

medicaid  
and the uninsured

**OUTREACH STRATEGIES FOR MEDICAID AND SCHIP:  
An Overview of Effective Strategies and Activities**

*Prepared by:*

Health Division  
Children's Defense Fund  
For the Kaiser Family Foundation

**April 2006**

# kaiser commission medicaid and the uninsured

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## EXECUTIVE SUMMARY

Over the last decade the percentage of low-income children without health insurance has fallen by over one third largely due to expansions in public coverage under Medicaid and State Children's Health Insurance Program (SCHIP). During this time, the SCHIP program was implemented with considerable attention and focus on eliminating unnecessary barriers to Medicaid and SCHIP enrollment and improving program outreach.

Medicaid currently serves approximately 25 million children<sup>1</sup> and SCHIP serves more than 6.1 million children a year.<sup>2</sup> However, despite these advances, nine million children lack health insurance. Over half are already eligible for Medicaid or SCHIP under current law<sup>3</sup> but remain un-served due to a variety of barriers highlighting the need for continued outreach.

During the recent economic downturn, fiscal constraints led many states to reverse successful outreach strategies. In addition, the Deficit Reduction Act of 2005 (DRA) allows states to impose premiums and cost-sharing that could cause beneficiaries (including children) to face additional barriers to maintaining coverage and access to care. The DRA also requires additional documentation to verify citizenship at application and/or recertification. These new requirements conflict with efforts to simplify enrollment that have been so effective.

Looking forward, the Congress may consider the "Cover the Kids" initiative that was included in the President's FY 2007 budget proposal, and Congress is also expected to take on the issue of reauthorizing SCHIP for FY 2007. The "Cover the Kids" campaign should be applauded for directing additional attention and funding for Medicaid and SCHIP outreach; however as was the case during the economic downturn, states are not likely to pursue aggressive outreach campaigns without stable and adequate program financing.

This paper highlights key components of effective outreach strategies to get children enrolled in Medicaid and SCHIP and also to get them access to care once enrolled. In addition, the paper examines how these strategies have been implemented in states, and the challenges of continuing to push for enrollment as states face continued fiscal pressures and barriers to participation are resurrected.

## Key Steps and Strategies for Successful Outreach

Medicaid and SCHIP outreach efforts can be most effective when they utilize a comprehensive definition of outreach that includes the following three components:

- 1) ***Targeting the eligible population through the development of culturally competent, consumer driven marketing strategies and multi-faceted campaigns with a focus at the local level.*** Outreach should be tailored to meet the needs of different groups of children within this population, especially those who are hardest to reach. Involving representatives from the targeted communities in all aspects of designing, planning and implementation of outreach activities will help assure that the message is responsive to concerns in the specific communities and culturally competent. To get health care to children, information about the existence and importance of relevant programs must be easily and locally available to the target audiences. This information transfer often involves mass media, community-based, person-to-person outreach, or some combination of these.
- 2) ***Facilitating enrollment and retention through public and private partnerships and simplified application and enrollment processes.*** Working closely in partnerships with other public programs, private businesses, and community-based organizations throughout the planning, design, and implementation stages is vital for successful outreach campaigns. State Medicaid and SCHIP agencies' collaborations with other state agencies and assistance programs such as WIC, child support, school lunch programs, subsidized child care, and Head Start have been successful in coordinating health insurance enrollment with enrollment in other public benefit programs. Safety-net programs can also provide expertise and technical assistance in improving the outreach and enrollment efforts of health programs. Additionally, school-based outreach can be effective, as well as "outstationing" eligibility workers to take Medicaid or SCHIP applications in various community settings. To ensure ongoing, enduring progress in reducing the number of uninsured children, states must continue to simplify application, enrollment, and recertification procedures for Medicaid and SCHIP. Additionally, where separately funded SCHIP programs exist, similar application and procedures for Medicaid and SCHIP will help achieve greater program coordination and reduce administrative burden for states.
- 3) ***Ensuring access to care through person-to-person contacts.*** Person-to-person outreach may be the most cost-effective strategy for states to pursue in improving participation in public health insurance programs. Such efforts are especially successful when done in partnership with public health or other agencies that have a community presence, and in conjunction with events that attract both youth and adults in the target market.<sup>4</sup> Person-to-person outreach can include all the stages of the outreach process, starting from increasing awareness, continuing throughout the application and enrollment process, and ultimately assisting clients in accessing care. Individualized assistance in the form of home visits, one-on-one contact at health clinics, schools, and community centers can be extremely useful in helping clients navigate the application and enrollment process and connect with the health care system. Community health workers can also serve as care coordinators to conduct case management in community-based clinics and other local sites that assist children in receiving services and help to eliminate barriers to access, such as a lack of transportation, problems navigating managed care networks, long delays in getting an appointment, an inability to leave work for an appointment, and lack of child care for their other children.

## **Adequate Funding Underpins Effective Outreach**

Outreach strategies can be very effective in enrolling people in the Medicaid and SCHIP programs and keeping them covered. From both the perspective of the child and public health, enrolling eligible children and families in Medicaid or SCHIP is a clear benefit. Adequate and stable funding for Medicaid and SCHIP programs is important for effective and sustainable outreach, as well as for maintaining and increasing children's enrollment.

The experience during the recent economic downturn demonstrates the direct link between available program financing and state outreach efforts. While states were making significant strides implementing effective outreach strategies, many states reversed some of these strategies when they hit a severe fiscal crisis beginning in 2001. Many states scaled back Medicaid and SCHIP outreach efforts and some imposed new barriers to enrollment, including waiting periods, caps on enrollment, income and asset verification requirements, and increased premiums. Although a recent 50 state survey indicates that these barriers are slowly being removed, many states still face fiscal struggles, and there is still uncertainty as to whether Medicaid and SCHIP will maintain the funding levels necessary to be able to respond to the needs of children and families.<sup>5</sup> The DRA permits states to impose cost-sharing and premiums for low-income beneficiaries that could result in additional barriers to maintaining coverage or accessing services.

Although the SCHIP program, with an enhanced federal matching rate, has been successful at providing millions of lower income children with health insurance, the program's financing structure has been problematic. The formulas for targeting funds to states have left some states with more funds than they could spend and other states needing additional funds to keep up with enrollment. Despite numerous legislative changes to the formula, last year \$1 billion in SCHIP funds reverted to the federal treasury while many children remained uninsured but eligible for public coverage. In addition, if federal funding for SCHIP is held constant, as proposed in the President's FY 2007 budget proposal, then SCHIP enrollment will decline and the number of uninsured children will increase unless states finance coverage for these children through Medicaid or with state-only funds.

## **Conclusion**

These challenges call for continued efforts on the part of advocates for children to protect the basic structures and guarantees of Medicaid and SCHIP while also working to increase enrollment of eligible children. With continued support from state and federal governments for increasing children's health coverage, and with the appropriate improvements in program funding, continued and improved outreach efforts will help reduce the number of uninsured children in the United States.

## INTRODUCTION

While the debate continues over how to get health care to everyone who needs it, the number of people in the United States living without health insurance climbed to a record 45.8 million in 2004. Medicaid and the State Children's Health Insurance Program (SCHIP), the major sources of public insurance coverage for low-income children, have played critical roles in holding the line on health insurance coverage for children, while the situation has continued to worsen for non-elderly adults. Between 2001 and 2004, the number of uninsured adults increased by 4.8 million people, to a total of 36.5 million, and the number of uninsured children actually declined slightly from 9.2 million to 9 million.<sup>6</sup> Eliminating unnecessary barriers to Medicaid and SCHIP enrollment and improving program outreach could achieve additional – and substantial – reductions in the number of uninsured children.

Tens of millions of children have benefited from Medicaid and SCHIP since their inception. According to the most recent data available, Medicaid serves 25 million children<sup>7</sup> and SCHIP serves more than 6.1 million children a year.<sup>8</sup> Between 2000 and 2003, coverage under Medicaid, SCHIP, and other state programs increased by 4.8 percent, while employer-sponsored insurance coverage dropped by 4.3 percent.<sup>9</sup> Also, from 2001 to 2004, the largest decreases in uninsured children came from populations whose family income qualified them for Medicaid or SCHIP.<sup>10</sup>

Outreach efforts have been responsible for much of the growth in children's enrollment in Medicaid and SCHIP. This outreach must be expanded further and, at the same time, there must be continued efforts to eliminate other barriers to Medicaid and SCHIP enrollment and stabilize funding for these programs. Of the nine million uninsured children ages 0 through 18 who lack health insurance in the U.S., more than 5.5 million are already eligible for Medicaid or SCHIP under current law<sup>11</sup> but remain un-served due to a variety of barriers. Since children constitute one-fifth of the uninsured overall, removing these barriers and enrolling eligible children could have a significant impact on the ranks of the uninsured in the United States.<sup>12</sup>

In recent years, many states facing severe budget shortfalls reduced eligibility and enrollment for health programs, and imposed barriers to enrollment for eligible children and families. In the last year, however, this trend appears to be reversing somewhat. For example, twenty states are taking various types of action to make it easier for children and families to enroll in and retain health coverage. Although 11 states made it more difficult for children to acquire or retain coverage in the last year, this is down from 2004, when nearly half the states enacted such measures.<sup>13</sup> Therefore, even while struggles to expand and protect funding for Medicaid and SCHIP continue, community advocates and private and public organizations must redouble their efforts to get all eligible children enrolled in Medicaid and SCHIP.

This paper highlights key components of effective outreach strategies to get children enrolled in Medicaid and SCHIP and also to get them access to care once enrolled.

Additionally, it examines how these strategies have been implemented in states, and the challenges of continuing to push for enrollment as funding is reduced and barriers to participation are resurrected. As this publication goes to press, there are enormous pressures on the Medicaid program, as a result of increased fiscal pressures from Hurricane Katrina, state and federal budget cuts, and increased pressure for federal waivers in state Medicaid programs. This calls for continued efforts on the part of advocates for children to protect the basic structures and guarantees of Medicaid and SCHIP while also working to increase enrollment of eligible children.

## BACKGROUND

### Expanding Children’s Health Insurance

Health insurance coverage is fundamental to ensuring children’s access to necessary and appropriate health services, including primary and preventive care, and specialized treatment for special needs. Since the mid-1990s, public health insurance expansions through Medicaid and the creation of the State Children’s Health Insurance Program (SCHIP) have provided critical health care for the nation’s poorest children, many of whom could not otherwise have afforded coverage. Improvements in public insurance coverage for children have contributed to notable declines in the number of uninsured children, and have helped offset some of the negative effects of cuts in other poverty reduction programs, such as welfare assistance. More recently, Medicaid and SCHIP have provided a buffer for low-income children, protecting them from the impact of economic downturns and drops in employer-based health coverage (see Table 1).<sup>14</sup>

**Table 1**

<b>Comparison of Uninsured Rates for Children and Adults</b>				
	<u>Children age 0-18</u>		<u>Adults age 19-64</u>	
Percent uninsured in:	<u>2001</u>	<u>2004</u>	<u>2001</u>	<u>2004</u>
All income groups	12.1%	11.6%	18.5%	20.5%
Under 100% of poverty	22.7	20.3	42.5	43.3
100-199% of poverty	18.2	16.9	34.5	36.8
200-299% of poverty	11.2	12.0	21.0	24.5
300% of poverty and above	5.2	5.1	9.5	10.5

Source: U.S. Census Bureau, the 2002 Current Population Survey Annual Demographic Supplements (CPS ADS) and the 2005 Annual Social and Economic Supplement (ASEC) to the Current Population Survey. Calculations by the Children’s Defense Fund, October 2005.

**Medicaid.** Established in 1965 under Title XIX of the Social Security Act, Medicaid is the main source of health insurance coverage for low-income children, families, and the elderly. Covering more than 50 million people, including 25 million children<sup>15</sup>, Medicaid provides a comprehensive health benefit package that includes primary and preventive care, acute and emergency services, and a set of services for children known as Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. Defined in law, EPSDT services consist of needed and as-needed screenings, any medically necessary services and treatment required for a child’s condition, illness or injury, as well as comprehensive

vision, dental and hearing care with no cost sharing for low-income children. Medicaid is also the single most important source of coverage for maternity services, and has been responsible for much of the reduction in infant mortality in the past 40 years.

In 1996, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) made a critical change in Medicaid eligibility by severing the automatic link that had existed between eligibility for cash assistance (welfare) and Medicaid. Severing this link resulted in both new opportunities and new challenges for outreach. Under the 1996 law, states can now offer health care coverage to low-income families regardless of whether the family received cash assistance. However, this new law also made it more difficult for states to identify and enroll people who were eligible for Medicaid, but who were not seeking cash assistance. Medicaid enrollment dropped in the aftermath of these welfare changes and many states used special Medicaid funds made available under PRWORA to implement new outreach strategies to encourage enrollment.<sup>16</sup>

On February 8 the President signed the Deficit Reduction Act of 2005 (DRA). The DRA includes a number of provisions to reduce Medicaid spending, many of which shift costs to beneficiaries and make it more difficult for beneficiaries to maintain and retain coverage. The DRA allows states to impose cost-sharing and premiums for low-income beneficiaries that could result in additional barriers to maintaining coverage or accessing services. The DRA also will require most new applicants and current beneficiaries at re-determination to provide additional documentation to verify citizenship. These new requirements conflict with efforts to simplify enrollment efforts that have been so effective.

**SCHIP.** Enacted in 1997, SCHIP was the largest expansion of public health insurance since the creation of Medicaid and Medicare. Today, SCHIP provides health insurance coverage to more than 6.1 million children in low-income families whose income exceeds Medicaid income eligibility limits.<sup>17</sup> Like Medicaid, SCHIP funding is shared between the states and the federal government, with the federal government contributing a matching amount for every state dollar spent on the program up to a capped amount. The SCHIP program includes incentives for states to participate, including enhanced federal funding, which is set at a higher level than is provided for the Medicaid program. Because SCHIP funding is capped, there is no individual entitlement to benefits; therefore not all children who are eligible and apply for SCHIP in a given state will be enrolled. States are also given greater flexibility under SCHIP than under Medicaid to determine how to design and administer their programs and to decide who will be eligible. SCHIP benefits are often less comprehensive than those provided under Medicaid. The SCHIP program will face reauthorization in 2007.

### **Defining Outreach: Three Components**

The term *outreach* is commonly used in public health insurance programs to describe efforts to increase enrollment in a particular program. It is most often applied to efforts that increase awareness of the existence and purpose of a program through targeted campaigns designed to help people actually get the services for which they are eligible. Outreach is comprised of three main components:















































