

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

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bipartisan group of national leaders and experts in health care and public policy.

James R. Tallon
Chairman

Diane Rowland, Sc.D.
Executive Director

kaiser
commission on
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

OUTREACH STRATEGIES FOR MEDICAID AND SCHIP

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 children¹ and SCHIP serves more than 6.1 million children a year.² However, despite these advances, nine million children lack health insurance. Over half are already eligible for Medicaid or SCHIP under current law³ 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.⁴ 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.⁵ 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.⁶ 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 children⁷ and SCHIP serves more than 6.1 million children a year.⁸ 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.⁹ Also, from 2001 to 2004, the largest decreases in uninsured children came from populations whose family income qualified them for Medicaid or SCHIP.¹⁰

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 law¹¹ 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.¹²

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.¹³ 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).¹⁴

Table 1

Comparison of Uninsured Rates for Children and Adults				
	<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 children¹⁵, 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.¹⁶

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.¹⁷ 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:

1. Targeting people who are potentially eligible for a program, and making them aware of their eligibility.
2. Assisting people who have been identified as eligible in actually enrolling in the program, and in renewing their coverage in the program at a later time if relevant.
3. Ensuring their access to care within the program.¹⁸

An Agency for Healthcare Research and Quality report reviewing evaluation studies identified nine discrete steps in the outreach process, from identification of the eligible population through the use of services after enrollment (see Table 2). They are listed below, grouped by their corresponding component. Each one of the steps may involve numerous strategies designed to achieve success in identifying who is eligible, getting them enrolled, retaining their coverage, and ensuring they get services within the program.

Table 2

Steps in the Outreach Process
<p>Targeting the Eligible Population</p> <p>Step 1: Identify and understand the potentially eligible population</p> <p>Step 2: Increase public awareness that the program exists</p> <p>Step 3: Increase understanding of eligibility for the program</p> <p>Step 4: Educate individuals about the program</p> <p>Step 5: Motivate individuals to take action to find out more about, or enroll in, the program</p>
<p>Enrollment and Retention</p> <p>Step 6: Facilitate individuals' actions needed to enroll in the program</p> <p>Step 7: Address systemic barriers to enrollment or action</p> <p>Step 8: Change state policies and program characteristics to address barriers</p>
<p>Ensuring Access to Care</p> <p>Step 9: Address access to care and use of services after enrollment</p>
<p><i>From Final Report: Review of the literature on evaluation of outreach for public health insurance and selected other programs. Prepared for the Agency for Healthcare Research and Quality by Barents Group, LLC.</i></p>

Outreach is a critical part of any children's health insurance program. Much of the expansion in children's coverage through Medicaid and SCHIP was due to outreach, rather than eligibility changes. Simply making uninsured children and families eligible for health care assistance does not ensure that individuals in the targeted population will know they are eligible, know about the program, or choose to participate.

The creation of SCHIP, for example, demonstrated the importance of outreach to the large number of uninsured children who became eligible for these public health insurance programs. Under SCHIP, states were required to create public outreach campaigns to educate families about the expanded availability of children's health insurance coverage.

States with a stand-alone SCHIP component were also required to design outreach programs to ensure that parents of eligible children were informed and understood how to enroll their children in SCHIP. Legislation accompanying SCHIP allowed up to ten percent of the federal funds allocated for SCHIP during the first five years to be used for program administration, which included outreach efforts.

States and communities have implemented a wide range of strategies for publicizing SCHIP programs, identifying and encouraging potentially eligible families to apply, and assisting in the enrollment process. SCHIP outreach activities have included widespread media campaigns and efforts to provide application assistance at community-based sites, such as schools, health clinics, child care programs, and other places frequented by families with children. Before the recent economic downturn began in 2001, improvements in SCHIP outreach processes also sparked a renewed interest in improving Medicaid outreach across the country and Medicaid enrollment expanded as a result of SCHIP outreach efforts and requirements to “screen and enroll” children who applied for SCHIP but were eligible for Medicaid.

Familiarity with the SCHIP program continues to grow, partially due to outreach efforts by many states. Seventy percent of low-income uninsured children have parents who have heard of SCHIP, up from 47 percent in 1999. However, this is below the comparable figure for the older Medicaid program, which 87 percent of parents of uninsured low-income children have heard about. The vast majority of these parents say that they would enroll their children in Medicaid or SCHIP if their children were eligible.¹⁹

Why is Outreach Still Important?

Despite gains in enrolling children in Medicaid and SCHIP, there are still 9 million children in the United States who do not have health insurance coverage. More than 5.5 million of these children are eligible for these programs but are not enrolled.²⁰ Many of these children remain uninsured because their parents have not been able to enroll them in public programs due to a lack of knowledge about the programs, and/or barriers to enrollment. A 1999 survey found that two-thirds of parents of eligible uninsured children (67 percent) have tried to enroll their children in Medicaid. Among these parents, over half (57 percent) were unsuccessful.²¹

Many of these children may be in families that are new to public assistance. Parents may be unaware of the availability of health insurance coverage, or they may know about the program, but not think they meet program eligibility criteria. Grandparents raising their grandchildren may not know that they can apply for health coverage for their grandchildren, even though they are not the parent. Other uninsured children may have been enrolled in public health insurance programs at one time, but lost coverage and did not reenroll during subsequent periods of eligibility. Eligible children and families also face barriers that include difficulties in navigating application and enrollment procedures,

complex and restrictive eligibility rules, and burdensome premiums and enrollment fees. Language barriers, immigrants' wariness of government, and the lingering perceptions about public health programs association with the welfare system compound these problems.

Outreach efforts directed at minority populations are particularly important because minority children make up a disproportionate number of uninsured children (see Table 3). These children are also more likely to go without needed medical care. A report on children's health disparities written by the Children's Defense Fund (with the support of the Aetna Foundation), entitled *Improving Children's Health: Understanding Children's Health Disparities and Promising Approaches to Address Them*, analyzes many of these health care disparities. For example, based on CDF's analysis of the 2002 National Health Interview Survey, Black children are about one-third more likely and Latino children are three-quarters more likely than White children to have gone two or more years since seeing a dental provider.²² Black and Latino children combined are almost more than twice as likely as White children to have gone two or more years without seeing a doctor, 60 percent more likely to have an unmet medical need, and 32 percent more likely to have delayed medical care due to cost.²³ Obtaining health insurance, especially when combined with continued outreach, can help reverse many racial disparities in these findings.

Children with health insurance, particularly publicly-insured children, are more likely to obtain preventive and primary medical care, more likely to receive dental care, and less likely to miss out on necessary medical or dental care because of their families' inability to afford the care.²⁴ Thus, continuous outreach efforts are also critical to sustaining efforts in reducing the numbers of uninsured children.

Table 3

Who are the Uninsured Children?	
Race and Ethnicity	Family Structure
39.7% are White	87.0% have at least one working parent
36.4% are Hispanic	65.7% have at least one parent who works full-time throughout the year
17.0% are Black	68.0% live in families with incomes above poverty
3.6% are Asian or Pacific Islander	52.0% live in a 2-parent household
2.2% are of more than one race	
1.1% are American Indian or Alaskan Native	

Note: Children are ages 0 through 18.
 Source: U.S. Census Bureau: 2005 Annual Social and Economic Supplement (ASEC) to the Current Population Survey (CPS); calculations by the Children's Defense Fund, 10/05.

OUTREACH STRATEGIES

Medicaid and SCHIP outreach efforts can be most effective when they utilize a comprehensive definition of outreach that includes each of its three components. Outreach must identify eligible children, assist the children in the enrollment and retention processes, and ensure that the children receive access to care once they are enrolled.²⁵ Multifaceted campaigns using public and private partnerships to develop consumer-driven marketing strategies that focus on local level and person-to-person contact are often the most successful outreach strategies. Below, we describe some of these effective outreach strategies and activities that help to overcome barriers to health coverage. Two effective state approaches (Texas and New York) are also highlighted in an Appendix to this report.

Targeting Eligible Children

✓ *Develop culturally competent, consumer-driven marketing strategies*

One of the first steps in Medicaid and SCHIP outreach is to identify the state or community's population of eligible, but uninsured children. Outreach should be tailored to meet the needs of different groups of children within this population, especially those who are hardest to reach. Local descriptive data about uninsured children are sometimes not readily available, presenting challenges to states and communities as they work to design and target outreach strategies effectively.²⁶ Collecting local data to target outreach to special populations requires the involvement of representatives from the targeted communities in all aspects of designing, planning and implementation of outreach activities. The message must be responsive to concerns in the specific communities.

Involving members of the target population is also critical to ensure the cultural competency of the material and message. In achieving this goal, the choice of media and the message content should be customized to appeal to the information needs of the specific high-priority target audience. Materials must use appropriate translation and the message must be tailored to be culturally specific or sensitive for non-English speaking and minority populations, which may perceive messages differently. Working closely with outreach workers who are experienced with the target population, sensitive in their personal interactions, and well-trained about the program will facilitate the connection and outreach to targeted populations.

✓ *Create a multifaceted campaign with a focus at the local level*

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.

Mass Media Outreach: In 1997, nearly all states launched outreach campaigns to educate families about the availability of publicly financed health care coverage for low-income

children after SCHIP was enacted. In most states, mass media campaigns, which included advertising, publicity, direct marketing, and public relations strategies have been the focus. These campaigns usually included radio and television spots, billboards, and print and bus ads. States also used promotional materials such as posters, stickers, toothbrushes, rulers, and water bottles displaying the name and logo of the states' programs as well as the number of a toll-free hotline to call for more information. Several state officials described the importance of marketing in promoting brand recognition for the new SCHIP program, raising awareness about the program and the importance of health insurance for children, while encouraging parents to enroll their children.²⁷

Direct marketing can be an effective strategy, particularly when the target audience is carefully selected. However, advertising and publicity require expensive repetition in order to achieve the desired objectives. For overall effectiveness, the number of times that a message reaches and is processed by a well-defined target population is more important than the size of the population reached.²⁸

Community-Based Outreach: Community-based outreach strategies use entities and individuals whom families already know and trust to help spread the word. They are the most likely to encourage eligible children to come forward. For instance, outreach workers may be based in local social services agencies, community agencies, or provider sites, and may be supported through public funds, private revenues, or foundation grants. There are also good examples of engaging faith communities and groups of students in outreach. Ideally, these efforts would send out information that builds on the messages in the state- or county-wide media campaigns.²⁹

Person-to-person Outreach: This outreach method takes the community-based approach a step further by using community outreach workers to establish personal contact with people to discuss the availability of health coverage for their children. In addition, these workers often assist families in the application and enrollment process. Individualized face-to-face contact allows the communicator to tailor the message to the prospective client's specific informational needs, situation, and language. It is often seen as a way to connect with hard-to-reach groups, such as working families with no previous experience receiving public benefits and immigrant families.³⁰ Some states employ outreach workers as case managers who can assist families with the application and enrollment process, and also help families deal with barriers to accessing care.

An interim evaluation of the SCHIP program found that while broader mass media marketing efforts were important in raising awareness of the existence of health coverage, more targeted community-based outreach and person-to-person strategies helped families overcome barriers to enrollment.³¹ The broader marketing attracted families' attention, sparked initial interest in SCHIP, and built brand recognition over the long run. However, community-based efforts used trusted voices from the neighborhood to contact families directly, discuss details of the program, answer questions and clarify misconceptions, and assist families in completing their program applications.³²

Combined Strategies: The effectiveness of consumer-driven outreach strategies highlights the importance of funding and using outreach strategies at many levels simultaneously. Combining statewide media marketing and local community-based outreach has proven to be an effective approach, with the two approaches working in a complementary fashion. Using local media, such as small community newspapers, shoppers' guides, flyers, radio stations (including non-English programming), signs on billboards and mass transit vehicles, and local newsletters are effective ways to reach target populations.

Widespread distribution of materials and application forms ensures that Medicaid and SCHIP information is available in numerous places for the target audience to access. For example, Medicaid and SCHIP flyers can be included in mailings such as utility bills and church bulletins, or in take-home packets distributed at schools for registration, report cards or sports participation. They can also be distributed at local events that appeal to both youth and adults in the target population.

Toll-free hotlines are a critical back up to broader marketing, providing families with a means of obtaining for further information about a program. They also can be used to access application forms, application status, health plan selection, and case management. Websites also have helped to increase awareness and public access to program information, with some states accepting applications on-line. All of these outreach methods will produce increases in Medicaid and SCHIP enrollment.

Mass-Media and Community-Based Outreach in Practice: Covering Kids & Families

Covering Kids & Families (CK&F) is a national program of the Robert Wood Johnson Foundation. The Foundation awards grants to state- and community-based programs to fund outreach efforts for Medicaid and SCHIP. They currently operate through 140 community-based programs and statewide projects in 45 states and the District of Columbia.

Since 2000, CK&F has sponsored a Back to School Campaign to encourage families to sign up their children for public health insurance programs. As part of this annual effort, CK&F invites organizations to become National Supporters, disseminating Back to School Campaign information and organizing events. State and local grantees also organize Back to School events, and new groups and organizations are also encouraged to host their own events. CK&F supports these events by providing free materials, such as posters, flyers, videos, toolkits, templates for newspaper articles, and public service announcements. They also sponsor a toll-free number, 1-877-KIDS-NOW, that parents can call to be connected to the Medicaid or SCHIP program office in their state. CK&F has successfully supported thousands of outreach and enrollment events through a combination of community-based efforts and state and national media coverage.

Source: Covering Kids & Families website, <http://www.coveringkidsandfamilies.org>.

Enrollment and Retention

✓ *Forge public and private partnerships*

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. About three quarters of all low-income children live in families that participate in the National School Lunch program, WIC, the Food Stamp program or Unemployment Compensation.³³ Many of them are also eligible for Medicaid or SCHIP. Collaboration can reduce the burden of multiple applications and facilitate enrollment by presuming eligibility for Medicaid or SCHIP when a family qualifies for one of these other programs. Experience with social safety-net programs can also provide expertise and technical assistance in improving the outreach and enrollment efforts of health programs.

New Jersey, for example, has engaged in partnerships with many state-level governmental organizations for health coverage outreach. In conjunction with the Division of Motor Vehicles, public health coverage information is sent out with a family's driver's license and vehicle registration renewal forms. The Division of Taxation mails out health coverage information to all families that meet income guidelines, and the state's electric and gas companies include an insert in customers' bills. The utilities companies also include informational messages in their on-hold phone recordings.³⁴

Sharing sites is another way to expand outreach. Some effective outreach efforts are school-based, and others are achieved by "outstationing" eligibility workers to take Medicaid or SCHIP applications in various community settings. Schools can be outlets for publicizing health insurance program information, for instance including information in newsletters or making applications available in their offices. Staff can also be trained to make referrals or even to assist parents in obtaining and completing application forms. Under Medicaid, eligibility workers must be stationed at federally qualified health centers, which are a major source of preventive and primary care for low-income children. While the state Medicaid agency makes the final eligibility decision, an outstationed worker not employed by the state agency can initially process the application. Community workers can make preliminary eligibility decisions, and help families complete and mail-in application forms. This method can be effective if combined with a simplified application form and presumptive eligibility.

✓ *Simplify the application and enrollment processes*

Enrollment: To ensure ongoing, enduring progress in reducing the number of uninsured children, states must continue to simplify application and enrollment procedures for Medicaid and SCHIP. Additionally, where separately funded SCHIP programs exist, similar application and enrollment procedures for Medicaid and SCHIP will help achieve greater program coordination. Creating user-friendly application and enrollment processes, and targeting services can be particularly effective in enrolling hard-to-reach populations. Continued emphasis on aligning Medicaid and SCHIP eligibility

determination systems and outreach strategies will save families from having to navigate the intricacies of two distinct systems and may help to recast Medicaid as a health coverage program, rather than just an adjunct to the welfare system.³⁵ Additionally, aligning Medicaid and SCHIP application and enrollment processes reduces the administrative burden for states with dual programs, and facilitates eligibility determination for families with changing financial circumstances.

Improvements in enrollment have contributed greatly to the increase in children's health coverage. Virtually all states with separate SCHIP programs have, to some extent, implemented simplified application and enrollment processes. Most states no longer impose asset tests or require face-to-face interviews in their separate SCHIP programs. Moreover, many states have extended some of these simplified application procedures to children's coverage under Medicaid, facilitating coordination between the two programs. In total, 45 states have eliminated face-to-face interviews and 46 have no asset tests for Medicaid and SCHIP applications.³⁶

There is still much additional work to be done, however. Many states still have not taken full advantage of opportunities to increase the number of children covered by Medicaid and SCHIP. Thirty-two states still impose waiting periods, requiring that children be uninsured for a minimum period before they can be enrolled in SCHIP or Medicaid. Only 20 states have established uniform income-eligibility standards for all children in a family, so that members of a family are not divided among programs based on age.³⁷ Instead of allowing parents to simply declare income that is then verified through matches with other data sources, like unemployment insurance wage, 41 states require parents to document income (for example, by producing pay stubs) when applying for coverage for their children.³⁸

Suggestions for Simplifying and Facilitating Application and Enrollment for Medicaid and SCHIP

- Reduce the length and complexity of application forms to the minimum necessary for eligibility determination
- Coordinate separate SCHIP programs with the existing Medicaid program
- Eliminate asset tests
- Ease eligibility verification requirements (e.g., allow self-declaration of income and assets, computer matching information)
- Make eligibility rules consistent for children of all ages
- Establish presumptive eligibility for children
- Eliminate waiting periods
- Implement "Express Lane Eligibility", which uses information from other need-based enrollment programs to expedite eligibility determinations for Medicaid and SCHIP
- Eliminate or reduce premiums and enrollment fees
- Accept applications by mail, telephone, facsimile, and the Internet
- Accept applications at sites other than public assistance (welfare) offices
- Provide assistance at times convenient for the population being served
- Arrange to accept applications by others on behalf of clients
- Establish 12-month continuous eligibility for children
- Allow applicants to submit their completed renewal application through the mail

Retention. Retention is currently the weak link in outreach efforts to expand Medicaid and SCHIP coverage, and significant improvements must be made. States are often more successful in enrolling low-income children in Medicaid or SCHIP than they are in maintaining health coverage after enrollment.

While 34 of the 36 states with separate SCHIP programs allow families to use the same form to apply for either Medicaid or SCHIP, only 17 of those states allow families to use a single form for Medicaid or SCHIP renewal.³⁹ Requiring different forms can be particularly problematic at redetermination because children’s eligibility may move back and forth between Medicaid and SCHIP as their age and/or family income changes. In many cases, children in the same family may be eligible for different programs. The complexity in using separate forms can result in delays or even children being dropped from the program at renewal if a child is found to be eligible for the other program, but is not automatically enrolled in it.

One study found that between 10 and 40 percent of all children enrolled in SCHIP were dropped at redetermination because their parents did not respond to renewal notices and/or submit renewal applications.⁴⁰ Very few states follow up with a phone call or visit. A review of four states that mail SCHIP renewal notices to families 60-90 days before the end of the child’s eligibility period found that 25 percent of dropped children re-enrolled within two months, suggesting that in many cases, parents did not intend to disenroll the children.⁴¹

Ensuring Access to Care

✓ *Make person-to-person contacts*

One-on-one or 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.⁴²

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. Outreach practices might involve helping clients with the initial application, appointments, documentation, follow-up inquiries and information. Person-to-person outreach is particularly effective when well-supported by supplementary information provided by brochures, websites, toll-free phone numbers, and so on.

Person-to-person outreach can go even further by providing individualized assistance in the form of home visits, training-the-trainers, individualized application assistance, and one-on-one contact at health clinics, schools, and community centers. In these cases, community health workers act as client advocates when applications go astray or seem to be denied unfairly. They also help clients to overcome other barriers such as linguistic, cultural, and cognitive challenges to the application and enrollment process.

**Promising Approach in Person-to-person Outreach:
Student Poverty Reduction OUTreach (SPROUT)**

The *CDF SPROUT* project aims to link high school and college students across the country to local community-based organizations in an effort to expand outreach and enroll uninsured children in SCHIP or Medicaid.

The original pilot program, formerly known as SHOUT (Student Health OUTreach), took place in New York City in 1998 and included graduate and undergraduate students from various departments within Columbia University. These students were trained by the Children's Defense Fund-New York's outreach staff on how to complete the new joint Medicaid/Child Health Plus and New York State's Children's Health Insurance Program (SCHIP) application. They also received cultural sensitivity training in the appropriate screening procedures for immigrants and other low-income populations.

Once trained, student volunteers were placed in community-based organizations to assist families with the enrollment process. Students fill an important role by partnering with community-based groups to help with outreach and enrollment efforts. Since the initial pilot program, *CDF SPROUT* initiatives have spread to several states across the country, including Texas, California, and continued efforts in New York.

To help ensure access to care, 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. In this case management model, health workers address barriers to accessing care, 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. Care coordination for children can include hotlines, home visiting, and community health advisor programs. These programs help families identify available providers, accommodate special needs, and overcome access barriers.

ADEQUATE FUNDING

A discussion about outreach strategies for Medicaid and SCHIP would not be complete without mention of financing. This report and others document the fact that outreach strategies can be very effective in enrolling people in the Medicaid and SCHIP programs and keeping them there. Effective outreach will almost certainly result in program growth. From both the perspective of the child and a public health perspective, enrolling eligible children and families in SCHIP or Medicaid is a clear benefit. However, the view from the state budget perspective is somewhat different. Ironically, successful outreach efforts can result in program cuts when enrollment grows and strains state budgets.

Unlike the federal government, states are required to balance their budgets. As they work to do so, growing health care costs can cause special challenges. Medicaid and SCHIP costs expand and contract in response to factors that are often outside a state's control, including economic forces and trends in other health insurance markets. Health care is a major item in most state budgets,⁴³ and while the state cost to cover a child under Medicaid or SCHIP is relatively low – especially in relation to the cost of long-term care for seniors – higher than expected enrollment in Medicaid or SCHIP can quickly lead to a deficit in a delicately balanced state budget.

In fact, recent progress made in securing health care coverage for children is being threatened by state budget shortfalls that have led to cuts in public health programs. Total state budget shortfalls for both 2003 and 2004 exceeded \$75 billion dollars. More than half the states projected 2005 shortfalls totaling between \$32 and \$36 billion, and additional states are likely to add to this total as budgets are finalized.⁴⁴ With continued funding shortages, states are less able and may be less willing to provide the state matching funds necessary to cover uninsured children under Medicaid and SCHIP.

As state funds have declined, many states have also scaled back outreach efforts – including promotional campaigns and application assistance provided to families by community-based agencies – that have been, and continue to be, essential to enrolling eligible children in SCHIP and Medicaid. Some states 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.⁴⁵

The Deficit Reduction Act of 2005, signed into law on February 8, 2006 by President Bush, eliminates some of the current protections for children in the Medicaid program. It allows states to charge families substantial new costs that the Congressional Budget Office estimates will lead to tens of thousands of people losing coverage, 60 percent of whom will be children.⁴⁶ Additionally, this new law mandates that states require all U.S. citizens, children and adults, to prove their citizenship by submitting a passport or birth certificate when they apply and/or reapply for Medicaid coverage. Experts estimate that between 1.4

and 2.9 million children currently enrolled in Medicaid do not have access to this required paperwork and could lose their coverage.⁴⁷ Collectively, these recent changes threaten rather than improve health coverage for needy children. Enrollment of children in Medicaid and SCHIP must be closely monitored following these legislative changes, and states should redouble their outreach efforts using effective outreach tools described in this report to ensure that vulnerable children have access to necessary health care.

While the SCHIP program has been successful at providing millions of lower income children with health insurance, its system of capped financing and formula driven allotments does not allow states to respond to changes in need, nor does it treat all states equitably. Differing SCHIP allotments – not to mention state match rates, income eligibility levels, and benefits – between the states regardless of need creates an uneven and constantly shifting playing field for vulnerable people to navigate. These inequities could be avoided, and enrollment outreach might be improved without fear of creating annual budget quagmires for the states, if the program funding were to be structured more like the popular Medicare system for the elderly. Such funding questions are just some of the issues that will need to be addressed when SCHIP is reauthorized (current authorization expires in 2007) and there is a new effort to facilitate enrollment of eligible children in the program.

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 would provide grants to states for Medicaid and SCHIP outreach. While the Administration estimates that this will increase costs by about \$5 billion over the next ten years due to expanded program enrollment, the Congressional Budget Office estimates a much lower cost due to lower enrollment expectations. As was the case during the economic downturn, states are not likely to pursue aggressive outreach campaigns without stable and adequate program financing. Eighteen states are expected to face funding shortfalls in their SCHIP programs for FY 2007 and program enrollment is likely to decline if federal allotment caps are not increased over current levels and states continue to face pressure to control Medicaid costs. If those funding pressures continue, it will become increasingly difficult for states to pursue aggressive outreach efforts with their limited resources.

CONCLUSION

To be truly effective in providing health care for vulnerable children, Medicaid and SCHIP programs must include consistent, quality outreach efforts. Outreach to children and families includes targeting people who are potentially eligible for a health program and making them aware of their eligibility; assisting those identified in enrolling and renewing their coverage under the program; and ensuring their access to care within the program. There is clear evidence that outreach works, and that increases in or improvements to outreach efforts boost program enrollment, leaving fewer children uninsured. Consistent outreach efforts and a predictable funding stream for children's health insurance programs would likely further reduce the number of uninsured children.

Outreach efforts should be ongoing and integrated as part of the health insurance programs to sustain the progress in children's coverage. Keys to effective ongoing outreach strategies include activities based on knowledge of the population to be reached, collaborative approaches and partnerships used throughout the outreach planning, operation, and evaluation phases with key players who understand the target population, and multifaceted campaigns that work closely with targeted families on an ongoing, person-to-person basis to ensure that families receive needed services.

It will be important to monitor the effects of the DRA on the enrollment and re-determination of children in Medicaid, with particular attention to the impact of new documentation requirements and the extent to which states use new authority to increase costs for families.

Adequate and predictable funding for Medicaid and SCHIP programs is important for effective and sustainable outreach, as well as for maintaining and increasing children's enrollment in Medicaid and SCHIP. With continued support from state and federal governments for increasing children's health coverage, and with the appropriate improvements in program funding, we can continue to expand and improve outreach efforts that will help reduce the number of uninsured children in the United States.

APPENDIX

PULLING OUTREACH STRATEGIES TOGETHER: Profiles of Outreach Activities in Texas and New York

Texas: Multifaceted Outreach, Enrollment, and Advocacy Strategies

Although Texas was late in starting its SCHIP program in April, 2000, the Texas SCHIP program provides an example of an effective SCHIP roll-out until cuts took effect on September 1, 2003. In the first nine months of the program, Texas enrolled more than 212,000 children in its SCHIP program, outpacing California, New York, Florida and other states comparable in size and ethnic and geographic diversity. The combined SCHIP and Medicaid programs for children in Texas are referred to as TexCare.

The multifaceted outreach campaign used in the launch of the Texas SCHIP program incorporated many of the effective strategies outlined in this report, including public-private partnerships and enrollment simplification. This case study provides an overview of state outreach strategies, key elements of Medicaid enrollment simplification, and effective community-based efforts that can be useful to other states.

Public-Private Partnerships: A critical element of Texas' outreach strategy involved state contracts with local community-based organizations (CBOs). Texas provided contracts to 50 CBOs that had strong local support and relationships with SCHIP and Medicaid eligible populations in their communities, including county health departments, non-profit social services organizations, religious organizations and local health clinics. CBO outreach activities focused on publicizing health coverage programs, providing application assistance, developing localized and culturally appropriate outreach plans, and coordinating with other local organizations to minimize duplication.

Texas also developed state agency partnerships, including a partnership with the Office of the Attorney General Child Support Division, to perform outreach to custodial parents, encouraging them to apply for SCHIP and Medicaid if their children were uninsured. In addition, the State conducted outreach through the Texas Workforce Commission, inserting TexCare promotional flyers with Unemployment Insurance Benefits applications, distributing materials to probation and parole offices through the Department of Criminal Justice, disseminating information to Food Stamp applicants through the state Department of Human Services, and incorporating information to individuals who had recently applied for driver's licenses through the Department of Public Safety.

Texas engaged the private sector in promoting outreach. HEB grocery stores printed toll-free telephone numbers on grocery bags, Reliant Energy put notices in utility bills reaching 1.5 million households, and Clear Channel Outdoor donated billboard space to promote children's health insurance. Texas also secured extensive media coverage, through a kick-off media tour in 12 cities, a statewide advertising campaign, and telethons designed to collect completed applications for children's health insurance rather than donations. Telethons were held in seven major Texas cities, generating tens of thousands of applications for SCHIP and Medicaid through free media coverage.

Medicaid Simplification--A Streamlined Eligibility Process: On January 1, 2002, the Texas Children's Medicaid application was streamlined so that it was the same simple mail-in application as that of SCHIP. Documentation requirements were reduced to the same standards as SCHIP, and the face-to-face interview requirement was removed.

With a streamlined eligibility process, CBOs began turning their attention towards Medicaid outreach for children alongside SCHIP outreach. In February 2002, outreach events and press coverage throughout the month promoted enrollment for children in both SCHIP and Medicaid. Local groups came together to collaborate on press, outreach, and enrollment activities during the same time frame to maximize impact. The streamlined Medicaid application process for children, combined with outreach and community education efforts across the state, resulted in an almost 30 percent increase in enrollment of children in Medicaid (equal to 318,155 children) in a one-year period (September 2001 to September 2002).

Community-Based Efforts: Outreach by community-based organizations also played a critical role in the enrollment of children in Medicaid and SCHIP. Below, several successful community-based efforts are described.

*Michael & Susan Dell Foundation "insure•a•kid" Texas Grants for School Outreach—*The Michael & Susan Dell Foundation insure•a•kid Texas Grants for School Outreach funded 10 statewide grants reaching 40 school districts and over 770,000 Texas students. The goal of the grants was to increase the number of eligible children enrolled in SCHIP and Medicaid by incorporating outreach and training into routine school activities. For the past three years, Children's Defense Fund Texas (CDF-Texas) has been working with eight school districts affecting over 317,000 children to ensure that school districts go beyond outreach and enrollment, to create a sustainable program and permanent school procedures that will continue to link children with health coverage beyond the grant period.

*Fiesta Supermarket and McDonald's Restaurant Outreach—*With the support of the Robert Wood Johnson Foundation Covering Kids and Families Initiative, CDF-Texas and the Gulf Coast SCHIP Coalition partnered with Fiesta Mart, Inc., a Houston-based chain of grocery stores with a strong Spanish-speaking customer base, and Greater Houston McDonald's Restaurants to hold a total of 13 city-wide children's health insurance sign ups. All together, these sign ups have assisted 8,313 families and 17,214 children in applying for SCHIP and Children's Medicaid. During each one-day campaign, application assistance was provided at from 10 to 40 restaurant and store locations throughout Houston, with individual locations managed by CBOs. Clear Channel Outdoor has promoted these events for the past three years through free billboards. Additional promotion was done through Fiesta Mart Inc. store circulars, McDonald's tray liners and earned media.

*Texas Healthy Child Weekend—*For the past four years, CDF-Texas has partnered with faith-based organizations to hold a Texas Healthy Child Weekend, which promotes enrollment in children's health insurance programs. CDF-Texas creates bilingual toolkits that are provided to congregations, with bulletin and pulpit announcements informing congregation members about how to apply for and renew children's health coverage. An interfaith advisory committee, including Texas Catholic Conference, the United Methodist Church, the Southwest Region of Progressive Baptist Ministers, the Presbyterian Church USA, and the American Jewish Committee, oversees the production of the toolkit and assists with statewide distribution.

Budget Pressures Threaten Children’s Coverage: Despite the initial success of SCHIP, the Texas Legislature enacted significant cuts to SCHIP eligibility and benefits as a result of a \$10 billion state budget shortfall in 2003. The state enacted an asset test, a 90-day waiting period, and increased the monthly premiums, eliminated all dental, vision, and hospice benefits, as well as most mental health benefits, and continuous eligibility was reduced from twelve months to six months.⁴⁸ In addition, the outreach efforts of community-based organizations under contract with the state were limited to renewal and utilization activities only, and marketing was severely restricted. As a result of these cumulative changes, SCHIP enrollment in Texas has decreased by over 180,000 children since the cuts began in September 2003.⁴⁹

Campaign to Restore SCHIP Achieves Partial SCHIP Restoration:

CDF-Texas led a 250-member statewide coalition called the “Campaign to Restore SCHIP” that successfully restored several aspects of the SCHIP program during the 2005 Texas Legislative session. Dental, vision, hospice and mental health benefits have been restored to the SCHIP benefits package; premiums have been reduced and will be more convenient for families to pay; additional funds were allocated to increase enrollment; and services were maintained for legal immigrant children. Another important provision requires that the Texas Health and Human Services Commission request additional funding from the state Legislature if there is a SCHIP shortfall before imposing a wait list, enrollment cap, or cuts to eligibility or benefits.

The Campaign used a variety of strategies, and as head of the coalition, CDF-Texas coordinated the following efforts:

- Forged partnerships with regional coordinators in 10 Texas communities to create local coalitions to support SCHIP restoration. Coordinators acted in concert, speaking with a unified message and organizing activities across the state at the same time. For example, organizing a kick-off press conference on the same day in several different parts of the state; distributing press releases in unison; compiling local impact data and family testimonials; and convening public hearings and policy briefings in a coordinated way.
- With local coordinators, CDF documented the impact of high rates of uninsured people on local emergency rooms, healthcare systems, businesses and communities. Data included: budget shortfalls facing hospitals due to cuts to SCHIP and Medicaid, costs of preventive versus emergency room treatment, increases in local property taxes to fund healthcare services, the loss of SCHIP matching funds for each county, diversion rates from emergency rooms because of overcrowding, school absenteeism and loss of attendance funds due to untreated illnesses and the costs to small businesses of rising healthcare premiums.
- CDF launched a family tracking project and followed 100 families with 219 children affected by the SCHIP cuts across Texas. The study found that 75 percent of children who lost SCHIP remained uninsured, and 89 percent of children who lost SCHIP delayed or missed healthcare, including care for serious illness. The study also found that private health insurance was either unavailable at work or was too costly for families to afford, and that SCHIP families work, but struggle to pay basic expenses. In addition, the study found that families on SCHIP were being forced to choose between paying higher premiums or using that money to pay for dental, vision, or other medical expenses no longer covered, and that many families were going into debt to pay for dental visits, medication, or critical medical tests for their children.

- CDF compiled the local impact data and family tracking project findings into a special report to the 79th Texas Legislature called "Facing Facts: The Cost of CHIP Cuts to Texas."
- The campaign, through CDF's coordination, worked with regional coordinators to launch a statewide media campaign, featuring family testimonials and local impact data on the need for SCHIP restoration.
- CDF recruited healthcare champions to support SCHIP restoration, including businesses and chambers of commerce, faith and community leaders and local elected officials to speak out about the local impact of SCHIP cuts.
- CDF organized a CHIP Congress during the Texas Legislative session for over 100 key statewide stakeholders to educate local leaders about the local impact of SCHIP cuts.

Despite these restorations, several key program challenges remain. Outreach to inform families about restored dental and vision services and reduced premiums will be essential to rebuild SCHIP enrollment. If enrollment is not restored, Texas will miss out on an estimated \$370 million in federal matching funds for the 2006-2007 biennium.

In addition, funding is not adequate to restore SCHIP enrollment to pre-September 1, 2003 levels. It will thus be critically important to ensure that SCHIP eligible children are enrolled without a waiting list or benefit reductions.

Recent CHIP Enrollment Loss

SCHIP enrollment has declined sharply by 28,709 children from December 1, 2005 to April 1, 2006. The reasons for the decline appear to be due to processing mistakes during transition to the new private contractor Accenture on December 1, 2005 and policy changes made to the renewal process for SCHIP.

Policy Changes

Policy changes include: reinstating the collection of enrollment fees for families without adequate notice; increasing the documentation requirements that families must provide with applications; complicating the EZ renewal process by requiring families to fill out a new application every 6 months; and running data broker checks on families' income and assets which has created a backlog of applications. Policy changes were also not clearly communicated to enrolled families or community based organizations that assist them with CHIP applications and renewals. As a result, families and community groups were not aware that enrollment fees had been reinstated or that additional verifications were required to complete renewal applications.

Processing Mistakes

Based on stories from families and SCHIP health plans, there is a wide body of evidence that mistakes have been made during the transition to the new SCHIP enrollment vendor Accenture. Families report that: applications were lost and parents are having to reapply two to three times to receive coverage; parents turned in their paperwork on time, but were not renewed; and that the contractor lost paperwork that parents had submitted. Families also report that premium payments were not credited to a child's account and that parents had been told incorrect premium amount by the contractor. Some families say that they have been denied because they were told that their children were non-citizens, when the children were in fact citizens and had been on SCHIP for a long period of time. Many families were terminated with very little notice, receiving notices in the mail that their children's coverage would be terminated within one or two days. Other parents found out that their children's coverage was terminated when they went to doctor's appointments or the pharmacist.

The cuts in Texas illustrate clearly how the success of outreach campaigns is linked to the financial stability of the state's Medicaid and SCHIP programs. However, recent enrollment declines raise questions about a more complicated renewal process and mistakes being made by the new SCHIP enrollment vendor. Appropriate and sustainable funding for Medicaid and SCHIP is needed in order to result in long-term increases in coverage.

New York:

Connecting Children and Families to Coverage Through Facilitated Enrollment

In recent years, New York has made enormous strides in increasing access to public health insurance for children and families. New York has created a more rational and effective health insurance system for working families through the creation of facilitated enrollment, a range of enrollment and renewal simplifications, program enhancements and systems improvements including streamlined unified applications, decreased documentation requirements, expansions of eligibility and benefits, implementation of mail-in renewal systems.

These efforts have measurable results. In just six years, the number of uninsured children in New York has dropped from 729,000 to 469,000, a 36 percent decrease. New York's rate of uninsured children is the lowest it has been in fourteen years. At the same time, enrollment in Child Health Plus has grown to 2 million children and teens. Nationally, the rate of uninsured children is one-third higher than New York's. In addition, for the first time in over a decade, New York's rate of uninsured adults is lower than the national average. Nearly 1.5 million low-income adults are getting the health care they need to stay healthy and working.

Connecting New York's Uninsured to Coverage:

The Facilitated Enrollment program (FE) is the cornerstone of New York's efforts to reduce barriers to enrollment for children and families. Launched in 2000, FE uses community-based organizations and health plans to find and enroll "hard to reach" New Yorkers who have historically been left out of public health insurance programs. Facilitated enrollment has placed more than 2,000 enrollment counselors in the community to assist families in signing up for Child Health Plus, Medicaid and Family Health Plus. Enrollers help screen families for eligibility, complete the application, gather the necessary eligibility documents, conduct the legally mandated face-to-face interview and, when necessary, select a managed care plan. Facilitated enrollers then submit the applications on behalf of families and provide follow-up or troubleshooting to ensure that the client is enrolled and can access health care services. Enrollers also help families with the annual renewal process.

Facilitated enrollment counselors can be found in every county throughout the state in places where the uninsured live and work – at local clinics, schools, community centers, community-based organizations, places of worship and other convenient locations. Because nearly 80 percent of New York's uninsured are workers or their dependents, all facilitated enrollment programs provide evening and weekend hours. Enrollers also reflect the cultural and ethnic diversity of New York's many communities, speaking more than 40 languages.

As a result, facilitated enrollment has become the backbone of New York's enrollment system for public coverage. Statewide, more than 50 percent of all Child Health Plus A (children's Medicaid), Medicaid and Family Health Plus applications and 100 percent of Child Health Plus B (NY's SCHIP program) applications are completed at facilitated enrollment sites. In New York City, more than 80 percent of Family Health Plus applications come through facilitated enrollers. In 2005, New York's facilitated enrollers submitted more than 500,000 applications on behalf of uninsured families.

Advocacy Efforts to Preserve Facilitated Enrollment:

Despite the overwhelming success of FE, the program has come under fire in New York's budget process. The 2004-05 Health and Mental Hygiene budget cut FE funding by 15 percent. The 2005-06 Health and Mental Hygiene Budget again proposed drastic cuts, including the elimination of the authority to conduct adult facilitated enrollment and a \$10 million (60 percent) cut in funding for community-based FE programs. Working in partnership with organizations from around New York State, including Child Health Now! Coalition members, community service providers, facilitated enrollment programs, health plans, health care providers and advocates, CDF-NY launched an aggressive advocacy campaign to preserve the program. Their efforts included releasing a joint report by the Children's Defense Fund-NY and The Children's Aid Society, "Community-based Facilitated Enrollment: Meeting Uninsured New Yorkers Where They Are". This report describes the work of the more than 100 community-based organizations statewide that provide unique and locally tailored outreach and enrollment activities. It was released at a press conference in Albany and distributed to the Governor and every State Legislator.

CDF-NY also held a FE Speak Out Day, which started with a breakfast briefing attended by two dozen legislators and staffers followed by legislative visits. More than 40 community-based and health plan enrollers made 80 visits to their elected officials in order to educate them about the merits of the program and how FE programs assist constituents in accessing public health insurance. Following the Speak Out Day, CDF-NY launched a post-card and letter-writing campaign targeting the Governor and Senate and Assembly Leadership. Intense media outreach also played an important role in this statewide campaign. Stemming from the coalition's efforts, the final 2005-06 budget fully funded community-based FE programs and restored authority for adult facilitated enrollment. As a result of tremendous advocacy effort, New York recently learned that CMS approved its waiver request extension to preserve the facilitated enrollment program. The preservation of the program will help ensure access to public health insurance for the hundreds of thousands of eligible yet uninsured children and families.

Advocacy efforts to preserve FE have broadened into a state and federal campaign to ensure that CMS does approve New York's request to allow health plans and health care providers to continue facilitated enrollment. Advocacy efforts have included meetings with key CMS staff as well as with state and congressional elected officials, a letter writing campaign, and a bi-partisan New York State Delegation briefing in Washington, DC to encourage New York's Members of Congress to urge CMS to approve New York's waiver request and preserve access to public health insurance.

Over the last six years, FE has grown to become an integral part of public health insurance enrollment in New York. Without the program, many working families would have to take time off from work to apply for or renew their health coverage at welfare or Medicaid offices, which are often difficult to get to and rarely have evening or weekend hours. New York's local district offices have also grown reliant on the program because the counties simply do not have the resources to handle the application workload and the legally mandated face-to-face interview now conducted by health plan and community-based facilitated enrollers. FE has proven its success by opening the doors to enrollment for hundreds of thousands of eligible New York children and families.

-
- ¹ Centers for Medicare and Medicaid Services. Medicaid Statistical Information System, FFY2002. Retrieved from the Internet at <http://msis.cms.hhs.gov/cognos/cgi-bin/ppdscgi.exe>. Calculations by the Children's Defense Fund, October 2005.
- ² Centers for Medicare and Medicaid Services. Revised FY2004 Annual SCHIP enrollment report, released May 23, 2005. Retrieved from the Internet at <http://www.cms.hhs.gov/NationalSCHIPPolicy/SCHIPER/list.asp> on April 4, 2006.
- ³ Children's Defense Fund calculations based on the U.S. Census Bureau's 2005 Annual Social and Economic Supplement (ASEC) to the Current Population Survey, October 2005.
- ⁴ Debra J. Ringold, Tricia M. Palmer Olsen, and Laura Leete, *Managing Medicaid Take-Up, SCHIP and Medicaid Outreach: Strategies, Efforts and Evaluation* (Albany, NY: Federalism Research Group, July 2003).
- ⁵ Donna Cohen Ross and Laura Cox, *In a Time of Growing Need: State Choices Influence Health Coverage Access for Children and Families* (Washington, DC: Kaiser Family Foundation, October 2005).
- ⁶ Children's Defense Fund calculations based on the U.S. Census Bureau's March 2002 Current Population Survey, Annual Demographic Supplement, and the 2005 Current Population Survey, Annual Social and Economic Supplement (ASEC).
- ⁷ Centers for Medicare and Medicaid Services. Medicaid Statistical Information System, FFY2002. Retrieved from the Internet at <http://msis.cms.hhs.gov/cognos/cgi-bin/ppdscgi.exe>. Calculations by the Children's Defense Fund, October 2005.
- ⁸ Centers for Medicare and Medicaid Services. Revised FY2004 Annual SCHIP enrollment report, released May 23, 2005. Retrieved from the Internet <http://www.cms.hhs.gov/NationalSCHIPPolicy/SCHIPER/list.asp> on April 4, 2006.
- ⁹ John Holahan and Arunabh Ghosh, *The Economic Downturn and Changes in Health Coverage, 2000-2003* (Washington, DC: Urban Institute for the Kaiser Family Foundation, September 2004).
- ¹⁰ Children's Defense Fund calculations based on the U.S. Census Bureau's March 2002 Current Population Survey, Annual Demographic Supplement, and the 2005 Current Population Survey, Annual Social and Economic Supplement (ASEC).
- ¹¹ Children's Defense Fund calculations based on the U.S. Census Bureau's 2005 Annual Social and Economic Supplement (ASEC) to the Current Population Survey, October 2005.
- ¹² *Ibid.*
- ¹³ Donna Cohen Ross and Laura Cox, *In a Time of Growing Need: State Choices Influence Health Coverage Access for Children and Families* (Washington, DC: Kaiser Family Foundation, October 2005).
- ¹⁴ John Holahan and Arunabh Ghosh, *The Economic Downturn and Changes in Health Coverage, 2000-2003* (Washington, DC: Urban Institute for the Kaiser Family Foundation, September 2004).
- ¹⁵ Centers for Medicare and Medicaid Services. Revised FY2004 Annual SCHIP enrollment report, released May 23, 2005. Retrieved from the Internet at <http://www.cms.hhs.gov/SCHIP/enrollment/SCHIP04rev.pdf> on October 25, 2005.
- ¹⁶ Debra J. Ringold, Tricia M. Palmer Olsen, and Laura Leete, *Managing Medicaid Take-Up, SCHIP and Medicaid Outreach: Strategies, Efforts and Evaluation* (Albany, NY: Federalism Research Group, July 2003).
- ¹⁷ Centers for Medicare and Medicaid Services. Medicaid Statistical Information System, FFY2002. Retrieved from the Internet at <http://msis.cms.hhs.gov/cognos/cgi-bin/ppdscgi.exe>. Calculations by the Children's Defense Fund, October 2005.
- ¹⁸ Mary Laschober, et al., *Final Report on Review of the Literature on Evaluation of Outreach for Public Health Insurance and Selected Other Programs* (Washington, DC: Barents Group, LLC for the Agency for Health Care Research and Quality, US Department of Health and Human Services, March 31, 2000).
- ¹⁹ Genevieve Kenney, Jennifer Haley, and Alexandra Tebay, *Familiarity with Medicaid and SCHIP Programs Grows and Interest in Enrolling Children is High* (Washington, DC: Urban Institute, July 2003). Retrieved from the Internet at http://www.urban.org/UploadedPDF/310817_snapshots3_no2.pdf on February 17th, 2005.
- ²⁰ Children's Defense Fund calculations based on the U.S. Census Bureau's 2005 Annual Social and Economic Supplement (ASEC) to the Current Population Survey, October 2005.
- ²¹ M. Perry, S.Kannel, R.B.Valdez, Lake, Snell and Perry, Chang, C. Medicaid and Children: Overcoming Barriers to Enrollment, for the Kaiser Commission on Medicaid and the Uninsured, January 2000.
- ²² 2002 National Health Interview Survey; analysis by the Children's Defense Fund, 2005.
- ²³ *Ibid.*
- ²⁴ Leighton Ku and Sashi Nimalendran, *Improving Children's Health: A Chartbook About the Roles of Medicaid and SCHIP* (Washington, DC: Center on Budget and Policy Priorities, January 2004).
- ²⁵ Mary Laschober, et al., *Final Report on Review of the Literature on Evaluation of Outreach for Public Health Insurance and Selected Other Programs* (Washington, DC: Barents Group, LLC for the Agency for Health Care Research and Quality, US Department of Health and Human Services, March 31, 2000).
- ²⁶ Laura Summer, Mary Brecht Carpenter, and Laura Kavanagh, *Successful Outreach Strategies: Ten Programs That Link Children to Health Services* (Washington, DC: National Center for Education in Maternal and Child Health, January 1999).
- ²⁷ Judith Wooldridge, et al., *Interim Evaluation Report: Congressionally Mandated Evaluation of the State Children's Health Insurance Program* (Washington, DC: Mathematica Policy Research, Inc. for the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, February 2003).
- ²⁸ Debra J. Ringold, Tricia M. Palmer Olsen, and Laura Leete, *Managing Medicaid Take-Up, SCHIP and Medicaid Outreach: Strategies, Efforts and Evaluation* (Albany, NY: Federalism Research Group, July 2003).

²⁹ Renee Schwalberg, et al., *Making Child Health Coverage a Reality: Lessons from Case Studies of Medicaid and Outreach and Enrollment Strategies* (Washington, DC: Kaiser Family Foundation, September 1999).

³⁰ Renee Schwalberg, et al., *Making Child Health Coverage a Reality: Lessons from Case Studies of Medicaid and Outreach and Enrollment Strategies* (Washington, DC: Kaiser Family Foundation, September 1999).

³¹ Judith Wooldridge, et al., *Interim Evaluation Report: Congressionally Mandated Evaluation of the State Children's Health Insurance Program* (Washington, DC: Mathematica Policy Research, Inc. for the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, February 2003).

³² Ibid.

³³ Genevieve Kenney, Jennifer Haley, and Alexandra Tebay, *Familiarity with Medicaid and SCHIP Programs Grows and Interest in Enrolling Children is High* (Washington, DC: Urban Institute, July 2003).

³⁴ Center for Medicare and Medicaid Services, U.S. Department of Health and Human Services, *New Jersey Outreach Strategies* (Washington, DC: U.S. Department of Health and Human Services, 2004). Retrieved from the Internet at <http://www.cms.hhs.gov/SCHIP/outreach/factnj.asp> on December 7th, 2004.

³⁵ Mary Laschober, et al., *Final Report on Review of the Literature on Evaluation of Outreach for Public Health Insurance and Selected Other Programs* (Washington, DC: Barents Group, LLC for the Agency for Health Care Research and Quality, US Department of Health and Human Services, March 31, 2000).

³⁶ Donna Cohen Ross and Laura Cox, *In a Time of Growing Need: State Choices Influence Health Coverage Access for Children and Families* (Washington, DC: Kaiser Family Foundation, October 2005).

³⁷ Donna Cohen Ross and Laura Cox, *In a Time of Growing Need: State Choices Influence Health Coverage Access for Children and Families* (Washington, DC: Kaiser Family Foundation, October 2005).

³⁸ Donna Cohen Ross and Laura Cox, *In a Time of Growing Need: State Choices Influence Health Coverage Access for Children and Families* (Washington, DC: Kaiser Family Foundation, October 2005).

³⁹ Donna Cohen Ross and Laura Cox, *In a Time of Growing Need: State Choices Influence Health Coverage Access for Children and Families* (Washington, DC: Kaiser Family Foundation, October 2005).

⁴⁰ Ian Hill and Amy Westpfahl Lutzky, *Is There a Hole in the Bucket? Understanding SCHIP Retention* (Washington, DC: Urban Institute, May 2003).

⁴¹ Donna Cohen Ross and Ian T. Hill, "Enrolling Eligible Children and Keeping Them Enrolled," *The Future of Children* 13, No.1 (*Health Insurance for Children*, Spring 2003): 81-97.

⁴² Debra J. Ringold, Tricia M. Palmer Olsen, and Laura Leete, *Managing Medicaid Take-Up, SCHIP and Medicaid Outreach: Strategies, Efforts and Evaluation* (Albany, NY: Federalism Research Group, July 2003).

⁴³ Alice Burton, et al., *State of the States 2006* (Washington, DC: State Coverage Initiatives and Academy Health, January 2006). Retrieved from the Internet at <http://www.statecoverage.net/pdf/stateofstates2006.pdf> on January 20, 2006.

⁴⁴ Elizabeth C. McNichol, *State Fiscal Crisis Lingers: Cuts Still Loom* (Washington, DC: Center on Budget and Policy Priorities, February 2005). Retrieved from the Internet at <http://www.cbpp.org/12-8-04sfp.htm> on April 11th, 2005.

⁴⁵ Donna Cohen Ross and Laura Cox, *In a Time of Growing Need: State Choices Influence Health Coverage Access for Children and Families* (Washington, DC: Kaiser Family Foundation, October 2005).

⁴⁶ Congressional Budget Office, *Congressional Budget Office Cost Estimate, S.1932, Deficit Reduction Act of 2005* (Washington, DC: Congressional Budget Office, January 27, 2006). Retrieved from the Internet at <http://www.cbo.gov/ftpdocs/70xx/doc7028/s1932conf.pdf> on February 2, 2006.

⁴⁷ Leighton Ku, Donna Cohen Ross, and Matt Broaddus, *Survey Indicates Budget Reconciliation Bill Jeopardizes Medicaid coverage for 3 to 5 million US Citizens* (Washington, DC: Center on Budget and Policy Priorities, January 2006). Retrieved from the Internet at <http://www.cbpp.org/1-26-06health.pdf> on January 27, 2006.

⁴⁸ Anne Dunkelberg and Molly O'Malley, *Children's Medicaid and SCHIP in Texas: Tracking the Impact of Budget Cuts* (Washington, DC: Kaiser Family Foundation, July 2004).

⁴⁹ Data provided by Children's Defense Fund Texas Office, January 2005.

The Kaiser Family Foundation is a non-profit, private operating foundation dedicated to providing information and analysis on health care issues to policymakers, the media, the health care community, and the general public. The Foundation is not associated with Kaiser Permanente or Kaiser Industries.

1330 G STREET NW, WASHINGTON, DC 20005
PHONE: (202) 347-5270, FAX: (202) 347-5274
WEBSITE: WWW.KFF.ORG/KCMU

Additional copies of this report (#7495) are available
on the Kaiser Family Foundation's website at www.kff.org.

