a school the more years that EE is implemented.

Roughly 40% of those children returning applications with Medi-Cal consent, however, were already enrolled in Medi-Cal or Healthy Families. *Eliminating these applicants, 19% in Year 1 and 8% in Years 2 and 3 of free school lunch–eligible children who were not already enrolled in Medi-Cal or Healthy Families applied for EE.*

This rate of return in Year 1 is consistent with the Urban Institute's estimate that 19% of school lunch children are uninsured, although the rate of return in Years 2 and 3 is lower. However, by applying the rate for all three years, the data shows that *EE still has the potential to reach 200,000 to 500,000 uninsured children.*[16] If a program was available to reach all uninsured children in the state, EE could serve as an even more useful gateway to provide health care for California's uninsured children.

Does EE Enroll Children into Medi-Cal?

EE is successful in enrolling uninsured children into presumptive eligibility. However, it has not been as successful in ensuring children receive continuing coverage.

Over the three years of the pilot, *68% of children who applied for EE and were not already enrolled in Medi-Cal or Healthy Families received temporary Medi-Cal benefits (presumptive eligibility). Of those who received temporary coverage 40% were enrolled into ongoing Medi-Cal (full scope, share-of-cost or restricted).* Eliminating those children enrolled into restricted coverage, the rate of children receiving temporary coverage who were enrolled in Medi-Cal drops down to 26%.

The children who were enrolled into share-of-cost or restricted Medi-Cal were transferred, starting in 2005-06, to Healthy Families or an available county program. Unfortunately data is not available on the status of the applications. The enrollment of these children into Medi-Cal, however, shows that if a statewide health program was available for all uninsured children, EE could be an avenue for providing such coverage.

However, the limited number of children overall not enrolling into Medi-Cal is disappointing. The large drop-off of children receiving coverage occurred primarily at the follow-up stage. A high percentage of families were denied coverage because of a failure to submit the follow-up form. This occurred even though substantial efforts were made by the State and advocates to streamline the follow-up process.

The low enrollment numbers are consistent with other programs that utilize a two-step application process. For example, in February 1996, the Children's Health and Disability Program (CHDP) Gateway found that 19% of children receiving presumptive eligibility resulted in Medi-Cal or Healthy Families coverage.[17] The low percentage of children completing the process could be attributable to CHDP's complicated follow-up process.[18] However, the experience of EE shows that however simplified, a follow-up process will always limit final enrollment.

Does EE Streamline the Enrollment Process?

Anecdotal information shows that families who complete the EE process are happy with the ease and speed of receiving coverage. However, the enrollment process at the school district and county level has increased administration, instead of lessening it.

A primary problem with the enrollment process is the high number of children who provide consent on the school lunch application, but who are already enrolled into Medi-Cal or Healthy Families (an average of 44% of applications received). Having to cull these children out substantially increases the need for administrative investment by schools and counties. For example, a county must utilize both state and county Medi-Cal databases to determine if an applicant is enrolled in Medi-Cal or Healthy Families.

In contrast, the CHDP Gateway consists of a point of service or Internet-based system that provides real-time information at the doctor's office on whether the child applicant is already enrolled in Medi-Cal or Healthy Families. As a result, the county only processes applications through the CHDP Gateway for children without Medi-Cal or Healthy Families coverage.

CONCLUSIONS & RECOMMENDATIONS

Express Enrollment (EE) was an ambitious project that attempted to integrate the enrollment processes between two public programs, something that in theory is simple but in practice is quite complicated. It is fair to say that EE was successful in making the initial enrollment process for families easier and more efficient. It also

successfully pushed the envelope in implementing critical new policies, in particular self-declaration of income and establishment of the school lunch application as a Medi-Cal application for presumptive eligibility purposes. Lastly, EE increased awareness in schools of the issue of uninsured children and created new partnerships within and between school districts and counties. However, EE's success in enrolling children into ongoing coverage was very limited. The different program eligibility requirements, the various administering entities, and the State's antiquated computer systems hindered implementation.

While not a success in the narrowest definition of the word, EE established important policy precedents and provided important intelligence on the benefits and pitfalls of coordinated enrollment systems. The ability to implement EE on a pilot basis was invaluable for this purpose. Early findings from the pilot were used to make mid-course corrections that were enacted through legislation (SB 1196-Cedillo). Now, at the pilot's end, findings from EE provide valuable recommendations for moving forward.

Essential Gateway Enrollment Elements

The conclusions from EE provide lessons that can be applied more broadly to current and future state efforts to use public programs to enroll uninsured children into health coverage, commonly called "gateways". The bottom line: if the capacity of gateways to identify uninsured children can be joined with modernized enrollment procedures and policies, there is the potential to enroll large numbers of uninsured children far more efficiently and effectively. Seven critical elements to a successful system follow. Some of these elements were already implemented by EE; others are improvements.

1. Technology to Screen for Insured Children.

Technology is required for EE to operate effectively. A big obstacle continues to be the children who enroll in EE, but who are already enrolled in Medi-Cal and Healthy Families. Unlike the CHDP Gateway, the process for checking current enrollment in Medi-Cal and Healthy Families is conducted manually at the county level. Significant time and resources would be saved if an automated process could cull out these children immediately.

One option is to build upon the CHDP Gateway technology so that school districts and counties are connected to a statewide electronic system that can process the applications for temporary benefits. School districts inputting information into an application system could submit their data files to the Gateway for processing. Once the information is submitted, the Gateway would be responsible for conducting a data match on whether the child already has Medi-Cal or Healthy Families, enrolling the child into temporary coverage, and transferring the information to the appropriate county.

While the CHDP Gateway system has experienced problems with duplicate records, the basic premise of electronic data matching versus manual should be built upon. In addition, any solution should build on the One-e-App system that has already been implemented and tested in school districts and counties implementing EE.

The need for enhanced technology to allow for data matching has become even more important after the adoption of the federal Deficit Reduction Act (DRA) of 2005. The DRA requires states to ask citizens or nationals applying for and renewing Medicaid to provide documentation of their status. To ensure the provision is met most efficiently, California is exploring the ability to electronically connect to public databases that already collect citizenship information to verify status instead of requiring documentation.

2. Temporary Coverage Until Determination.

In EE, children receive temporary Medi-Cal coverage until a determination is made for continued coverage. This is possible because federal rules stipulate that temporary coverage can last until a determination is made on receipt of a Medi-Cal application. However, a county is still responsible for meeting the federal 45-day time limit for processing an application.

California, through EE, received federal approval to designate the school lunch application with Medi-Cal changes the start of a Medi-Cal application. Federal officials only required a space

on the school lunch application seeking the parent's signature under penalty of perjury.

By allowing for the continuation of coverage until a determination is made, the EE child obtains coverage quickly and that coverage continues while his or her application is being processed. Not only does this help families, but it also gives the counties adequate time to complete the final determination. At the same time, it maintains federal processing rules to ensure the timely processing of applications.

3. Information Collected in One Step.

The EE experience, and that of other programs, demonstrates that a two-step process for collecting information from a family will result in limited enrollments. A two-step process was created for EE because of concerns that requesting too much information up-front would negatively impact school lunch enrollment, which has a simpler application process.

Although EE has a streamlined follow-up process, the number of families replying to the second request remains limited. A one-step process will result in increased enrollments and is preferable for an enrollment gateway system. However, the decision on what information to request up-front must be balanced against the potential impact to public programs.

4. Simpler Documentation Requirements.

EE allows the school lunch application to serve as documentation of income and residency. This is a critical policy that helped limit school district and county workloads and made the enrollment process less complicated for families. Another important policy implemented by EE was the consolidation of multiple state forms into a single, simpler follow-up form. The new form took the place of state forms already in existence. If an enrollment system requires follow-up, it is essential that the collection of the information be as streamlined as possible.

5. Inclusion of Healthy Families and County Programs.

Through EE, if a child is ultimately determined ineligible for full scope Medi-Cal and appears eligible for Healthy Families or a local/county program, his or her application is forwarded to these programs. Since this transfer happens at a later stage, eligible children can fall through the cracks. A more effective approach is to process the application at the front end for all health coverage programs.

This policy would increase the efficiency of an enrollment system by ensuring that every uninsured child has the opportunity to find coverage. EE shows that children eligible for share-of-cost or restricted Medi-Cal will apply. Since these children are most likely eligible for Healthy Families or a county program this policy is particularly important. The availability of a statewide program that covers all uninsured children will even increase its importance. The use of technology could assist in these efforts, ensuring the timely and automatic transfer of applications to the appropriate program.

6. Financing Mechanisms.

One of the difficulties with expanding EE is the limited funding available to schools to implement a program. It is critical that funding resources are available to implement the program effectively. Support could be provided through grants or by allowing gateways to access the State's per child application assistance fee. In addition, the introduction of any technology would require funding to design the technology solution as well as for equipment, training, and technical assistance.

7. Federal Flexibility.

The simplest and most effective enrollment gateway system would deem a child eligible for Medi-Cal or Healthy Families based on participation in public programs with comparable eligibility rules. This would help streamline the current complications in the system due to slightly different eligibility rules for each program. However, this common sense approach is not allowable under federal law. Without such flexibility, any enrollment streamlining among programs will be cumbersome. The State should push for federal flexibility to create this type of efficient enrollment system.

Next Steps

EE is only one of several gateway efforts taking place in the state. Despite these multiple efforts, the State's current gateway efforts are not coordinated or maximally efficient. To remedy the situation, efforts have sought to use the lessons from EE to develop unified gateway proposals. The 100% Campaign has introduced legislation (SB 437-Escutia) that would create an electronic enrollment system that builds upon the CHDP Gateway and incorporates school lunch and WIC. In addition, health and advocacy organizations, including The Children's Partnership, have filed a statewide ballot initiative (Proposition 86) to cover all children. The initiative includes the implementation of a gateway enrollment system.

In order to build an effective gateway enrollment system, there remain some critical policy issues that must be addressed. The EE experiment provides invaluable lessons and suggests many elements in the blueprint for moving ahead on enrollment reforms. Because there are many stakeholders and several difficult issues to resolve, we recommend establishment of a work group to review and refine the suggested blueprint and focus specifically on the following two issues: (1) designing and financing a technology solution; and (2) addressing the trade-offs of a one-step versus a two-step process.

Through this examination, a more coherent state policy could be created to develop a unified gateway enrollment program. The Children's Partnership is committed to assisting in this effort, which we believe will help get needed health care to children in California as well as help other states trying to modernize enrollment for children.

ENDNOTES

[1] Michael Cousineau and Eriko Wada, *Express Lane Eligibility Project, Evaluation Report* (Los Angeles: USC Division of Community Health, July 2006).
[2] UCLA Center for Health Policy Research, California Health Interview Survey, 2003.
[3] Kaiser Commission on Medicaid and the Uninsured, *Enrolling Uninsured Low-Income Children in Medicaid and SCHIP* (Washington, D.C., 2005).
[4] Urban Institute, 2002 National Survey of American Families, 2005. Includes children 17 and under.
[5] State financing did cover coverage and administrative costs associated with Medi-Cal.
[6] Alum Rock Elementary, Santa Clara County; Del Norte Unified; Fresno Unified; Los Angeles Unified; Laytonville and Point Arena, Mendocino County; Lucia Mar, San Luis Obispo County; Redwood City Unified, San Mateo County; San Diego City Schools; and Siskiyou Unified.
[7] If the initial application is not a Medicaid application, then the presumptive eligibility period is time-limited.
[8] Alum Rock Elementary in Santa Clara County also received funding from the David and Lucile Packard Foundation through Consumers Union.
[9] op. cit. (1).
[10] Food services are limited in the time that can be allocated to EE. If a district wants to use food service staff for EE, it must designate non-school lunch funds.
[11] Some children are determined EE-ineligible and do not receive temporary coverage. These children may still be eligible for Medi-Cal if allowable income deductions are applied. This information is obtained through the MC 368. If a child is ultimately found ineligible for Medi-Cal, the application is forwarded to Healthy Families or an available county program.
[12] Total enrollment includes those children whom were express enrolled, as well as those who were deemed ineligible for express enrollment but whose parents completed the full Medi-Cal application forwarded to them by the county social services agencies.
[13] Full scope provides full Medi-Cal benefits at no cost while share-of-cost provides benefits at a cost, depending on income. Restricted Medi-Cal is available for undocumented persons requiring emergency or pregnancy-related care.
[14] Department of Health Services, compiled by the USC Division of Community Health. MEDS data is not always current and might differ from the data collected from the counties.
[15] op. cit. (4).
[16] Note that the data comparison is not exact since the pilot data represent free-lunch participants while the Urban Institute data covers all participants, including those paying reduced-price.
[17] Gateway Business Objects Report Generator, California Department of Health Services, July 2006.
[18] CHDP Gateway requires that a family complete a Medi-Cal/Healthy Families application after the initial presumptive application. Under EE, the school lunch application is a Medi-Cal application and a final determination requires the completion of a one-page form.