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Making Child Health Coverage a Reality: Lessons From Case Studies of Medicaid and CHIP Outreach and Enrollment Strategies

Prepared for
The Kaiser Commission on Medicaid and the Uninsured
Washington, DC
by
Renee Schwalberg, Ian Hill, Hilary Bellamy
and Judith Gallagher
Health Systems Research, Inc.
Washington, DC

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THE HENRY J. KAISER FAMILY FOUNDATION

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The Kaiser Commission on Medicaid and the Uninsured serves as a policy institute and forum for analyzing health care coverage and access for the low-income population and assessing options for reform. The Commission, begun in 1991, strives to bring increased public awareness and expanded analytic effort to the policy debate over health coverage and access, with a special focus on Medicaid and the uninsured. The Commission is a major initiative of the Henry J. Kaiser Family Foundation and is based at the Foundation's Washington, D.C. office.

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This report was commissioned by the Kaiser Commission on Medicaid and the Uninsured with support from the Henry J. Kaiser Family Foundation. A detailed analysis of the four case studies, entitled *Making Child Health Coverage a Reality: Case Studies of Medicaid and CHIP Outreach and Enrollment Strategies* (publication #2159), is also available. This work is part of a larger study on outreach and enrollment that also includes a national survey and focus groups of low-income families. The authors would like to acknowledge the contributions of Patricia Seliger Keenan of the Kaiser Commission staff in completing this study.

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Overview of Findings

The large number of children without health insurance has been a national and state concern for more than a decade. To address this problem, Congress first began to expand Medicaid eligibility for children in the late 1980s with the Omnibus Budget Reconciliation Act of 1986. In 1997, when the number of uninsured children had reached 11.3 million, Congress created a new source of coverage for low-income children in the Children's Health Insurance Program (CHIP), codified in Title XXI of the Social Security Act. In addition, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, commonly known as welfare reform, severed the link between Medicaid and cash assistance, creating the opportunity to reshape Medicaid as a health insurance program rather than a welfare program.

These expansions present states with the challenge of identifying and enrolling the large population of uninsured children in their Medicaid and CHIP programs. This challenge is twofold: 1) families, particularly those with no previous connection to the welfare system and no experience receiving public benefits, must be informed that these programs exist and that their children may be eligible; and 2) systems must be instituted to enroll eligible children in insurance programs with minimal administrative burden.

To explore these issues on the state and local levels, the Kaiser Commission on Medicaid and the Uninsured commissioned a study of Medicaid and CHIP outreach and enrollment systems with support from the Henry J. Kaiser Family Foundation. This study describes four states' strategies for reaching out to and enrolling children in Medicaid and CHIP to highlight the particular issues and challenges states face as they design these strategies. The study sites selected were Santa Clara County (San Jose), California; Bibb County (Macon), Georgia; Cuyahoga County (Cleveland), Ohio; and Bernalillo County (Albuquerque), New Mexico. Ohio and New Mexico used CHIP to expand Medicaid, Georgia created a separate state CHIP program, and California took a combined approach. Summary sheets on each of the study sites are attached at the end of the report.

Methods

The four study sites were chosen to represent a range of geographic regions, sizes, demographic distributions, and CHIP implementation strategies. The demographic and program characteristics of the study states are shown in Table 1. The study methods involved three- to four-day site visits to each site; during these visits, interviews were conducted with officials of state Medicaid and CHIP programs, state public health departments, and child advocacy organizations and primary care associations. The next two to three days were spent in the local communities, interviewing administrators of social services agencies, front-line eligibility workers, outreach workers, and representatives of provider agencies (such as public health departments, hospitals, and managed care plans) and other agencies involved in promoting health insurance programs for children or assisting with enrollment. Standard protocols were used for each category of informant.

Outreach and Enrollment Strategies

The four case study states and communities provided examples of a wide range of strategies for publicizing Medicaid and CHIP programs, identifying and referring potentially eligible families, and streamlining and simplifying the process of eligibility determination. Many initiatives observed in local communities addressed more than one of these concerns. Therefore, for clarity in our analysis, we will distinguish between these two issues as follows:

- **Outreach efforts** include efforts to raise public awareness, inform families of new insurance programs, and encourage them to apply.
- **Eligibility strategies** include efforts to streamline the process of applying for coverage, including simplification of application processes and creation of new avenues for applying through community-based organizations and providers.

Outreach Strategies

A variety of approaches to outreach is available, including mass media campaigns, community-based outreach, and one-on-one casefinding and educational efforts. Some of the study states have invested considerable amounts in outreach for Medicaid and CHIP: for example, California has devoted $21 million in Medicaid and CHIP administrative funds to its outreach efforts, and Ohio is allocating $13 million in outreach funding available through the welfare reform legislation to its counties to promote enrollment in Healthy Start. Most of the study states used a combination of outreach strategies, as described below.

- **Mass Media**. In most of the study states, mass media and public relations strategies were the focus of state-level outreach initiatives. Three of the four states (California, Georgia, and New Mexico) contracted with marketing firms to develop their media campaigns. These campaigns typically include radio and television spots, print ads, bus cards, and billboards, as well as such collateral materials as posters, stickers, toothbrushes, rulers, and water bottles. These materials display the name and logo of the states' programs as well as the number of a toll-free hotline to call for more information. The study states have made substantial efforts to reach non-English-speaking populations with their media campaigns. However, in most cases, these media campaigns were developed without the benefit of extensive market research or pilot testing of outreach messages with the target audiences.

- **Community-Based Outreach**. Community-based outreach efforts are in place to varying degrees in all four study states. These strategies allow families to receive information from members of the community whom they know and trust; ideally, the messages and information received from these community members will build on the messages in the state- or county-wide media campaign. Community-based outreach workers may be based in local social service agencies, community agencies, or provider sites, and may be supported either with public funds or through private agencies' revenues or foundation grants. Table 2 displays the strategies used in each of the study counties.

- **One-on-One Outreach**. The most personal outreach method is to approach people individually and discuss the availability of health coverage for their children. This strategy requires that outreach workers be trusted by their clients, and ideally that they themselves be members of the target community. Examples of this strategy were found in only two study states (California and Georgia).

Eligibility and Enrollment Strategies

The four study states have taken numerous steps to simplify the eligibility and enrollment process for children, each implementing the basic strategies of shortening and simplifying application forms and expanding points of access in the community. Beyond this, three states (California, Georgia, and Ohio) have also begun using mail-in applications for at least one of their child health programs. The critical features of each state's eligibility determination process are shown in Table 3.

These strategies reflect both a recognition that traditional application forms, which determine eligibility for multiple health and welfare programs, and traditional application procedures, which require at least one visit to a social services agency, can serve as barriers to coverage. In all cases, these states have tried to create simpler application forms for publicly-sponsored health insurance while also establishing a range of structures or mechanisms in communities through which to apply so that families can avoid the potential stigma associated with a visit to the welfare office.

Implementation Issues

The experiences of the four study states illuminate important issues in the development and implementation of outreach and enrollment strategies. In the area of outreach, a number of dilemmas became apparent, including the following:

- **Alignment with vs. separation from Medicaid.** For a variety of reasons, some states have chosen to distinguish their CHIP programs from Medicaid; however, implementing a new program requires developing a new infrastructure and may take time to become operational. In addition, while a separate approach may isolate the program from Medicaid's public program image, it also sacrifices the opportunity to reach out to Medicaid-eligible families and to promote the two as a single, coordinated program of health insurance.

- **Media-focused vs. community-based approaches.** The study states focused most of their energies on mass-media approaches in the hope of blanketing their states with messages about the importance of insurance and the availability of new or expanded programs. However, our interviews on the local level highlighted the importance of personal approaches to outreach, based on face-to-face encounters with people who speak families' language and can directly address their fears and concerns. Outreach in community settings, such as schools, was noted as a critical avenue for informing families of these programs.

- **Reaching working parents through employers vs. preventing "crowd-out."** Although state officials face the challenge of reaching low-income working families, most have not taken steps to reach them where they are most likely to be found: at work. Targeting the employers least likely to provide health insurance (such as retail stores and restaurants) was not mentioned as a strategy by most state officials, presumably because working with employers would discourage them from offering insurance for employees' dependents.

- **Tailoring messages to local needs vs. consistency across the state**. Three of the four states studied (California, Georgia, and New Mexico) implemented their media-based outreach efforts on the state level, while Ohio delegated the major responsibility for outreach to the counties. While the statewide approach affords consistency across the state, locally-based outreach efforts have the advantage of being tailored to the needs of the community. A combination of state-directed and locally-designed strategies can be effective, with coordination and training for local agency staff to assure that the information they provide is consistent and accurate.

While the eligibility simplification strategies adopted by the study states show great promise, many complex problems surround their implementation. This study has shed new light on the challenges inherent in implementing streamlined access while also maintaining program accountability, and it demonstrates the difficulty of seamlessly layering incremental system reforms upon an eligibility infrastructure and bureaucracy that is old, large, and well-established. In the course of their efforts to simplify application forms and create community-based avenues for applying for coverage, the states we studied have encountered numerous complex challenges, including the following:

- **Short forms that are not necessarily short, or simple to complete.** Application forms, no matter how short, are rarely as simple as they appear and constitute a hurdle that some families, especially those with lower incomes and complex structures, may find difficult to overcome. While the study states have shortened forms and simplified their application processes by dropping the asset test for children, many still require extensive verification of birth dates, residency, parental income, and citizenship. While certain essential information must be collected and verified, states like Georgia and New Mexico have apparently succeeded in reducing application size and verification requirements to the maximum extent possible.

- **Community-based intake points without funding or infrastructure support.** Simply training staff at local agencies and provider settings to take on and support an entirely new role as surrogate eligibility/intake sites is simplistic and problematic. Interpreting and helping families to understand ambiguous rules and policies, filling out complex forms, and collecting numerous documents that families often consider quite personal is a time-consuming task to take on in addition to other full-time responsibilities. The lack of seed money (in California, New Mexico, and Ohio) or retrospective reimbursement (in New Mexico) to support the infrastructure necessary to fulfill this role undermines agencies' ability to carry out the function effectively.

- **While Medicaid and cash assistance programs have been de-linked at the policy level, they remain closely connected at the program level**. Medicaid eligibility processes, even with reforms, are still intimately linked to the welfare systems in which they were originally incorporated. County social services offices remain the primary intake point for a large proportion of families, and the workers in these offices may inconsistently or incorrectly implement changes in eligibility policy, leading to unnecessary requests for verifications or documentation of assets. Moreover, social services workers often prefer that families apply for all possible programs, rather than expediting Medicaid applications. Further complicating efforts to simplify application processes is the fact that in many states (including California, New Mexico, and Ohio), social services agencies are overseen by the counties, not by the state, making it difficult to assure that new policies are implemented correctly and consistently.

- **Management information systems still link Medicaid to other social services programs**. Another operational issue is the integration of the computer systems that control enrollment in Medicaid and other public benefits. This integration can stymie efforts to simplify eligibility and maintain enrollment: community-based eligibility workers may not be able to initiate a Medicaid application for a family that has an active Food Stamp record, for example, or Medicaid benefits may be inappropriately cancelled if eligibility for another program is terminated.

Further complicating the simplification of Medicaid eligibility for children is the addition of enrollment systems for CHIP. While New Mexico and Ohio used CHIP to expand Medicaid, California and Georgia created separate programs, with separate eligibility and enrollment systems. While these are both centralized, straightforward processes, they create the challenge of coordination with Medicaid and enrollment of children in Medicaid where appropriate.

Conclusions and Lessons Learned

These findings carry significant implications for state and local policy. The first is the need to integrate Medicaid and CHIP eligibility determination systems and outreach strategies so that they complement and reinforce each other. This effort will involve:

- Distributing outreach materials widely so that they reach all segments of the target populations;
- Designing application forms that integrate the themes and messages of media campaigns;
- Fully informing and training community workers so that they can consistently assist families with applications for Medicaid and CHIP; and
- Using application systems and processes that reinforce the image of the program as accessible and user-friendly.

Moreover, the study demonstrated the need to employ outreach strategies at all levels, including community-based and one-on-one strategies as well as mass media campaigns, and to fund these approaches more equally. While mass media efforts serve the important purpose of raising awareness among families of the existence of health coverage for their children, community-based and one-on-one strategies finish the job by giving families essential information and assistance in actually enrolling their children in these programs.

States are investing an unprecedented amount of time, energy, and resources into creative strategies designed to take maximum advantage of the opportunities presented by Title XXI. Importantly, these states have recognized that neither outreach nor eligibility simplification efforts alone can succeed in getting children into care; rather, they have combined their efforts to raise public awareness of new programs with those aimed at facilitating access. However, as encouraging as these efforts are, this study shows that much room for improvement exists in such areas as market research to support outreach efforts, investment in strategies for enrollment simplification, and careful and rigorous evaluation and monitoring efforts to discern the relative effectiveness of alternative outreach and enrollment strategies.

Ultimately, the goal of fully enrolling eligible populations into programs like Medicaid and CHIP may never be reached until the systems and structures that support them are completely de-linked from those that support public welfare programs. As policymakers work to cover children in low-income working families, it is apparent that further steps are needed to ensure that families are aware of the availability of publicly-sponsored health coverage and can take advantage of it without enduring onerous enrollment processes.

Table 1: Characteristics of Case Study States				
Characteristic	**California**	**Georgia**	**New Mexico**	**Ohio**
Geographic region	West	Southeast	Southwest	Midwest
Total population, 1997[1]	31,925,000	7,481,000	1,757,000	11,227,000
Percent of population under 200% of poverty, 1997[2]	36.9%	32.8%	44.7%	28.8%
Number (%) of uninsured children under 200% FPL, 1995-1997[3]	1,216,000 (12.7%)	249,000 (11.8%)	111,000 (17.7%)	203,000 (6.4%)
Number of children covered by Medicaid, 1997[4]	3,333,000	693,000	219,000	763,000
CHIP strategy	**Combination program**	**Separate state program**	**Medicaid expansion**	**Medicaid expansion**
Date of CHIP Implementation	July 1998	September 1998 (Bibb Co.) December 1998 (statewide)	March 1999	January 1998
Program name	Medicaid: Medi-Cal CHIP: Healthy Families	Medicaid: Right from the Start Medicaid (RSM) CHIP: PeachCare for Kids	New Mexikids	Healthy Start
Pre-CHIP Medicaid eligibility thresholds[5]	200% FPL to age 1; Medicaid minimum thereafter	185% FPL to age 1, 133% FPL for children ages 1-5, 100% FPL for children ages 6-18	185% FPL through age 18	Medicaid minimum
Post-CHIP eligibility thresholds	Medicaid expansion to 100% FPL for children born after 9/30/83; CHIP covers those above Medi-Cal limits up to 200% FPL through 18	200% FPL through age 18	235% FPL through age 18	150% FPL through age 18

[1] AARP, Reforming the Health Care System: State Profiles, 1997. Washington, DC. 1997
[2] Urban Institute analysis of March Current Population Survey, 1998.
[3] United States Bureau of the Census, March 1998, 1997, and 1996 Current Population Surveys.
[4] Urban Institute estimates based on data from HCFA-2082 reports.
[5] National Governors' Association, 1997. Medicaid minimum is 133% FPL to age 6, 100% FPL for all other children born after 9/30/83, and AFDC levels for older children.

Table 2: Community-Based Outreach Efforts in Case Study States					
	California	***Georgia***		***New Mexico***	***Ohio***
Program	*Medi-Cal/ Healthy Families*	*Right from the Start Medicaid*	*PeachCare*	*New Mexikids*	*Healthy Start*
Principal source of funding and oversight	Provider Agency	State	Social Services Agency	State	County
Mobile Van					✔
Health Fairs	✔	✔		✔	✔[3]
Conference	✔		✔		
TANF	✔				
Labor					✔[4]
Schools				✔	✔
Health Care Providers	✔	✔	✔[2]		✔[3]
Churches		✔			
Child Care			✔		
Community Development Services			✔		
Legal Services			✔		
Employers	✔	✔			
Corporate Partnerships	✔[1]	✔			

[1]State is responsible for corporate partnerships in California.

[2]State is responsible for working with health care providers in Georgia's PeachCare program.

[3]A provider agency also participates in health fairs in Ohio and takes sole responsibility for working with health care providers.

[4]A community action agency is responsible for outreach efforts with labor in Ohio.

Table 3: Features of Medicaid/CHIP Eligibility Determination Systems						
	California		**Georgia**		**New Mexico**	**Ohio**
CHIP strategy	Combination		Separate state program		Medicaid expansion	Medicaid expansion
Relationship of CHIP and Medicaid eligibility process	Linked process		Separate process		Same process	Same process
Program name	Medi-Cal	Healthy Families	RSM	PeachCare	New Mexikids	Healthy Start
Length of application form	4-page mail-in form or 6-page standard form*	4-page form (+ 4 pages instruction)	3 or 6 pages, depending on form used	2 pages	2 pages	3 pages
Number of verifications required (e.g., pay stubs, birth certificates)	Up to 16	2	0-3	0-1**	4	5 (plus verification of employment and dates)
Sources of help completing application	Application assistants	Application assistants	RSM workers	Hotline staff	Application assistants	Contracted provider staff
Interview vs. mail-in	Either	Mail-in	Interview	Mail-in	Interview	Mail-in
Number of visits	2	0	1-2	0	1-2	0
Maximum time to determination	45 days	20 days	45 days	10 days	45 days	30 days
Frequency of recertification	Quarterly	Annually	Every 6 months	Annually	Annually	Every 6 months

* Application form introduced 11/30/99. At the time of the site visits, the 28-page mail-in form was still in use for Medi-Cal and Healthy Families.
** Documentation of legal immigrant status required as follow-up for non-citizen children only; not sent in with application.

Case Summaries

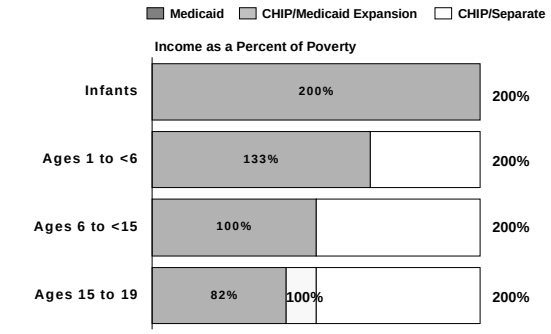
CASE SUMMARY: CALIFORNIA

In California, approximately 1,216,000 low-income children, or 26 percent of children with family incomes below 200 percent of poverty, are uninsured. Approximately 100,000 children are expected to enroll in the state's Child Health Insurance Programs (CHIP) in fiscal year 1998. In addition, in 1997, 3.3 million children were enrolled in Medi-Cal, the state's Medicaid program.

To provide coverage for uninsured children, the state took a combined approach to the use of CHIP funds (see Figure 1). First, the Medi-Cal income eligibility standards for children were expanded to cover all children through age 18 with family incomes below poverty. In addition, a separate program called Healthy Families was created to cover children in families with incomes below 200 percent of poverty who are not eligible for Medi-Cal. These expansions were implemented in July 1998. By December 1998, 53,000 children had enrolled in the CHIP programs.

Figure 1

Medi-Cal/Healthy Families Income Eligibility Levels



Note: Federal Poverty Level is $16,700 for a family of four in 1999.
SOURCE: Schwalberg et al., 1999.

This case study explored both state- and local-level efforts to identify and enroll eligible children in Medi-Cal and Healthy Families. The local case study was conducted in the city of San Jose in Santa Clara County, an economically, ethnically, and linguistically diverse county where approximately 25,000 uninsured children reside.

OUTREACH EFFORTS

The California Department of Health Services (DHS) administers the Medi-Cal program and is responsible for statewide efforts to raise public awareness of both Healthy Families and Medi-Cal for children. The outreach efforts have been combined into a single campaign with a logo advertising "Healthy Families/Medi-Cal for Kids." The state is investing $21 million a year in Medi-Cal and CHIP administrative funds to support outreach efforts, largely focusing on mass media and public relations strategies such as:

- A statewide media campaign, with TV and radio spots, print ads, bus cards with tear-off flyers, and billboards;
- Promotional materials, including pins, information cards in ten languages, and stickers and posters targeted at various ethnic groups, all promoting the toll-free Healthy Families hotline;
- Corporate partnerships and sponsorships, including arrangements with supermarkets, pharmacies, and a utility company to distribute information to customers;
- A public relations campaign, including press releases about Healthy Families and Medi-Cal enrollment simplification efforts.

In Santa Clara County, additional outreach efforts are being conducted by local agencies, both public and private, focusing primarily on community-based and one-on-one strategies. For example:

- The Santa Clara Family Health Plan, a public-sector managed care organization, used its own funds to conduct a community outreach conference in April 1998 to publicize the Healthy Families program to local organizations. The Plan also educates employers of low-wage workers through local Chambers of Commerce; distributes fact sheets in several languages; and works with pharmacists and physicians in specific ethnic communities to identify uninsured children among their clients.
- The Santa Clara Valley Health and Hospital System, the county's system of public hospitals and clinics, is using grant funding to support outreach workers, who go door to door in low-income neighborhoods to find potentially eligible families and educate community-based organizations about the programs. These workers are from the local community, speak their clients' languages, and are trusted by community members.

ELIGIBILITY DETERMINATION FOR MEDI-CAL AND HEALTHY FAMILIES

Traditionally, eligibility determination for public benefits in California is overseen and conducted at the county level, through county social service agencies or by county employees outstationed at clinics and hospitals. Healthy Families, however, is overseen by a state agency called the Managed Risk Medical Insurance Board, and eligibility determination is conducted centrally through a contract with Electronic Data Systems (EDS). Eligibility standards and policies for both programs are set at the state level.

State Policy

The implementation of Healthy Families brought with it several efforts to streamline Medi-Cal eligibility determination for children. The asset test, waived for pregnant women since 1994, was waived for children in the income-based eligibility categories, and a shortened mail-in application form was developed. The state has not adopted presumptive eligibility or continuous enrollment for children.

The shortened application form released in July 1998 combined the applications for Medi-Cal and Healthy Families. Despite its colorful and engaging design, the form had several drawbacks: a total of 28 pages long, it required families to calculate their income themselves and determine which program each child was eligible for. Moreover, if the family applied for the wrong program for their child, the form would only be forwarded to the correct program if a permission box had been checked. A new, shorter and simpler form was released in December 1998.

Another major effort to encourage enrollment was the training and deployment of "application assistants" in community-based agencies throughout the state. These assistants receive a payment of $50 (increased from $25) for each successful application they submit to either program.

Local Implementation

On the local level, families may apply for Medi-Cal in person at the county social services agency, or they may use the mail-in application, with or without the help of an application assistant, to apply for Medi-Cal or Healthy Families.

Applying through the Santa Clara County Social Services Agency requires at least two visits to the agency. During the first visit, the applicant is given a packet with a six-page application form, and an appointment is made for the applicant to return with the completed form and required documentation. At the second visit, the applicant reviews the form with an eligibility worker, who requests any missing information and assesses the family's Medi-Cal eligibility. Most applicants must make a third visit to supply missing documentation. Eligibility determinations are made within 45 days.

In evaluating Medi-Cal applications, the eligibility workers first evaluate the entire family for Medi-Cal eligibility before assessing the children's eligibility for the income-based eligibility categories. If a family's income is above the Medi-Cal eligibility level, eligibility workers do not routinely evaluate the children's eligibility for Healthy Families, as this is not a Medi-Cal program and they have not been trained to do so. If an applicant is interested in Healthy Families, the eligibility worker will give them a copy of the mail-in application form.

The "application assistants" in Santa Clara County are located in 47 agencies, including private providers' offices, community health centers, social service agencies, and grassroots community groups. With practice, they report that they can help a family to complete the application in 30 to 45 minutes. However, the agencies have found that the "finder's fee" is not sufficient to cover the time their workers spend on application assistance, and they do not have time to help with large numbers of applications in addition to their full-time jobs. Therefore, although they are willing to help their clients complete applications, most have not been able to offer this service to the community at large.

LESSONS LEARNED

In its first four months of operation, Healthy Families enrolled approximately 33,000 children statewide. To many, this is an impressive start for a brand-new program. However, the case study revealed several issues that may have kept the state from even greater success in enrolling uninsured children in Healthy Families and Medi-Cal.

- The state's outreach strategy links the two child health insurance programs, Healthy Families and Medi-Cal, by using a single logo and a combined application form. However, this approach carries the risk of confusing the public and linking Healthy Families to a welfare system that families may prefer to avoid. The ultimate challenge, therefore, will be to distinguish Healthy Families/Medi-Cal for Kids from cash assistance.

- Fears of Immigration and Naturalization Service (INS) enforcement also create a barrier to outreach efforts. State officials estimate that 60 percent of uninsured children eligible for Medi-Cal or Healthy Families are Latino. However, families are hesitant to enroll due to concerns about the effect of the use of public services on their efforts to become citizens or legal residents.

- On the local level, the major lesson from this case study is the difficulty of simplifying a program operated by a long-established county welfare bureaucracy. For example, while the Medi-Cal asset test for children has officially been waived, many eligibility workers still request asset information, either because they do not understand the new policy or they believe that files without this information will be considered incomplete. This challenge is compounded by the need to implement these changes in 58 counties individually.

- Finally, the case study emphasized the importance of locally-based outreach efforts tailored to the needs of individual communities. While the state's mass media campaign has raised awareness of the program, the efforts of local agencies, supported largely with private funds and making use of trusted community members, appeared to be critical in encouraging families to apply.

California has taken many steps to create a system to cover all children with family incomes under 200 percent of poverty. However, it appears that the use of two programs and two eligibility determination systems produces a reality that may not reflect the policy goal.

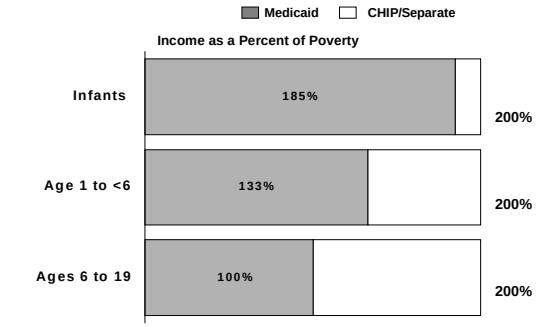
CASE SUMMARY: GEORGIA

In Georgia, approximately 249,000 low-income children, or 26 percent of children with family incomes below 200 percent of poverty, are uninsured. Approximately 79,000 children are expected to enroll in coverage under the state's Children's Health Insurance Program (CHIP) by fiscal year 2000. In 1997, 671,000 children were covered by Georgia's Medicaid program, known as Right from the Start Medicaid (RSM).

Georgia's CHIP program creates a separate state program called PeachCare for Kids for children who are ineligible for Medicaid but have family incomes below 200 percent of poverty (see Figure 1). A pilot program was implemented in September 1998, with statewide implementation beginning in December 1998.

Figure 1

Medicaid and PeachCare Eligibility Levels



Note: Federal Poverty Level is $16,700 for a family of four in 1999.
SOURCE: Schwalberg et al., 1999.

This case study explored the state's strategies for identifying and enrolling children in Medicaid and PeachCare and examined their implementation on the local level in Macon, Bibb County. The city of Macon is the urban center of the seven-county region where PeachCare enrollment efforts were piloted. The region is home to approximately 7,000 children who are eligible for PeachCare, and the county has high rates of poverty, teen pregnancy, and illiteracy. As of December 1998, 4,000 children applied to and about 600 were enrolled in PeachCare through the pilot program.

OUTREACH EFFORTS

Georgia's efforts to publicize Medicaid and PeachCare include both community-based outreach and a state-directed media campaign.

Community-based outreach efforts for Medicaid have been conducted by the state Department of Human Resources (DHR) since 1993. DHS employs 143 outreach workers who are stationed in health departments, hospitals, schools, Head Start centers, community action agencies, and other community agencies throughout the state. These workers are responsible for identifying uninsured children and pregnant women, determining their eligibility for Medicaid, and providing information and assistance regarding enrollment in PeachCare. Outreach staff work during non-traditional hours and use a variety of strategies to publicize the programs, including presenting information to local businesses and community groups and distributing information at stores and community events.

In addition, the state has contracted with an advertising agency to conduct a statewide media campaign to inform families about the PeachCare program, including brochures, billboards, posters, transit ads in both Spanish and English, and a television and radio campaign. These materials focus entirely on PeachCare; no mention is made of the availability of Medicaid for lower-income children. A toll-free hotline has also been established through another contractor; hotline staff send out PeachCare applications on request and provide help completing the program application.

In Bibb County, four outreach workers are actively involved with promoting both PeachCare and Medicaid. In addition, several community agencies have independently become informed about the PeachCare program and have begun working to distribute information to their clients. These include the county's child care resource and referral agency, the Bibb County Health Department, the local Legal Services clinic, and the Area Agency on Aging (which informs grandparents of the availability of coverage for their grandchildren). At the time of the study, the outreach workers have not been involved with any of these agencies and have offered them no training or information about the services they provide.

ELIGIBILITY DETERMINATION FOR RSM AND PEACHCARE

Because Medicaid and PeachCare are separate programs, the eligibility and enrollment processes for the two are distinct. Medicaid eligibility determination is conducted at the local level, while PeachCare eligibility is determined by a central contractor for the entire state. The state's policies regarding eligibility determination processes and their implementation in Bibb County are described below.

State Policy

Traditionally, Medicaid eligibility determination has been conducted by the Department of Family and Children's Services office in each county. Since the introduction of the outreach program, children's Medicaid eligibility has also been determined by the outreach workers. In either case, a family must have a face-to-face interview with either a social services worker or an outreach worker. Families with incomes above the poverty level must provide verification of

their income, and eligibility must be redetermined every six months, with a face-to-face interview at least once a year. The state has not implemented presumptive or continuous eligibility for children.

Eligibility for PeachCare is determined using a one-page, two-sided form that is mailed to the state's eligibility contractor. The only verification required is proof of citizenship for children of legal aliens and others whose citizenship is questionable. Income eligibility information must be confirmed (by mail) annually. If children appear to be eligible for Medicaid, the PeachCare application is forwarded to a special team of Medicaid workers for assessment and then sent to the county social services office for final eligibility determination.

Local Implementation

In Macon, families may enroll their children in Medicaid through either the local social services office or the outreach workers. Applications for PeachCare are available at a variety of agencies throughout the county, and the outreach workers offer assistance in completing the application.

If a family chooses to apply at the social services agency, two visits are necessary. At the first visit, the applicant completes a form to identify the programs for which the family is applying, and at the second visit a worker conducts a detailed interview to determine the family's eligibility for these programs. If a family is applying only for Medicaid, they may pick up the three-page application and mail it back or drop it off with the required verifications, which include proof of income (if above the poverty level) and citizenship (if this is determined to be an issue). If a family's income is too high to qualify for regular Medicaid, the worker will first explore the child's potential eligibility for the Medically Needy program. If this avenue is not promising, the worker may refer the family to PeachCare by providing the application and advising the family to fill out as much of it as they can and mail it in. However, the workers are not trained on PeachCare and cannot provide detailed assistance with the form or information about the program.

The outreach workers provide an alternative to the traditional application process. These workers, in addition to identifying potentially eligible children and informing parents about the availability of coverage, can determine children's eligibility for Medicaid using a six-page application form and a computer system located at the agencies that house them. They distribute this form to interested applicants, who fill out two pages of it at home, and then return for an in-person interview, during which the worker uses the rest of the form to document that the necessary verifications have been received. The worker then uses the computer system to determine eligibility. If the family appears to be eligible for PeachCare, the worker will give them the application and an envelope addressed to the enrollment contractor. They can also help the clients fill in the application if necessary.

LESSONS LEARNED

Georgia's policy mandate regarding health insurance for children is clear: insure children, provide comprehensive benefits, and require parents to contribute, if nominally, to the cost of insurance. This policy is reflected in practices designed to eliminate barriers to participation such as arduous eligibility and enrollment requirements and extensive verifications. The state's efforts to promote this program include both a media campaign and the use of community-based outreach workers who have strong roots in the community, the trust of their clients, and a willingness to work at non-traditional times and places to find and enroll eligible children. Georgia's experience implementing these policies illustrates several important challenges.

- The use of a separate state CHIP program, distinct from Medicaid and marketed as an insurance product rather than a public benefit program, was designed to appeal to working families. However, this strategy presents the challenge of effective coordination with Medicaid. Although PeachCare applications are forwarded to Medicaid when appropriate, the program is not advertised as providing access to Medicaid for those who are eligible. Thus, Medicaid-eligible families may be unlikely to take advantage of the mail-in application process available through PeachCare.

- The use of a community-based outreach effort dedicated to enrolling pregnant women and children in Medicaid and CHIP is a critical strategy in making these programs accessible and allowing applicants to avoid the cumbersome social services system. However, the outreach workers are trained only in these health insurance programs; they cannot enroll families in or provide detailed information about other public programs for which they may be eligible.

- The reliance on outreach workers, all of whom are state employees, to publicize the PeachCare program at the local level may undermine efforts to work with other community agencies who have frequent contact with low-income working families. In Bibb County, several such agencies are actively involved in training their workers about the PeachCare program and in distributing program information to their clients. However, outreach workers have not coordinated with or supported these efforts.

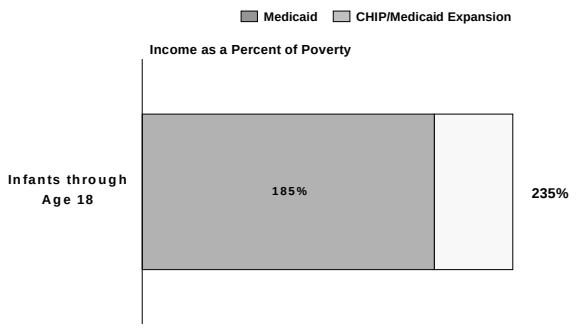
Through the state's outreach efforts and the simple PeachCare application form, Georgia has the elements in place to create a streamlined, accessible system of enrollment in health insurance for children. Improved coordination among the various agencies and programs involved in this system could only enhance the state's ability to identify and enroll all children who are eligible for either of its two child health insurance programs.

CASE SUMMARY: NEW MEXICO

In New Mexico, 111,000 low-income children, or 30 percent of children with family incomes below 200 percent of poverty, are uninsured. The state estimates that the majority of these uninsured children are eligible for Medicaid but not enrolled and another 5,500 will be eligible under Children's Health Insurance Program (CHIP) criteria. In 1997, 206,700 children were covered by the state's Medicaid program.

New Mexico's CHIP program expands Medicaid eligibility for children from 185 up to 235 percent of poverty and was implemented in March 1999 (see Figure 1). The state opted to use one program name—*New Mexikids*—to serve those eligible for Medicaid and CHIP.

Figure 1
***New Mexikids* Eligibility Levels**



Note: Federal Poverty Level is $16,700 for a family of four in 1999.
SOURCE: Schwalberg et al., 1999.

This case study explored both state- and local-level efforts to identify and enroll eligible children in *New Mexikids*. The local case study was conducted in the city of Albuquerque in Bernalillo County and in the neighboring town of Bernalillo located in semi-rural Sandoval County.

OUTREACH EFFORTS

The *New Mexikids* program and related outreach efforts are administered by the New Mexico Human Services Department's Income Support Division, using a total of $300,000 in Medicaid administrative funds. The *New Mexikids* campaign was launched in August 1998 at a large public event at the Albuquerque zoo. At the time of the case study, New Mexico's efforts to raise public awareness about the program had been primarily focused on a statewide public information campaign, with a small but growing emphasis on community-based activities.

- The campaign features a number of promotional materials, including frisbees and water bottles for adolescents and rulers, growth charts, and toothbrushes for school-age children.

- Posters with tear-off sheets and flip cards printed in English and Spanish were widely distributed to schools and through direct mail campaigns. Numerous print ads were also placed in statewide newspapers and other publications.

- Radio spots were produced in English, Spanish, and Navajo and were aired on several radio stations through the state.

All of the *New Mexikids* outreach materials feature one toll-free phone number for people to call to get more information. Phone line staff ask callers where they heard about the program so that state officials can determine the most effective outreach methods.

The approval of the state's CHIP plan in January 1999 has allowed the state to broaden the *New Mexikids* campaign to use additional communication channels, such as television; more community-based events, such as health fairs; and partnerships with corporations, such as Wal-Mart.

ELIGIBILITY DETERMINATION FOR NEW MEXIKIDS

Medicaid eligibility is determined by a network of county-level social services offices staffed by state employees. Described below are changes that have been made in New Mexico Medicaid policy in recent years in an effort to simplify the application process.

State Policy

Over nine years ago, New Mexico began using a two-page Medicaid application and allowed specific community-based providers to initiate Medicaid applications, eliminating the requirement that families go to a social services office for an interview. In 1995, the state expanded Medicaid coverage to 185 percent of poverty for children under age 19 and waived the asset test. Presumptive eligibility and 12-month continuous coverage for children were implemented in July 1998.

Also in July 1998, New Mexico expanded the types of community providers who can initiate a Medicaid application to include representatives from hospitals, health centers, Indian Health Service, schools, and local health departments. These applications are still

processed by state staff in county social services offices. At this time, these community providers are not reimbursed for their services, though officials have not ruled out this possibility.

Local Implementation

Families may initiate a Medicaid application through community providers or at their local social services office. If a family chooses to apply through a designated Medicaid On-Site Application Assistance Provider, the provider screens the applicant to make an initial determination of eligibility and assists the individual in filling out the two-page application. These local providers estimate that it takes from 20 to 45 minutes to complete an application, which is then sent to the local social services office for eligibility determination. While the on-site application process was anxiously awaited, some community providers have become less enamored with the process as they try to deal with burgeoning staff workloads.

Some on-site providers have elected to also become certified presumptive eligibility providers. Under this program, the provider must complete two applications for every child—that is, a preliminary form as well as a follow-up form within ten days. Unlike Medicaid applications, the presumptive eligibility process is handled entirely between providers and Consultec, the state's fiscal agent. Social services offices are not involved in presumptive enrollment or eligibility determination.

Families that elect to submit an application through a local social services office must complete a face-to-face interview. Clients who submit their applications through a provider do not have to come to the social services office for an interview, because the meeting with the community provider fulfills this requirement. Although this option is simpler for families, it is reported that community providers are more likely than social services workers to make errors on the applications, slowing the enrollment process.

LESSONS LEARNED

Given the high proportion of uninsured children in New Mexico who are eligible for Medicaid, New Mexico officials have concentrated their efforts on enrolling families under 185 percent of the poverty level. After roughly five months of using the expanded on-site providers and three months after the launch of the *New Mexikids* outreach campaign, New Mexico had received 1,859 presumptive eligibility applications and 6,000 children had enrolled in Medicaid. Several important issues have arisen from New Mexico's experience identifying and enrolling these children.

- In the first phase of its outreach campaign, the state relied on a statewide media campaign to get the word out about the program. In its next phase, the state is increasing its emphasis on community-based strategies, providing the opportunity to develop more tailored messages and materials for unique populations or local communities. This two-stage approach provides an opportunity to evaluate the relative effectiveness of the two approaches and to explore how the two can work in tandem.

- The state's experience also demonstrates the complexity of implementing community-based enrollment strategies. While community providers were initially enthusiastic about serving as application assistants, many became overwhelmed by the resulting workload, and their efforts to manage the extra demands may jeopardize access for some clients. For example, some local health departments schedule appointments for Medicaid applications, as opposed to completing applications on the spot.

- New Mexico's experiment with presumptive eligibility for children is also instructive. Although many providers were interested in participating in the new program, providers of high-cost and emergency care were most likely to report that participation was cost-effective. Providers who do not rely on quick reimbursement found less value in a system that requires them to file two application forms for each child within ten days.

- As in many states, the New Mexico case study reinforces the challenge of consistent implementation of state policy across numerous autonomous counties. It is expected that policy shifts take time to trickle down to the front-line workers, and a complete cultural shift within social services offices is a lengthy process. This time lag may lead to inconsistent application of state policies; for example, some social services offices still use the long application form that determines eligibility for Medicaid, Food Stamps and cash assistance, and others are requiring clients who initiated an application through local providers to come to the office for a face-to-face interview.

The simplicity of the New Mexico program is its strongest feature: one income ceiling for all children, one program name and identity, one toll-free phone number, a short application, 12 months continuous coverage, minimal documentation, and the option of presumptive eligibility. The challenge lies in consistently applying these policies at the local social services offices and in ensuring that the provider community can absorb the workload of completing applications so that a system that was designed to be simple remains so in its day-to-day operation.

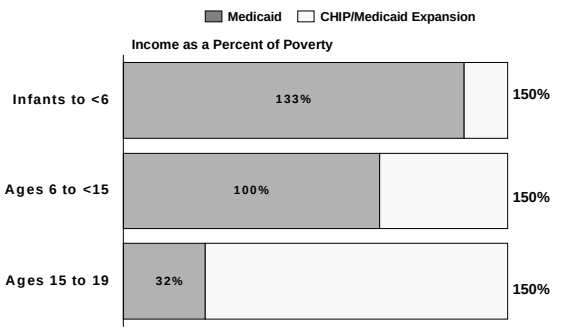
CASE SUMMARY: OHIO

Approximately 203,000 low-income children in Ohio are uninsured, representing 17 percent of children with family incomes below 200 percent of poverty. Approximately 133,000 uninsured children are expected to enroll in Ohio's Children's Health Insurance Program (CHIP). In 1997, 866,300 children were enrolled in Healthy Start, the state's Medicaid program for children.

In January 1998, Ohio implemented Phase I of its CHIP initiative and expanded Medicaid to 150 percent of the federal poverty level (FPL) (see Figure 1). In the program's first year, 35,300 children were enrolled.

Figure 1

Ohio Healthy Start Eligibility Levels



Note: Federal Poverty Level is $16,700 for a family of four in 1999.
SOURCE: Schwalberg et al., 1999.

This case study explored both state- and local-level efforts to identify and enroll eligible children in Healthy Start. The local case study was conducted in Cuyahoga County in Northeastern Ohio, which includes the metropolitan area of Cleveland, an ethnically diverse city with a strong medical community.

OUTREACH EFFORTS

The Ohio Department of Human Services (DHS) administers the Healthy Start Program and takes the lead on the few state-level outreach efforts for the program. However, most Healthy Start outreach efforts are conducted at the county level.

Through an RFP process, the state allocated $13 million in funds available through Section 1931 of the welfare reform law to counties for outreach and enrollment efforts. Sixty-two of Ohio's 88 counties applied for funds. In addition to specific community-based activities, most of the county plans include local media campaigns, each with its own logo and slogan.

In addition to the county-based efforts, the state supported the development of a limited number of outreach materials as well as television and radio spots and a statewide toll-free Healthy Start hotline.

The Cuyahoga County outreach and enrollment plan incorporates a number of strategies. For example:

- The county sponsored a Healthy Start media campaign featuring a county-specific logo and slogan, fact sheets, television and radio spots, and promotional materials, such as yo-yos and water bottles. All materials include the phone number of the local Cuyahoga County Healthy Start hotline, which is administered by the city's public hospital under contract to the local DHS office.

- The Cuyahoga County Healthy Start staff partnered with labor unions to host enrollment drives at employer sites and union halls.

- A portion of the county's outreach budget was allocated to school-based activities, including a mailing to parents of students enrolled in special education and evening enrollment drives at schools.

ELIGIBILITY DETERMINATION FOR HEALTHY START

Eligibility standards and policy for Healthy Start are set on the state level, though the 88 local human services offices that process applications operate relatively autonomously. This section describes the changes in eligibility and enrollment policies that Ohio has instituted to increase access to coverage for uninsured children.

State Policy

To streamline the eligibility determination process, Ohio designed a two-page mail-in application, removed the asset test for children, and eliminated the need for a face-to-face interview. At this time, the state has not implemented presumptive eligibility or 12-month continuous coverage.

Healthy Start has used the two-page Combined Programs Application since 1989. The application is for pregnant and postpartum women, infants, and children wishing to apply for Medicaid, WIC, and other state health programs. The application is available in WIC clinics, health clinics, county welfare offices, and through the statewide Healthy Start hotline. The application can be mailed to the county human services offices; an interview is not required.

State health and welfare officials are currently meeting to revise the application to address some common

problems with the form. In addition, an interagency committee is planning to translate the application into Spanish.

Local Implementation

In Cuyahoga County, Healthy Start applications can be mailed to the human services offices, completed at one of the program offices listed above, or completed with the help of contracted application assistants.

The Cuyahoga County human services agency has gone through an extensive reorganization in an attempt to de-link Medicaid from welfare in the eyes of the public. As a result, a separate department within the county DHS office processes Healthy Start applications. As face-to-face interviews are not required, the Healthy Start caseworkers interact with applicants mainly by telephone.

To make eligibility determinations, caseworkers review applications and verifications, send a verification checklist to those applicants who have submitted an incomplete application, and send reminder letters after 20 days for missing documentation. Once the application and paperwork are complete, caseworkers make the eligibility determination. Healthy Start participants go through the re-determination process every six months through county field offices, where cases are transferred after initial eligibility is determined.

According to Healthy Start caseworkers, their greatest challenges lie in collecting required verifications, particularly those related to applicants' work history, and working with the state's Medicaid computer system, which continues to link Medicaid to cash assistance and other benefits. For example, clients who receive both Healthy Start and Food Stamp benefits and miss their 3-month Food Stamp re-determination interview receive a letter automatically generated from the statewide computer system informing them that their benefits have been terminated. To counteract the erroneous letter, local caseworkers must manually send a separate letter telling these clients that they have *not* been cut off of Healthy Start.

Cuyahoga County also funded four vendors—two hospitals and two health centers—to help identify uninsured children and to serve as application assistants and aid eligible families in completing applications. In general, vendors are pleased with their role in assisting families to enroll in the program, but like the county caseworkers, vendors are frustrated by the amount of time required to collect verifications, particularly those related to past employment.

LESSONS LEARNED

Because Ohio's CHIP program started relatively quickly, it has more implementation experience from which to learn than other states. The state uses a sophisticated data system to track enrollment and disenrollment. Ten months into the 18-month period for which the state has had access to federal welfare reform funds, Ohio recruited and retained 34 percent of potential eligibles. However, a significant number of children who had enrolled in Healthy Start later dropped off the program, either due to an increase in family income or failure to re-apply at the six-month re-determination period. The case study highlights issues that have arisen in the course of Ohio's outreach and enrollment efforts.

- Ohio's county-based outreach strategy has the advantages of drawing upon counties' knowledge of their own communities and providing the opportunity to tailor outreach messages to local needs. A drawback of this approach is that the messages may be uncoordinated and inconsistent.

- Unlike many states, Ohio's Medicaid application form is not a problem—verification appears to be the greatest barrier. Since Cuyahoga County contracted with four community vendors to assist families in applying for coverage, the county denial rate has dropped from 50 to 30 percent, as more applications are submitted with complete documentation. This county's experience underscores the value of using application assistants to carefully target the most troubling problems with enrollment, which vary considerably by state and locally.

- Cuyahoga County's experience illustrates the practical challenges involved in de-linking Medicaid and other social service programs. Though the county has gone to great lengths to create a distinct eligibility and enrollment system for Healthy Start, the program remains tied to cash assistance and Food Stamps through both its computer systems, which cause unnecessary termination of benefits, and its staff, which has long experience enforcing the more rigorous requirements of Medicaid and find the transition to a streamlined system difficult.

While Ohio's simple application and the ability to apply through the mail without completing a face-to-face interview makes it relatively easy for families to gain access to Healthy Start, a significant number of families later drop off the program. After ten months of experience in implementing a host of new outreach and enrollment efforts, Ohio's next challenge will be to further examine the factors that contribute to disenrollment.

Making Child Health Coverage a Reality

Case Summaries: Sources of Data

Data regarding the number of low-income uninsured children, estimated CHIP enrollment, and current Medicaid enrollment were compiled from:

Number of Uninsured
United States Bureau of the Census, March 1998, 1997, and 1996 Current Population Surveys. Health Insurance Statistics, U.S. Bureau of the Census.
http://www.census.gov/hhes/hlthins/lowinckid.html

Estimated CHIP Enrollment
National Conference of State Legislatures. Children's Health Insurance Program: Expected Enrollment Numbers for Approved CHIP Plans.
http://www.ncsl.org/programs/health/enroll.htm.

Medicaid Enrollment
Urban Institute estimates prepared for The Kaiser Commission on Medicaid and the Uninsured, based on data from HCFA-2082 reports.

1450 G Street NW, Suite 250, Washington, DC 20005
Phone: 202-347-5270, *Fax:* 202-347-5274,
Web Site: www.kff.org

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