REACHING OUT:
Successful Efforts to Provide Children and Families with Health Care

A Series of Community Voices Publications

BY

Sharon Silow-Carroll • Stephanie E. Anthony • Heather Sacks • Jack A. Meyer

Community Voices
HEALTHCARE FOR THE UNDERSERVED

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JUNE 2002

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Economic and Social Research Institute

Prepared for

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About the Economic and Social Research Institute

The Economic and Social Research Institute (ESRI) is a nonprofit organization that conducts research and policy analysis in health care and in the reform of social services. ESRI specializes in studies aimed at enhancing the effectiveness of social programs, improving the way health care services are organized and delivered, and making quality health care accessible and affordable.

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SUMMARY

Despite serious efforts to enroll people in Medicaid and the State Children's Health Insurance Program (S-CHIP), estimates suggest that between six and seven million children and, roughly, three million adults are eligible but not enrolled in these public coverage programs. Barriers to enrollment include lack of information, cumbersome application and recertification processes, and premiums or enrollment fees. In addition, certain populations are particularly difficult to reach: immigrant families, people with language or cultural differences, people who have had negative past experiences with government agencies, people who perceive a stigma associated with publicly funded programs, low-wage workers in small businesses, and individuals facing geographic or logistical barriers.

While states have made progress in streamlining the application/enrollment process, the outreach that is necessary to engage and enroll individuals essentially takes place at the *community* level — in community health centers and clinics, county health departments, a range of community-based organizations (CBOs), as well as churches, bodegas, and beauty parlors. Particularly, in a time of budget shortfalls and fiscal constraints, communities must focus on effective strategies for connecting individuals and families to critical health care programs.

Community Voices[1] (CV) learning laboratories across the country are engaged in a number of innovative and successful community-based outreach and enrollment strategies. These communities place particular emphasis on breaking down barriers to enrolling and retaining "hard-to-reach" populations in public coverage programs. This report presents a menu of such approaches, along with personal stories that exemplify both the successes and frustrations that communities face. It also presents public policies that help and hinder their efforts, along with policy recommendations geared to facilitate community-based enrollment in and retention of health coverage. Finally, it includes an inventory of resources (websites, reports, newsletters) available to community workers and policymakers.

Community Voices learning laboratories across the country are engaged in a number of innovative and successful community-based outreach and enrollment strategies.

Successful CV Outreach/Enrollment Strategies

Developing Innovative Out-Stationing and Technical Tools: Placing enrollment workers in a variety of neighborhood settings (e.g., family support centers, schools, libraries, churches) beyond traditional enrollment offices expands opportunities for people to learn about and apply for coverage. West Virginia has had success with enrollment workers visiting nursing homes where employees' children are often eligible for Medicaid or S-CHIP and where residents tell their children about the programs. Computer systems like Denver Health's AppTrack allow enrollment workers to maximize mobility throughout the community.

Addressing Language and Cultural Differences: CV experiences indicate the need to approach individuals with an understanding of their historical and cultural backgrounds – from using outreach materials in languages and at educational levels that are specific to the communities involved, to ensuring that community workers speak the languages and/or are of the same ethnic background as target populations, to addressing the fears and misconceptions many immigrant families have about enrolling in public programs. Asian Health Services in Oakland, California, has hired outreach workers who speak Cantonese, Vietnamese, and Korean, and who understand the cultural norms of the target populations.

Enlisting Neighborhood Residents, Community Health Workers, or "Promotoras": Neighborhood residents, generally women who have enrolled in Medicaid or S-CHIP for themselves or for their children and can

[1] Community Voices: HealthCare for the Underserved is a five-year national effort in which 13 community organizations across the country received grants to help increase access to health care, promote quality and cost-effective care, and strengthen the safety net. It began in 1998, and is funded by the W.K. Kellogg Foundation. See Appendix B for a list of CV Learning Laboratories and Directors.

speak from their own experiences, can be enlisted to engage community members and participate in the outreach process. They are generally volunteers, but CV organizations such as New York's Alianza are in the forefront of "professionalizing" these women as paid employees, which reinforces the value of their role, helps the women develop important skills, and provides an entry into the workforce for low-income individuals.

Ensuring a "User-Friendly" Atmosphere and Process: The place where people apply for programs should be pleasant, clean, and colorful with a children's play area, if possible, and easily accessible by public transportation. Outreach/enrollment workers should be friendly and respectful. The process should be quick and efficient (within the constraints of the state-determined application form and documentation requirements), with applications in multiple languages and multi-lingual workers. The site should offer "one-stop shopping" such as West Virginia's Family Service Centers, whereby a person may have her/his needs assessed and receive a variety of health/social services (in the current economic environment, such outreach is particularly likely to uncover a number of unmet needs). Enrollment kits, such as those provided by the Ingham Health Department in Michigan containing a calendar, caseworker contact information, health tips, a *Parents* magazine, and an application for the WIC program help to educate enrollees and keep them "connected."

Building Relationships with Community Organizations: Working with hospitals and safety net providers helps in identifying potential applicants at the time they access health care services. The hospitals and other health care practitioners benefit as well as the patients, by securing reimbursement for the care provided. Enrollment staff in emergency rooms at the Henry Ford Health System in Detroit, for example, identify potential enrollees, assist with forms, and actually bring the applications to a "Family Independence Agency" office for processing.

Successful approaches working with schools include: coordinating with school-based clinics and nurses, free and reduced lunch programs, and athletic coaches; setting up enrollment desks at kindergarten registrations, open school nights, after-school program registrations, and Head Start sites; and arranging with schools to provide promotional materials, information, and applications.

Also, CV sites stress the importance of building "informal" relationships with local churches, clubs, libraries, and shops that are willing to distribute material; and approaching employers to inform them about programs for which they and/or their workers may be eligible.

Forming Outreach Collaboratives: When local and state agencies involved in outreach and enrollment activities formally collaborate and coordinate efforts, the sum is often greater than the parts. Such coordination helps to pool resources, share "best practices," and avoid duplication of efforts. All of the CV learning laboratories are based on collaborations among organizations that share basic goals, and work together to achieve them. CV-El Paso is one of 150 CBOs and small businesses that participate in the West Texas CHIP Collaborative, which oversees the S-CHIP outreach and enrollment efforts in a six-county region.

Participating in Community Events: Educating the public about health programs and the enrollment process through community events may include sponsoring or participating in local health fairs; setting up information booths at street festivals; making presentations at clubs, churches, work sites, and other gatherings; and placing enrollment workers at camp registrations. While this process is labor-intensive (at times requiring four or five interactions to attain one enrollment), a key ingredient is not just "showing up," but really *engaging* with potential applicants.

Using Local Media and Marketing: A community-based marketing campaign should focus on the characteristics of the targeted local populations, using grassroots outreach to connect with both potential applicants and health care providers. Such a campaign should include the provision of culturally and language-appropriate information and tools for enrollment.

It may utilize local media (TV and radio), kiosks at malls, newspaper inserts, and promotional material attractive to children and parents.

Providing Scholarships: In states that impose application and recertification fees and/or premiums for S-CHIP, enrollment can be facilitated through financial assistance for the most needy. FirstHealth of the Carolinas provides enrollment fee scholarships for families unable to afford the $50 or $100 enrollment and recertification fees. Whereas most states do not impose enrollment fees, scholarships for S-CHIP premiums and co-pays could be considered when families are experiencing special financial or other hardships.

State Policies that Help Community Efforts

Beyond state efforts to promote enrollment through publicity campaigns and a streamlined enrollment process (e.g., shorter applications, joint application for Medicaid and S-CHIP, elimination of asset tests, presumptive eligibility, reduced documentation requirements), community workers cite the following *additional* efforts by some states that help them in their outreach and enrollment efforts, and that should be expanded:

- Visits from or placement ("co-location") of state Medicaid/S-CHIP workers with community workers in CBOs; the state workers educate and/or assist with enrollment tasks;
- Active, high-profile support and involvement of the governor or other high-ranking state official(s);
- Reduced waiting period between the end of private coverage and eligibility for public coverage;
- Medical care or vouchers for low-income pregnant women who have not yet completed the application process or who do not otherwise receive Medicaid services; and
- Retrospective Medicaid and S-CHIP payment for ER visits, which motivates hospital staff to facilitate enrollment in public coverage.

State and Federal Policies that Hinder Community Efforts

While many state actions are facilitating community efforts, other state and federal policies are frustrating local outreach and enrollment activities. Some barriers are *political or philosophical* in nature:

- The non-eligibility of both documented families and individuals arriving in the U.S. within the last five years and undocumented immigrants for federally funded health coverage programs results in uninsured immigrants going without needed primary and preventive care, needing more costly care later, and using ERs inappropriately. Federal funds are not available to cover these groups, except for emergency care, but states do have the option to expand eligibility to these groups using state-only dollars. Those states not currently covering these populations should consider the long-term benefits of doing so;
- State requirements for information about non-custodial fathers when mothers apply for Medicaid and other social services keep many mothers (who want to maintain positive relationships with the fathers) from applying for coverage for themselves and their children. States should consider eliminating this requirement; and
- Many states do not recognize school-based clinics, which are accessible to children and teenagers and already providing important primary and preventive care, as "participating providers" under Medicaid or S-CHIP. States should follow New Mexico's lead in piloting school clinics as Medicaid providers and expanding such policies, if proven successful.

The majority of state and federal policy obstacles that CV organizations have encountered are associated with *financial constraints:*

- States may impose enrollment freezes in S-CHIP to limit state spending growth; even when such freezes end, there is an added challenge of restoring the public's faith in the public program;
- Stringent Medicaid eligibility criteria, particularly for adults without dependent children, force communities to turn away large numbers of applicants for public coverage; some CV communities are trying to offer alternative health plans for those not eligible for Medicaid or S-CHIP and unable to afford coverage, although such plans often lack secure, long-term funding and remain relatively small in scale;
- CBOs face limited state payments for *outreach*, reflecting a lack of recognition of the value of outreach efforts needed to get people in the door before enrollment can proceed; and

- Very low payment rates by states to health plans and providers leads to an insufficient number of plans and providers available to serve public program enrollees.

These financial barriers are likely to be exacerbated during the current economic downturn, and communities and states will be challenged merely to *sustain* current outreach, enrollment, and benefit levels in Medicaid and S-CHIP, much less expand coverage. Policy options include the following:
- States can use unspent federal S-CHIP funds from FY 1998 toward enhancing outreach, permitted under the Benefits Improvement and Protection Act of 2000;
- Policymakers can help by providing new federal grants for outreach;
- States can expand Medicaid and S-CHIP eligibility – including "expansion populations" such as childless adults – using new flexibility granted under the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative;
- Policymakers should refocus the debate toward the need to invest in health programs as a long-term strategy toward building a healthier and more productive society, *particularly* in difficult economic times as more people may need help from public programs such as Medicaid and S-CHIP;
- Such investment includes providing financial and technical support for innovative, community-based coverage programs such as the El Paso-Community Voices' Primary Care Plan; the University of New Mexico Care Plan; the Ingham Health Plan in Michigan; Family Care in Alameda County, California; and FirstConnection in North Carolina (described in Box O); these plans provide essential care to previously uninsured individuals and serve as critical pilots for broader programs; and
- Policymakers should concentrate on developing affordable coverage options for small businesses and low-income workers.

In addition to exploring some of the policy options listed above, communities will need to adjust to the economic slowdown and tighter financial constraints within their current programs. For example, they may need to focus on outreach and enrollment strategies that are most cost-effective, and shift some resources toward identifying and addressing related social welfare needs. Local governments and CBOs will need to be creative in seeking other funding sources (including private foundations) to preserve the progress they have made and to continue their successful outreach activities.

Beyond enrolling eligible people in coverage, ongoing challenges remain. They include: 1) helping enrollees navigate and appropriately utilize the complex health care system; 2) encouraging healthy lifestyles, prevention, and early intervention; 3) reducing non-financial obstacles to care related to language and culture, lack of transportation and child care, and other barriers; 4) *keeping* people enrolled in coverage; 5) ensuring adequate provider capacity to serve enrolled populations; and 6) expanding access to coverage and services to people who are not currently eligible for public programs and who cannot afford private insurance.

SECTION 1. INTRODUCTION

This report highlights innovative, community-based Medicaid and State Children's Health Insurance Program (S-CHIP) outreach and enrollment efforts associated with the W.K. Kellogg Foundation's Community Voices: HealthCare for the Underserved program. Community Voices (CV) is a five-year national effort begun in 1998 in which 13 community organizations across the U.S. received grants to help increase access to health care, promote quality and cost-effective care, and strengthen the safety net.[2]

One of the primary activities of CV grantees involves supporting programs that facilitate enrollment of the uninsured into existing publicly subsidized coverage programs. **Through partnerships and collaboration among community-based organizations (CBOs), health care systems, health departments, universities, state agencies, religious institutions, schools, and neighborhood businesses, Community Voices has been a key force in developing innovative outreach and enrollment strategies.**

The CV grantees and their partner organizations have placed a special focus on the "hard-to-reach" populations – those that have faced particular barriers to

[2] See Appendix B for list of CV Learning Laboratories and Directors.

enrolling and remaining in health programs despite being eligible. CV has experimented with a range of approaches aimed at finding and engaging with these individuals, building trusting relationships that are so important to keeping them connected with the community, and ensuring appropriate access to and use of the health care system.

This report presents lessons learned by individuals and organizations with first-hand, on-the-street experience. It is based on interviews with CV project directors, outreach workers, and enrollment specialists, and a comprehensive review of related literature and resources. In Section 2, we delineate the hard-to-reach populations and describe the major obstacles to enrollment. Section 3 identifies elements of a successful outreach/enrollment approach, including examples of specific CV initiatives and experiences. In Section 4, we describe public policies that have facilitated CV efforts and that should be broadened. And, we present public policies that have hindered CV efforts – including financial constraints and remaining gaps in coverage – along with recommendations for eliminating or reducing these policy barriers. Appendix A presents an inventory of resources (websites, reports, newsletters) for outreach/enrollment community workers and policymakers.

We present these findings to help community workers and organizations, as well as local, state, and federal policymakers, better understand how they can help promote both enrollment in health coverage programs, and ultimately, a healthier society.

BACKGROUND

Medicaid and the State Children's Health Insurance Program (S-CHIP) are intended to provide comprehensive health coverage to low-income children and to some adults who lack access to private health insurance. These federal- or state-funded, state-administered programs allow states flexibility in setting income eligibility criteria and conducting enrollment, within certain federal guidelines. But over the years, it has become clear that being eligible does not ensure enrollment in these programs. A number of barriers to enrollment have kept millions of children and adults who are eligible for Medicaid or S-CHIP from participating.

These uninsured individuals, primarily children, are more likely than insured individuals to suffer adverse consequences including restricted access to primary and preventive care, poor health outcomes, avoidable hospitalizations, and high morbidity in hospitals.[3] **A recent survey revealed that eligible but uninsured children are seven times as likely not to get needed care as those with insurance coverage; 21 percent of parents of eligible but uninsured children delayed or skipped medical care for their children because they believed they could not pay for it. Also, 27 percent of parents of eligible but uninsured children delayed or skipped dental care for their children in the last year, and 14 percent of parents of eligible but uninsured children delayed or failed to fill a prescription of a sick or injured child because they did not know how they would pay for it.**[4]

In recent years, many states have intensified their efforts to enroll eligible people in public coverage through simplified applications, mail-in enrollment, elimination of asset tests, and other measures (outlined in Section 4). These important state measures have helped a great deal. **But the outreach that is necessary to engage and enroll individuals essentially takes place at the community level. It is at this local level — in community health centers, county health departments, and a range of community-based organizations — that some of the most innovative**

[3] Newacheck, P.W., J.J. Stoddard, D.C. Hughes, and M. Pearl. "Health Insurance and Access to Primary Care for Children." *New England Journal of Medicine,* 338(8):513-9, 1988; Hadley, J., E.P. Steinberg, and J. Feder. "Comparison of Uninsured and Privately Insured Hospital Patients: Condition on Admission, Resource Use, and Outcomes." *Journal of the American Medical Association,* 265(30):374-9, 1991.
[4] "Key Findings of a National Survey of Families: Comparing Households with Insured Children Versus Those with Uninsured Children Eligible for S-CHIP/Medicaid Coverage." Prepared by Wirthlin Worldwide for the Robert Wood Johnson Foundation *Covering Kids* program. August 2, 2001.

and successful enrollment strategies have been developed and tested.

MEDICAID AND S-CHIP

Medicaid, the state-administered program that provides health insurance coverage to low-income individuals, covers approximately 40 million people.[5] Federal guidelines mandate that states cover certain categories of low-income individuals (such as children and pregnant women), and states have the option to cover additional groups of low-income people and to supplement the benefit package beyond the required minimum. The federal government and states share the cost through a system in which state Medicaid expenditures are matched by federal dollars at rates that range from 50 percent to 76 percent in FY 2002.

The State Children's Health Insurance Program (S-CHIP) was enacted as part of the Balanced Budget Act of 1997 to expand health insurance coverage to children in families with incomes too high to qualify for Medicaid, but too low to be able to afford private insurance. S-CHIP extends coverage to all children in families with incomes up to 200 percent of the federal poverty level (FPL). States and U.S. territories can extend coverage to this population by expanding Medicaid coverage (21 states/territories), creating a separate children's health insurance program (16 states/territories), or combining both (19 states/territories).[6] Under S-CHIP, states receive annual block grants totaling $48 billion over a 10-year period. The federal government provides states an "enhanced match" at a rate higher than its contribution toward Medicaid, to encourage states to implement the program.

Initially, S-CHIP enrollment was slow due to varying implementation schedules (some states did not begin enrolling kids in S-CHIP until 2000) and the need to increase awareness about the new program. More recently, both the federal government and the states, and some private foundations, have placed a major emphasis on outreach and enrollment initiatives in an effort to reduce the number of uninsured and maximize the use of available federal and state dollars dedicated to these programs. Appendix A includes an inventory of websites, reports, and newsletters that describe many of these initiatives and provide guidance to community workers and policymakers.

While much progress has been made, millions of people who are eligible are still not enrolled. The American Academy of Pediatrics estimates that between six and seven million children are eligible for Medicaid or S-CHIP but are not enrolled in the programs.[7] **Other research suggests that just over two million children were eligible for S-CHIP at the end of 2000 but were not enrolled. In addition, roughly three million low-income adults were estimated to be eligible for Medicaid but not enrolled in early 2001.**

OUTREACH, ENROLLMENT, AND RETENTION

Outreach is generally defined as the process of finding the "targeted" populations who are eligible for Medicaid and S-CHIP, and increasing their awareness about the programs and about their eligibility for the programs. Outreach includes educating people about the importance of health insurance coverage for themselves and their children, developing and distributing literature (e.g., flyers, pamphlets, and posters) describing the programs and their eligibility requirements, partnering with community-based organizations to inform clients, conducting massive media campaigns, and referring people to enrollment personnel. People engaged in these activities may be called "outreach workers," "community health workers," or other titles.

Enrollment encompasses the application and eligibility determination processes whereby people complete and submit an application form, have their income and assets reviewed to determine if they fit the financial eli-

[5] Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, www.kff.org.

[6] HCFA, S-CHIP website, www.hcfa.gov/init/chip-map.htm; includes 50 states, plus the District of Columbia, Guam, Virgin Islands, American Samoa, Puerto Rico, and the North Mariana Islands.

[7] See HCFA website for all State Child Health Plans at www.hcfa.gov/init/chpa-map.htm. Current as of August 2001.

gibility requirements, and receive certification that they are enrolled in the program. **While most communities have separate outreach workers and enrollment workers because these jobs require different skill sets, others use individuals who are trained to conduct both outreach and enrollment.**

The S-CHIP legislation highlights the importance of and necessity for outreach and enrollment by requiring states to specify how they intend to conduct these activities. In the State Child Health Plans that states submitted to the Health Care Financing Administration (HCFA) to get approval for their S-CHIP programs, states were required to describe "procedures for outreach to families of children likely to be eligible" for the program, and how they intend to inform people about, and assist them with, enrollment in S-CHIP as well as other programs (Medicaid, private insurance) for which they might be eligible (Section 2102).

The federal guidelines limit the amount of a state's funding allotment that can be used for outreach, stating that no more than 10 percent can be used for the total costs of outreach, the provision of direct health services to eligible children (as opposed to services covered through the S-CHIP-funded insurance plan), and administrative costs. Many states and communities engaged in outreach efforts are supplementing these funds with grants from charitable foundations and other private donors.

One of the areas that has been too often ignored is retention, or keeping eligible people enrolled in the appropriate coverage program. Medicaid and S-CHIP beneficiaries must regularly undergo recertification in order to re-establish eligibility (the time intervals and processes vary by state), and eligible enrollees who fail to do so are dropped from the programs. **Reasons people do not re-enroll include lack of awareness about the need, process, or timetable for recertification; misconceptions about continued eligibility; negative experiences with the program; and other obstacles similar to those preventing initial enrollment** (discussed in the following section).

CV communities have been making important inroads in outreach and enrollment, largely by taking a broader view. In addition to the tasks outlined above, for example, "outreach" may include assessing and addressing a wider range of individual and family needs, as well as continuing engagement with individuals to ensure access to and appropriate use of health care services. Further, CV communities are focusing energies beyond the initial application process, maintaining relationships and tackling the challenges involved in *keeping* these populations enrolled.

Section 2. Barriers and Hard-to-Reach Populations

A number of barriers prevent people from enrolling in Medicaid or S-CHIP even though they are eligible for the programs. General barriers include lack of information, a complicated application process, and financial obstacles (fees or premiums). In addition to these barriers, the CV communities identified several sub-populations of the uninsured that are particularly difficult to find and/or to enroll (and retain) in Medicaid and S-CHIP. These include individuals in immigrant families, people who are wary of government-assistance programs because they perceive a stigma or have had negative past experiences, and low-wage workers in small businesses. Other individuals are difficult to reach because they face geographic or logistical barriers that prevent outreach workers from engaging with them or maintaining contact with them. These obstacles and hard-to-reach groups are discussed, in turn, below. Section 3 discusses ways that CV communities are breaking down barriers to reach some of these populations.

General Barriers to Enrollment

There are a number of reasons that people who are eligible for Medicaid or S-CHIP remain uninsured. Following are some of the primary barriers to enrollment:

- ***Lack of information.*** Many families do not know that public insurance programs exist, do not know that they may be eligible for public programs, or do not know how to apply for them. *Misinformation* about eligibility rules results in some people assuming they are ineligible when in fact, they do meet the program's criteria; for example, some people continue to believe that Medicaid eligibility is limited to single-parent families receiving cash assistance. **Results from a recent Denver Health survey highlight a substantial lack of awareness about Medicaid and S-CHIP among uninsured Denver residents. For example, among parents with unin-**

sured children, 71 percent of those interviewed were not familiar with the S-CHIP program.[8]

- ***Cumbersome processes.*** Whereas many states have made progress in this area, in many other states, the application process remains long, confusing, and bureaucratic. Some states require face-to-face interviews in a limited number of locations, necessitating appointments (sometimes only available during regular work hours) and adequate transportation. Others require written proof of income, bank statements, and other documents, as well as third-party verification. Applicants frequently do not follow through in getting the documentation needed to complete the applications (one CV director points out that this is the primary reason for enrollment denials). Confusing eligibility criteria, multiple applications for different programs, lengthy review and acceptance processes, and frequent recertification requirements pose additional obstacles to applying and maintaining enrollment.
- ***Premiums and enrollment fees.*** Premiums and enrollment fees (and re-enrollment fees) are barriers to enrollment for many low-income families. Even relatively low premiums and fees reduce participation among people who have many competing demands for their limited funds.

PEOPLE IN IMMIGRANT FAMILIES

Perceived Threat to Residency Status

About one-third of low-income, uninsured but eligible children are from immigrant families.[9] Many of the CV communities with large numbers of immigrants, such as El Paso, New York, and Oakland, found that eligible individuals with family members who are either undocumented or with temporary residency status are often reluctant to come forward to enroll in Medicaid and S-CHIP. Outreach workers in New York mention that many immigrants are suspicious of "free" government programs (see Box A). These individuals fear that any contact with the government in which they have to provide personal and financial information may jeopardize their own or a family member's ability to stay in the United States.[10] According to CV directors in El Paso, it is very difficult to assuage this fear, even though enrollment workers do not ask about the residency or immigration status of family members when enrolling an eligible person in Medicaid or S-CHIP.

Misconceptions about Welfare Reform Laws

A related issue is that some immigrants continue to meet criteria for Medicaid, despite changes made by the Welfare Reform Law of 1996, but are not aware that they are eligible for public health insurance coverage. The 1996 reforms stated that, in general, immigrants who entered the U.S. before August 22, 1996, may still be eligible for Medicaid coverage. Immigrants who entered after that date are barred from federally funded coverage under Medicaid and S-CHIP for the first five years in this country, except for emergency services. However, states can extend Medicaid coverage at their own expense (e.g., without federal matching dollars) to this group. Children born in the U.S. to immigrants continue to be eligible for Medicaid and S-CHIP regardless of when their parents entered the country.

BOX A. FEAR OF CONTACT WITH GOVERNMENT

"The [S-CHIP] population is afraid of INS; they want to know the 'catch'; they don't believe it could be free.

"We have to tell them that there is no need to fear INS and that this is either a free or low-cost plan."

—ALIANZA DOMINICANA
OUTREACH WORKER, NEW YORK

[8] Gabow, Patricia A., Elizabeth M. Whitley, Stephanie P. Denning, and Barry D. Liss. "Awareness of and Attitudes Toward Medicaid and Child Health Plan," Denver Health, Pending Publication.
[9] Ku, Leighton and Shannon Blaney. "Health Coverage for Legal Immigrant Children: New Census Data Highlight Importance of Restoring Medicaid and S-CHIP Coverage," Center for Budget and Policy Priorities, Revised October 10, 2000; General Accounting Office, "Medicaid: Demographics of Nonenrolled Children Suggest State Outreach Strategies," GAO/HEHS- 98-93, March 1999.
[10] This trepidation by immigrants remains prevalent despite a 1999 clarification by the Immigration and Naturalization Service (INS) that receiving Medicaid or S-CHIP would not be considered grounds for determining that an immigrant might become a "public charge."

There is evidence that many immigrant families do not have a clear understanding of the new rules. For example, enrollment by *citizen* children of immigrants (i.e., children who remained eligible) fell sharply after the 1996 laws were passed, indicating a false assumption that they were no longer eligible.

Barriers Related to Language and Cultural Differences

Immigrant families also face barriers related to language and cultural differences. Border communities and other areas with large numbers of immigrants have significant numbers of people who do not speak English and come from a variety of cultural backgrounds (especially Spanish-speaking individuals and individuals from Asian and African communities). Language barriers prevent people from reading and understanding program brochures, pamphlets, posters, and advertisements. In addition, individuals who do not speak English as a first language may need one-on-one assistance in understanding and completing often confusing enrollment applications. Many people are also hesitant or unwilling to accept assistance from people outside their cultural communities. They may be distrustful of others' motives, or there may be certain cultural habits or customs that must be addressed to make outreach and enrollment efforts effective.

People Distrustful of Government Programs Based on Past Experience

The California Rural Indian Health Board (CV: Sacramento) recognizes that historic problems have caused many Native Americans to be distrustful of federal and state government programs. In California, for example, S-CHIP applicants with proper Indian documentation have been commonly sent bills, despite Native Americans' exemption from monthly premiums and co-payments. According to the CV director, "the message quickly spreads that, again, the State cannot be trusted." State program officials know they need to gain the trust of Indian families for outreach and enrollment initiatives to be effective. They are challenged to explain the rationale for the programs, consider the specific needs of multiple tribes with very different cultures and experiences with the government, and make sure the enrollment problems are eliminated.

Another population that is difficult to reach is women who have had an unpleasant past experience with Medicaid and/or welfare (previously AFDC, now TANF) programs.[11] Many women who have enrolled in these programs say they have been treated with disrespect by enrollment workers and have been dismayed by the bureaucratic "red tape" involved. Such encounters discourage people from applying for public programs for themselves or their family members. To reach these women and to prevent this from happening to other potential enrollees, outreach and enrollment workers are challenged to make the enrollment process as pleasant an experience as possible, to create a welcoming environment, and to treat applicants with respect.

People Who Want to Avoid a Welfare Stigma

A common barrier to enrollment faced by communities around the country is a "welfare stigma" associated with government-subsidized programs. This occurs both among former Medicaid or welfare recipients who are reluctant to go back on the "public dole," and among uninsured, near-poor working mothers who have never received government assistance before, but who have children now eligible for S-CHIP or Medicaid. Particularly among this latter group, many women do not want to be perceived as receiving government "hand-outs," or feel ashamed for accepting assistance from government programs. Identification cards deemed embarrassing and other program features that "advertise" a person's enrollment in government programs exacerbate this problem (see Box B).

[11] Prior to 1996, people (mostly women) receiving cash assistance through the Aid to Families with Dependent Children (AFDC) program were automatically eligible to enroll in Medicaid. After welfare reform (Temporary Aid to Needy Families, or TANF, legislation) was passed in 1996, the programs were "de-linked," although many families who were eligible for AFDC when welfare reform was passed are still eligible for Medicaid.

Box B. Dealing with Welfare Stigma in Michigan

"Many eligible people are still viewing Medicaid as welfare. They've had bad experiences with Medicaid or the welfare system in the past, and don't want to go back. We let them know that they don't have to go back to the welfare office, that Medicaid has been detached from welfare. We also let them know that we've [the public health system] changed, and are trying to be more responsive. Applying requires only a short visit of about 20 minutes; the application is down to two pages, with no income verification. They like the fact that we use the honor system.

"Some are embarrassed about accepting public assistance. Most of them are working women. So we let them know that they are paying taxes, which pays for this service.

"To really remove the stigma, though, Michigan has got to remove the big, ugly, blue Medicaid card! I had one of those cards when I was pregnant 18 years ago, and I hated it! Women have said to me, 'I just die when I have to pull out that Medicaid card…' "

—Rebecca Popoff

HEALTH REPRESENTATIVE, INGHAM COUNTY HEALTH DEPARTMENT, LANSING, MICHIGAN

Small Businesses that Employ Low-Wage Workers

Many small business owners and their employees are unaware that low-wage workers (and their families) may be eligible for Medicaid or S-CHIP. In many of these firms, health insurance is not offered or the premiums are too expensive for people to afford, leaving low-income working people – including some business owners – uninsured. In addition, most self-employed individuals are unable to obtain group insurance coverage, and may be unable to afford or obtain insurance in the individual insurance market. They often do not realize that their children, if not they themselves (in states that have implemented family coverage under S-CHIP) may be eligible for government-subsidized health programs.

CV outreach workers have found that many small business owners are distrustful of outreach workers, and resistant to learning about public health insurance or allowing outreach workers to approach their employees on or near the work site. They may fear that work will be disrupted, or they will be asked to contribute toward the coverage, or perhaps, provide proof that all of their workers are documented.

People with Geographic or Logistical Barriers

Populations that are transient, homeless, and/or living in rural areas are often difficult to reach through traditional marketing or neighborhood outreach activities. Those without permanent residences are very difficult to keep "connected" after their initial contact with the health care system.

One CV outreach worker from Detroit's Henry Ford Health System noted that **young, transient people who come to emergency rooms or clinics are the most difficult to enroll in public programs. They include young men living on the streets who do not have a telephone or who give a fake address, so it is impossible to maintain contact or follow up with them.** Also, women who are victims of domestic abuse frequently do not want to be traced to where they are staying, so they refuse to give correct addresses. Despite providing self-addressed, stamped envelopes to send back documentation needed for enrollment, the health system achieves only a 3 percent return rate among these applicants. In an effort to improve this rate, outreach workers try to let the individuals know that there is always an "open door," and they provide them with money to obtain picture identification cards and bus

tokens or cab vouchers. Engaging this population, however, remains a major challenge.

Reaching potential enrollees living in rural areas, and reaching specific groups that are scattered geographically pose additional challenges. Although enrollment efforts in CV: Sacramento have yet to begin, the CV director fears that it will be difficult to target Native American children in schools for S-CHIP enrollment, since these children are not concentrated in one school or school system, but rather are scattered in schools throughout rural parts of California.

SECTION 3. SUCCESSFUL COMMUNITY VOICES STRATEGIES

Community Voices organizations and their partners have played a key role in developing and implementing innovative strategies to engage and enroll eligible people in health coverage. They have experimented with approaches aimed at tearing down the barriers to obtaining and retaining coverage, with particular focus on "hard-to-reach populations." They have encountered both successes and frustrations, and there is much that can be learned from all of these experiences.

Following is a "menu" of successful approaches undertaken at Community Voices sites across the country.[12] Some are innovative strategies that target particularly hard-to-reach populations (e.g., addressing language and culture, utilizing outreach workers — sometimes referred to as promotoras — engaging employers of small businesses). Others are more general strategies that have proven successful with all eligible populations (e.g., out-stationing, building relationships with community organizations, forming collaboratives). We present numerous examples of specific CV experiences and innovations that may be replicated in other communities.

> CV outreach workers have found that many small business owners are distrustful of outreach workers, and resistant to learning about public health insurance or allowing outreach workers to approach their employees on or near the work site.

Clearly, however, there is no "one size fits all" outreach and enrollment strategy. **Each community should design its approach according to the particular characteristics of its eligible uninsured population, the resources available, the nature of the relationships among CBOs in the area, and the level and type of state outreach and enrollment activity.**

INNOVATIVE OUT-STATIONING AND TECHNICAL TOOLS

Traditional eligibility and enrollment sites include social service agencies, federally qualified health centers, and hospitals receiving disproportionate share hospital (DSH) payments. However, **nearly all of the CV sites engaged in enrollment activities place enrollment workers in a variety of additional neighborhood settings. This strategy of "out-stationing" provides convenient, accessible locations for learning about and applying for Medicaid, S-CHIP, and other programs.** Common out-stations include neighborhood clinics, schools, libraries, churches, Head Start/childcare programs, WIC clinics, and other places frequently visited by families with eligible children. Other sites may be effective out-stations as well.

CV: West Virginia has achieved much success by out-stationing enrollment workers in primary care centers and family resource centers. These workers also have had much success visiting nursing homes to engage and educate both staff and elderly residents about public coverage (see Box C). In addition, West Virginia utilizes "parent educators" who go to homes to teach child development and basic parenting skills, along with assistance with health plan enrollment. Some of these workers are AmeriCorps members who are often public assistance recipients themselves and receive a stipend for national service.

Out-stationing is greatly enhanced with effective tools. Denver's integrated health care system, Denver

[12] The primary organizations conducting these efforts varies; they include county health departments, safety net health systems, nonprofit community centers, or collaboratives of these organizations. Appendix B provides a list (including contact information) of the CV organizations and their directors.

Health, utilizes an innovative computer system that allows enrollment workers to accept applications in schools, libraries, and other locations around the community (see Box D).

One CV grantee, Ingham County Health Department in Michigan, found that placing staff in CBOs was not cost-effective. They prefer building relationships with CBOs to encourage referrals to their central office (discussed further below). They acknowledge, however, that location is important; their central enrollment office is across the hall from a teen clinic, so they get many walk-in applicants from women who have just learned that they are pregnant.

Box C. Targeting Nursing Homes in West Virginia

"We have found great success in working with nursing homes, for several reasons:

"First, nursing homes have low-wage employees who often lack health insurance. We can sign their children up for S-CHIP/Medicaid, and best of all, we can get their income information on the spot from the nursing home's human resources department.

"Second, we also can target the senior citizens who are dually eligible for Medicaid and Medicare.

"Third, we have found that seniors are very effective in communicating S-CHIP/Medicaid information to their children and grandchildren, and ensuring that they sign up and utilize the insurance once they have it."

—Brian Cunningham
OUTREACH PROJECT DIRECTOR, WV HEALTHY KIDS COALITION AND THE WV PRIMARY CARE ASSOCIATION, WEST VIRGINIA.

Box D. AppTrack Application Tracking System in Denver, Colorado

AppTrack is a computer program utilized by Denver Health that allows enrollment workers to track the Medicaid and S-CHIP application process from "intake to eligibility determination." It holds applications for several public programs, and can track an individual's status, documentation, and reasons for pending or denied applications, as well as respond to queries concerning staff performance and charge data. This computer system allows the workers to accept applications in schools, libraries, and other locations as they rotate around the community.

AppTrack was initiated as a result of Denver Health's 1998 overhaul of its Medicaid enrollment process. The main features of the new enrollment system include the development of the AppTrack system and the creation of the position of "enrollment specialist."

Denver Health hired 29 full-time enrollment specialists who are located in most of its provider sites, including its inpatient hospital, 11 community-based health centers, and 12 school-based health centers. Denver Health also hired several outreach/enrollment specialists, two of whom are funded by the CV: Denver Health. These workers are enrollment specialists who work in the community and carry laptop computers loaded with the AppTrack system.

Denver Health also employs community health advisors who primarily conduct outreach and health education. Denver Health considers its new system a success. In 1999, enrollment workers accepted over 51,000 applications, which generated $33 million in reimbursement for care that would have otherwise been uncompensated. In 2000, 75,000 people applied, generating $37 million in reimbursement.

Source: Personal communication with Dr. Elizabeth Whitley
Director of Community Voices, Denver Health, Denver, Colorado.

Box E. Language and Cultural Sensitivity in Oakland, California

Oakland-Community Voices views building trust between its workers and the community as the most important feature of its outreach and enrollment efforts. CV: Oakland's outreach efforts are conducted by Asian Health Services (AHS), which serves primarily Chinese, Vietnamese, and Korean populations; and La Clinica de la Raza, which serves mostly Hispanic people.

Because they serve people with such diverse ethnicities and cultures, it is essential for outreach workers to speak the languages of the target populations and be trusted by members of the community. AHS has hired outreach workers who speak Cantonese, Vietnamese, and Korean.

AHS produces literature and products with program names/toll free numbers in multiple languages that are distributed at locations in the community where immigrant families gather. Korean outreach workers target Korean churches and senior centers, and work closely with CBOs including the Korean Community Center of the East Bay; Vietnamese workers go to nail salons and beauty schools; and to reach Chinese populations, workers make monthly visits to English as a second language (ESL) classes and sewing factories. They have also done outreach in massage therapy centers.

Sources: Personal communications with Joann Wong, Health Education Department Manager; Dung Nguyen, Coordinator, Community Liaison Unit, Asian Health Services; and Tomiko Conner, Project Director for Community Voices, Oakland, California.

Addressing Language and Cultural Differences

Community Voices sites are particularly active in breaking down barriers to enrollment related to language and culture faced by immigrant populations (described in Section 2). CV organizations use outreach materials that are written in languages and at educational levels that are specific to the communities involved. They use outreach and enrollment workers who speak the languages and/or are of the same ethnic background as the people in the communities. They acknowledge the fears and misconceptions many immigrant families have about enrolling in public programs, and they approach individuals with an understanding of their historical and cultural backgrounds.

- The California Rural Indian Health Board has designed a culturally sensitive outreach/enrollment initiative that will target members of 44 Native American tribes in rural and urban parts of California, and also extending from Oregon in the north to Mexico in the south.
- The CV: Oakland program has designed very targeted outreach strategies to engage and build trust with their Hispanic and various Asian populations (see Box E).
- A member of the CV: Northern Manhattan collaborative must teach the very concepts of insurance to a new immigrant population unfamiliar with that approach to health care (see Box F).
- In Denver, where officials find it difficult to recruit Spanish-speaking workers, staff are taught basic and intermediate conversational Spanish on site two times a week.
- The CV project directors in El Paso stress that it is essential to clarify the Medicaid and S-CHIP eligibility rules for immigrant families. The West Texas CHIP Collaborative, of which CV: El Paso is an instrumental member, is in the process of developing Spanish public service announcements that directly address these issues.

BOX F. TEACHING THE INSURANCE CONCEPT TO NEW IMMIGRANTS

Alianza Dominicana, a member of the Northern Manhattan Community Voices collaborative, is a community organization providing comprehensive services for Dominicans recently settled in the New York City neighborhood of Washington Heights/Inwood. Fundamental to Alianza's approach is the conviction that the best way to reach "underserved" communities is to acknowledge their history and culture.

As an immigrant community, people in Washington Heights are frequently unfamiliar with the very concept of health insurance. There is no system of health insurance in the Dominican Republic, so they have neither experience with nor expectations about health insurance. As they did in the Dominican Republic, many new Dominican immigrants go to the doctor when they are sick, and receive assistance on a fee-for-service basis. Thus, when they see public information about Child Health Plus (New York's S-CHIP), they cannot fully comprehend its meaning, namely paid-in-advance insurance coverage subsidized by the government. Public information campaigns about Child Health Plus simply do not connect with this immigrant population.

A critical part of the outreach worker's job, then, is to explain what insurance is, and to overcome the misconceptions people have about Child Health Plus or Medicaid.

Source: Paolo Mejia, Sally Findley, Karina Feliz, Donna Sherard, Brian Johnson, and Miriam Mejia. Unpublished draft of Community Voices New York Outreach and Enrollment Report, September 2001.

ENLISTING NEIGHBORHOOD RESIDENTS, COMMUNITY HEALTH WORKERS, OR "PROMOTORAS"

One of the areas in which Community Voices is taking a leading role is in the "promotora" (health promoter) movement. This involves enlisting neighborhood residents, generally women who have enrolled in Medicaid or S-CHIP for themselves or for their children, to engage with community members and participate in the outreach process. These individuals are highly successful because they are trusted members of the community and speak from their own experience. They are generally volunteers, but CV is making considerable progress in hiring neighborhood residents as paid staff, thereby "professionalizing" them and legitimizing their value. In the training to become outreach volunteers or employees, these women obtain valuable skills that can help them enter or expand their opportunities in the labor force.

Following are some important points for CBOs to consider when using neighborhood residents, community health workers, or promotoras.

1. ***Identify good candidates.*** It is helpful to identify individuals who have gone through the enrollment process; who are pleased with the health program; who are comfortable with approaching and talking to people; and who have an energetic, outgoing, and positive personality.
2. ***Recruit for participation.*** CBOs must have a method for enlisting potential workers and volunteers. The Alianza Dominicana multi-service agency (a New York CV partner) has an "outreach community mobilization unit" in which staff recruit volunteers from the city's Welfare Employment Program (WEP), summer Youth Employment Program, and Alianza client base to become promotoras (see Box G). WEP participants attend school three days a week and are committed to voluntary work the other two days. Ten WEP volunteers, who have received basic training (see next paragraph), help in the distribution of flyers, conduct door-to-door outreach, and make weekly visits to the Coalición Inmigrante (Immigrant Coalition), informing newly arrived immigrants about Child Health Plus (New York's S-CHIP) and inviting them to visit Alianza. The WEP workers administer a very simple survey, asking whether anyone in the family needs insurance, and if so, they are asked for their phone number and address so an enroller can contact them within 24 hours.[13] WEP volunteers receive a $100 certificate after undergo-

[13] Mejia, Paolo, Sally Findley, Karina Feliz, Donna Sherard, Brian Johnson, and Miriam Mejia. Unpublished draft of Community Voices New York Outreach and Enrollment Report, September 2001.

ing training. In Oakland, La Clinica de la Raza offers store vouchers as an incentive in recruiting promotoras.

3. ***Conduct training.*** There should be an initial training session to educate the individuals about the basic elements of the public health programs, eligibility criteria, the application process, and referral instructions. In New York, an outreach and enrollment training program was developed by Alianza Dominicana with the assistance of the Mailman School of Public Health of Columbia University, both partners in the Community Voices initiative. This five-part training series covers the steps for screening and facilitated enrollment, strategies for effective outreach, communication skills for working with individuals and groups, how to track outreach efforts and know what is working, and role plays on working as a team in a community. A version has been adapted for promotoras and other persons doing only outreach and enrollment. The training program is conducted by Alianza staff and supplemented by a notebook of materials to which participants can refer later when they encounter questions as they work. Periodically, staff are brought together for additional special topic training sessions.[14]
4. ***Agree on specific areas of responsibility.*** There should be an understanding of the scope of the individual's "territory"; in some cases, this area is limited to the individual's building, other times the person is asked to canvass the immediate neighborhood, as well as to engage neighbors and acquain-

Box G. Rosa the Promotora

Rosa is from the Dominican Republic and has lived in Washington Heights in New York City for over 30 years. Rosa makes a living by doing cleaning work and selling used clothes. For over a year now, she has been a volunteer promotora at Alianza Dominicana, doing outreach and enrollment for Medicaid programs. She became interested and excited about doing the work through her own experience with health insurance and Alianza. Previously uninsured herself, Rosa discovered the existence of both Medicaid benefits and the work that Alianza Dominicana does for the Northern Manhattan community when caseworkers signed her up.

On an informal basis, Rosa talks with people, ranging from friends and acquaintances to individuals in the street, about the governmental insurance benefits. She uses the flyers provided by Alianza and refers them to Alianza for further assistance. More often than not, Rosa brings them into the center herself. Rosa performs the work with outgoing, uninhibited eagerness and is responsible for capturing a significant number of people eligible for Medicaid benefits, nearly comparable to the paid Alianza employees. According to Rosa:

"There are a lot of needy people here; there's a lot of misery. You should do good in life; you should share what there is. If I'm given the opportunity to help someone, then I should do it. Everybody should have Medicaid; it helps poor people out a lot. And if there's help right here, you shouldn't go hide.

"To sit down with someone, and tell them about all the help that they can get in the center here. To help people — many don't know how to speak English, so you need to make the help easier for them to get. It's a blessing from God. I go to church, but this is for the people.

"You need to talk straight with people. People aren't that difficult; you can gain their trust easily enough. Then the people who I talk with go and talk with other people, and on, and on."

Excerpted from unpublished draft of Community Voices New York Outreach and Enrollment Report, compiled by Paolo Mejia, Sally Findley, Karina Feliz, Donna Sherard, Brian Johnson, and Miriam Mejia, September 2001.

[14] Mejia, et. al., 2001.

tances at beauty parlors, bodegas, churches, and wherever and whenever the opportunity arises.

5. ***Acknowledge successful work.*** While most some community health workers are volunteers and are not looking for remuneration, it is important to acknowledge their efforts in some way. An annual dinner, a plaque, and/or financial incentives that show appreciation let these individuals know that their efforts are highly valued. Alianza gives volunteers $100 certificates, and is working on securing continuing education credits as a way to encourage some of them to pursue their education. As noted above, the growing movement toward professionalizing community health workers by hiring them as paid staff shows much promise, as it reinforces the valuable role that these individuals play, and provides an entry into the workforce for low-income individuals.

6. ***Conduct periodic updates.*** There should be follow-up refresher classes and as-needed training to keep both paid staff and volunteers up-to-date on program rules and policy changes.

ENSURING A "USER-FRIENDLY" ATMOSPHERE AND PROCESS

Community Voices experiences underscore the importance of having an enrollment setting and process that are as user-friendly as possible. The physical space, whether a centralized office, or one of many neighborhood sites, should be pleasant, clean, and colorful. There should also be a children's play area, and it should be easily accessible by public transportation.

The process should be as quick and efficient as possible, within the constraints of the state-determined application form and documentation requirements. Application forms in multiple languages and enrollment workers who speak the language of applicants are critical to streamlining the process. Also, it is important that the enrollment workers be friendly and respectful, and that they follow through in obtaining required documentation. In states that do not require written verification of income, the "honor system" is appreciated and helps build trust between the applicant and the worker. These approaches are particularly helpful when trying to engage people who are reluctant to enroll because they had unpleasant past experiences with public programs.

Similarly, to reduce reluctance by people who associate a stigma with public programs, Michigan outreach workers suggest reminding parents of eligible children that they are contributing to the programs by paying taxes that support Medicaid and S-CHIP. Stigma is also reduced if public coverage is "mainstreamed" through contracts with commercial insurers, and enrollment cards that look like private insurance cards.

A few enrollment workers stressed the importance of continuing engagement from the time of application through delivery of medical services, i.e., helping enrollees navigate through the system. Some CV sites, such as the Ingham County Health Department in Michigan, provide new enrollees with a kit that includes a calendar, the name of the caseworker along with how and when to contact him/her, health tips, a *Parents* magazine, and information about and an application for the WIC program.

In New York, once an individual comes in to the Alianza Center for Health Promotion, a "facilitated enroller" is responsible for working with that person until any and all applications are successfully submitted. The enroller calls to congratulate parents when their application is accepted, and she/he also is responsible for follow-up to see how the family is doing once insurance coverage is obtained. The enroller reminds the newly insured client to schedule a check-up, and calls the family once a month during the first three months to find out if the beneficiary is using the health system. After the first three months, the enrollment worker contacts the client at six-month intervals, as well as to remind the enrollee about and assist with recertification. A database tracks all contacts and enrollments, which assists the program supervisors in monitoring enroller performance.[15]

[15] Mejia, et. al., 2001.

It is particularly helpful to establish "one-stop shopping," where individuals can have their needs assessed and receive a variety of services. In depressed economic times, such outreach is especially likely to uncover a number of unmet needs. Some states have one application that allows family members to qualify for more than one program. For example, Family Resource Centers in West Virginia are places where families may apply for and receive such services as health coverage enrollment, tutoring, training, food stamp recertification, and others. New York's Alianza multi-service agency conducts "internal" enrollment (in addition to external outreach) at all of its sites. Each facilitated enroller monitors the health insurance status of participants in a designated group of Alianza programs, looking for uninsured adults or children under age 19 who may be eligible for Medicaid or S-CHIP. [16]

Although mail-in applications are helpful for many applicants, one enrollment specialist in Ingham County, Michigan, prefers and encourages in-person application. The latter process allows enrollment workers to ensure correct and complete answers, verify eligibility, fully explain the program, and assess other needs as well.

Building Relationships with Community Organizations

All of the CV organizations stress the importance of developing and nurturing relationships with schools and CBOs, as well as local grocery stores, churches, beauty parlors, and other places where people visit and congregate. This approach permits the outreach effort to go beyond the limited sites where enrollment workers may be stationed. It multiplies the number of places where potential applicants can pick up literature and forms, view posters and other notices about Medicaid and S-CHIP, ask questions to individuals who are briefed about the programs, and get referrals to enrollment sites and workers.

These relationships with neighborhood organizations and businesses include both formal and informal associations. Many CV sites have developed formal relationships, for example, with such groups as health clinics, physician offices, mental health organizations, Planned Parenthood, day care centers, schools, churches, teen parenting centers, and WIC satellite centers. Solid relationships may take years to develop; they can be nurtured through an understanding that working together can be mutually beneficial. CV-Oakland's efforts, for example, are facilitated by 25- to 30-year-old relationships among the county's clinics and nonprofit organizations.

Working with Safety Net Providers

Working with safety net institutions is particularly helpful to both the enrollment effort and the health system's bottom line. Eligible but uninsured people can be easily identified at "point of service," that is, at the time they access health care in emergency rooms or clinics. The hospitals and other health care practitioners generally benefit by having their patients enrolled in Medicaid, S-CHIP, or another insurance product that reimburses them for the care provided. Examples of Community Voices grantees engaged in these relationships include the following:

- Safety net health systems generally place enrollment workers in emergency rooms (ERs), clinics, and inpatient settings. While Detroit does not have a designated safety net provider, ERs have become the de facto safety net. Detroit's Henry Ford Health System has two enrollment workers in the ER whose function is to meet with all uninsured clients entering the ER to determine whether they qualify for any insurance or assistance program. **For those eligible for Medicaid, the staff help with the five-page application and seven separate forms (sent to the bank, physician, and others), and actually bring the application to a "Family Independence Agency" office for processing.** Other uninsured people may be eligible for (and assisted in applying for) MIChild (S-CHIP), PlusCare (an indigent care program in Wayne County), or the Voices of Detroit Initiative (VODI). VODI, a Community Voices project, enrolls clients in a "virtual managed care" system comprised of a formal, integrated network of service providers who provide primary care and other services to members on a sliding fee scale. VODI is available to adult Detroit residents with income less than 250 percent of the federal poverty level who are not eligible for other coverage programs.
- FirstHealth of the Carolinas, a large health care network, conducts enrollment through its inpatient and outpatient settings, and through its dental clinics that serve large numbers of low-income, unin-

[16] Mejia, et. al., 2001.

sured families (see Box H).

- Denver Health places 29 full-time "enrollment specialists" in almost every one of its sites, including its inpatient hospital, 11 community-based health centers, and 12 school-based health centers.
- The Ingham County Health Department in Michigan has built relationships with hospital emergency room staff who provide information and make referrals when patients arrive without coverage. They also have relationships with community physicians and pharmacies who will accept vouchers for Medicaid/S-CHIP reimbursement even before the enrollment process is complete. This enables pregnant applicants to obtain critical prenatal care and prescription drugs immediately.
- Oakland-CV's outreach and enrollment efforts are facilitated by long-standing working relationships with two clinics, La Clinica de la Raza and Asian Health Services, which serve large numbers of Hispanic and Asian (Chinese, Vietnamese, and Korean) populations, respectively.

Working with Schools

Establishing relationships with and having a "presence" in schools and Head Start sites is critical. Covering Kids, a national program of the Robert Wood Johnson Foundation that connects eligible families to S-CHIP and Medicaid coverage, sponsored a Back-to-School 2001 Campaign outreach and enrollment drive in all 50 states and the District of Columbia. Specific strategies include:

- Conducting on-site enrollment events and application assistance during fall registrations, immunization fairs, and back-to-school fun fairs;
- Distributing brochures at health fairs, schools, and school administration meetings;
- Collaborating with the Free and Reduced Lunch Program to include information about S-CHIP in the application form; providing on-site enrollment at schools where the majority of children are enrolled in the Free and Reduced Lunch Program;
- Working with junior high and high school athletic coaches to help identify students who do not have health insurance;
- Distributing back-to-school promotional items such as pencils, book covers, posters, school supply check-lists, and t-shirts; and
- Working with school nurses to identify potentially eligible children.

The National Education Association's Health Information Network also recommends additional ways that school staff can help to enroll students:

- Enlisting the help of social workers and guidance counselors as a source of information and assistance;
- Distributing written materials at PTA meetings, in school newsletters, with report cards, school lunch

Box H. S-CHIP Enrollment at Dental Clinics

FirstHealth of the Carolinas, a private, nonprofit rural health care network in North Carolina, augments its other outreach strategies by incorporating S-CHIP enrollment into its dental clinic registration process. FirstHealth has three dental care centers that treat Medicaid and indigent children through age 18.

The centers require that parents of uninsured children seeking treatment at the dental centers complete a Health Choice (North Carolina's S-CHIP) application when completing the health history paperwork, prior to treatment. The dental care center staff, who have undergone special training in the application process, provide the needed assistance in completing the forms. This assistance led to an average one percent monthly conversion of patients from uninsured to insured status during the first year of operation.

Source: Personal communication with Shelly Davis, Community Development Coordinator, FirstHealth of the Carolinas, Inc., North Carolina.

Box I. Establishing Relationships in El Paso, TX

The West Texas CHIP Collaborative targets three main "sectors" of the community for outreach and enrollment activities: schools, small businesses, and faith-based organizations.

1. Over 182 elementary, middle, and high schools help the Collaborative educate students and families about S-CHIP during CHIP Week, a week-long, community-wide outreach campaign, and throughout the year. A trained S-CHIP representative is located in every participating school to answer questions about the programs and refer people to eligibility workers for enrollment.
2. The Collaborative works with businesses through the local chamber of commerce and by directly contacting small businesses to educate employers and employees about Medicaid and S-CHIP.
3. The Collaborative works with the Catholic Diocese and other faith-based organizations to set up information booths outside church services on certain weekends throughout the year.

Sources: Personal communication with Jose Moreno, Former Executive Director, Community Voices, and Esteban Zubia, Project Manager, Regional CHIP Office, El Paso, Texas.

menus, field trip announcements, and parent/teacher conference notices; and
- Making outreach a part of routine school registration activities.

Establishing Ties to Religious and Civic Institutions, Merchants, and Employers

It is also helpful to build "informal" relationships with local churches, libraries, employers, and shops that are willing to put up posters and leave pamphlets about the health programs on counter-tops and bulletin boards (see Box I). Religious leaders may incorporate the message about the importance of enrollment and health promotion into sermons and church activities.

To address the difficulties enrolling low-wage workers from small businesses, the CV: New York outreach includes approaching small employers and independent taxi drivers one-on-one to discuss a new insurance product for low-wage workers, and to get a better sense of the programs for which they and their workers may be eligible.

CV-El Paso has placed a heavy focus on conducting outreach efforts in small businesses in the community. Officials have worked with the chamber of commerce, as well as working directly with businesses, to raise awareness about programs for which employees may be eligible. In February 2001, the West Texas CHIP Collaborative held a press conference at which local businesses pledged to distribute information about Medicaid and S-CHIP to their employees.

In Oakland, Asian Health Services has developed relationships with sewing factories, English as a second language (ESL) classes, nail salons, senior centers, beauty schools, vocational schools, CBOs, massage therapy centers, and Korean churches. Outreach workers who speak the languages visit these locations on a monthly basis to distribute literature and speak to potential enrollees or family members/friends of eligible people about the programs. Their experiences illustrate that it takes time, patience, perseverance, and knowledge of cultural norms to gain the trust of employers (see Box J).

Box J. Bringing Fruit in Oakland, CA

"In developing its relationships with local sewing factories that employ many uninsured Chinese women with families, Asian Health Services (AHS) workers went to each of the factories in the area once a month and knocked at the door. Many of the owners either closed the door in their face, or accepted literature and then closed the door. A few owners welcomed the workers immediately.

"There was one factory owner who was 'courted' for 6-8 months. It is customary for Chinese people to bring fruit when they visit people as a sign of respect. So for months, the AHS workers would visit this particular owner bringing fruit until he finally trusted them enough to let them speak to the workers. At all of these factories, AHS would only go at lunch so as not to disrupt working hours."

—Joann Wong
HEALTH EDUCATION DEPARTMENT MANAGER, ASIAN HEALTH SERVICES

Forming Outreach Collaboratives

When local and state agencies that are involved in outreach and/or enrollment activities formally collaborate and coordinate efforts, the sum is often greater than the parts. Such coordination helps to pool resources, share "best practices," and avoid duplication of efforts.

Collaboration among the major outreach organizations is a major factor in West Virginia's successful enrollment drive. In cooperation with the Community Voices Project, the WV Healthy Kids Coalition (a Robert Wood Johnson Foundation *Covering Kids* Grantee) and the WV Primary Care Association have joined forces to mount an all-out push to find and enroll children and adults in public health insurance programs at the local level. This collaborative has outreach coordinators covering the majority of West Virginia counties.

Additionally, El Paso-Community Voices is part of the 150-member West Texas CHIP Collaborative, which conducts outreach and enrollment in a six-county region (see Box K).

Participating in Community Events

An important method of educating the public about health programs and the enrollment process is through community events. This involves either sponsoring or participating in local health fairs; setting up information booths at street festivals; making presentations to various groups; and placing enrollment workers at open school nights, after-school program registrations, or camp registrations. Outreach workers acknowledge that this process is labor-intensive, at times requiring four or five interactions with people before they actually enroll. A key ingredient is not just "showing up," but really engaging with potential applicants.

In El Paso, the West Texas CHIP Collaborative sponsors an annual "CHIP Week," an outreach effort that includes school and community presentations, door-to-door campaigns, telethons, and public service announcements. In Oakland, Asian Health Services sets up booths and distributes literature during Chinese street festivals that take place several times a year, including during the Lunar New Year. Community health advisors in Denver make an effort to "get out" into the community and build relationships with potential applicants (see Box L).

Using Local Media and Marketing

As mentioned above, part of an outreach strategy involves placing notices, pamphlets, and applications in libraries, churches, beauty parlors, and other trusted locations where people visit and/or congregate. But a

BOX K: COLLABORATION IN EL PASO, TX

In El Paso, the West Texas CHIP Collaborative oversees the S-CHIP outreach and enrollment efforts in the six-county region. The Collaborative is a group of 150 CBOs, including schools, health clinics, small businesses, churches, and nonprofits working together to raise community awareness about the Medicaid and S-CHIP programs. El Paso-Community Voices is a member of the Collaborative, and was one of the organizations instrumental in developing the outreach plan for the region and a one-time financial support contributor for the initiative.

In addition to targeting schools, small businesses, and faith-based organizations, the Collaborative's workers (including seven full-time outreach workers and 20 summer interns) canvass the region by distributing literature in malls, grocery stores, and other locations that people frequent.

The Collaborative was created in April 2000 to facilitate enrollment in Texas' S-CHIP program, which began enrolling people on June 1, 2000. By August 2000, over 16,000 children had applied for S-CHIP in the region; over 4,000 had enrolled, and another 4,000 were awaiting eligibility determination. In addition, the region made 1,500 Medicaid referrals.

The Collaborative set a self-imposed goal of enrolling 20,000 kids; by July 2001, they had reached 80 percent of that goal. In April 2001, the Collaborative received an award from the state for the highest enrollment for a region with a population over 500,000, and now serves as a model for other parts of the state.

Sources: August 2000 Status Report of Collaborative, and personal communication with Jose Moreno, Former Executive Director, Community Voices; and Esteban Zubia, Project Manager, Regional CHIP Office, El Paso, Texas.

BOX L. BREAKING THE ICE IN DENVER

"You meet so many interesting people through presentations. I presented to a small audience in an early childhood education program. They are what is considered the parent group. I passed out all the information on health care and did my presentation. I encouraged them to ask questions. They were quiet at first, but slowly they began to ask about the programs and what it would take to enroll.

"I realized that before I could get them to confide in me, I had to break the ice. I had taken some bubbles with me for the children. I gave each parent a bottle and kept one. I proceeded to blow the bubbles and then they started to join in. We all laughed. By the time we finished the meeting, we were shaking hands and they were asking me to return, so they could bring their friends. It's amazing how a simple bubble could break the ice."

-Benita Muniz-Gallegos
COMMUNITY HEALTH ADVISOR, NORTHWEST DENVER
For full text, see the W.K. Kellogg Foundation Community Voices website: www.communityvoices.org.

community-based organization, often in collaboration with state agencies and coalitions, can conduct a focused marketing campaign based on the culture and characteristics of the local, targeted populations. It is also important to target health care providers, who are often the first ones to encounter and identify uninsured individuals, and play a critical role in referring patients to organizations that conduct enrollment.

A successful marketing campaign focuses on a grassroots outreach effort linked with provision of information and tools for enrollment. In addition to placing material in community businesses and organizations (schools, churches, clinics), a local marketing campaign should include:

- Advertisements in local newspapers, radio, and television stations — in Spanish and/or another language depending upon the target population in the area;
- Information and enrollment kiosks at malls;
- Physician appearances on local television and radio talk shows;
- Newspaper inserts containing information about the program, eligibility and application forms; and
- Promotional materials that are attractive and appeal to children and parents. The West Virginia outreach effort includes producing and distributing child-friendly promotional products (see Box M).

Providing Scholarships

In states that impose enrollment and recertification fees (e.g., North Carolina, Texas, Colorado) and/or premiums for S-CHIP, enrollment can be facilitated through financial assistance for the most needy. Health Choice, North Carolina's S-CHIP, provides coverage for children of families with incomes between 100-200 percent of the federal poverty level. However, families between 150-200 percent of the poverty level are required to pay a one-time enrollment fee of $50 per child, with a maximum of $100 per family. The FirstHealth system provides enrollment fee scholarships for families unable to afford the fee. During the year 2000, FirstHealth was able to assist 78 percent of the families in Moore County required to pay an enrollment fee and 90 percent of those families in Hoke County required to pay a fee. North Carolina also requires recertification fees for S-CHIP; FirstHealth provides scholarships to cover these fees as well.

Even for those states that do not impose enrollment fees, the S-CHIP program generally does require some premium and cost-sharing requirements. Scholarships for those fees can be considered when families are experiencing special financial hardships or circumstances.

Section 4. Government Policies that Influence Community Enrollment Efforts

While outreach and enrollment essentially take place at the community level, both state and federal policies have a considerable influence on local efforts. CV directors and outreach/enrollment workers report public policies that assist them, as well as public policies that frustrate them. Below, we present these policies, along

Box M. Black Bear Beanie Babies in West Virginia

Through a contract from the West Virginia CHIP Agency, the WV S-CHIP collaborative purchases promotional materials including Beanie Babies in the shape of the state animal, the black bear, which has been very popular. It also purchases and distributes CHIP t-shirts, hats, sunglasses, toothbrushes, pencils, flyers/brochures, posters, and yo-yos.

As part of its back-to-school effort, the collaborative has purchased hundreds of backpacks stuffed with school supplies that outreach coordinators will give to children who return health insurance questionnaires and/or have sports physicals at outreach clinics.

Source: Personal communication with Brian Cunningham,
WV Healthy Kids Coalition and the WV Primary Care Association, West Virginia.

with recommendations for expanding the helpful ones, and eliminating or reducing those that hinder enrollment.

State and Federal Policies that Hinder Community Efforts

While there are some state actions that are facilitating community efforts, other state and federal policies are frustrating local outreach and enrollment activities. Some of these barriers are related to philosophical or political issues, while many are based on financial constraints. Following are some of the obstacles that CV organizations have encountered:

Political and Philosophical Barriers

- ***Non-eligibility for many immigrants.*** The exclusion of recent immigrants (those arriving after August 22, 1996, and residing in the U.S. less than five years) and undocumented immigrants from federally funded health coverage programs has been termed frustrating and counter-productive by many outreach workers. Uninsured immigrants go without needed primary and preventive care, and wind up going to ERs, which is a more costly and often inappropriate setting. Further, as discussed above, access to appropriate health care is important to promote healthy and productive members of society. States do have the option to expand eligibility to these groups using state-only dollars, and should consider the long-term benefits of doing so.
- ***Requiring information about non-custodial fathers.*** The practice of obtaining information about non-custodial fathers when mothers apply for Medicaid and other social services is one of many ways states attempt to identify non-custodial fathers and require them to contribute toward child support. This particular method, however, has the unintended negative consequence of keeping many mothers from applying for coverage for themselves and their children. According to some CV workers, some women want to maintain positive relationships with the fathers, who may be providing occasional assistance and gifts. The women do not want to "turn the dads in." To eliminate this "disincentive" to enroll, states should consider eliminating this requirement, and hold non-custodial parents accountable for their financial responsibility to their children in other ways.
- ***School-based clinics are often not Medicaid providers.*** Managed care, the primary form of Medicaid and S-CHIP coverage for children, is problematic when school-based clinics are not recognized as "participating providers." **While some state budget officials have expressed concern that Medicaid reimbursement to school-based clinics would lead to schools shifting costs of some non-medical services to the Medicaid budget, advocates stress that schools are already providing important primary and preventive health care, and they should be adequately reimbursed and supported.** In September 2001, New Mexico began to pilot a program in which five school-based clinics are designated Medicaid managed care sites and recognized as the "primary care provider" for children. Other states would benefit from similar pilots and/or monitoring New Mexico's progress and following suit, if the pilot proves successful without large, unjustified cost implications.

Barriers Related to Financial Constraints

- ***State enrollment freezes and budget caps.*** Aggressive community-level activity has been frustrated when the state has frozen enrollment in public programs, generally due to budget shortfalls or spending caps. Examples include the following:
  - In North Carolina, the state froze S-CHIP (Health Choice) enrollment in early 2001, leaving 15,000 children on its S-CHIP waiting list. FirstHealth enrollment activities were left "in limbo," as enrollment levels declined due to attrition (since children must re-enroll every year, a certain number fail to re-enroll each month because parents move, family income rises, or other reasons). Over the months of the freeze, about 20,000 children left the program. After nine months, the freeze was lifted with the passing of the state budget at the end of September 2001. But enrollment has fallen dramatically in the interim, due to attrition without new enrollment. FirstHealth and other enrollment organizations have new challenges in restoring public trust; they must convince parents that Health Choice will not disappear again.
  - In Colorado, TABOR (Taxpayers Bill of Rights, which was enacted in 1992) prohibits annual

state spending growth greater than 5 percent in any one sector of the economy. This limits the ability to expand enrollment substantially, unless savings can be generated elsewhere in the program.

- ***Stringent eligibility criteria.*** Stringent Medicaid eligibility criteria, particularly for adults without children, force communities to turn away large numbers of applicants for public coverage. **While eligibility varies from state to state, overall, more than four out of five uninsured adults (without children) with incomes below 200 percent of the federal poverty line are ineligible for Medicaid or other public health coverage.**[17] Also, an adult generally must be disabled for at least one year before being eligible for Medicaid,[18] precluding critical early intervention for some people and frustrating outreach workers (see Box N). **Outreach and enrollment workers also are frustrated at having to exclude certain family members, such as fathers and grandmothers. Thus, even with effective outreach and enrollment, there are still populations that are outside the current public and private insurance systems.**

While eligibility varies from state to state, overall, more than four out of five uninsured adults (without children) with incomes below 200 percent of the federal poverty line are ineligible for Medicaid or other public health coverage

- ***Limited state payments for outreach.*** States generally provide payments to local organizations engaged in S-CHIP enrollment, often based on the number of applications completed. States frequently do not, however, help cover the costs of the outreach that is needed up front to find potential applicants, engage them, educate them about the programs and eligibility criteria, and get people "in the door." This payment system reflects a lack of recognition of the value of outreach, and forces some CBOs to seek private grants, reallocate funds from other areas, and/or cut back their outreach activities.
- ***Inadequate reimbursement to providers.*** Another obstacle occurs when states do not provide sufficient funding or regulatory requirements to ensure provider participation at a level that would adequately serve public program enrollees. In El Paso, S-CHIP reimbursement has been so low that many physicians and other providers do not want to take these patients. The local safety net is inadequate to

Box N. Stringent Eligibility Criteria Frustrates Outreach

"In Michigan, we encounter low-income people with diabetes, whose vision is failing. Laser surgery would reverse the blindness that is setting in, but these folks are not eligible for Medicaid and can't afford the treatment.

"We know of one woman who was operating day care in her house. She once watched eight kids, but now she has only three because her vision is failing. Her income met the financial criteria for Medicaid, but since she was still able to see shapes, Medicaid's Medical Review Team consistently ruled that she was not disabled. We tried three times to get her Medicaid, but she has to wait until she's completely blind and unable to work for one year to get the coverage and the surgery. But by that time, they can't reverse the blindness."

-Polly McGreevy
OFFICE OF PUBLIC POLICY INITIATIVES, HENRY FORD HEALTH SYSTEMS, DETROIT, MICHIGAN

[17] *The Health Care Safety Net: Millions of Low-Income People Left Uninsured.* Families USA, July 2001.

[18] Also, according to federal SSI criteria, a person with a disability that precludes him/her from doing any kind of work for which they are suited and that is expected (and documented by a physician) to last for at least a year or to result in death (such as certain forms of cancer and some neurological cases) is eligible for Medicaid.

treat even those enrolled in public programs, not to mention the children in the state who are in the process of enrolling in S-CHIP.

Generally, the policy barriers described above are related to financial constraints at the state level. They are likely to be exacerbated during the economic downturn, as state tax revenues decline while the need for state-funded health and social welfare services (e.g., by people who lose their jobs and their families) expands. States will be challenged, and will likely require additional federal support, merely to sustain current enrollment and benefit levels in Medicaid and S-CHIP. *Actually expanding eligibility, funding, and reimbursement rates may be very difficult – though not impossible – during an economic slowdown.*

States, for example, can use unspent federal funds from FY 1998 toward enhancing outreach, permitted under the Benefits Improvement and Protection Act of 2000. Policymakers can help by supporting proposals that would provide federal grants for outreach.

In addition, states can expand Medicaid and S-CHIP eligibility using new flexibility granted under the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative in 2001. The primary goal of HIFA is to encourage new comprehensive state approaches that will increase the number of individuals with health insurance coverage while not increasing current-level Medicaid and SCHIP spending. The federal government puts a particular emphasis on broad statewide approaches that maximize private health insurance coverage options, and that target resources to populations with incomes below 200 percent of the federal poverty level (FPL). *States may include "expansion populations" such as childless adults, as well as increasing income limits for children and parents.*

Policymakers also can help by refocusing the debate toward the need to invest in health programs as a long-term strategy toward building a healthier and more productive society, *particularly* in difficult economic times. In addition to maintaining and expanding existing public programs, policymakers could invest by providing financial and technical support for innovative, community-based coverage programs. A few CV communities, for example, have developed health plans for people who are not eligible for Medicaid or S-CHIP and who are unable to afford coverage (see Box O). Such plans help provide essential care to previously uninsured individuals, and serve as critical pilots for broader programs. However, without an ongoing, stable funding source, they generally struggle with budgetary constraints and, to date, remain relatively small in scale.

Finally, policymakers must concentrate on developing affordable coverage options for small businesses. A small number of states have instituted premium subsidy programs. Their experiences, to date, indicate that like the outreach/enrollment efforts described in this report, enrolling private employers and workers is a "hard sell," requiring door-to-door education and outreach.

> In El Paso, S-CHIP reimbursement has been so low that many physicians and other providers do not want to take these patients.

Meanwhile, communities will need to adjust to tighter financial constraints, for example, by focusing on outreach and enrollment strategies that are cost-effective. Local governments and CBOs will need to be creative in seeking other funding sources (including private foundations) to preserve the progress they have made and to continue their successful outreach activities. They may need to shift some resources toward retaining those people already enrolled, helping them navigate and utilize the health care system effectively, and identifying and addressing related social welfare needs.

STATE POLICIES THAT ENHANCE ENROLLMENT AND FACILITATE COMMUNITY EFFORTS

State Policies to Simplify the Enrollment Process

After slow enrollment during S-CHIP's early years, most states have responded by taking steps to simplify the application and enrollment process and intensify information campaigns. These state policies have, indeed, been very successful in expanding enrollment and in facilitating local outreach and enrollment efforts, and

should be adopted universally. Specific state-level strategies include the following: [19,20]

- ***Simplified application and submission.*** Many states made the application forms shorter and easier to understand, requiring less information. Some allow applicants (for initial enrollment and/or recertification) to submit forms by mail or Internet, or apply through a statewide toll-free hotline.
- ***Joint application for S-CHIP and Medicaid.*** Among the 32 states that have separate S-CHIP programs, 28 use joint applications for Medicaid and S-CHIP. This allows the states to create a unified outreach message and makes application easier.
- ***Elimination of face-to-face interviews.*** Forty states and the District of Columbia have eliminated requirements for in-person interviews, reducing the "hassle" factor, particularly for working people.
- ***Reduced documentation requirements.*** Generally, states have reduced verification requirements. Some require only proof of income and immigration status of non-citizens (while others require verification of child's age and deductions from gross income). Ten states allow self-declaration of income without written proof, and some conduct computer matches with records from other agencies.
- ***Elimination of asset tests.*** Removing the inquiry into the personal property a family owns makes it easier for low-income children to qualify, makes families less reluctant to apply, and simplifies the application process. Forty-two states and the District of Columbia dropped the asset test in both their Medicaid for children and S-CHIP programs.
- ***Consistent income eligibility levels.*** Forty states and the District of Columbia cover all children under the age of 19 up to 200 percent of the FPL (15 of these states cover children above 200 percent of the FPL).
- ***12-month continuous eligibility.*** Thirteen states have extended Medicaid and S-CHIP eligibility to one year before recertification (even if a family's income or circumstances change during the year) to decrease paperwork for families and subsequent administrative costs. Continuous eligibility also makes it more likely that children will fully benefit from preventive services, and less likely that medical treatment will be disrupted.
- ***Presumptive eligibility.*** Some states allow immediate, temporary enrollment for a child already enrolled in other public assistance programs such as WIC, Head Start, or subsidized child care, if preliminary information suggests the family is Medicaid- or S-CHIP-eligible. Many states have presumptive eligibility for pregnant women in Medicaid.
- ***Expanded out-stations.*** Enrollment sites have been expanded to more convenient (and less "intimidating") locations, some with extended hours.
- ***Media campaigns.*** Nearly all states have stepped up media campaigns to inform the public about S-CHIP; they generally contract with private and/or local organizations to conduct information dissemination and outreach.

Additional State Efforts that Facilitate Community Efforts

Beyond state efforts to simplify the application and enrollment process, many states have taken additional steps that help communities in their outreach and enrollment efforts. Following are some of these state actions reported in CV communities, which should be adopted by states nationwide:

- ***Assistance from and "co-location" of state workers.*** **Many CV organizations note that it has been helpful when state workers come to communities to assist and conduct enrollment, or to educate CBOs about the rules and changes in public coverage programs and about successful outreach strategies.** In New Mexico, the state places "Response: Medicaid On-Site Assistance" (MOSA) workers at community sites and school-based settings. The MOSA workers inform individuals as to the eligibility and information requirements needed to qualify for Medicaid. By decentralizing eligibility workers to community-based sites, access to publicly sponsored programs is improved.
- ***Support from governor.*** Having a governor or other high-ranking state official championing the enrollment process can be very helpful to community-based efforts. West Virginia's Governor Bob Wise, for example, created much publicity for S-CHIP enrollment by visiting five rural clinics. He also

[19] "Making it Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures: Individual State Profiles." Prepared by Donna Cohen Ross and Laura Cox, Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured. October 2000.

[20] See HCFA website for all State Child Health Plans at www.hcfa.gov/init/chpa-map.htm. Current as of August 2001.

helped recruit volunteers to go door-to-door with S-CHIP/Medicaid information in low-income neighborhoods.

- ***Reduced waiting period.*** Some states have reduced the amount of time that children leaving private insurance must wait before they are eligible for public coverage, allowing communities to enroll more uninsured children. North Carolina, for example, reduced this waiting period from six months to two months.
- ***Vouchers for services.*** Some states provide medical care for low-income pregnant women who do not otherwise receive Medicaid services, or who are first applying for Medicaid or S-CHIP coverage. For example, Michigan's Maternity Outpatient Medical ("MOM") vouchers are given to certain low-income pregnant women,[21] to allow them immediate access to prenatal care, while assuring the providers of such care timely reimbursement for their services. MIChild workers give these vouchers to pregnant applicants, help the young women choose a clinic that participates in the program, and even schedule their first appointment.
- ***Retrospective payment for ER visits.*** Michigan is among the states that allow retrospective payments for three months for people who are eligible but not yet enrolled in Medicaid or S-CHIP coverage when they visit an emergency room. This helps hospitals, particularly safety net institutions, obtain needed reimbursement, and provides incentives for ER staff to facilitate and promote enrollment.
- ***Potential to use database to notify of eligibility.*** **In New Mexico, the state has developed a database with income-related information to determine whether certain low-income people are eligible for a tax rebate.** This system could potentially be used to identify people eligible for Medicaid/S-CHIP based on income criteria, so that states could notify those who are not enrolled. This strategy has been debated within the state.

Box O. Community-Based Health Plans Try to Fill Void

A few CV organizations have been involved in establishing community-based health plans for the uninsured. Outreach and enrollment workers in each of these localities are knowledgeable about these local health plans as well as Medicaid and S-CHIP eligibility, and help determine which of the options is appropriate, if any.

UNM Care Plan: The University of New Mexico Health Sciences Center established the UNM Care Plan, a managed care program for uninsured residents of Bernalillo County, New Mexico, with family incomes below 235 percent of FPL. The plan pools county indigent care funds with resources of local safety-net providers, and links uninsured patients with primary care providers at accessible, neighborhood-based clinics in Albuquerque. Begun in 1997, the program had approximately 14,000 enrollees as of October 2001.

Ingham Health Plan (IHP): IHP is a health coverage program for uninsured residents of Ingham County, Michigan, with incomes below 250 percent of the FPL who are not eligible for Medicaid or other public coverage programs, and for former enrollees in the State Medical Plan program. Administered by the nonprofit Ingham Health Plan Corporation, IHP began in 1998 and had an average enrollment of 11,500 to 12,000 during 2001. A major media promotion campaign in October 2001, followed by grassroots community outreach, is expected to lead to a jump in enrollment at the end of 2001 and into 2002.

Primary Care Plan: The El Paso Community Voices Primary Care Plan for the Uninsured provides comprehensive benefits using managed care principles to cover some of the county's 70,000 uninsured individuals below 100 percent of the FPL. The plan is administered by El Paso First Health Network (EPFHN), a managed care plan owned by the El Paso County Hospital District. Begun in 1999, the plan had roughly 2,500 Primary Care Plan members as of March 2001.

[21] Such as new applicants to MIChild and those under 18 years old who are eligible but choose not to participate in Medicaid for confidentiality or other reasons.

Box O. Community-Based Health Plans Try to Fill Void (Continued)

FirstConnection: FirstConnection is a two-year pilot case management and health care services program for uninsured children and adults in the rural mid-Carolinas (Moore and Montgomery Counties) with incomes less than 200 percent of FPL and not eligible for other public coverage programs. It was developed and is operated by FirstHealth of the Carolinas, a not-for-profit health system. Begun in May 2000, 91 adults and 84 children were enrolled as of October 2001.

Family Care: Family Care is a subsidized health plan designed to meet the needs of uninsured working families, including undocumented residents, in Alameda County, California. It was developed and is administered by the Alameda Alliance for Health, a nonprofit, public health plan serving more than 73,000 Alameda County residents. The program began in July 2000, and had enrolled 3,935 people as of November 2001.

Source: Silow-Carroll, Sharon, Stephanie E. Anthony, Paul A. Seltman, and Jack A. Meyer. *Community-Based Health Plans for the Uninsured: Expanding Access, Enhancing Dignity.* Prepared by the Economic and Social Research Institute for the W.K. Kellogg Foundation, A Series of Community Voices Publications, November 2001, (with updated enrollment numbers).

Section 5. Conclusion: Ongoing Challenges

Communities across the country are making great progress in reaching and enrolling eligible children and adults – including some "hard-to-reach" populations – in public coverage programs. This report has highlighted the many successful techniques pursued by Community Voices organizations and their partners. But we also have revealed some remaining holes in the fabric of the safety net that disrupt and pull families and communities apart. The frustrations faced by communities that are trying to patch those holes will likely be exacerbated by adverse economic conditions and tighter public budget constraints.

We have pointed out that challenges go beyond filling out applications and submitting forms. Enrolling eligible people is only the beginning of the process toward ensuring access to appropriate, quality health care. Once people are enrolled in public (or private) health coverage, ongoing challenges include: 1) helping enrollees navigate and appropriately utilize the complex health care system; 2) encouraging healthy lifestyles, prevention, and early intervention; 3) reducing non-financial obstacles to care related to language and culture, lack of transportation and child care, and others; 4) keeping people enrolled in coverage; and 5) ensuring adequate provider capacity to serve enrolled populations.

And, of course, a broader societal challenge involves expanding access to coverage and services to people who are not currently eligible for public programs and who cannot afford private insurance. Other Community Voices publications focus on some of these populations, such as uninsured workers, widowed and divorced older women, and men of color.[22] There are few, if any, viable options for these groups who remain outside of any current insurance/payment program. In order to create a productive, healthy society, the real goal is enabling all individuals and families to obtain appropriate, affordable health care.

[22] See Community Voices publications at www.communityvoices.org. Relevant reports include: *Workers Without Insurance: Who Are They and How Can Policy Reach Them?* (Bowen Garrett, Len M. Nichols, and Emily K. Greenman, The Urban Institute, October 2001); *Too Few Options: The Insurance Status of Widowed or Divorced Older Women* (Amanda McCloskey, Rachel Klein, Families USA, March 2001); *A Poor Man's Plight: Uncovering the Disparity in Men's Health* (John A. Rich, M.D., Marguerite Ro, MPH, DrPH, February 2002).

Appendix A. Resources for Outreach/Enrollment Community Workers and Policymakers

Websites

www.stateserv.hpts.org
National Conference of State Legislatures – Summaries of all S-CHIP plans and amendments, general state information, issues briefs.
TARGET: POLICYMAKERS

www.nashp.org/progs/prog0001.htm
National Academy for State Health Policy – Children's Health Insurance Program (CHIP) Implementation Center; information and tools to assist states in planning, implementation, and refinement of their Children's Health Insurance Programs.
TARGET: POLICYMAKERS, STATE ADMINISTRATORS, COMMUNITY-BASED ORGANIZATIONS, HEALTH CENTERS

www.kff.org
Kaiser Family Foundation – Reports on S-CHIP, access to care, family profiles.
TARGET: POLICYMAKERS

www.cbpp.org/shsh
Center for Budget and Policy Priorities – Start Healthy/Stay Healthy campaign information – national outreach effort to identify children from low-income working families who may be eligible for free or low-cost health insurance programs.
TARGET: COMMUNITY-BASED ORGANIZATIONS, HEALTH CENTERS, VOLUNTEERS

www.brightfutures.org
Promoting health education and well-being of children birth-21. Publications, special topics areas; guides, printed information.
TARGET: COMMUNITY-BASED ORGANIZATIONS, HEALTH CENTERS

www.ncemch.org
National Center for Education in Maternal and Child Health – Databases, reports, MCHLine, National Maternal and Child Health Clearinghouse, MCH projects database.
TARGET: POLICYMAKERS

www.coveringkids.org
National health access initiative funded by the Robert Wood Johnson Foundation to help states and local communities increase the number of eligible children. Profile of grants to the states.
TARGET: PARENTS, POLICYMAKERS, PRESS (SECTIONS TARGETING EACH ARE DISTINGUISHED)

www.nccic.org
National Child Care Information Center – publications, different child care topics with reports.
TARGET: POLICYMAKERS

www.insurekidsnow.gov
Overview of state's programs. Provides links to each state. Questions and answers regarding S-CHIP.
TARGET: PARENTS, ACTIVISTS, COMMUNITY-BASED ORGANIZATIONS, HEALTH CENTERS

www.childrensdefense.org/health-chip.htm
Children's Defense Fund – Comprehensive overview of S-CHIP and the different health issues affecting children, frequently asked questions, articles and reports.
TARGET: PARENTS, POLICYMAKERS, STATE-LEVEL OFFICIALS

www.nga.org
National Governors Association – Center for Best Practices. Reports, summaries of the states.
TARGET: POLICYMAKERS, STATE-LEVEL OFFICIALS

www.amchp1.org
Association of Maternal and Child Health Programs – Reports, fact sheets, issues briefs, position papers.
TARGET: POLICYMAKERS, STATE-LEVEL OFFICIALS

www.astho.org
Association of State and Territorial Health Officials – the ASTHO Report, briefs, Primary Care Network News newsletters.
TARGET: STATE-LEVEL OFFICIALS

www.familiesusa.org
Families USA – Legislative information-state and federal, reports from other organizations, publications, press releases.
TARGET: GENERAL PUBLIC, POLICYMAKERS

www.insureakid.org
Insure·a·kid – Community-wide partnership to increase number of insured children in Texas. Community events, volunteering opportunities, overview of benefits, online application.
TARGET: COMMUNITY MEMBERS, PARENTS

www.cwla.org
Child Welfare League of America – Links to state programs, fact sheets.
TARGET: PARENTS, GENERAL PUBLIC

www.hcfa.gov/init/children.htm
Health Care Financing Administration – State contact information, approved plan information, enrollment statistics, outreach, title XXI legislation, regulations and allotment notices, White House information.
TARGET: POLICYMAKERS

www.hcfa.gov/init/outreach/outhome.htm
Health Care Financing Administration – Outreach Information Clearinghouse.
TARGET: POLICYMAKERS, COMMUNITY-BASED ORGANIZATIONS, HEALTH CENTERS

www.aap.org/advocacy/S-CHIP.htm
American Academy of Pediatrics – S-CHIP provisions, fact sheets, reports, evaluations of state programs
TARGET: POLICYMAKERS, ADVOCATES

www.childrenshealthmatters.org
Children's Health Matters – Outreach program to facilitate enrollment in Medicaid and other health insurance programs, and to ensure access to quality health care. Offers Medicaid Outreach Resource Kit; directories of programs and state agencies; local programs, press releases, newspaper articles
TARGET: OUTREACH AND ENROLLMENT ORGANIZATIONS

REPORTS

"Enrolling and Retaining Low-Income Families and Children in Health Care Coverage." A part of the Department of Health and Human Services effort to work with states on access to health benefits.
http://www.hcfa.gov/init/outreach/progress.pdf

"Reaching our Children: A Compendium of Outreach Models." Describes strategies used to increase enrollment in public health care insurance programs and highlights community-based projects that focus on increasing access and preventive services to children.
http://www.hrsa.gov/childhealth/outreach.htm

"Putting Express Lane Eligibility into Practice." Details the practice of utilizing information from other public benefits programs to quicken enrollment into Medicaid and S-CHIP.
http://www.kff.org/content/2000/2211/expresslane.pdf

"Marketing Medicaid and CHIP: A Study of State Advertising Campaigns." Nationwide analysis of states' advertising campaigns to enroll eligible kids into health coverage programs.
http://www.kff.org/content/2000/2213/2213.pdf

"Addressing the Barriers to Covering Kids." Details the research conducted in support of the campaign to enroll eligible children in Medicaid and S-CHIP.
http://www.coveringkids.org/infocenter/docs/WirthlinCKIrpt4-01.pdf

"How Social Workers Can Link Children to Free and Low-Cost Health Insurance." Describes how social workers can play an integral role in improving the health status of children they serve.
http://www.cbpp.org/5-4-01health.pdf

"Enrolling Children in Health Coverage: It Can Start with School Lunch." Reports on how state child nutrition agencies and local school districts explored the school lunch program as an avenue for effective outreach.
http://www.cbpp.org/1-1-01health.pdf

"Exploring a New Option: Section 1115 Demonstration Waivers Under the State Children's Health Insurance Program." Provides background on the waivers and general assistance to states that may consider this alternative.
http://204.131.235.67/programs/health/Forum/1115waivers.htm

"CHIP Under the Microscope: An Evaluation of the Effectiveness of CHIP Outreach and Enrollment Practices in Hamilton County, Ohio." Details successful practices and recommends improvements to ensure children receive access to care.
http://www.cdfcinti.org/microscope.pdf

SHOUT Tool Kit – Student Health Outreach Project. Student-run project conceived to recruit students to work on enrolling children in S-CHIP.
http://www.childrensdefense.org/health-publications.htm

"Making it Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures." A study of the enrollment process in the 50 states and Washington, D.C.
http://www.kff.org/content/2000/2166/

Highlights from the Promotoras/Community Health Workers Grantees Convening June 2000. Discusses challenges and successes of promotoras model.
http://www.calendow.org/pub/publications/promotore.pdf

NEWSLETTERS

"Sign them Up" by the Children's Defense Fund. Quarterly newsletter that highlights successful outreach and enrollment strategies throughout the states.
http://www.childrensdefense.org/signthemup.htm

"Bright Notes" The newsletter of Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.
http://www.brightfutures.org/newsletter/index.html

"S-CHIP Update" Monthly update from the American Academy of Pediatrics.
http://www.aap.org/advocacy/schiprep.htm

"asap!Update" Tri-annual publication of Families USA.
http://www.familiesusa.org/html/asap/asap.htm

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