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ABSTRACT

Despite expansions in children's health insurance programs, rates of uninsurance in California continue to be high. Noting that absenteeism due to poor health is associated with school failure and asserting that schools offer an established framework on which to build a coordinated approach to enrolling children in health insurance programs, this report identifies four sets of California initiatives on which policymakers and schools could build school-based programs. The initiatives discussed are built on an existing platform, provide access to the target population, have the capability to offer comprehensive services, present opportunities for sustainability, and have the potential to include a tracking and evaluation mechanism. Section 1 of the report provides a rationale for school-based approaches to children health insurance program enrollment and describes current California efforts. Section 2 presents guidelines for building school-based health insurance programs. Section 3 describes several sources of funding that program planners may wish to pursue. Section 4 describes initiatives on which policymakers or schools could build school-based health insurance outreach, enrollment, utilization, and retention programs: (1) Healthy Start; (2) Proposition 10--First 5 California; (3) National School Lunch Program; and (4) the use of health coordinators. Throughout the report, examples are provided to illustrate how health insurance programs may be implemented in schools. Because some of the options may require legislative, policy, or procedural changes, Section 5 offers recommendations for schools and for policymakers to maximize the effectiveness of children's health insurance efforts in California. (Contains 46 endnotes.) (KB)

Building for a Healthy Future

Sustaining School-Based Enrollment in Health Insurance Programs

Consumers Union

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MAY 2003

Consumers Union

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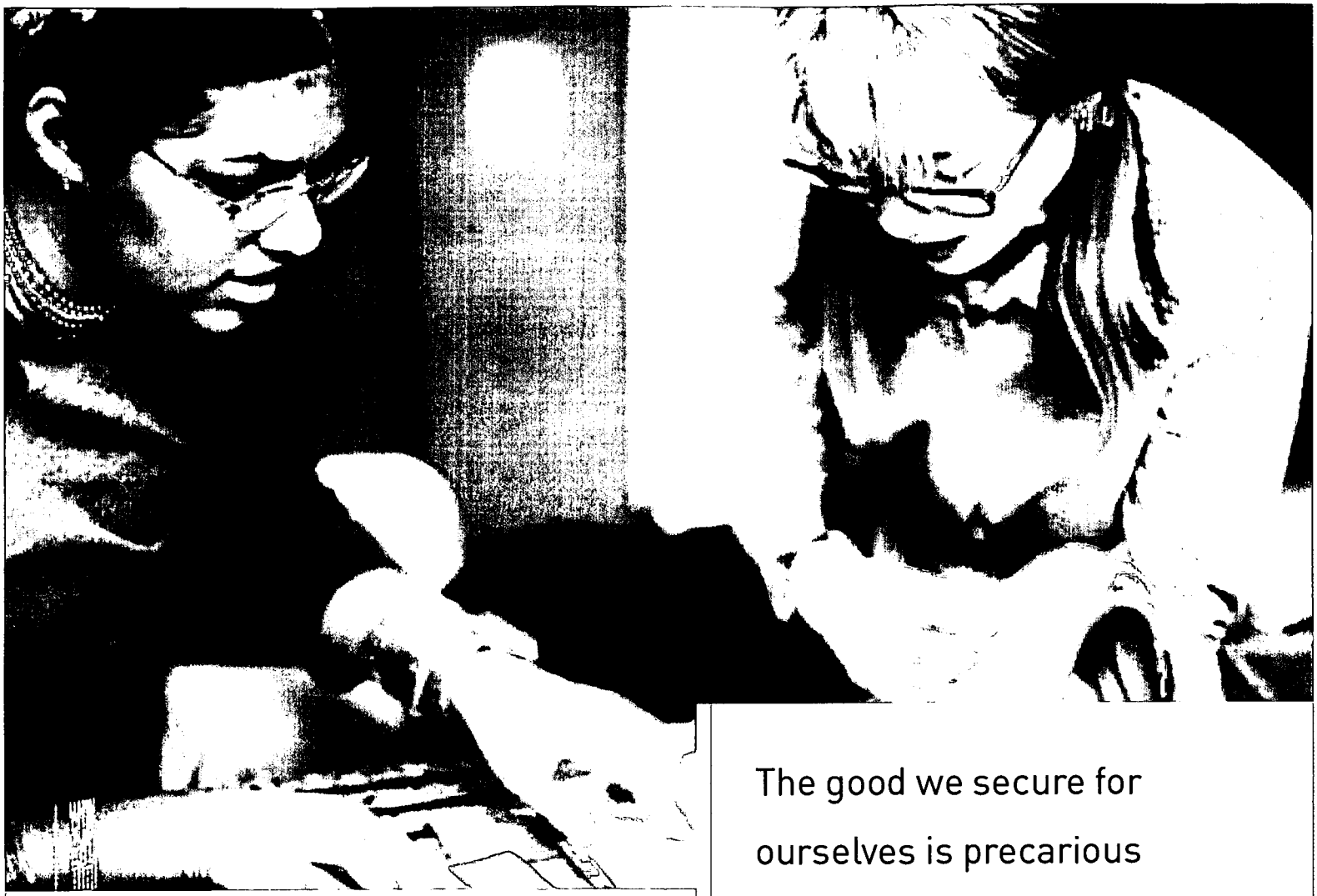


The good we secure for ourselves is precarious and uncertain . . . until it is secured for all of us, and incorporated into our common life.

— JANE ADDAMS

Executive Summary

Despite expansions in children's health insurance programs, rates of uninsurance in California continue to be high. Some 1.6 million California children remain uninsured; of these, more than 1.1 million are eligible for Healthy Families and Medi-Cal.

Schools serve as a key, community-based site for Healthy Families and Medi-Cal outreach, enrollment, and education. Schools are a logical place to reach large numbers of young people who are eligible for these government-sponsored health insurance programs. They are trusted, community-based organizations that have established relationships with the families of eligible children, and they have the flexibility to develop unique outreach and enrollment approaches that reflect the culture and needs of their communities. A school or school district can decide what services it wishes to offer and what funding to pursue, which is important since there is no one way to develop and manage a children's health insurance outreach and enrollment program.

Although few resources are available to California public schools, the rationale for schools to help more children obtain health insurance is compelling. Absenteeism due to poor health is associated with school failure, and in recent years, both the federal and state governments have begun to hold schools accountable for students' academic achievement. In order for children to succeed academically, they must be healthy enough to attend school regularly. They also must be able to see, hear, and think clearly and to be free from the pain and discomfort of illness. Therefore, school-based programs that help families obtain health insurance are a critical link in the connection between health and learning.

Schools offer an established framework on which to build a coordinated approach to enrolling children in health insurance programs. This report identifies four sets of California initiatives on which policymakers and schools could build school-based programs. Each initiative can contribute to a stable, consistent, and flexible program that supports health insurance outreach, enrollment, and utilization activities within the school system. Each initiative also provides a mechanism to ensure that health insurance activities occur regularly as a normal part of school operations. The initiatives can be adapted as necessary to meet the needs of local communities.

The four sets of California initiatives discussed in the report are particularly useful because they: (1) are built on an existing platform, (2) provide access to the target population, (3) have the capability to offer comprehensive services, (4) present opportunities for sustainability, and (5) have the potential to include a tracking and evaluation mechanism.

CALIFORNIA INITIATIVES

☐ **Healthy Start.** The Healthy Start Support Services for Children Act was established by the California Legislature in 1991. The legislation's purpose is to connect California's most vulnerable children and families with the support and tools they need to live healthy and productive lives.

☐ **Proposition 10—First 5 California.** In November 1998, California voters passed Proposition 10, the California Children and Families Act. The goal of Proposition 10 is to promote early childhood development from prenatal to age 5 through comprehensive, collaborative, and integrated services in the areas of education, health, and child-care programs.

☐ **The National School Lunch Program.** The National School Lunch Program (NSLP) was established more than 50 years ago. The NSLP provides low-income children with free and reduced- price lunches to ensure the health and well-being of the nation's children.

☐ **Health Coordinators.** Health coordinators, currently in place in some California schools, have primary responsibility for school-based health insurance activities. If resources permit, designating a school staff member who works as a health coordinator for a school or a school district is a sensible option. However, a regional or countywide coordinator may be more feasible for resource-strapped schools.

Some of the options presented in this report may require legislative changes or realignment of governmental or school policies and procedures. Thus, included in the report are two sets of recommendations—one for schools and one for policymakers—that are aimed at maximizing the effectiveness of children's health insurance efforts in California.

RECOMMENDATIONS FOR SCHOOLS

☐ **Schools need to maximize reimbursements under the Local Education Agency (LEA) Medi-Cal Billing Option and the Medi-Cal Administrative Activities (MAA) program.** There is a great deal of potential for increasing the reimbursement that schools receive under these two programs. Reaching out to school personnel and district staff to make the processes for reimbursement more user-friendly will likely encourage greater use of these funding streams and increase the utilization of health and social services.

☐ **Schools can reinvest the reimbursements received under the Medi-Cal Administrative Activities (MAA) program in health and social services.** The reimbursements schools receive under the Medi-Cal Administrative Activities (MAA) program are unrestricted and, therefore, Medi-Cal dollars reimbursed under MAA do not have to be reinvested in health and social services for students. To ensure funding for insurance enrollment, however, schools may want to consider reinvesting a predetermined proportion of their MAA funds in health-related programs.

☐ **Schools may want to consider using federal education dollars from Title I and Title V of the No Child Left Behind Act (NCLB) to promote health insurance enrollment.** Under Title I and Title V of the NCLB, the federal government provides schools with federal funding to remove obstacles that get in the way of children's academic success. Poor health is one such obstacle. Thus, schools may want to consider using some of their federal funding to help families obtain health insurance.

☐ **Schools with new and existing Healthy Start grants may want to include health insurance outreach and enrollment in their plan for sustainability.** Health insurance outreach is not a prerequisite to receiving a Healthy Start grant. Providing health services and enrolling children in Healthy Families and Medi-Cal may help grantees sustain themselves over time through reimbursements from the LEA Medi-Cal Billing Option (LEA) and the Medi-Cal Administrative Activities (MAA) programs, and through the reimbursements received by Certified Application Assistants (CAA).

☐ **Schools that partner with First 5 California county commissions in order to implement a School Readiness program may want to include health insurance activities in their programs.** School Readiness programs are required to include a health and social services element in their plans. Because good health is a prerequisite to learning, local programs may want to include health insurance activities in their program.

☐ **School districts may want a health coordinator to manage their health insurance outreach, enrollment and retention programs.** The position of health coordinator can become part of each school district's organizational structure. If adequate funds are available, the position can be created in all school districts across the state. Given limited resources, regional or county health coordinators are an alternative.

RECOMMENDATIONS FOR STATE AND LOCAL POLICYMAKERS

☐ **Policymakers need to create a Local Education Agency (LEA) Healthy Families Billing Option that will allow schools to claim reimbursement for services they already provide to students.** Under current law, schools can be reimbursed for services they provide to children enrolled in Medi-Cal, yet they cannot seek reimbursement for similar health-related services provided to students who are enrolled in Healthy Families. A LEA Healthy Families Billing Option would increase funding for California schools, and also enable the state to maximize federal funding.

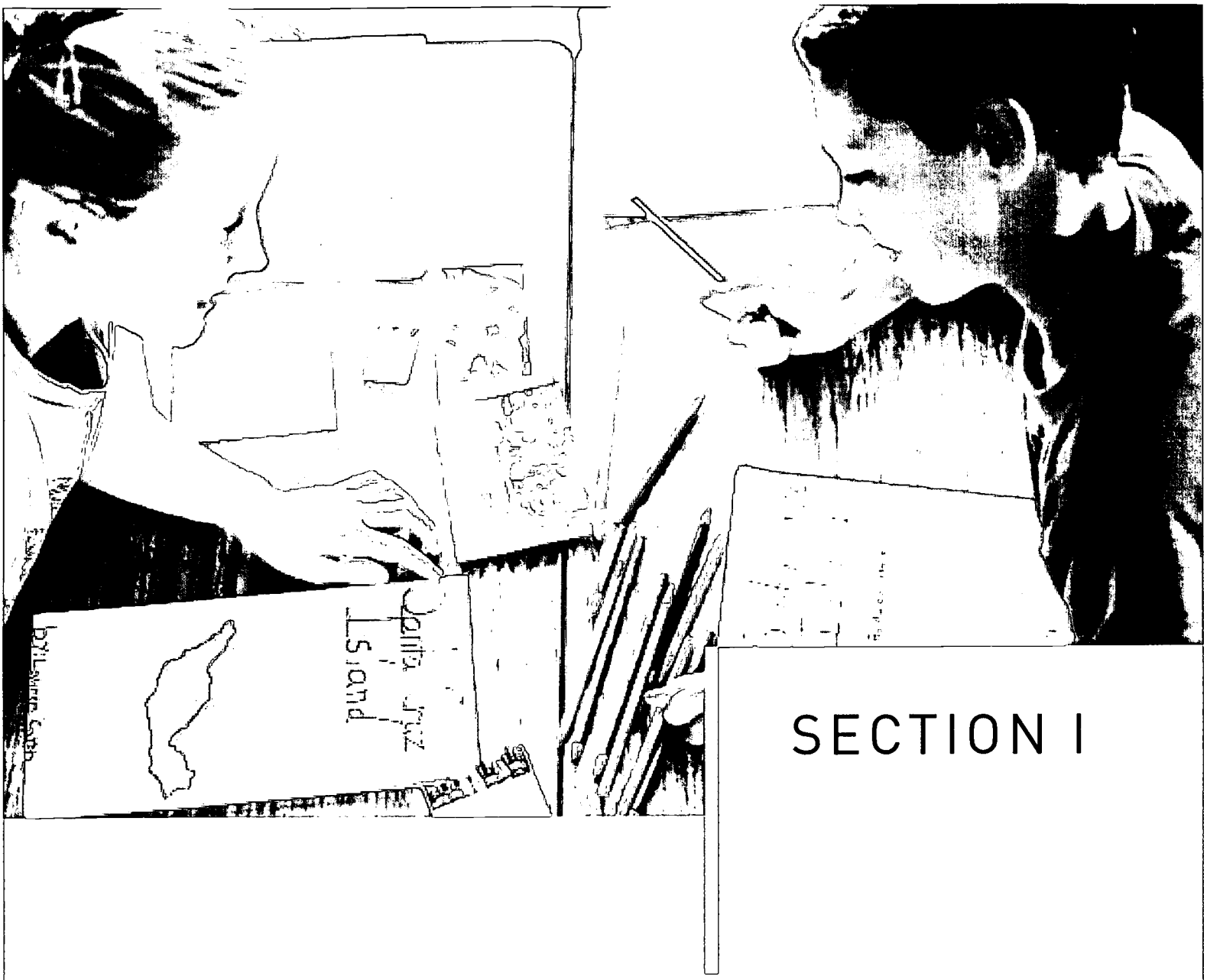
☐ **Policymakers need to continue reimbursing Certified Application Assistants (CAAs) for enrolling children in the Healthy Families and Medi-Cal programs.** This year, the Governor has proposed in his 2003–2004 budget to cut fees and training for CAAs, people who help families fill out applications to enroll and stay enrolled in Healthy Families and Medi-Cal. The savings achieved through these cuts are only short-term and will be at the expense of California's children and families.

☐ **Policymakers need to continue funding Healthy Start.** State funding for Healthy Start is uncertain due to the state's budget shortfall. Given the success of this initiative, and the fact that many eligible schools have yet to apply for and receive a grant, policymakers need to continue to support this program.

☐ **Healthy Kids Initiatives need to promote health insurance outreach and health education.** To date, a number of counties have pooled locally available resources, including county Proposition 10 funds, to create county health plans called Healthy Kids. These plans target children whose parents are unlikely to know they qualify for coverage, and who would therefore benefit from outreach and health education.

☐ **Policymakers need to continue providing bulk copies of the Request For Information (RFI) form at no-cost to all school districts in California.** This form, which many schools distribute in the back-to-school packets with the National School Lunch Program application, has proven to be an effective outreach tool. It has become an institutionalized mechanism for reaching out to families and informing them about health insurance options for their children. Due to the state's budget shortfall, however, it is uncertain at this time whether the state will continue to provide schools with this invaluable service.

Over the past four years, the state, schools, and local communities have successfully worked to decrease barriers and help families obtain affordable health insurance coverage for their children. The economic downturn and the state's enormous budget shortfall now threaten this progress. We urge policymakers and schools to meet the challenge of these difficult times by ensuring the health and learning of California's most valuable asset: its children.



SECTION I

Introduction

The creation of the State Children's Health Insurance Program (SCHIP) in 1997[1] expanded children's health-care coverage to low- to moderate-income children and led to a newfound emphasis on outreach and enrollment activities. Estimates suggest that SCHIP and Medicaid, known in California as Healthy Families and Medi-Cal respectively, offer the opportunity to provide health insurance to almost three out of four uninsured children in California.[2] Because of this potential, California communities have developed a variety of innovative outreach and enrollment strategies to inform low- to moderate-income families about health insurance programs available to them for free or low-cost.

Schools serve as a key, community-based site for Healthy Families and Medi-Cal outreach, enrollment, and education. Schools are a logical place to reach large numbers of young people who are eligible for these government-sponsored health insurance programs. They are trusted, community-based organizations that have established relationships with the families of eligible children. Children spend the majority of their day at school, so school staff and teachers are likely to know if children are unable to perform well academically because of health-related problems. Furthermore, each community is unique, consisting of different populations with different needs and resources. Schools reflect the communities they serve. Although the ideal outcome for every community might be the same—healthy children who are emotionally and physically ready to learn and succeed in school—the particular strategies used at the community level to achieve this goal can, and very likely should, vary. There is no one way to develop and manage a children's health insurance outreach and enrollment program: a school or school district can decide which services it wishes to offer and what funding to pursue and has the flexibility to develop unique approaches that reflect the culture and needs of its community.

Despite the scarce resources available to California public schools, the rationale for them to help more children obtain health insurance is compelling. Absenteeism from poor health is associated with school failure, and in recent years, both the federal and state governments have begun to hold schools accountable for students' academic achievement. In 2001, Congress passed the No Child Left Behind Act of 2001.[3] Prior to that, in 1999, California created its own statewide accountability system known as the 1999 Public Schools Accountability Act.[4]

Both of these reforms place strong emphasis on academic testing. However, in order for children to succeed academically, they must be healthy enough to attend school regularly. They also must be able to see, hear, and think clearly and to be free from the pain and discomfort of illness. Therefore, school-based programs that help families obtain health insurance are a critical link in the connection between health and learning.

The *Healthy Kids, Healthy Schools* project of Consumers Union, funded by the David and Lucile Packard Foundation and The California Wellness Foundation, works to increase enrollment of youth from low- to moderate-income families in Medi-Cal, Healthy Families, and other health insurance programs. The overarching goal of the *Healthy Kids, Healthy Schools* project is to improve the health of California's children by making health insurance coverage available to children statewide through school-based outreach and enrollment. Over the last four years, the *Healthy Kids, Healthy Schools* project has worked in partnership with schools, community-based organizations (CBOs), and county and state agencies to test a variety of promising outreach and enrollment strategies.

The past four years of work have confirmed the enthusiasm and effectiveness of schools in promoting students' health, and have highlighted the critical need for school-based programs to facilitate children's access to health insurance. In this report, the *Healthy Kids, Healthy Schools* project identifies four sets of California initiatives on which policymakers and schools could build school-based programs. Section IV, "California Initiatives," outlines each initiative and discusses how it can contribute to a stable, consistent, and flexible program that supports health insurance outreach, enrollment, and utilization activities within the school system. Section IV also discusses the reasons for recommending the initiatives based on guidelines set forth in section II. Each initiative provides a mechanism to ensure that health insurance activities occur regularly as a normal part of school operations. The initiatives can be adapted as necessary to meet the needs of local communities.

Without long-term, sustainable resources, schools face difficulties in maintaining the programs they have already developed as well as in expanding services to increase the scope of their programs and the numbers of children they reach. For this reason, the *Healthy Kids, Healthy Schools* project researched and identifies in section III a number of potential funding sources for school-based health insurance activities. These funding sources are not mutually exclusive; schools can use a combination of them. Additionally, neither schools nor local or state governments have to pay the entire bill for health-related activities. Instead, schools can

generate revenue to fund their programs from partnerships with foundations or from sources such as the federal government that already dedicate funds for health-related activities.

The next section provides a set of guidelines for building school-based health insurance programs. Schools and policymakers can use these guidelines to develop and implement programs that best suit the needs of both the state and local communities.

SECTION II

Guidelines for Building a School-Based Program

While children tend to be healthy, those without health insurance are less likely to have access to needed health care and therefore are more likely to have unmet medical needs. Compared to their insured peers, uninsured children are four times more likely to experience a delay in seeking care, over five times more likely to have gone without needed medical care, and five times more likely to use the emergency room as a regular place of care.[5]

Health insurance coverage is not only linked to better health but also is connected to school attendance and academic success. Children with health insurance are more likely to attend school regularly. They are also more likely to perform better when they are in school. Two California studies have demonstrated these connections. A study of third-grade students in California's Oakland and Alameda public schools found a direct connection between absenteeism and school performance.[6] Moreover, a recent report evaluating the health status of children newly enrolled in the Healthy Families Program found that, after enrolling in the program, California children in the poorest health missed less school and improved their school performance.[7]

The relationship between students' health and school attendance appears to have long-lasting effects and is important not only to children's achievement in the short-term but also to their long-term success. According to a recent review of the literature that investigated the consequences of being uninsured, poor health has a negative effect on educational attainment, and improving children's health will likely lead to greater educational attainment and higher income as adults.[8]

Despite expansions in children's health insurance programs, rates of uninsurance continue to be high. Some 1.6 million California children remain uninsured; of these, more than 1.1 million are eligible for Healthy Families and Medi-Cal.[9] Schools offer an established framework on which to build a coordinated approach to enrolling children in health insurance programs.

Schools and school districts can choose their own approaches to develop and operate their health insurance outreach programs. Some schools may want to designate their own staff to perform health insurance outreach and enrollment activities. Others may want to join with CBOs or county agencies to reach out to families and help them access health-care services through enrollment in health insurance programs. Ideally, health insurance–related activities will become a self-sustaining, permanent part of the school system's infrastructure, both across each district and statewide, thereby eliminating the duplication or absence of services or disruptions in programs when staffing and funding changes occur.

Based on our research and experience, we identified four sets of California initiatives that can serve as a framework for developing and operating a school-based program. They are particularly useful because they: (1) are built on an existing platform, (2) provide access to the target population, (3) have the capability to offer comprehensive services, (4) present opportunities for sustainability, and (5) have the potential to include a tracking and evaluation mechanism. Schools and policymakers seeking to establish a school-based program that supports and sustains health insurance outreach, enrollment, utilization, and retention may wish to consider the following features when selecting a structure on which to build their programs:

1. Building on an existing platform. Incorporating health insurance activities into an existing program is an attractive option for schools. Building upon and working within an established framework is likely to be less costly and more efficient for resource-strapped schools than creating an entirely new school-based program.

2. Aiming for the target population. Each of the proposed initiatives in section IV is focused on children. Some provide access to all children in a school regardless of age or immigration status, while others provide access only to a specific population of children, such as children ages 0 to 5 or children receiving the National School Lunch Program (NSLP) application. Identifying their target population can help policymakers and schools and determine which initiatives best meet their needs.

3. Considering comprehensiveness. *Comprehensiveness* refers to the program's ability to offer a full range of health insurance services, i.e., outreach to eligible students, enrollment of children and youth, utilization of health coverage, and retention in the insurance program. The California initiatives outlined in this report differ in their levels of comprehensiveness. A comprehensive option would support all four services. But, depending upon available resources, schools may choose to focus on only one or two of these services.

- *Outreach.* Reaching out to families who have children eligible for free or low-cost health insurance is the first step in enrolling children in health insurance programs. Schools and their partners can inform families about health insurance through a variety of different strategies, including (but not limited to) parent-to-parent outreach, peer-to-peer outreach, and sending a Request for Information (RFI) form home with the NSLP application.

- *Enrollment.* Once families become aware of their children's potential eligibility for free or low-cost health insurance programs, the next step is to enroll them. For many families, the application and enrollment process is difficult to navigate. They may need assistance in documenting their income or filling out the application, or they may be determined ineligible by a program and need help in appealing the decision. To overcome these difficulties, school staff can be trained to enroll families in Healthy Families and Medi-Cal. Schools can also partner with local CBOs or counties that can assist in the enrollment process.

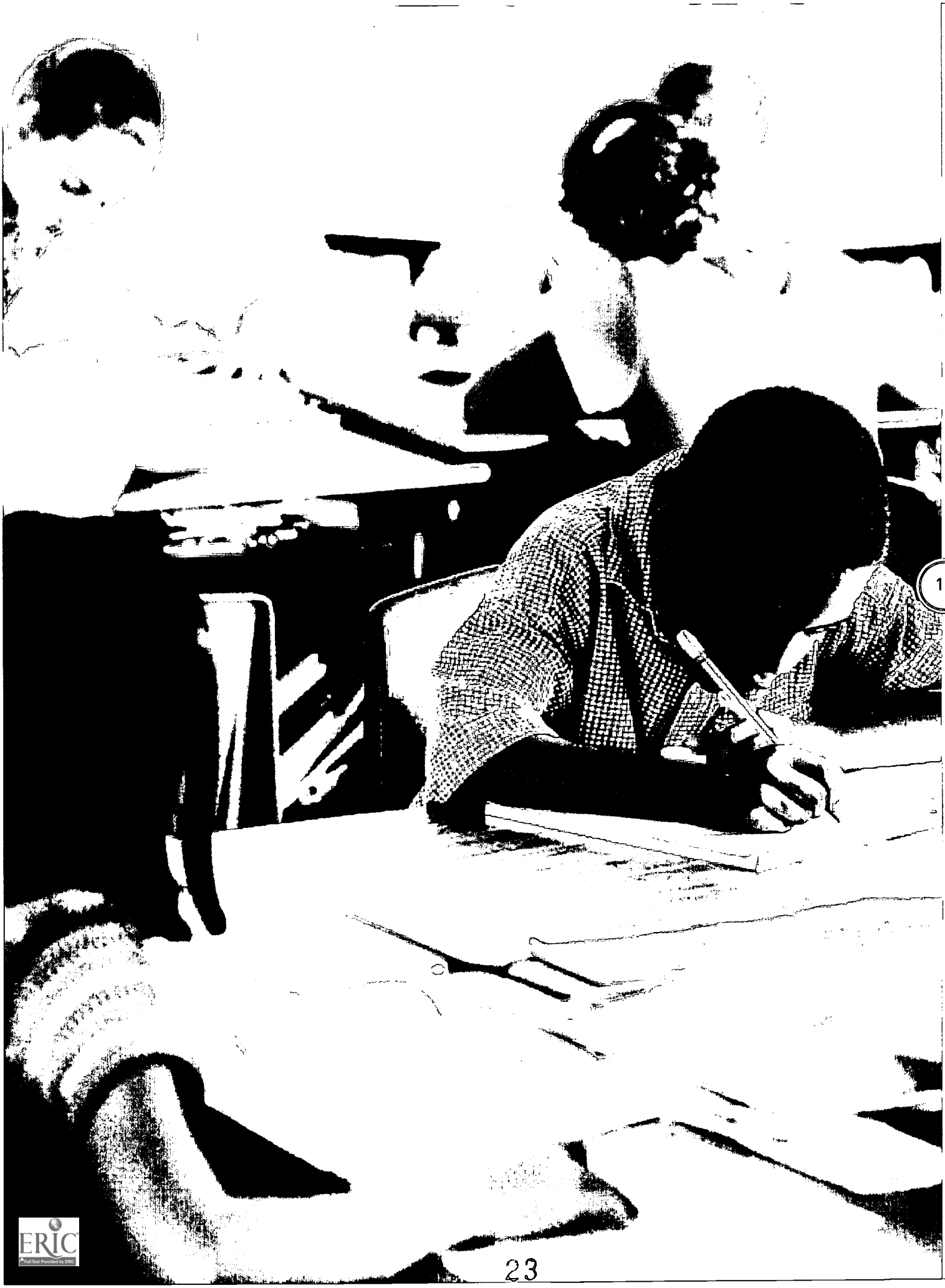
- *Utilization and retention.* Just enrolling a family in a health insurance program does not guarantee that parents understand how to utilize health services and get the health care that their children need. For some families, this may be their first experience with health insurance or with an HMO (Health Maintenance Organization). Immigrant families often come from countries where health care may be free or medications available without a prescription. Therefore, educating families about their health insurance plan is important. Families who understand their health plan and their rights under their health plan are more likely to utilize services, to value those services, and to maintain their children's health insurance.

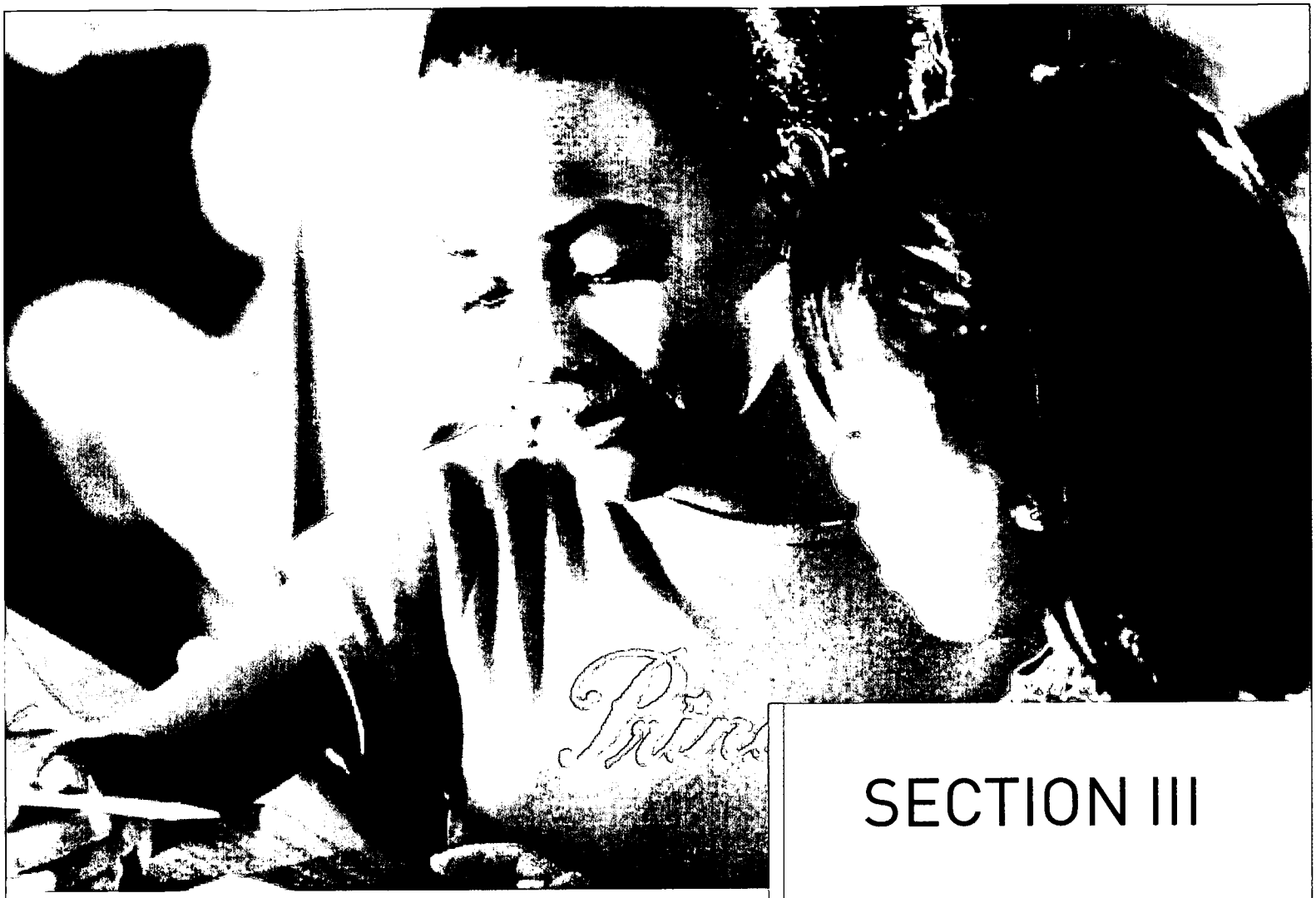
Emphasizing one service over another has tradeoffs. The more complete the program is, the more likely it will reach its goal of healthy children who are ready to learn. However, the more complete the program, the more difficult it will be to find the resources to permanently support it. A less comprehensive program, or one phased in over time, may be less costly and more realistic.

4. Working toward sustainability. *Sustainability* refers to maintaining a program over time. Planning for sustainability means strategic planning, coordination of activities, forming partnerships, and leveraging financial and nonfinancial resources to maximize resources and ensure future funding and operation of the program.

5. Including tracking and evaluation. Programs demonstrate their effectiveness by tracking and evaluating their activities. Developing a "track record" and demonstrating success can help programs get or keep funding and identify strategies that are not working and need adjustment. A school-based health insurance outreach and enrollment program, therefore, should have a mechanism for collecting and evaluating outreach, enrollment, utilization, and retention data. For example, programs could compare outreach activities such as enrollment events, distribution of RFIs, or participation in back-to-school nights, and gauge their effectiveness according to the number of children that enroll in a health insurance program.

Available funding is a critical part of choosing a program structure. The next section describes several sources of funding that program planners may wish to pursue.





SECTION III

Funding Sources for School-Based Programs

SPECIAL FUNDS FOR SCHOOLS AVAILABLE UNDER MEDI-CAL

Medi-Cal has successfully enabled schools to increase health resources and to fund staff who conduct outreach and enrollment. Local school districts and county offices of education can use local education funds as the state match for Medi-Cal and draw down federal funds as reimbursement for providing health-related services to students. Schools may participate in two different programs: (1) the Local Education Agency (LEA)[10] Medi-Cal Billing Option, which reimburses schools for health services provided to students; and (2) the Medi-Cal Administrative Activities (MAA) program, which reimburses schools for carrying out health-related administrative duties, such as outreach or enrollment assistance. Schools access these funds through the state Department of Health Services; they do not receive reimbursement directly from the federal government. Together these two programs provide schools with funding that they can use to promote health insurance outreach, enrollment, utilization, and retention.

Local Education Agency (LEA) Medi-Cal Billing Option

In 1989, Congress established a mechanism through which schools could recover revenues spent on health-related services provided to students enrolled in Medicaid. As a result, California schools can receive partial reimbursement for providing health-related services to students eligible for Medi-Cal. To be eligible for this funding in California, the LEA must be enrolled as a Medi-Cal provider, and the services must be covered under Medi-Cal, medically necessary, and performed by a qualified provider. Services mostly include those provided to students with special education needs as part of an Individualized Education Plan (IEP) or an Individualized Family Support Plan (IFSP) and may include health and mental health assessments, treatments, transportation, and Targeted Case Management. Reimbursement for LEA services is based on time spent or on a flat-fee structure according to the terms specified by the

California Department of Health Services. The provider participation agreement requires LEAs to reinvest the reimbursements in health and social services.

Approximately 45 percent of California school districts, or 500 of the 1,100 districts, currently participate in the LEA Medi-Cal Billing Option program. These districts generated approximately $79 million in revenue during the 2001–2002 school year, up from $60 million the previous year.[11] Every year a greater number of schools participate in this program, and the amount claimed typically increases with each year of participation. Still, the state of California does not maximize this federal revenue source. In 2000, a report by the General Accounting Office (GAO) found that California schools could receive approximately $20 million more in Medi-Cal annually and that, on average, California claimed less per Medicaid-eligible child than many other states.[12]

Despite the great revenue potential of the LEA Medi-Cal Billing Option, schools choose not to participate in this program for several reasons. Schools must first lay out the expenditures for health services, and then they receive only partial reimbursement for them. Additionally, some districts shy away from the administrative work required to participate in the program. Lack of participation may also be due to confusion or lack of knowledge about the program. Some district staff have not "bought into" the process and, therefore, do not actively bill for time spent on reimbursable services. California school districts may also hesitate to participate because of the state's requirement that they develop a collaborative planning group made up of local stakeholders from the school district, county agencies and the community, or because revenues are restricted and must be used solely to fund additional health and social services within the community. Still other districts, particularly those that are smaller, will receive only a small return on their significant investment in time and, therefore, feel that it is not worthwhile.

This funding mechanism is not currently available to schools providing health-related services to students enrolled in the Healthy Families Program. However, with changes to the state child health plan, California could potentially maximize federal revenues by developing and implementing a LEA Healthy Families Billing Option. California schools could use reimbursements received under this potential funding stream to promote health insurance enrollment and the utilization of health services by children in California's schools. The creation of a LEA Healthy Families Billing Option could also increase schools' participation in the LEA Medi-Cal Billing Option because of the greater potential for total revenue these two programs could generate. California Assembly Member Wilma Chan has introduced legislation during the 2003 legislative session to create a LEA Healthy Families Billing Option, Assembly Bill 368.

Medi-Cal Administrative Activities (MAA)

Schools are also eligible to receive the federal share of Medi-Cal through the Medi-Cal Administrative Activities (MAA) program, which provides partial reimbursement to schools that perform health-related administrative activities. Reimbursable activities include providing information to families, helping families enroll their children in the Healthy Families and Medi-Cal programs, and referring families to covered services, such as mental health treatment, dental care, physical therapy, speech therapy, and immunizations.

School districts that want to participate in MAA must first submit a "claiming plan" to either the Local Education Consortium (LEC)[13] or a participating local county health department. The claiming plans are consolidated and sent to the Department of Health Services and, occasionally, also to the federal government for approval. Plans identify the activities the district plans to bill for under MAA as well as the staff who will carry them out. Next, districts must complete an annual time survey in which employees who perform reimbursable activities record the time they spend in those activities over a one-month period. Districts are reimbursed based on the averages recorded during that one-month period.

Of the 1,100 California school districts, approximately 40 percent, or 400, participate in MAA. During the 1999–2000 school year, districts generated approximately $18.3 million in MAA revenue for California's schools.[14] Revenues, on average, increase each year that districts participate in the process. Unlike LEA funding, MAA reimbursements do not have to be reinvested in health and social services for students. The funds are "unrestricted"—they may or may not be used for health activities—and they may be returned to the school's general fund. Schools have the option, however, of imposing their own restrictions on MAA funds. They can require that the funds be reinvested in health and social services for children, therefore generating ongoing revenue for health insurance outreach, enrollment, and utilization activities.

Despite its great revenue potential, not all districts choose to participate in the MAA program, nor do all participating districts maximize this revenue source. Since MAA funds are unrestricted, some district staff do not want to participate in MAA because their offices receive little or no reimbursement for their work. Other districts find the process confusing or do not plan in advance to conduct their time survey during the first couple of months of the school year, the time period that produces the greatest amount of revenue for schools. Small districts or those that are wealthier and have fewer Medi-Cal-eligible children may not pursue this funding source given the administrative work and time that it entails. Lastly, small or poor districts may find this funding option difficult to pursue given that they must first lay out the expenditures for health services, and then they only receive partial reimbursement for them.

The LEA/MAA Programs and Healthy Start in the Santa Maria-Bonita School District

In the Santa Maria-Bonita School District (SMBSD), in Santa Barbara, California, Healthy Start sites are located at several schools, making available a variety of services to students, families, and parents. The Santa Maria-Bonita Healthy Start is the leading enrollment entity of children for the Healthy Families/Medi-Cal programs in the county.

Increasing the number of children who have access to affordable health care is a top priority for the program, and a full-time position has been dedicated to Healthy Families and Medi-Cal application assistance. In addition, all Healthy Start staff are trained as Certified Application Assistants (CAAs).

As part of the original Healthy Start grant, the district applied to receive LEA Medi-Cal reimbursements. The SMBSD generates over $100,000 per year in LEA Medi-Cal reimbursements due in great part to the successful Healthy Families/Medi-Cal application assistance program provided by the Healthy Start program. The majority of these reimbursements are used to maintain the services of the Healthy Start program, including outreach for and enrollment in Healthy Families and Medi-Cal.

In addition, SMBSD has applied for and completed the necessary time surveys to claim Medi-Cal Administrative Activities (MAA) funds, which will be reinvested in outreach, enrollment, and other health services that the Healthy Start program offers. The program anticipates receiving approximately $150,000 to $200,000 per year in MAA reimbursements.

Certified Application Assistants

Certified Application Assistants (CAAs) are members of the community who are trained to assist families in enrolling in the Healthy Families and Medi-Cal programs. Nearly two-thirds, or 61.3 percent, of all Healthy Families/Medi-Cal applications sent to the state are completed with the assistance of a CAA.[15] CAAs also help enrollees with their annual eligibility reviews and other program details. All CAAs are affiliated with an Enrollment Entity (EE). The Enrollment Entity, not the individual CAA, receives $50 for each successful enrollment and $25 for each successful reenrollment. A school can, and a number already do, become an Enrollment Entity and train staff as CAAs to assist families in filling out their Healthy Families/Medi-Cal applications. CAAs are highly effective in serving diverse populations, including those that are often hard to reach, such as rural communities and non-English-speaking families. However, as a result of California's budget shortfall, state funding for CAA assisted enrollments remains uncertain at this time.

Certified Application Assistants at Vista Square School in Chula Vista

In the Beacon Family Resource Center, a Healthy Start site at Vista Square School in Chula Vista, a mom called an onsite CAA who was working as part of the *Health-Insurance Access Through Schools (HATS)* program in San Diego because she had concerns about her teenage daughter. The teen had become despondent, was crying excessively and was exhibiting noticeable depressive behaviors. In addition to providing crisis referrals, the CAA helped the family enroll their daughter in Healthy Families. The doctors found the teenager's hormone levels were four times higher than normal. With medication she is doing very well and is preparing for her very special Quinceañera. Because the CAA was a visible part of the school environment, the mom knew who to trust and who would help.

THE FEDERAL NO CHILD LEFT BEHIND ACT OF 2001 (NCLB)

The federal No Child Left Behind Act of 2001 (NCLB) is a reauthorization of the Elementary and Secondary Education Act (ESEA), enacted in 1965. The NCLB made major changes to ESEA and increased the federal government's role in K–12 education. The NCLB is the main federal education law, and most schools across the nation receive some type of federal aid under the NCLB. Titles I and V of the NCLB are two sources of funding that schools use to remove obstacles children face in learning. Because of the connection between good health and learning, these two programs offer potential opportunities for schools that want to fund school-based health insurance efforts.

No Child Left Behind Act: Title I

The federal government provides aid to schools for the education of disadvantaged youth under Title I of the NCLB. Approximately 83 percent of California schools receive Title I funds.[16] These funds provide supplementary educational and related services to children who attend schools with a high proportion of low-income students, which is determined by the number of students participating in the National School Lunch Program (NSLP) and/or

Using Title 1 to Promote Students' Health in Pasadena Unified School District

The Pasadena Unified School District uses federal NCLB Title I money (which is given to schools serving low-income communities) to fund one bilingual outreach worker to coordinate, promote, and conduct outreach for Healthy Families/Medi-Cal and other free and low-cost health-care programs. The outreach worker is a member of the Children's Health Access Taskforce, a group of 35 nonprofit and county organizations working together to develop effective outreach and enrollment strategies for these health insurance programs.

CalWORKS, the state's public assistance program. Some schools already use these funds to support staff in conducting health insurance outreach and enrollment.

No Child Left Behind Act: Title V

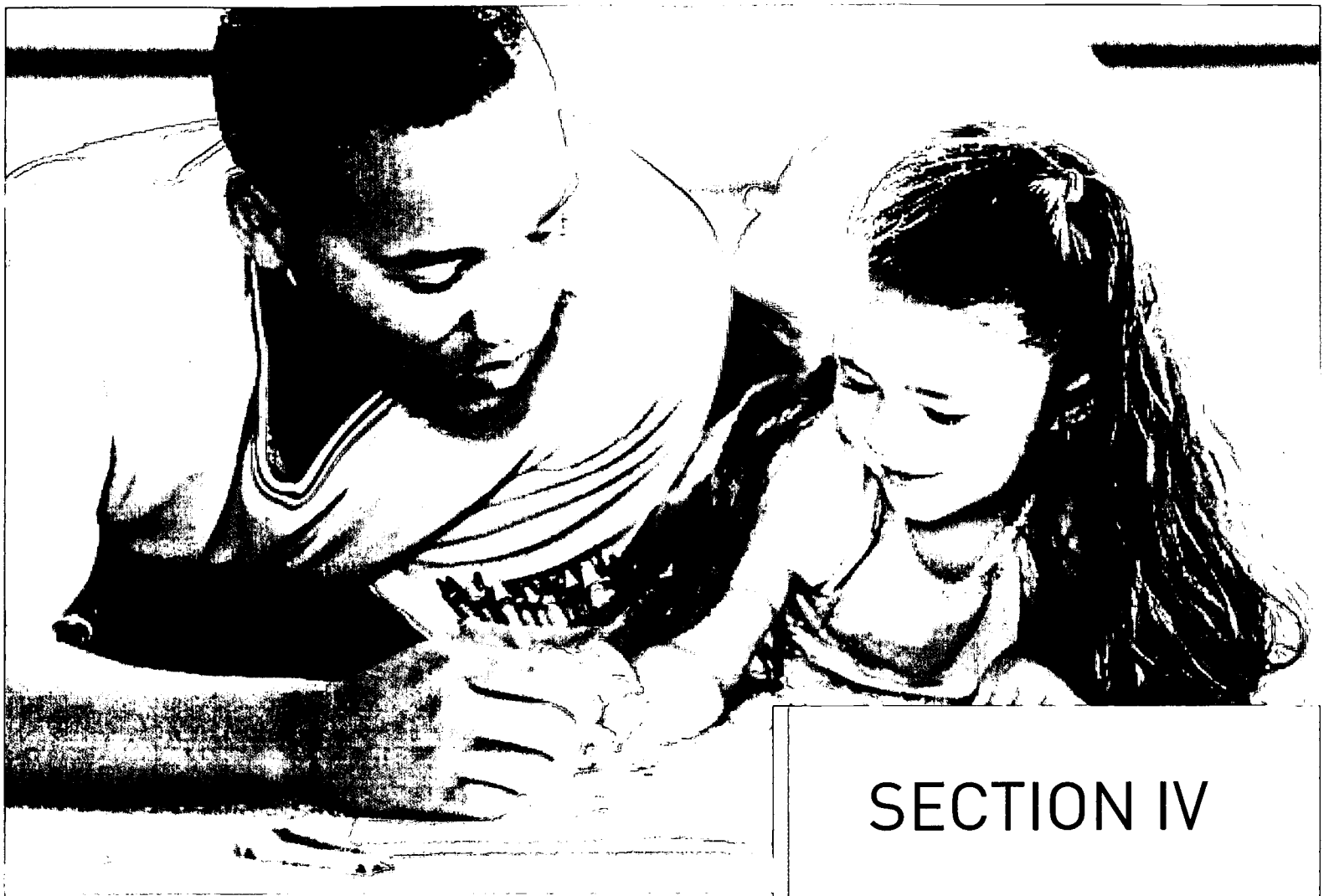
Under Title V of the NCLB, schools have a second opportunity to use federal education funds to address students' health needs. Title V is a block grant that states can use to promote innovative approaches to improve student achievement.[17] Schools can use this funding in a variety of ways, including hiring and supporting school nurses and expanding school-based mental health services. School nurses are often the first to know when a child is experiencing health-related problems and whether a child has health insurance. In California, some school nurses are trained to enroll children in free and low-cost health insurance programs. Schools may also use Title V funds for "activities that encourage and expand improvements throughout the area served by the LEA that are designed to advance student academic achievement."[18] Therefore, schools can potentially use these funds to hire outreach and enrollment workers. In addition, Title V regulations allow LEAs to make grants to, and enter into contracts with, nonprofit service providers. Thus, LEAs can potentially hire community-based organizations for outreach and enrollment activities.

PRIVATE FUNDING

Partnerships With Private Foundations

Developing partnerships with private foundations is yet another possible mechanism for funding school-based health insurance outreach and enrollment. Foundations can help expand the financial base needed to carry out these activities. Some foundations have funded individual schools or districts. For example, both the David and Lucile Packard Foundation and the California Endowment have provided schools with resources to carry out outreach and enrollment projects.

The next section describes four sets of California initiatives on which policymakers or schools can build school-based health insurance outreach, enrollment, utilization, and retention programs.



SECTION IV

California Initiatives

HEALTHY START

The Healthy Start Support Services for Children Act was established by the California Legislature in 1991.[19] The Healthy Start program is administered by the California Department of Education (CDE). The legislation's purpose is to connect California's most vulnerable children and families with the support and tools they need to live healthy and productive lives.

The Superintendent of Public Instruction awards two types of grants to Healthy Start grantees: planning and operational grants. Planning grants are awarded in the amount of $50,000.[20] These funds can be used for a period of up to two years to develop an integrated school-community assessment and service delivery plan. Operational grants are awarded in the amount of $300,000 for a period of three to five years to implement proposed plans.[21] Schools also receive $100,000 for start-up costs.[22] Grants are awarded through a competitive process.[23] During the first 10 years of the Healthy Start Initiative, from 1991 to 2001, CDE awarded a total of 1,446 grants—635 operational grants and 811 planning grants.[24] Currently, operational grants support programs serving 1,368 schools.[25]

Local Healthy Start initiatives strive for measurable improvements in such areas as school readiness, educational success, physical health, emotional support, and family strength, with the ultimate goal of improving the lives of the children and families served. To achieve these goals, local Healthy Start grantees support the provision of educational, health, mental health, and social services at or near school sites so that students come to the classroom ready to learn. Initiatives bring together stakeholders, including schools, county agencies, and parents from the local community, to form a collaborative. The collaborative assesses the needs and strengths of the community and develops an integrated service delivery plan. The idea is to coordinate fragmented resources and create a seamless system of support and services for students and families.[26]

Why Choose Healthy Start?

Healthy Start provides an existing and proven school-based platform upon which to build and implement health insurance activities. Healthy Start grantees are well integrated into the fabric of their respective communities and school systems. Families see Healthy Start sites as a trusted community resource, recognizing them as a safe place to go to when they are in need of services and support. School personnel also view Healthy Start as a resource and trusted support they can rely on when students are confronted with obstacles that hinder learning, such as poor health.

Healthy Start sites are located primarily in low-income schools, which means they serve communities with the greatest proportion of children eligible for free or low-cost health insurance. Elementary schools, grades 1 to 6, are eligible to receive a Healthy Start grant if at least 50 percent of students' families receive cash assistance (CalWORKs), have limited English proficiency (LEP), or are eligible for the National School Lunch Program (NSLP). For schools with grades 7 to 12, the requirement is 35 percent of children enrolled in these same programs. Income guidelines for CalWORKS and NSLP are comparable to the income eligibility guidelines for Healthy Families and Medi-Cal.[27]

Some Healthy Start grantees already provide health-related services to students. In fact, the Healthy Start Request for Applications (RFA) requires each local education agency (LEA) with an operational grantee to enroll as a Medi-Cal provider in order to generate revenue to support the program. Once enrolled, LEAs can bill Medi-Cal through the LEA Medi-Cal Billing Option for services provided to students at the Healthy Start site. Some Healthy Start programs also perform health-related administrative activities under the Medi-Cal Administrative Activities program and claim partial reimbursement for conducting health insurance outreach or helping families with the eligibility process. Additionally, some Healthy Start initiatives partner with the county to provide space at a school site for a county Medi-Cal eligibility worker to accept and complete Medi-Cal applications.

Healthy Start grantees make a commitment to the state to maintain services after state funding ends. Thus, from their inception, many grantees develop a sustainability plan and begin to obtain additional resources through partnerships and grants. Estimates show that approximately 80 to 84 percent of Healthy Start grantees sustain themselves over time.[28]

Each year, grantees must submit data to the California Department of Education. These data are compiled into an annual report that includes schoolwide data and information about core

clients who have been targeted to receive comprehensive support and services. All grantees must report education results as well as data from other service areas that represent the goals of the program. Health is one such area. While Healthy Start does not require grantees to report on health insurance outreach, enrollment, utilization, and retention, the yearly reporting requirement provides an opportunity to monitor health insurance outreach and enrollment outcomes.[29]

The potential for building on the Healthy Start Initiative is great. Healthy Start provides an existing and proven platform that promotes comprehensive programs; grantees serve communities with the greatest proportion of uninsured children; and sustainability is a commitment made by all grantees to the state. However, ironically health is not a required component of the Healthy Start Initiative. Some grantees, therefore, may choose not to focus on health insurance enrollment. So existence of a Healthy Start program in a district does not automatically mean it is a vehicle for a health program. Additionally, because there is no requirement that grantees compile specific data about health insurance outreach, enrollment, utilization, and retention activities, tracking of performance is not guaranteed. Finally, state budget appropriations for Healthy Start have fluctuated in recent years due to the budget crisis and, therefore, availability of these funds may vary in future years.

PROPOSITION 10—FIRST 5 CALIFORNIA

In November 1998, California voters passed Proposition 10, the California Children and Families Act.[30] The goal of Proposition 10 is to promote early childhood development from prenatal to age 5 through comprehensive, collaborative, and integrated services in the areas of education, health, and child-care programs.[31] One state commission and 58 local county commissions carry out the work of the initiative.

Proposition 10 services are funded by a 50-cent-per-pack tax on cigarettes, generating approximately $600 million annually.[32] The state California Children & Families Commission, or First 5 California, administers 20 percent of the revenue generated by the Proposition 10 tax.[33] The state commission provides statewide leadership and technical assistance to the 58 county commissions. The county commissions receive the remaining 80 percent of Proposition 10 revenue.[34] These 58 commissions develop strategic plans that meet the First 5 California guidelines on funding local child development programs and services; however, the county commissions have the flexibility to tailor funding and programs to meet local needs.

The state and local First 5 California commissions have developed two initiatives that offer schools opportunities to connect children with health insurance programs: School Readiness and the Healthy Kids Initiatives.

The School Readiness Initiative

The School Readiness Initiative ("School Readiness") under Proposition 10 provides an excellent opportunity for schools and their partners to shape a proposal that incorporates health insurance outreach and enrollment activities. School Readiness is a collaborative effort among the state and county commissions and their local partners. The purpose of School Readiness is to improve the ability of families, schools and communities to prepare children to enter school ready to succeed. To achieve this goal, School Readiness grantees connect early childcare programs with school sites and also provide needed services to children and their families at or near schools.

Each School Readiness program must support children in their communities through five "essential and coordinated elements:" health and social services; early care and education; parenting and family support; school capacity and readiness; and site infrastructure, administration, and evaluation. Specific services offered under the guiding elements are based on local community needs.[35] Therefore, the Initiative supports school-community partnerships and includes the local community in a needs assessment process. In turn, these partnerships can help schools obtain additional resources to perform activities like health insurance outreach and enrollment.

School Readiness efforts are based at schools or in school-linked settings, targeting 1,385 schools, or about 800,000 children under age 6. Eighty-five percent of these children are low-income, 45 percent are English-language learners, and an estimated 75 percent are Latino. Note, however, that the Proposition 10 Initiative, including School Readiness, targets only children from prenatal through age 5.[36]

The State Commission allocated $206.5 million in School Readiness funds, which are being distributed over a three-to-four year time frame.[37] While the deadline for submitting an application is June 15, 2003, there are still opportunities for already-funded programs to fold health insurance activities into their plan.[38] School Readiness programs receive their funding allocations over a period of four years beginning the date their application is approved.[39] County commissions must provide a 1:1 match to access these funds.[40] Funding is allocated

by the State Commission according to county birth rates and the number of students in schools in the lowest three deciles of the Academic Performance Index (API).[41] As of September 2002, 36 counties began implementing approximately 100 School Readiness programs.[42]

Healthy Kids Initiatives

Several county First 5 California commissions are using a combination of funding sources, including their Proposition 10 funds, to finance health insurance coverage for children in their local communities. These commissions, in collaboration with local partners, provide comprehensive coverage to children ineligible for Healthy Families or Medi-Cal insurance programs because their families earn too much to qualify for the programs or because they are undocumented immigrants and, therefore, ineligible for the state-sponsored programs. These "Healthy Kids Initiatives" often include outreach and enrollment activities to ensure that children are enrolled in Healthy Kids or other health insurance programs for which they may be eligible, including Healthy Families and Medi-Cal. To date, Santa Clara, San Francisco, San Mateo, Solano, Los Angeles, Riverside, and Stanislaus Counties have in place or are in the process of implementing Healthy Kids Initiatives.

Why Choose one of the First 5 California Efforts?

Building upon the infrastructure of Proposition 10 is a viable option for schools that want to reach California's youngest children and enroll them in health insurance programs. Unlike other platforms, Proposition 10 provides a substantial, dedicated funding stream. The School Readiness and Healthy Kids Initiatives offer schools two potential mechanisms to connect children with health insurance. Implemented together, these programs offer comprehensive services that go beyond outreach and enrollment to help families learn to access health-care services through their health insurance plans and to help troubleshoot health-related problems.

A statewide evaluation of the School Readiness Initiative is under way. The evaluation will assess program impact in all five "essential and coordinated elements" by measuring child, family, school, and community outcomes. The School Readiness Initiative's emphasis on evaluation may encourage programs that choose to perform health insurance activities to track outreach, enrollment, utilization, and retention activities and measure outcomes in students' health over time. While these initiatives provide great opportunities for schools, services provided through Proposition 10 funding are limited in scope because they serve primarily young

children from prenatal to age 5. Additionally, these two programs create new service delivery systems that have yet to become completely integrated into local communities.

THE NATIONAL SCHOOL LUNCH PROGRAM

The National School Lunch Program (NSLP) was established more than 50 years ago to ensure the health and well-being of the nation's children. The NSLP provides low-income children with free and reduced-price lunches. It is administered at the federal level by the U.S. Department of Agriculture (USDA). In California, the program is administered by the California Department of Education, and schools or districts oversee the administration of the program locally.

The NSLP serves approximately 2.6 million children in California. Estimates suggest that almost 70 percent of California's low-income, uninsured children live in families that participate in the school lunch program.[43] The eligibility guidelines for the NSLP are similar to those used for the Healthy Families and Medi-Cal programs, so children enrolled in the NSLP are also likely to be eligible for these health insurance programs. Some schools in California use the NSLP application as an outreach tool to inform families about public health insurance programs available to children. Schools with more resources follow up with families who request assistance and help them enroll their children in a health insurance program. Beginning in the 2003–2004 school year, several schools plan to go one step further and use the NSLP application as a Medi-Cal application (see "Express Lane Eligibility," below).

The Request for Information (RFI) Form

The National School Lunch Program offers an effective process for conducting health insurance outreach in California. Starting in 1998, the state Department of Health Services (DHS), the Managed Risk Medical Insurance Board (MRMIB), which administers Healthy Families, and the state Department of Education (CDE) worked with Consumers Union to develop a Request for Information (RFI) form. Schools send this form home with the school lunch program application or "back-to-school packets" to inform families about the potential for health insurance coverage. The California Department of Education annually sends RFIs to food service directors with a letter encouraging them to participate in this process. DHS, through the School Health Connections Office, also sends a similar letter to district and county school

superintendents. Interested schools and districts can request free bulk copies of the RFI in 11 different languages from DHS.

In the basic implementation of the process, food service directors include RFIs in the back-to-school packets with the school lunch program application. Interested parents return the completed forms to the schools, and the food service directors then forward them to DHS. DHS, in turn, sends families a Healthy Families/Medi-Cal application. This has proven to be an effective outreach method for schools with limited resources.

Schools with greater resources may decide to implement a more advanced RFI process and do their own follow-up, contacting families and assisting them with the enrollment process. Alternatively, schools that want to conduct follow-up activities may choose to partner with community-based organizations or local coalitions that can assist families. Completed RFI forms are forwarded to outreach and enrollment workers who contact the families and invite them to enrollment events, individual appointments, or drop-in hours.

The RFI process has proven to be an effective outreach tool for children's health insurance programs. It has shown that if the workload is manageable, schools are a willing and effective partner in the effort to make health insurance accessible to families. Participation by California schools in the RFI process increases each year. According to the Healthy Families/Medi-Cal "Referral Source for January 7, 2002," schools continue to rank as one of the top referral sources for Healthy Families/Medi-Cal applications. However, there is no mechanism in place to follow RFIs from point of contact to actual enrollment. As a result, while we know that the RFI response rate is high, we do not know how many parents filling out RFI forms actually complete the Healthy Families/Medi-Cal application and get their children enrolled in the programs.

Express Lane Eligibility

An innovative enrollment process, Express Lane Eligibility, signed into law in October 2001,[44] authorizes the use of the information in the NSLP application to determine children's Medi-Cal eligibility.

To date, a small amount of funding has been proposed to implement the program, which is scheduled to begin in July 2003. With permission from the child's family, children who appear to be income-eligible for Medi-Cal will be preenrolled in Medi-Cal, and information already obtained in the NSLP application will be sent to the Healthy Families and Medi-Cal programs

for a complete eligibility determination. Parents may be contacted for additional information not contained on the NSLP application, such as immigration documentation; however, they will not have to complete a regular Healthy Families/Medi-Cal application.

Why Choose the National School Lunch Program

The NSLP provides another well-established, existing platform on which to build school-based health insurance outreach and enrollment activities. Sending home the NSLP application is a routine school function. Families are familiar with the process and place a great deal of trust in the program. It targets all children in grades K–12 who are likely to be eligible for Healthy Families and Medi-Cal.

Additionally, this platform provides schools with the opportunity to expand their outreach and enrollment activities over time, as they are increasingly able to obtain more resources for these activities. Schools can choose from the different strategies, according to the level of resources available to them. Using the RFI in its most basic form as an outreach tool does not require a great deal of staff time or funding, making it easier for schools with few resources to sustain the program over time. Schools with greater resources may choose to have staff follow up with families who request assistance through the RFI and educate families about the health insurance system and how to contact their doctors. Or schools may choose to participate in the Express Lane Eligibility process.

Keep in mind, however, that the NSLP option is limited in its ability to track and monitor health insurance activities. For example, we do not currently know how many parents filling out the RFI forms actually complete the Healthy Families/Medi-Cal application and get their children enrolled in the programs.

HEALTH COORDINATORS

If resources permit, designating a staff member who works as a health coordinator for a school or a school district is a sensible option. Several school districts and counties have already adopted this approach. Its main drawback is that it requires most districts to create a new position. Ideally there would be one health coordinator in each district. However, a regional or countywide coordinator may be more feasible for resource-strapped schools. The idea is to have one person whose sole responsibility is to oversee all health insurance activities in schools within a specific geographic area.

The health coordinator has primary responsibility for the program. The coordinator assesses the health needs of students, develops a districtwide outreach and enrollment plan, coordinates strategies, manages the collection and evaluation of program data, and plans for the program's sustainability. The coordinator also works to bring together key stakeholders from the school and the community to build partnerships with them that strengthen and sustain program activities over time, extending limited resources.[45] Ideally the coordinator will help form partnerships within schools among staff and between the school and the community. One advantage of this approach is that school staff know there is a trusted colleague to whom they can refer students in need. Community groups also benefit because the health coordinator can provide outside groups a point person who can help them to navigate an otherwise complex school system.

Why Choose the Health Coordinator Approach?

To date, this approach has been implemented in several districts around the state. It is an ideal structure to work toward because it allows one point of contact for health-related programs. Many schools carry out a number of health insurance–related activities, so having one person designated to systemize and coordinate multiple programs helps to avoid duplication of services and fragmented service delivery, allowing schools to extend the availability of limited resources over time. It also offers opportunities for stable growth: the health coordinator is able to focus on developing program services and systems, building a comprehensive school-based infrastructure that supports and sustains health insurance outreach and enrollment activities through a variety of different strategies.

While this option provides the ideal mechanism for school-based health insurance programs, it is resource-intensive and therefore difficult for many districts to consider given the current tight budgets. However, schools may be able to develop partnerships with private foundations to support the additional position. Also, it is a mechanism that schools could plan for and implement in the future when resources are more plentiful.

The Health Coordinator in the Alum Rock Unified Elementary School District

Since 1998, the Alum Rock Unified Elementary School District, in San Jose, California, has performed a variety of outreach and enrollment activities to enroll families in affordable children's health insurance programs. With a grant from the David and Lucile Packard Foundation, the district hired a health coordinator to develop, implement, and coordinate its program. The health coordinator has implemented several outreach methods, including using the National School Lunch Program (NSLP) and the Request for Information (RFI) form as vehicles to inform parents about the program; making presentations about the program to the principals at the district's 25 schools; using student emergency cards and health surveys to identify uninsured children; and organizing enrollment events. The health coordinator has also established the Alum Rock Community Collaborative, a group of school personnel, county staff, the California Teachers Association (CTA) and local organizations that assists families with the enrollment process.

As a Certified Application Assistant, the health coordinator helps families with the application process during scheduled appointments and office hours. To increase the utilization and retention of children in health insurance programs, the coordinator provides enrolled families with education and information on how to effectively use their health benefits.

The health coordinator has also played a key role in the county-school partnership that was established to plan for and implement the new Express Lane Eligibility process when it begins in July 2003. The health coordinator serves as a bridge between the county social services agency and the school district in the implementation of the new enrollment process. The county-school partnership has developed a modified school lunch application and a memorandum of understanding between the district and the Santa Clara County Social Services Agency. In addition, the partnership will organize a unified education campaign to inform families about this new opportunity to enroll children in Medi-Cal through the school lunch program, communicating the message that children who eat well and receive health services are ready to learn.

The health coordinator has been using Healthy Tracker since April 2002 to track and monitor all outreach and enrollment activities and will continue to use the database to monitor the success of Express Lane Eligibility. Healthy Tracker is a database specifically designed to track data on outreach, enrollment, utilization and retention of applicants' health insurance. It can also track data on student health and program outcomes. The database was developed by Consumers Union to assist schools and other organizations.

SECTION V

Recommendations

This report offers policymakers and schools different structural and financial approaches for continuing and increasing children's enrollment in health insurance programs. Development of school-based health insurance programs ideally should become a self-sustaining part of both the health and education communities. Some of the options presented in this report may require legislative changes or realignment of governmental or school policies and procedures. Thus, two sets of recommendations are presented—one for schools and one for policymakers—both are aimed at maximizing the effectiveness of children's health insurance efforts in California.

RECOMMENDATIONS FOR SCHOOLS

☐ **Schools need to maximize reimbursements under the Local Education Agency (LEA) Medi-Cal Billing Option and the Medi-Cal Administrative Activities (MAA) program.** There is a great deal of potential for increasing the reimbursement that schools receive for providing health-related services to students. Some schools already provide these services on a regular basis, yet they do not receive any reimbursement. Other schools participate in these programs but do not maximize their claims for reimbursement. Additional districts or school personnel do not know about these two programs, and others find the processes confusing. Reaching out to school personnel and district staff to make the processes for reimbursement more user-friendly will likely encourage greater use of these funding streams and also increase the utilization of health and social services.

☐ **Schools can reinvest the reimbursements received under the Medi-Cal Administrative Activities (MAA) program in health and social services.** Unlike the reimbursements schools receive under the LEA Medi-Cal Billing Option, reimbursements received under the Medi-Cal Administrative Activities (MAA) program are unrestricted and, therefore, Medi-Cal dollars reimbursed under MAA do not have to be reinvested in health and social services for students. Funds can be returned to the school's general fund, or may be used to promote the health and well-being of students. Schools may want to consider reinvesting a predetermined

proportion of their MAA funds in health-related programs. This reinvestment may increase staff participation, and therefore increase reimbursements for the school because staff will see funding coming back to the programs that generated these funds.

☐ **Schools may want to consider using federal education dollars from Title I and Title V of the No Child Left Behind Act (NCLB) to promote health insurance outreach and enrollment.** In recent years, the federal government has begun to place a great deal of emphasis on academic testing and has begun to hold schools accountable for students' academic achievement, as measured by these tests. Under Title I and Title V, the federal government provides schools with federal funding to remove obstacles that get in the way of children's academic success. Poor health is one such obstacle. Students are more likely to perform well on academic tests when they can see, hear, and think. Thus, schools may want to consider using some of their federal funding to help families obtain health insurance, and ensure that students gain access to needed health care services.

☐ **Schools with new and existing Healthy Start grants may want to include health insurance outreach and enrollment in their plan for sustainability.** Health insurance outreach is not a required activity under Healthy Start. Thus, while a number of Healthy Start grantees across the state have been successful in facilitating children's enrollment in health insurance programs, health insurance outreach and enrollment may not be a priority when compared to other critical needs in local communities. Additionally, programs may not want to offer comprehensive health insurance activities because to do so is resource-intensive. However, providing health services and enrolling children in Healthy Families and Medi-Cal may help grantees sustain themselves over time through reimbursements from the LEA Medi-Cal Billing Option (LEA) and the Medi-Cal Administrative Activities (MAA) programs, and through the reimbursements received by Certified Application Assistants (CAA).

☐ **Schools that partner with First 5 California county commissions in order to implement a School Readiness program may want to include health insurance activities in their programs.** School Readiness programs are required to include a health and social services element in their plans. Because good health is an integral prerequisite to learning, local programs may want to include health insurance outreach, enrollment and health education. While Proposition 10 funds are designated for children ages 0 to 5, older siblings are also likely to benefit from these services.

☐ **School districts may want a health coordinator to manage their health insurance outreach, enrollment and retention programs.** The position of health coordinator can become

part of each school district's organizational structure. Adding the position may be contingent upon the number of uninsured children in a district or the number of low- to moderate-income children in a district based on NSLP data or receipt of CalWORKS funds. In the case of a large district, the health coordinator can target schools with the greatest need. If adequate funds are available, the position can be created in all school districts across the state. Given limited resources, regional or county health coordinators are an alternative.

RECOMMENDATIONS FOR STATE AND LOCAL POLICYMAKERS

☐ **Policymakers need to create a Local Education Agency (LEA) Healthy Families Billing Option that will allow schools to claim reimbursement for services they already provide to students.** California schools are missing out on federal funding for medically-related services they already provide to students. Under current law, schools can be reimbursed for services they provide to children enrolled in Medi-Cal, however schools cannot seek reimbursement for similar health-related services provided to students who are enrolled in Healthy Families. Expanding the LEA Billing Option to the Healthy Families program would allow schools to use local education dollars as the state match and receive reimbursement for services rendered to children enrolled in Healthy Families. This would increase funding for California schools, and it would enable the state to maximize federal funding.

☐ **Policymakers need to continue reimbursing Certified Application Assistants (CAAs) for enrolling children in the Healthy Families and Medi-Cal programs.** Over the past four years, California communities have built a statewide infrastructure facilitating children's enrollment in and utilization of Healthy Families and Medi-Cal. However, this infrastructure is being dismantled. Last year, the state eliminated community- and school-based outreach contracts. This year, the Governor has proposed in his 2003–2004 budget to cut fees and training for CAAs, people who help families fill out applications and enroll in Healthy Families and Medi-Cal. The savings achieved through these cuts are only short-term and will be at the expense of California's children and families. Moreover, the state will pay more in the future to rebuild this community-based infrastructure.

☐ **Policymakers need to continue funding Healthy Start.** Healthy Start currently operates in approximately 12 percent of California's schools; yet 27 percent of California schools are eligible for a Healthy Start grant.[46] Unfortunately, state funding for this successful initiative is uncertain due to the state's budget shortfall. Given the success of this program and the fact

that many eligible schools have yet to apply for and receive a grant, policymakers need to continue to support this program and ensure that more children and families have the opportunity to benefit from this collaborative system of supports and services.

☐ **Healthy Kids Initiatives need to promote health insurance outreach and health education.** To date, a number of counties have pooled locally available resources, including county Proposition 10 funds, to create county health plans called Healthy Kids. These plans target children whose parents are unlikely to know they qualify for coverage because their family income is greater than the income eligibility requirements for Healthy Families and Medi-Cal, or because they are undocumented immigrants, and therefore not eligible for Medi-Cal or Healthy Families. Once they are enrolled, families that have not previously been enrolled in traditional health plans may need assistance understanding their rights and responsibilities under their health plan.

☐ **Policymakers need to continue providing bulk copies of the Request for Information (RFI) form at no-cost to all school districts in California.** This form has proven to be an effective outreach tool and is an institutionalized mechanism for reaching out to families and informing them about health insurance options for their children. Schools have become familiar with the process, and each year a greater number of schools participate in it. Scores of schools find the workload to be manageable and do not feel overburdened because they do not have to dedicate a significant amount of resources in staff hours or money. Due to the state's budget shortfall, it is uncertain at this time whether the state will continue to provide schools with this invaluable service. However, policymakers need to continue to support the RFI process as a cost effective means to get Healthy Families and Medi-Cal applications to families.

Conclusion

Over the past four years, the state, schools, and local communities have successfully worked to decrease barriers and help families obtain affordable health insurance coverage for their children. The economic downturn and the state's enormous budget shortfall now threaten this progress and are forcing policymakers to make extremely difficult choices. These choices include reinstating barriers to health insurance in order to help balance the state's budget. These savings are only short-term, however, and will have an incalculable impact on California's children and families. Economic hardship and uncertainty are also forcing many families to make difficult choices, often between food and shelter or health care. As a result, California families need access to health insurance now more than ever. The challenge for policymakers is to maintain the progress the state has made over the past couple of years and to redouble efforts to promote the health and well-being of our state. One way to maintain this progress is to support schools in their outreach, enrollment, utilization, and retention programs. We urge policymakers and schools to meet the challenge of these difficult times by making the suggested policy or program changes to improve the health and learning of California's most valuable asset: its children.

Notes

1. Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4901.
2. R. E. Brown, S. Alex, and L. Becerra, *Number of Uninsured Californians Declines to 6.2 Million—2 Million Are Eligible for Medi-Cal or Healthy Families*, Healthy Policy Fact Sheet by UCLA Center for Health Policy Research (Mar. 2002).
3. Pub. Law 107-110, 115 Stat. 1425 (2002).
4. Ed. Code, § 52050 et seq.
5. American College of Physicians—American Society of Internal Medicine, *No Health Insurance? It's Enough to Make You Sick: Scientific Research Linking Lack of Health Coverage to Poor Health* (1999).
6. Yee, G. *Health, Absenteeism and Academic Achievement: A Case Study.* Oakland, CA(2001).
7. Managed Risk Medical Insurance Board, Healthy Families, *Children's Health Status Assessment Project—First Year Results*, Data Insights Report No. 10 (Nov. 2002), retrieved March 10, 2003 from www.mrmib.ca.gov/MRMIB/HFP/PedsQLYr2CHHS.pdf.
8. J. Hadley, *Sicker and Poorer: The Consequences of Being Uninsured: A Review of the Research on the Relationship Between Health Insurance, Health, Work, Income, and Education*, prepared for the Kaiser Commission on Medicaid and the Uninsured (May 2002).
9. See *Supra* note 2.
10. A Local Education Agency (LEA) is defined in subdivision (h) of Welfare and Institutions Code section 14132.06 as the governing body of any school district or community college district, the county office of education, a state special school, a California State University Campus, or a University of California campus.
11. E. Touhey, personal communication, Oct. 2, 2002.
12. U.S. General Accounting Office, *Medicaid in Schools: Poor Oversight and Improper Payments Compromise Potential Benefit*, testimony before the Committee on Finance, U.S. Senate, 106th Cong., (2000), retrieved from www.gao.gov/archive/2000/h600087T.pdf.
13. A Local Education Consortium (LEC) is defined in subdivision (q) of Welfare and Institutions Code section 14132.47 as "a local agency that is one of the service regions of the California County Superintendent Educational Services Association."
14. G. Rivers, personal communication, Oct. 5, 2002.

15. Managed Risk Medical Insurance Board, Healthy Families, *December 2002 Enrollment Summary.*
16. California Department of Education, *Title I in California Programs and Policies,* retrieved Oct. 3, 2002, from www.cde.ca.gov/iasa/titleone/programs.html.
17. Pub. Law 107-110, § 5131, 115 Stat. 1781 (2002).
18. *Id.*
19. Ed. Code, § 8800 et seq.
20. California Department of Education, Healthy Start and After School Partnerships Office, *Healthy Start: Request for Applications 2000–2001.*
21. Grantees are not required to apply for a planning grant if they can demonstrate that they meet the requirements for an operational grant. See *supra* note 20.
22. See *supra* note 20.
23. See *supra* note 20.
24. California Department of Education, Healthy Start and After School Partnerships Office, *Fact Sheet: Healthy Start Support Services for Children Act 2000-2001.*
25. *Id.*
26. See *supra* note 20.
27. *Id.*
28. N. Halfon et al., *The Healthy Start Initiative in California: Final Report,* submitted to California Department of Education, Healthy Start and After School Partnerships Office by UCLA Center for Healthier Children, Families & Communities (2001).
29. See *supra* note 20.
30. Health & Saf. Code, §§ 130100 – 130155.
31. Health & Saf. Code, § 130100.
32. B. Marquez, personnel communication, January 8, 2003.
33. Health & Saf. Code, § 130105.
34. *Id.*
35. California Children & Families Commission, *Guidelines and Tools for Completing a School Readiness Program Application* (Mar. 2002), retrieved May 15, 2002, from www.ccfc.ca.gov/ SchoolReady.htm.
36. California Children & Families Commission, *Power Point Presentations: County Commission School Readiness RFF Overview* (Aug. 2001), retrieved May 15, 2002, from www.ccfc.ca.gov/ SchoolReady.htm.
37. California Children & Families Commission, *School Readiness Funding Opportunities: Frequently Asked Questions* (December 2002), retrieved March 10, 2003, from http:// www.ccfc.ca.gov/ PDF/SRI/FAQ-12-02.pdf.

38. *Id.*
39. *Id.*
40. *Id.*
41. *Id.*
42. B. Marquez, personnel communication, January 8, 2003.
43. The Children's Partnership. (December, 2002). *The Majority of California's Low-Income Uninsured Children Are Enrolled in the School Lunch Program: A Strategy for Reaching Nearly 700,000 Children With Health Insurance* (Express Lane Eligibility Issue Brief). Santa Monica, CA.
44. Assem. Bill No. 59 (2001–2002 Reg. Sess.).
45. Key stakeholders are likely to include a wide variety of people—for example, school nurses, Healthy Start staff, after-school staff, health clerks, food service staff, counselors, teachers, coaches, school district administrators and staff, students, parents, county agencies, local CBOs, and local business owners.
46. Lisa Villarreal, personal communication, Feb. 25, 2002.

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