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

Prepared for
The Kaiser Commission on Medicaid and the Uninsured
by
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Health Care Systems Research, Inc
Washington, DC

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THE HENRY J. KAISER FAMILY FOUNDATION

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

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Chapter I

Synthesis of Study Results

The large number of children without health insurance has been a national and state concern for more than a decade. To address this problem, Congress first began to expand Medicaid eligibility for children in the late 1980s, when the Omnibus Budget Reconciliation Act of 1986 (OBRA-86) first allowed states to expand coverage to young children living in poverty, regardless of their eligibility for cash benefits. Beginning in the early 1990s, states have used Federal options and research and demonstration waivers to further expand eligibility for Medicaid to children in low-income families.

Despite these efforts, the proportion of children without insurance has remained substantial. By 1994-95, 10.6 million children were uninsured. This group includes 4.5 million children with family incomes that should qualify them for Medicaid, and an additional 3 million children with family incomes below 200 percent of poverty (Ullman, et al., 1998). Moreover, the proportion of children with private health insurance has declined: in 1987-89, 74 percent of children had private insurance, compared to 66 percent in 1994-96 (Children's Defense Fund, 1997).

In 1997, when the number of uninsured children had reached 11.3 million, Congress passed the Balanced Budget Act of 1997, creating a new source of coverage for low-income children in the Children's Health Insurance Program (CHIP), codified in Title XXI of the Social Security Act. CHIP expanded public-sector health coverage to a new population of low-income working families, permitting states to create new health insurance programs (or to expand existing Medicaid programs) to cover children with family incomes up to 200 percent of the Federal poverty level (FPL).

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

The idea of simplifying eligibility determination processes for children is not new. Building on their success enrolling Medicaid-eligible pregnant women through streamlined application systems, states began eliminating asset tests and developing shortened application forms for children in the late 1980s. By 1997, 29 states had dropped the asset test for children, 25 states had developed mail-in Medicaid application forms, and 35 states had shortened their

application forms for pregnant women and/or children (National Governors' Association, 1997). However, in their first few months of implementation, states have not realized the success enrolling children that they did with pregnant women.

To further explore these issues, the Kaiser Commission on Medicaid and the Uninsured commissioned a three-part study of Medicaid and CHIP outreach and enrollment systems with support from the Henry J. Kaiser Family Foundation. This study included a national survey of families of children potentially eligible for Medicaid, with a particular focus on four states, and four communities in those states. The study included three elements:

- An over-sample representing these four communities in the national survey;
- Focus groups of families with children eligible for Medicaid, both enrolled and not enrolled in the program, in the four study communities; and
- Case studies describing and analyzing the outreach and enrollment systems in place in the study communities.

This study describes four states' strategies for reaching out to and enrolling children in Medicaid and CHIP in order to highlight the particular issues and challenges states face as they design these strategies. This report presents the results of the four case studies. The study sites selected were Santa Clara County (San Jose), California; Bibb County (Macon), Georgia; Cuyahoga County (Cleveland), Ohio; and Bernalillo County (Albuquerque), New Mexico.

Methods

The four study sites were chosen to represent a range of geographic regions, sizes, demographic distributions, and CHIP implementation strategies. Table I-1 shows critical characteristics of each of the study sites.

The study methods involved three- to four-day visits conducted at each site by two-person teams. Each site visit began with a day in the state capital, during which officials of state Medicaid and CHIP programs, state public health officials, and representatives of child advocacy organizations and primary care associations were interviewed. The next two to three days were spent in the local communities, interviewing administrators of social services agencies, front-line eligibility workers, outreach workers, and representatives of provider agencies (such as public health departments, hospitals, and managed care plans) and other agencies involved in promoting health insurance programs for children or assisting with enrollment. Standard protocols were used for each category of informant.

Table I-1
Characteristics of Case Study States

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

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

The case studies explored two major issues: the extent and approach of states' and communities' efforts to identify and reach out to families with potentially eligible children, and the degree to which eligibility determination processes for both Medicaid and CHIP were simple and consumer-friendly. Many initiatives observed in local communities addressed both of these concerns. Therefore, for clarity in our analysis, we will distinguish between these two issues as follows:

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

This report is organized into five chapters. This chapter presents an analysis of the findings of the four case studies in the areas of outreach and enrollment. The four chapters that follow provide more detailed case studies of the outreach and eligibility efforts observed on the state and local levels in each of the four study states.

Outreach and Enrollment Strategies

The four case study states and communities provided examples of a wide range of strategies for publicizing Medicaid and CHIP programs, identifying and referring potentially eligible families, and streamlining and simplifying the process of eligibility determination. This section reviews the strategies in use in the study states, first in the area of outreach and then in the realm of eligibility determination and enrollment.

Outreach Strategies

As defined in the previous section, outreach efforts include initiatives aimed at raising public awareness, informing families of new insurance programs, and encouraging them to apply. Effective outreach depends upon a state's or community's ability to do the following:

- Identify and describe populations of children potentially eligible for the program;
- Reach these children's families through appropriate communication strategies;
- Inform their families of the benefits of the program; and
- Motivate their families to engage the health insurance application process.

A variety of approaches is available to accomplish these goals, including mass media campaigns, community-based outreach, and one-on-one case-finding and educational efforts. These strategies, as defined below, can be seen as a continuum based on their distance from the target audience, the amount of time the audience is exposed to the message or information provided by the communication, and the potential for interaction between the communication source and the audience member.

- **Mass media**. This category includes efforts to inform the public at large of the availability of coverage, to promote the program, and to provide basic information about how to apply. Although the design of mass media messages may be informed by market research and may be targeted to specific sub-populations, this strategy does not include contact with individual consumers.

- **Community-based outreach.** This approach includes the provision of promotional information to potentially eligible families in community settings, such as community group meetings and public events. Individuals in the community, such as child care providers, school personnel, employer representatives, or outreach workers can provide information about health coverage directly to families and answer general questions about the application process.

- **One-on-one outreach**. This approach, the most personal of the three, involves direct, intensive contact between an outreach worker and a potentially eligible family. This may include targeting specific neighborhoods or communities for outreach, going door to door to find families with uninsured children, and describing programs in detail to encourage families to apply. In some states, these outreach workers distribute applications and assist with enrollment as well. Community-based and one-on-one outreach activities can work in tandem with media promotion efforts by helping families to turn a heightened awareness or general knowledge into action.

In most of the study communities, we observed a combination of mass media, community-based outreach, and one-on-one case-finding in their CHIP and Medicaid outreach efforts. The specific efforts and issues observed in each category are discussed in turn below.

Mass Media

In most of the study states, mass media and public relations strategies were the focus of state-level outreach initiatives. Three of the four states (California, Georgia, and New Mexico) contracted with marketing firms to develop their media campaigns. These campaigns typically include radio and television spots, print ads, bus cards, and billboards, as well as such collateral materials as posters, stickers, toothbrushes, rulers, and water bottles. These materials display the name and logo of the states' programs as well as the number of a toll-free hotline to call for more information. The mass media strategies used in each of the study states, and the source of funding and oversight for each, are displayed in Table I-2.

The study states have made substantial efforts to reach non-English-speaking populations with their media campaigns. California's posters and collateral materials are printed in ten languages; New Mexico's radio ads have been produced in English, Spanish, and Navajo; and Georgia's campaign is produced in English and Spanish.

California, Georgia, and New Mexico coordinate and implement their media and other outreach efforts at the state level. Ohio, by contrast, has delegated responsibility for outreach to the 88 individual counties. Cuyahoga County, the site of our case study, has contracted with an advertising agency to develop radio and TV ads, brochures, and collateral materials; many of these are available in English and Spanish.

Few of the study states based their media campaigns on market research and their messages were rarely pre-tested on sample audiences of low-income families. Rather, these campaigns were designed and implemented quickly, in order to meet demanding timelines and ambitious enrollment goals. Thus, the states and communities did not have the opportunity to tailor their media messages to address some of the concerns of low-income families or to explore how best to present their programs to encourage enrollment.

One issue that might have been addressed in a pretest is whether and how to present the connection between CHIP and Medicaid. The two states with separate CHIP programs, California and Georgia, handled this issue in opposite ways; California developed a single logo promoting "Healthy Families/Medi-Cal for Kids," while Georgia's PeachCare campaign does not mention Medicaid at all. (The two states that used CHIP to expand Medicaid have both renamed their Medicaid programs for children, so Medicaid is not mentioned in their promotional materials.) The advantage of California's approach is that the campaign applies to the total population of low-income families with children, while Georgia's describes a program that is only available to children with family incomes above the Medicaid eligibility limit. However, the disadvantage of the combined approach is that negative impressions of the Medicaid program that have developed over the years may influence the public's acceptance of the new program. This issue will be addressed further in the section on eligibility and enrollment strategies.

Table I-2
Mass Media Outreach Activities in Case Study States

	California	***Georgia***		***New Mexico***	***Ohio***
Program	*Medi-Cal/ Healthy Families*	*Right from the Start Medicaid*	*PeachCare*	*New Mexikids*	*Healthy Start*
Principal Sponsor(s)	State	State	State	State	County, State, Provider Agency
Formative Research					
Audience Research			✔		✔[2]
Mass Media Outreach					
Logo/slogan	✔		✔	✔	✔[2]
Newspaper/Print	✔			✔	
Brochures, Fact Sheets, Flyers	✔[1]		✔	✔	✔
Direct Mail	✔				✔[3]
Collateral Items	✔		✔	✔	✔[2]
Posters	✔		✔	✔	
Transit Ads	✔	✔	✔		✔[3]
Billboards	✔	✔	✔		
Public Relations	✔		✔	✔	
Television	✔		✔		✔[4]
Radio	✔		✔	✔	✔
Hotline	✔		✔	✔	✔

[1] A provider agency also sponsors brochures/fact sheets/flyers in California.

[2] The County is the only sponsor of formative research, logo/slogan and collateral items in Ohio.

[3] The state and county do not sponsor direct mail or transit ads in Ohio.

[4] Provider agency does not sponsor television ads in Ohio.

Community-Based Outreach

Community-based outreach efforts are in place to varying degrees in all four study states. These strategies provide families the benefit of receiving information from members of the community whom they know and trust; ideally, the messages and information received from these community members will carry and build on the messages in the state- or county-wide media campaign. The specific community-based channels and activities used in each of the study states, as well as their sponsoring agencies, are shown in Table I-3.

Community-based outreach workers may be based in local social service agencies, community agencies, or provider sites. Examples of these efforts include:

- In **Georgia,** community-based outreach workers employed by the state Department of Human Resources hand out information at street fairs, give presentations at community meetings, and work with local employers to distribute brochures about the state's Medicaid and CHIP programs.

- In **Cuyahoga County, Ohio,** the county social services agency uses a van, known as the Kids HealthMobile, which goes to neighborhood health fairs, parades, and other local events to promote Healthy Start. The county is also working with local school districts to distribute information to students and to conduct open houses in the evenings to present the program to parents, answer questions, and distribute applications.

- In **New Mexico**, the state Medicaid agency and state health department work together to promote the New Mexikids program at health fairs and other community events, distributing brochures and information about the program. Another distribution channel that New Mexico officials rely on is the school system; posters and flyers are distributed to interested schools and then distributed with report cards, at parent-teacher conferences, and in school newsletters.

Table I-3
Community-Based Outreach Efforts
in Case Study States

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

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

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

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

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

All of these efforts are supported with public funds from either the state or the county level. In addition, private and non-profit agencies may also conduct community outreach efforts, either with their own funds or with foundation support.

- In **Santa Clara County**, a local public-sector managed care organization has hired an outreach coordinator to promote the state's Healthy Families/Medi-Cal for Kids programs to community groups. This staff member, who is paid out of the plan's general revenues, has made presentations to local Chambers of

Commerce and provided brochures to pharmacists to distribute with prescriptions. The plan has also developed fact sheets about Healthy Families in English, Spanish, Chinese, Vietnamese, and Cambodian. These fact sheets are distributed through churches, food banks, schools, and child care centers. The plan also sponsored an outreach conference to introduce Healthy Families to the community, which was attended by more than 200 representatives of schools, churches, providers, and community groups.

- In **Bibb County**, Georgia Legal Services has become involved in promoting PeachCare for Kids on the local level. This agency provides legal assistance in civil matters, including divorce, bankruptcy, housing, and public benefits, to people with incomes under 125 percent of the federal poverty level in 23 counties in central Georgia. During the client intake process, agency staff gather information about all sources of income and are therefore in an excellent position to assess clients' eligibility for Medicaid and PeachCare. The agency's staff received training in the PeachCare program and the use of the application form from staff of Georgia Legal Services in Atlanta. Since that training, the agency has begun to distribute PeachCare brochures in its waiting room and its paralegals assist clients in filling out the application form if they report on intake that their children do not have health insurance.
- In **Cuyahoga County**, the Universal Health Care Action Network of Ohio (UHCAN), a statewide organization that works for justice in health care, works with local unions to enroll their members' children in the Healthy Start program. UHCAN works with four unions, most closely with the Service Employees International Union (SEIU), representing roughly 8,000 employees of hospitals, nursing homes, hotels, and sports venues. UHCAN and SEIU coordinated with Healthy Start staff to host events at six nursing homes, three hotels, and the SEIU union hall, where Healthy Start caseworkers filled out applications on site. In four months, the unions had submitted about 170 Healthy Start applications.

These efforts help to bring program information to the community through agencies and individuals that families know and trust, and they can serve to reinforce the messages of the media campaign if the two efforts are coordinated. In Georgia, for example, the brochures, posters, and flyers distributed in the community display the logos and messages seen on billboards and on television. In other cases, the two strategies are less synchronous. In Cuyahoga County, Ohio, each of the agencies that houses the outreach workers has developed its own brochure, posters, and, in one case, transit ads; one hospital has also established its own telephone hotline, distinct from the county-wide hotline. These materials do not contain the logos used in the county's media campaign.

One-on-One Outreach

The most personal outreach method is to approach people individually and discuss the availability of health coverage for their children. This strategy requires that outreach workers be trusted by their clients, and ideally that they themselves be members of the target community. Only two examples of this strategy were evident in our study communities. These cases are described below.

- In **Georgia**, the outreach workers described above also work individually with clients to promote Medicaid and PeachCare and to assist with applications. The outreach workers are housed in health departments, hospitals, schools, Head Start centers, community action agencies, and other community-based locations. Although these workers are state employees, they are hired from within the communities in which they work; these workers are expected to be familiar with the community and its resources and to be invested in helping their neighbors. The success of these workers is rooted in the strong bond they feel with their clients and the degree of trust the community places in them.
- In **Santa Clara County**, the local public health and hospital system has hired four indigenous outreach workers to conduct door-to-door outreach in the Latino and Vietnamese communities. These workers focus on door-to-door canvassing in low-income neighborhoods and on organizing and educating community-based organizations, particularly in the Vietnamese community. This strategy has allowed them to identify potentially eligible families who might not use county clinics. Of the families reached through these outreach efforts, 75 percent complete applications. This effort is funded by a private foundation grant.

A critical element of effective one-on-one outreach is thorough training of outreach workers; the more information a worker can provide, the more useful the worker can be to his or her clients. However, these workers are generally lay members of the community, not social service professionals. Therefore, the sponsoring agencies must negotiate the tension between training their workers to meet all of their clients' needs and overwhelming them with more information than they can handle. This problem was particularly evident in Georgia, where outreach workers and their supervisors both reported that the greatest disadvantage of their role was their inability to counsel clients about their eligibility for Food Stamps or cash assistance. However, to train them in all available programs for children would be impractical and would undermine their focus on health coverage for children. In the absence of complete program information, therefore, coordination and referral channels between outreach workers and other sources of information and support are essential.

Eligibility and Enrollment Strategies

Raising public awareness of the importance of health insurance and the availability of new programs is the critical first step toward enrolling eligible children into expanded Medicaid and/or CHIP programs. However, these strategies alone are unlikely to succeed unless they are accompanied by additional efforts to simplify and streamline the actual processes used to apply for and obtain coverage. States learned this lesson over a decade ago when implementing the various Medicaid eligibility expansions for pregnant women and infants. Beginning in 1986 and continuing through the early 1990s, the vast majority of states recognized that the existing complex and confusing eligibility process for Medicaid—actually the process for Aid to Families with Dependent Children (AFDC) to which Medicaid coverage had been linked—created a barrier to coverage, and they took dramatic steps to make the application process easier and more accessible. These steps included dropping assets limits from eligibility criteria for Medicaid-only coverage, shortening application forms, out-stationing eligibility workers at provider sites in the community (freeing families from the need to apply at a local welfare office), and permitting prenatal care providers to extend short-term presumptive eligibility to women who appeared to be eligible for Medicaid based on a cursory review of income, among others (Hill, 1987; Hill, 1992). These strategies appeared to succeed in achieving improved enrollment and rates of early entry into care among the target population (U.S. General Accounting Office, 1991; Kenney and Dubay, 1996), and these lessons were not forgotten by states when the enrollment challenges surrounding CHIP presented themselves.

Like many states across the nation, the four study states have recently taken numerous steps to simplify the eligibility and enrollment process for children. Some of these efforts predated CHIP, while others were added as an element of new children's insurance initiatives, but all share the goal of extending health coverage to both the large number of children already eligible for but not enrolled in Medicaid, as well as those children to whom new coverage options are being offered. As detailed in Table I-4, each of the four states included in this study have implemented new processes that fundamentally hinge on two strategies:

- **A shortened and simplified application form**. Each state has developed a new form, or reissued existing forms, for Medicaid and/or CHIP coverage that are shorter, simpler, and require less verification than those that serve to assess eligibility for cash assistance, Food Stamps, and Medicaid coverage.
- **Expanded points of access in the community**. Each state has also established mechanisms through which families can receive assistance in obtaining and/or completing an application in the community at sites other than traditional county social services offices.

Beyond this, three of the states—California, Georgia, and Ohio—have also made it possible for families to complete applications for at least one program entirely on their own and simply mail them in to a state or local agency for processing and eligibility determination. Brief summaries of the eligibility and enrollment simplification strategies employed by the study states are provided below.

- **California**. During the summer of 1998, California released its combined Healthy Families/Medi-Cal for Kids application packet. The packet was attractive, colorful and engaging, and was designed to permit families to complete an application for either program on their own and submit it by mail. Unfortunately, the packet was also very long (28 pages of forms and 12 pages of instructions) and complex (requiring families to calculate their "countable" income and determine which program they were eligible for, among other confusing features). The packet, which received immediate and widespread criticism (Center on Budget and Policy Priorities, 1998) was being redesigned at the time of our site visit in an effort to make it simpler for families to complete, and a revised application form was released in December 1998.

  California also launched its new "Application Assistants" initiative in conjunction with the launch of its Healthy Families program. Through this effort, the state trained staff in hundreds of community-based agencies and provider sites to help families complete the new application form. These application assistor agencies are paid a "finders fee" for every successful application with which they assist.

- **Georgia**. The State of Georgia developed a new, one-page form for its CHIP expansion—called "PeachCare for Kids"—to complement its existing three-page "Right from the Start Medicaid" (RSM) form for pregnant women and children applying for Medicaid-only coverage. A primary vehicle through which families can obtain and complete either form is the state's platoon of nearly 150 RSM Outreach Workers. These workers, state employees who were initially trained in 1995 in conjunction with Georgia's RSM Medicaid expansion, are deployed statewide in a broad range of community-based agencies and conduct active outreach to families who might otherwise choose to not seek assistance at the county social services office. RSM outreach workers can assist families with completing Medicaid applications, or simply give families PeachCare applications that they can subsequently complete and submit to the state or county by mail.

- **New Mexico**. In anticipation of federal approval of its CHIP expansion, New Mexico breathed new life into an eligibility simplification strategy that was actually nine years old. The state had implemented its Presumptive Eligibility (PE) and Medicaid On-Site Application Assistance (MOSAA) forms, each two pages in length, in the late 1980s to permit pregnant women to apply for Medicaid coverage at prenatal care provider sites. In 1998, state officials decided to use the same instrument, along with its newly adopted Presumptive Eligibility for children policy, to boost enrollment of children. New Mexico launched an aggressive training series during the summer with a broad range of community-based agencies and providers, including schools. Staff of these entities, once trained, can meet with families and complete an application, which is subsequently forwarded to local social services agencies for processing.

Table I-4
Features of Medicaid/CHIP Eligibility Determination Systems

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

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

- **Ohio**. Like New Mexico, the State of Ohio also used its existing short form—the Combined Program Application—for its Medicaid/CHIP expansion, called Healthy Start. The application, four pages in length, is available in WIC clinics, local health departments, county welfare offices, and through the state Department of Human Services' toll-free hotline, and can be completed by families on their own and submitted by mail. In addition, in some counties, families can receive direct assistance in completing their applications from providers and other community-based agencies that have received training in the process.

These strategies reflect both a recognition that traditional application forms, which determine eligibility for multiple health and welfare programs, and traditional application procedures, which require at least one visit to a social services agency, can serve as barriers to coverage. In all cases, these states have tried to create simpler application forms for publicly sponsored health insurance while also establishing a range of structures or mechanisms in communities through which to apply so that families can avoid the potential stigma associated with a visit to the welfare office. The range of eligibility strategies employed by the states is illustrated in Figure I-1.

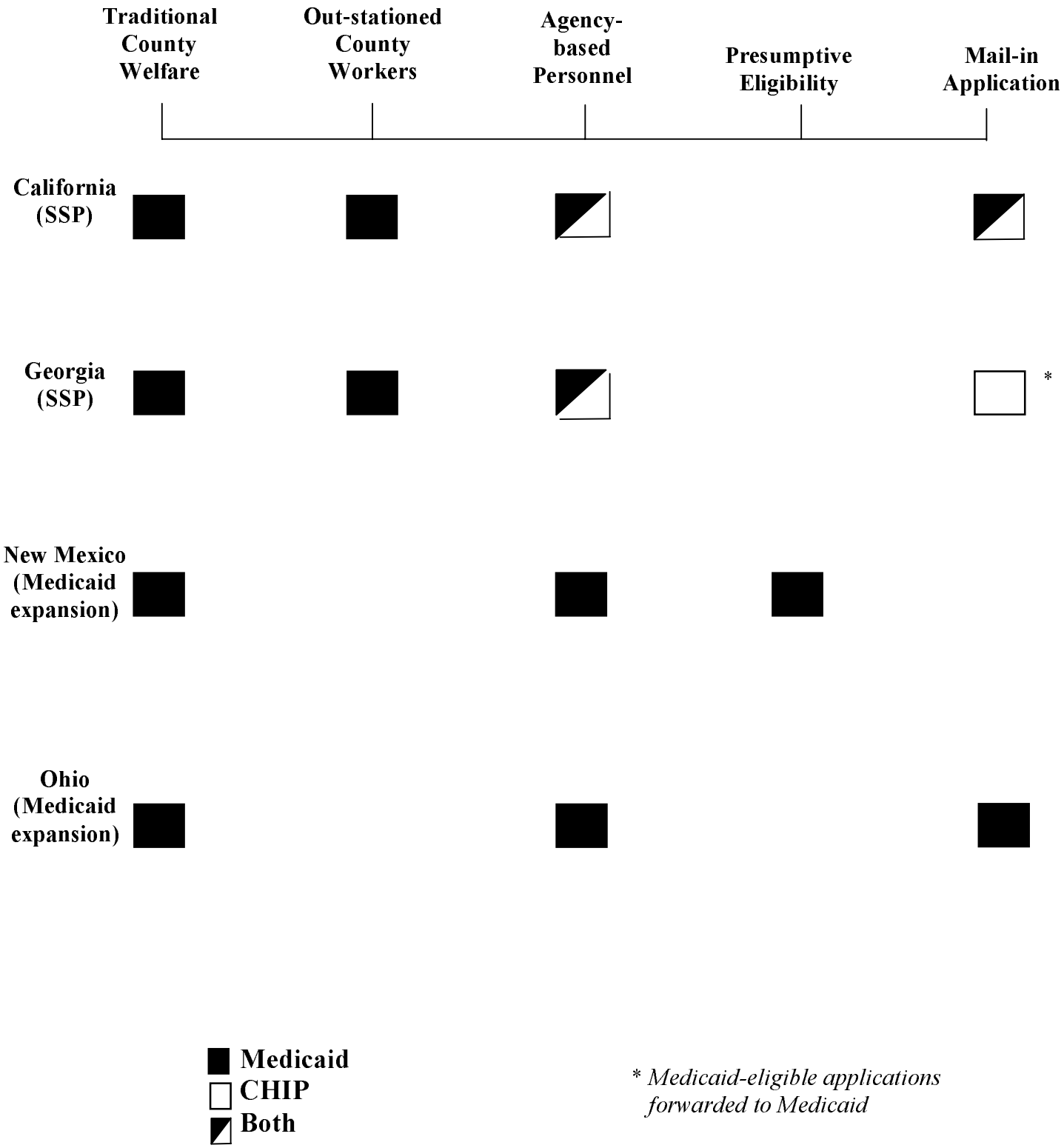
Unfortunately, however, these efforts have not succeeded in permitting any of the states to implement a truly simple process, nor one in which eligibility for Medicaid and CHIP are determined in a straightforward or seamless manner. Rather, as is also illustrated in Figure I-1, each state's eligibility process remains highly dependent on its existing social services infrastructure, including agencies, facilities, staff, and management information systems, and necessary and unavoidable interactions between clients and these systems too often undermine the promise of an easy, stigma-free application process.

Recognizing the pitfalls inherent in expanding access to coverage for children, two of the study states have used administrative data from their application and enrollment systems to analyze the success of their efforts to enroll and retain children in their Medicaid and CHIP programs. These efforts are described below.

- California collects data generated by mail-in applications to the Healthy Families program and posts them on the Managed Risk Medical Insurance Board (MRMIB) web site (similar results of the mail-in Medi-Cal application are not available on a statewide basis, as these applications are processed by the state's 58 counties individually). These data show that, of the 41,755 applications processed between June and December 1998, nearly 60 percent were completed without the help of an application assistant. Of those that had to be mailed back because of errors, 92 percent were completed without assistance. The leading reason that children are found to be ineligible for Healthy Families is that their family incomes are low enough to qualify them for Medi-Cal.

Figure I-1.

Case Study State Strategies to Determine Medicaid and CHIP Eligibility



- Ohio produces a monthly report analyzing enrollment and retention in the various eligibility categories included in Healthy Start, the state's Medicaid program for children. For example, from application records, state officials learned that of the 71,877 children enrolled in Healthy Start between January and October 1998, more than 75 percent had either been enrolled in Medicaid themselves in the past or had a sibling who had been enrolled in the program—thus, only one-quarter were truly new to the program. Therefore, outreach efforts would need to target newly eligible families if enrollment is to continue to grow. In addition, enrollment data showed that only 45,250 children were actually enrolled in the expanded Healthy Start program on 31 October 1998, as 26,267 of the year's enrollees had dropped off of the program. This information alerted officials to the need to examine the program's rate of retention.

Implementation Issues

The case studies illuminated a number of issues, tensions, and challenges that have arisen in the study states in the course of the implementation of their outreach and enrollment efforts. These are discussed, in turn, in the following sections.

Issues in the Implementation of Outreach Strategies

As mentioned above, the study states moved quickly to implement their CHIP programs. Understanding the need to inform the public about these new programs, states have launched ambitious marketing campaigns, investing heavily in media campaigns, establishing or expanding the use of existing toll-free hotlines, and distributing information and program applications. These expenditures may come from Medicaid administrative funds, for which states receive a 50 percent match from the Federal government, or from the CHIP administrative allotment (states are permitted to devote no more than 10 percent of their CHIP expenditures, for which they receive the higher CHIP matching rate, to administration.) States' investments in these efforts can be substantial: for example, California is currently devoting $21 million to its statewide outreach effort, including $12 million in CHIP funds and $9 million in Medicaid administrative funds (including both the Federal and state shares), and in Ohio, $13 million in funds available through the Section 1931 of the Personal Responsibility and Work Opportunity Reconciliation Act (the 1996 welfare reform law) were allocated to the counties for outreach and enrollment efforts.[1] This level of effort is unusual for a public benefit program, and reflects the high priority that governors and state Medicaid agencies place on the identification and enrollment of uninsured children.

[1] The welfare reform legislation included $500 million in funding to be passed on to the states to support efforts to assure that former recipients of Aid to Families to Dependent Children did not lose Medicaid coverage as a result of the transition to Temporary Assistance for Needy Families. This funding was available until June 1999.

However, in the rush to make these programs operational, states may have sacrificed some of the research and planning that might have made their outreach efforts more effective. Failing to conduct formative research to guide the outreach effort and to segment the audience is a common pitfall of public programs. Without this research, messages cannot be targeted to specific sub-populations (such as ethnic minorities, working families, and immigrant parents of citizen children) who are over-represented among the uninsured. Moreover, without pre-testing the campaigns' messages, state officials cannot be sure that they are presenting the program in a way that effectively promotes the program and addresses families' concerns.

The reliance on mass media at the state level may itself have been a result of tight timelines; hiring an advertising or marketing agency to implementing a media campaign can take much less time and effort on the part of state officials than crafting community-based outreach strategies. However, in emphasizing the media-based approach, states sacrifice the benefits of community-based and one-on-one outreach that were demonstrated so clearly in the case studies: the personal attention of trusted community members, the provision of information in the clients' language that addresses their concerns about involvement in a public program, and personal coaching in taking knowledge to action—a leap that may not be made without the guidance of these community members and outreach workers.

A longer planning phase might also have allowed state officials to grapple with some of the dilemmas that became apparent in the case studies. Closer attention to issues surrounding the public perception of Medicaid, fears on the part of immigrant families, and the division of responsibility between the state and local levels might have made for more targeted, effective outreach strategies. These issues included the following:

- **Alignment with vs. separation from Medicaid**. A major barrier to children's enrollment in Medicaid appears to be the program's image in the eyes of low-income families. For a variety of reasons, parents are reported to be extremely reluctant to be involved in the Medicaid program. In Georgia, for example, it is reported that people find the workers at social services agencies who traditionally take applications to be rude and condescending; in California, state officials, application assistants, and outreach workers reported that Latino families are reluctant to apply for Medi-Cal for fear of being considered a "public charge" by the Immigration and Naturalization Service (INS).

  The reputation of the Medicaid program that has developed over three decades can seriously undermine efforts to promote a new program, even one that is designed to be consumer-friendly. Therefore, states may choose to distinguish their programs from Medicaid, even, as in Georgia, going so far as to promote it as entirely separate from the Medicaid program for children. Although this approach may insulate the program from Medicaid's poor public image, it sacrifices the opportunity to reach out to Medicaid-eligible families as well as those eligible for CHIP. Of course, the advantage of an outreach effort that combines the promotion of CHIP and Medicaid is its efficiency—only one campaign is needed—and its ability to promote the two as a single, coordinated

health insurance program. This was California's approach to promoting the Healthy Families and Medi-Cal for Kids programs.

- **Media-focused vs. community-based outreach**. Another critical decision centers on the emphasis of the outreach effort. As described above, the study states focused most of their energies on mass-media approaches, in the hope of blanketing their states with messages about the importance of insurance and the availability of new or expanded programs. However, our interviews on the local level served to highlight the importance of more personal approaches to outreach, based on face-to-face encounters with people who speak families' language and can directly address their fears and concerns. Not only can agencies and individuals hosting community-based events provide more information than can a television or radio ad, they can do so with an understanding of families' needs. Outreach workers can reassure families that, for example, the CHIP program is not "welfare;" they can explain the importance of insurance; and they can describe how the program works and how care is delivered. Thus, their efforts can reinforce the messages of the media campaigns while putting those messages in concrete terms that are meaningful to families.

- **Reaching working parents through employers vs. preventing "crowd-out."** In promoting their CHIP programs, state officials face the challenge of reaching the population of low-income working families, many of whom have never before been involved with public benefit programs. Recognizing that these families are unlikely to be reached through traditional channels, states have struggled with the problem of how to reach them. For the most part, they have not taken steps to reach them where they are most likely to be found: at work. Targeting the employers least likely to provide health insurance (such as retail stores and restaurants) was not mentioned as a strategy by most state officials, presumably because working with employers would discourage them from ever offering insurance for employees' dependents. (An exception was Georgia, where efforts are being made to work with employers in the restaurant and service industries statewide.)

  On the local level, however, "crowd-out" was not a major concern. Local agencies described giving presentations and distributing materials at local Chambers of Commerce in California, working with restaurant chains to include brochures with workers' paychecks in Georgia, working with unions to promote the program among their members in Ohio. The policy goal of preventing substitution of public coverage for private did not discourage efforts to locate low-wage workers and provide them with information about sources of coverage for their children.

- **Tailoring messages to local needs vs. consistency across the state**. Three of the four states studied had implemented their media-based outreach effort on the

state level, and one, Ohio, delegated the major responsibility for outreach to the counties. The advantage of the statewide approach is, of course, consistency. This is evident from the experience in Ohio, where the counties are developing separate media campaigns. The locally-driven approach can also cause confusion; Cuyahoga County's radio ad describes the Healthy Start program as being available to residents of Cuyahoga County, potentially misleading families who live in the other ten counties in the Cleveland media market.

Nonetheless, outreach efforts tailored to the needs of the community are essential. The locally directed outreach efforts that have emerged in California and Georgia, independently of public funding, show great promise in identifying families unknown to public systems. The efforts of the managed care organization and the public health system in Santa Clara County were described earlier; in Georgia, a range of social service agencies, including the local legal services agency, the child care resource and referral center, and the Area Agency on Aging have begun educating their clients and using their networks to identify uninsured children. Thus, a combination of state-directed and locally-designed strategies is necessary for effective outreach, with coordination and training for local agency staff to assure that the information they provide is consistent and accurate.

The range of outreach efforts in place in the study states and the newness of the programs they promote emphasize the importance of ongoing evaluation of outreach strategies. So far, it appears that states are monitoring the number of calls received on their hotlines and the number of program applications received. However, more intensive research and evaluation efforts are necessary to fully understand the process through which people hear about public insurance programs and are motivated to pursue further information and then to apply. Surveys, focus groups, and analyses of administrative data will all be necessary to explore the effectiveness of each outreach strategy. Moreover, as this information is compiled, mechanisms will be needed to assure that evaluation findings are used to enhance and improve states' and communities' efforts to reach families of uninsured children.

Implementation Challenges Surrounding the Eligibility Process

While the eligibility simplification strategies adopted by the study states show great promise, a closer examination reveals the many complex problems that surround their implementation. This study has shed new light on the challenges inherent in implementing streamlined access while also maintaining program accountability, and the difficulty of seamlessly layering incremental system reforms upon an eligibility infrastructure and bureaucracy that is old, large, and well-established. Some of the critical implementation issues discussed with state and local officials focused on the particular strategies they adopted, while other larger, cross-system issues concerned the incorporation of children-specific enrollment strategies into existing eligibility infrastructures. These issues are discussed in turn below.

Strategy-Specific Implementation Issues

In implementing their efforts to simplify application forms and create community-based avenues for applying for coverage, the states we studied have encountered numerous complex and confounding challenges. These challenges include:

- **Short forms that are not necessarily short, or simple to complete**. By dropping the asset test from the eligibility determination process for children, states take the most important step toward making their application forms simpler and shorter. Theoretically, this makes it possible for states to focus their information collection more narrowly on family composition, income, and residency/citizenship. Unfortunately, the verification of these facts can, depending on the state's approach, involve significant effort on the part of families to collect and submit paperwork that can be difficult to obtain. Items such as birth certificates for all children in the home, Social Security cards for all family members, addresses of absent parents, receipts for child support, divorce or separation papers, rent receipts, alien registration cards or other verification of immigration status, and verification of income were consistently required by each of the states we interviewed, and were reportedly difficult for some families to provide. (Producing employment verification for the 12 months preceding application, sometimes required in Ohio, was reported to be especially problematic for families.)

  Furthermore, even the shortest forms tended to have as attachments such multi-page items as instructions for completing the application, declarations of recipient rights and responsibilities; statements of citizenship, alienage, and immigration status; and forms for identifying potential sources of third-party insurance coverage, among others. These items make forms more complicated and potentially confusing, while also increasing their length substantially. The most egregious example of this was the combined application for Healthy Families/Medi-Cal for Kids in California which, in its original form, comprised 28 pages. Even the revised form, however, is 10 pages long when forms and instructions are considered.

  In the states' defense, the management of a means-tested public insurance program requires that certain essential information be collected and verified so that accountability can be maintained. And, in states like Georgia and New Mexico, where packets from two to four pages in length are used, officials have apparently succeeded in reducing application size and verification requirements to the maximum extent possible. However, this study has shown that application forms, no matter how short, are rarely as simple as they appear and constitute a hurdle that some families, especially those with lower incomes and complex structures, may find difficult to overcome.

- **Community-based intake points without funding or infrastructure support.** The theory that agencies and providers located in the communities where

families live represent more accessible, pleasing, stigma-free, and appropriate sites at which to apply for health insurance is a sound one. The majority of states, including all four studied here, have acknowledged that potential clients do have negative perceptions of the welfare system, which may in fact keep families away from local social services sites; many states have therefore taken steps to address this problem. However, this study has clarified that simply training staff at these agencies and provider settings and presuming that they can easily take on and support an entirely new role as surrogate eligibility/intake sites is simplistic and problematic.

In fact, during our interviews, we learned that the excitement among community-based staff surrounding the prospect of actively helping children to obtain health insurance wears off quickly as they face the realities associated with interpreting and helping families to understand ambiguous rules and policies, filling out complex forms, and collecting numerous documents that families often consider quite personal. In addition, these staff, whether serving in clerical or professional capacities, have other full-time responsibilities. The additional workload associated with helping families to complete applications is not insignificant, nor is it easily accommodated into an otherwise busy day. Finally, the fact that neither seed money nor retrospective reimbursement is extended by most states (California being the exception in this sample) for fulfilling this role or to support the infrastructure necessary to fulfill it places immediate stress on the agencies and undermines their ability to carry out the function effectively.

These frustrations were voiced by community-based staff in New Mexico, Ohio, and even California (where the initial $25 finders fee was quickly judged inadequate to support the time required to assist with applications, with the state's slow rate of reimbursement serving to exacerbate the problem). Only in Georgia, where dedicated RSM outreach workers, on salary with the state, serve as the community-based intake point for families, was this issue not raised.

- **Mail-in applications that require a face-to-face interview**. The theory that a mail-in application process can permit families to obtain health coverage for their children without ever seeing an intake worker is another one that holds great promise and appeal. However, this goal is not always so simple to achieve. Rather, due to the complexity of forms and requirements for the submission of multiple items of verification, the states we interviewed reported anecdotally that a high proportion of applications received by mail are either incorrect or incomplete. Sometimes, if the receiving agency is a local social services office, eligibility staff send notices to these applicants requesting that they appear in person to reapply and/or submit the needed verification; this practice was reported as occasionally happening in both California and Ohio.

  In none of the four states we studied were blank application forms widely distributed across a broad range of traditional and nontraditional sites, such as

doctors' offices, libraries, supermarkets, mall kiosks, and schools. Rather, forms could most often be obtained from the providers and community agencies that were trained to assist applicants. Therefore the promise of the mail-in strategy was not often fully realized.

- **Potentially limited viability of the Presumptive Eligibility option for children**. New Mexico was the only state we studied that had adopted presumptive eligibility (PE) for children. There, the state's policy requires providers extending short-term presumptive eligibility to children to submit a complete application for full eligibility within 10 days of presumptive eligibility determination, using a form and process nearly identical to that used for PE. As a result, a large number of providers who had initially become qualified to determine PE were quickly opting to not function in that capacity, judging that it was not worth their time and effort to complete an additional application process when a full application form had to be submitted so quickly anyway. That, coupled with the fact that the slight financial exposure associated with the costs of a well-child or sick visit would likely be covered by retroactive three-month Medicaid coverage, served to discourage many of the providers we spoke with from participating in PE.

  The primary exception to this scenario was at a children's psychiatric hospital in Albuquerque. Here, uninsured children needing crisis mental health care were being admitted to the institution, which was incurring immediate and high costs. Providers at this site felt a direct financial incentive to determine PE and extend immediate short-term coverage to children.

  These experiences provide interesting insight into the appropriateness of PE for children as opposed to pregnant women. Uninsured pregnant women, like the children admitted to the institution in Albuquerque, are much more likely to need high-cost care and present significant financial exposure to the providers caring for them. Therefore, PE serves as an important device both to improve these individuals' access to care and to protect the providers willing to serve them. For children with routine, lower-cost needs, the need for immediate financial coverage appears less urgent for providers and may not in fact provide enough direct incentive to take on the additional role of determining and extending presumptive eligibility.

Systemic Issues

Beyond the specific challenges associated with the implementation of individual eligibility strategies, a host of more fundamental, system-based challenges arose in the study states as they worked to institute enrollment reforms. These included:

- **Medicaid eligibility processes, even with reforms, are still intimately linked to the welfare systems in which they were originally incorporated.** In all four of the states we studied, expansions of Medicaid eligibility, through

traditional means or new CHIP authority, represent at least part of the states' overall initiative to extend health insurance to uninsured children—in New Mexico and Ohio, CHIP is being implemented entirely via Medicaid expansions, while in California and Georgia, separate state programs are being layered upon expansions of Medicaid. As such, all four states have relied upon existing state and county infrastructures to process applications, issue identification cards, and monitor eligibility status for newly eligible children. This connection, we found, has served to at least complicate, and in some cases seriously undermine, states efforts to maximize enrollment of children.

At one level, the continued link between health insurance programs for children and traditional social services systems perpetuates the perception among potential clients that Medicaid is "welfare." According to officials in all the states we visited, many potential clients harbor extremely negative feelings toward the welfare system, including Medicaid, and these feelings serve to keep many families from even attempting to apply for coverage. This effect was described as especially acute among low-income working families who would never consider themselves welfare recipients. Some of these negative feelings appear to be fostered by employees of the social services systems themselves; eligibility caseworkers, many of whom have worked on programs such as AFDC, Food Stamps, and Medicaid for years prior to recent reforms, are commonly viewed as negative, judgmental, and more interested in unearthing fraud and abuse than helping families. In fact, the caseworkers we interviewed tended to be much more supportive of families and voiced considerably more positive opinions of families that needed health insurance than those seeking cash and food assistance. Regardless, the negative perceptions toward the "system" persist and, by all accounts, serve to keep people away.

At another level, the continued link between Medicaid and other welfare programs and systems creates more concrete and tangible negative effects. For example, in California, state and local officials report that they have not received clear guidance from the INS regarding whether or not receipt of Medicaid benefits penalizes a family applying for citizenship. This lack of clarity regarding whether children's enrollment in Healthy Families/Medi-Cal for Kids will result in being considered a "public charge" appears to have kept countless Latino parents from seeking health insurance for their children.[2]

As described above, despite states' significant efforts to create alternative avenues for families to apply for Medicaid, county social services offices in each of the states we visited remain the primary intake point for a large portion,

[2] In response to publicity about this issue, the INS issued new guidance on May 26, 1999 clarifying its treatment of CHIP benefits. This guidance states that "the receipt of Medicaid and CHIP benefits, with the exception of institutionalization for long-term care, cannot be considered in making a public charge determination." However, considerable effort will still be needed to inform immigrant families of this policy.

if not the majority, of families. Resulting from this link, a number of additional problematic cross-system issues emerged from the site visits, including:

- In recent years, state and county social services workers have been required to keep track of many complex eligibility policy and rule changes associated with welfare reform, immigration law, and Medicaid. Therefore, reforms designed to streamline and simplify eligibility for children represent a small part of these workers' responsibilities. In fact, we learned that caseworkers often did not fully understand new rules (e.g., dropping the assets test for children in California) and thus were not necessarily implementing state policy accurately. Similarly, not all caseworkers had received training about new eligibility rules and/or the links between traditional Medicaid coverage and new CHIP coverage.

- Local caseworkers do not necessarily support new efforts to allow community-based agencies to complete applications for families. In both California and New Mexico, some workers expressed resentment that "their jobs" were being performed by amateurs in the field and frustration that they were being forced to "clean up after" these agencies by processing incomplete or inaccurate forms.

- Social services workers continue to prefer that families applying for aid apply for every possible program that they might be eligible for, rather than simply for health insurance. For example, some caseworkers we interviewed in California and New Mexico did not like or endorse the short forms that were being instituted for children and reported that they preferred to have families complete the longer, multi-program applications they traditionally used. This action not only undermines the goals of more quickly and simply extending coverage, but also can often lead to families' failing to complete the more complex, onerous, and intrusive process of exploring Food Stamp and/or TANF eligibility.

- Problems also creep into the process as a result of the complex management information systems that support program operations. For example, our site visit to Ohio revealed that families receiving both Food Stamps and Medicaid who miss their three-month Food Stamps re-certification interview receive a computer-generated letter informing them that their failure to appear has resulted in the loss of both Food Stamps and Medicaid benefits, despite the fact that families do not need to reestablish their children's Medicaid eligibility for a full six-month period. County caseworkers had to address this problem by manually generating and sending out correction letters to these families informing them that, in fact, their children's Medicaid eligibility was still active. The confusion and frustration among families that such messages create can only serve to undermine their perceptions of the program.

- Finally, the fact that social services systems are county-governed in the majority of states—including three of the states we studied—creates enormous challenges for the consistent implementation of state policy and rule changes. In fact, we consistently heard that there was widespread and significant variation across counties (even in the state-administered system in New Mexico) in how policies were implemented and with regard to the attitudes and approaches to eligibility determination that were embraced by social services administrators and caseworkers. Therefore, the experience with the system of one family in one part of the state may be very different from the experience of another family in another part of the state, contributing to variable perceptions of the system.

▪ **Creating a separate infrastructure for processing CHIP eligibility creates a new set of cross-system challenges**. To avoid the many negative perceptual and system-related consequences that stem from links to the welfare system, some states have opted to create an entirely new infrastructure for managing eligibility determination and enrollment of children under CHIP. In our study sample, this was the case in both California and Georgia. Based on our analysis of this approach, this strategy appears to succeed, on one hand, in allowing for a more centralized and straightforward process. On the other hand, however, this approach appears to create a different set of challenges surrounding the interactions of these new systems with the social services systems responsible for Medicaid. The BBA statute's requirement that all children be screened for Medicaid before being enrolled in CHIP forms the basis of this problematic interaction. For example:

  - In California, the first version of the combined Healthy Families/Medi-Cal for Kids application required families to calculate their income and determine which program they were eligible for. They were then required to mail their application to either of two places—the central state agency responsible for determining Healthy Families eligibility (the Managed Risk Medical Insurance Board, or MRMIB), or the appropriate county responsible for determining Medi-Cal eligibility. Depending on whether or not the family also checked a permission box allowing either agency to forward the application to the other in case they were found ineligible for the program they applied for, the two agencies may or may not actually exchange the application.

    The state has largely addressed this problem by creating a single intake point—MRMIB—for all applications; this agency then reviews applicants' income and forwards the form to the appropriate state or local agency for placement in either Healthy Families or Medi-Cal.

    However, county welfare workers will not assist families with applying for Healthy Families; they consistently reported that they were not

trained in Healthy Families eligibility rules, that it was not their job, and that all they could do was give families a form and refer them to a community-based application assistant.

- In Georgia, a similar arrangement has been made whereby PeachCare for Kids applications are processed by a single state contractor—Dental and Health Accounting Consultant Services, or DHACS—while the separate RSM Medicaid applications are processed on the local level. Here again, the state has established mechanisms for the two infrastructures to forward applications between themselves (i.e., DHACS will forward an application from a family with income below the PeachCare standards to RSM, and vice versa), and RSM outreach workers will help families complete either an RSM or a PeachCare application. However, once again, county social services workers in Georgia will not assist families in applying for PeachCare, for reasons similar to those stated by caseworkers in California.

These experiences suggest that effective implementation of the Medicaid "screen and enroll" requirement of the BBA is not simply nor easily achieved.

As was the case with outreach, the states studied in this project do not appear to be investing significant resources in evaluating the relative effects and effectiveness of their eligibility simplification strategies. Rather, partly due to the limitations of MIS systems and partly due to lack of planning, they tend to simply monitor gross indicators such as overall rates of enrollment rates as a means of tracking their "success." This is unfortunate, because the alternative approaches being tested in the states offer a unique opportunity to gain a deeper understanding of what works and what doesn't when trying to streamline and maximize enrollment. Administrative data should, in most states, be available to monitor such key indicators as numbers of applications received, rates of approval and denial, reasons for denial, numbers of presumptive eligibility cases and rates of successful conversion to full Medicaid eligibility, numbers and rates of case closures, reasons for closures, and reapplication rates, and to differentiate these measures among the various programs (Medicaid and CHIP) and forms being employed. Such information can then be applied to making system corrections and improvements.

Conclusions and Lessons Learned

The major findings of this study focused on the continuing connection between Medicaid and cash assistance and the effect of this persistent linkage on outreach and enrollment systems for both Medicaid and CHIP. Eligibility and enrollment systems cannot be reformed simply by layering new procedures upon an existing bureaucracy. The roots of these social services systems are deep and substantial; systemic reform may be difficult to effect until staff have turned over, computer systems have been replaced, and a new generation of families becomes accustomed to thinking of public-sector health coverage as distinct from cash assistance and other public benefits. At present, however, it is evident that, while Medicaid and cash

assistance programs have been de-linked at the policy level, they remain closely connected at the program level.

The study states, for the most part, recognize this dilemma, and have responded in diverse ways. Two of the study states, Georgia and California, established CHIP programs that are separate from Medicaid. In marketing its program, PeachCare for Kids, Georgia has made a clear attempt to separate it from Medicaid in the public eye and has instituted an eligibility determination process that does not rely at all on the social services infrastructure. California, on the other hand, also uses a separate eligibility system for Healthy Families, but promotes the program as connected to "Medi-Cal for Children." While each of these approaches has its advantages, neither can both reach all segments of the population of uninsured children and overcome the stigma many families associate with Medicaid.

The other two study states used Title XXI to expand their Medicaid programs. Both gave these programs new names—Healthy Start in Ohio and New Mexikids in New Mexico—to distinguish them from the traditional Medicaid program and both have made substantial efforts to institute enrollment processes that circumvent the traditional social services system. However, these systems essentially represent adaptations of the Medicaid eligibility determination process, in Cuyahoga County, Ohio by using a separate staff of eligibility workers, and in New Mexico by using a shortened form administered by community-based providers and offering the option of presumptive eligibility. Again, while these represent excellent first steps in the creation of streamlined Medicaid enrollment systems, their implementation on the local level can be subject to a variety of pitfalls, from inconsistent use of shortened application forms, to computer systems that persist in linking Medicaid eligibility to Food Stamp enrollment, to eligibility workers who, out of habit, request more extensive documentation than the program requires. Therefore, while outreach efforts tout these programs as new, consumer-friendly sources of health care coverage for children, families may find themselves entangled in complex bureaucracies once they apply.

These findings, therefore, have significant implications for state and local policy. The first is the need to integrate Medicaid and CHIP eligibility determination systems and outreach strategies so that they complement and reinforce each other. This will involve designing application forms that integrate the themes and messages of media campaigns, distributing outreach materials widely so that they reach all segments of the target populations, fully informing and training community workers so that they can consistently assist families with applications for Medicaid and CHIP, and using application systems and processes that reinforce the image of the program as accessible and user-friendly.

One important avenue toward enrollment simplification is to take advantage of all of the options available for streamlining eligibility. For example, of the study states, only New Mexico had implemented one-year continuous Medicaid eligibility for children, although Georgia provides one-year coverage under PeachCare, and California will enroll Healthy Families children in Medi-Cal if their family incomes rise. Continuous eligibility could both help to improve retention rates among Medicaid-eligible children and would further the effort

to disentangle Medicaid from the social services system, as re-determination visits would not be required. Likewise, only New Mexico has employed presumptive eligibility for children, although findings from the case study did not reveal consistent success with the program. For many providers, presumptive eligibility only adds a layer of complexity to the Medicaid enrollment process, as the full Medicaid application (with which these providers are also authorized to assist) must be filed for each child as well. Only providers of high-cost and emergency services report that the presumptive eligibility option is valuable to them, as it allows for prompt reimbursement for their services. This finding confirms the analysis reported by officials in the other study states that the policy would benefit providers more than it would families.

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

This study has reinforced the positive finding that states are investing an unprecedented amount of time, energy, and resources into creative strategies designed to take maximum advantage of the opportunities presented by Title XXI. Importantly, these states have recognized that neither outreach nor eligibility simplification efforts alone can succeed in getting children into care; rather, they have combined their efforts to raise public awareness of new programs with those aimed at facilitating access. However, as encouraging as these efforts are, this study has also highlighted that much room for improvement exists in such areas as:

- Conducting careful market research to better define and segment the varied populations of children who may be eligible for coverage;

- Continuing to invest in strategies for simplifying applications and making points of access more available in the community so as to eliminate the need for families to interact with local social services systems; and

- Conducting careful and rigorous evaluation and monitoring efforts to discern the relative effectiveness of alternative outreach and enrollment strategies.

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

Chapter II

California

Background and Overview

Despite a history of expansive coverage of pregnant women and children, approximately 1.7 million children remain uninsured in California.[3] Of these children, 660,000 are potentially eligible for Medi-Cal, California's Medicaid program, based on their families' income, and 400,000 have family incomes between 100 and 200 percent of the federal poverty level. Sixty percent of the uninsured children in California are Latino, and 90 percent are U.S. citizens.

At the time of the passage of the Balanced Budget Act, the state covered pregnant women and infants up to 200 percent of the federal poverty level (FPL) under Medi-Cal and those between 200 and 225 percent of FPL under the state-funded Access for Infants and Mothers (AIM) program. Medi-Cal coverage extended to children under age six up to 133 percent of FPL and through age 14 up to 100 percent of poverty. Older adolescents were covered if their family incomes were below the state's income maintenance standard, which was last set in 1989 and is $934, or 82.1 percent of the federal poverty level, for a family of three.

In addition to these standards for enrollment in no-cost Medi-Cal, the state's medically needy program, known as "share-of-cost" Medi-Cal, allows the family to enroll in the program and receive coverage only for the cost of services above the difference between the maintenance level and the family's monthly income.

The Title XXI Child Health Insurance Program funds were used to expand eligibility using a combination of a Medi-Cal expansion and a separate state program. The Medi-Cal expansion involved an accelerated phase-in of poverty-level children under age 19, and a separate program called Healthy Families was created to cover children with family incomes under 200 percent of poverty who are not eligible for no-cost Medi-Cal. This program offers covers the benefits given to state employees through the California Public Employees Retirement System (CalPERS) through a choice of managed medical, dental, and vision plans in each county.

[3] UCLA Center for Health Policy Research, 1998 *Uninsured Children: Putting the Challenge in Context.*

Administrative Structure for Medi-Cal and Healthy Families

The Medi-Cal program is administered by the California Department of Health Services (DHS). Eligibility standards and enrollment policies are determined by the Department's eligibility branch, but all eligibility processes are conducted and overseen by the state's 58 counties. The eligibility branch also has responsibility for state-level outreach efforts for both Medi-Cal and Healthy Families.

The Healthy Families program is overseen by the Managed Risk Medical Insurance Board (MRMIB), a state agency created in 1990 to manage special health programs including AIM, the Health Insurance Plan of California (the HIPC), and the Major Risk Medi-Cal Insurance Program. MRMIB has contracted with Electronic Data Systems (EDS) to conduct eligibility determination and enrollment functions for Healthy Families. DHS, however, was assigned responsibility for outreach and public education for the program.

Case Study Design

To examine the process of outreach and enrollment in Medi-Cal and Healthy Families, a three-day site visit was conducted in October 1998. The site visitors spent one day in Sacramento meeting with officials of the Department of Health Services' Medi-Cal Eligibility and Maternal and Child Health Branches, the Managed Risk Medical Insurance Board, and the California Primary Care Association to discuss statewide eligibility policies and outreach efforts.

To observe Medi-Cal and Healthy Families outreach and enrollment systems on the local level, the site visit team spent the next two days conducting interviews with county social services officials, eligibility workers, outreach workers, and provider and partner agencies in the city of San Jose, in Santa Clara County, an economically, ethnically, and linguistically diverse county with a population of 1,739,800. Over half of the residents of the county were born outside of California, and nearly one quarter were born outside of the United States. Nearly 150,000 people are enrolled in Medi-Cal in Santa Clara County; this population represents 30 ethnicities and speaks 27 languages. Of the 73,000 people eligible for Medi-Cal only (that is, not receiving cash assistance), 47 percent are under age 18. It has been estimated that there are 25,000 uninsured children in the county.

The county is the center of Silicon Valley and includes extreme wealth as well as high levels of poverty. In 1996, approximately one third of the county's children lived in families with incomes below 185 percent of poverty, and one child in seven lived in poverty. A map showing the location of Santa Clara County is included at the end of the case study as Appendix A.

Eligibility Determination Process

Traditionally, eligibility determination for Medi-Cal is overseen and conducted at the county level, either at county social service agencies or by county employees out-stationed at Federally Qualified Health Centers and Disproportionate Share Hospitals. However, eligibility policy is set at the state level. These policies are described in this section; the following section describes their implementation in Santa Clara County.

State Policy

Before the implementation of Healthy Families, California had taken few options for streamlining Medi-Cal eligibility for children. The state implemented presumptive eligibility for pregnant women in 1993 and eliminated the asset test for this population in 1994. The passage in July 1998 of Senate Bill 903, a companion to the legislation creating Healthy Families, expanded the asset test waiver to include children in the percent of poverty programs. Until the advent of Healthy Families, the state had not developed a short form or a mail-in application form for Medi-Cal.

When the state expanded Medi-Cal's eligibility standards for children under the CHIP legislation, it continued its conservative approach to the eligibility determination process. The state has not chosen to allow presumptive eligibility for children. State officials report that the state's Child Health and Disability Prevention (CHDP) program substitutes for presumptive eligibility by offering state funding for child health screens for all children with family incomes below 200 percent of poverty. If a child screened by the CHDP program is later determined to be eligible for Medi-Cal, the state will receive federal match for any payments to the CHDP provider for 30 days before the child's enrollment in Medi-Cal. Therefore, although providers supported presumptive eligibility for children for Medi-Cal and Healthy Families, this provision was not endorsed by the state legislature.

Similarly, the state did not choose to implement 12-month continuous eligibility for children eligible for Medi-Cal. Children may remain enrolled in Healthy Families for 12 months without re-qualification as long as premium payments are made; however, Medi-Cal eligibles must have their income verified quarterly. If a child's family income rises, the child may be enrolled in Healthy Families, but HCFA does not define this policy as continuous eligibility.

However, the state did choose two approaches to encourage and simplify enrollment in Healthy Families and Medi-Cal for children: the development of a shortened application form and an effort to train staff of community-based agencies to assist families in completing this form. These two efforts are described below.

The Shortened Form

Traditionally, Medi-Cal eligibility has been determined using a form called the MC210. With the passage of the state's CHIP legislation, a new application form was developed to assess children's eligibility for either Healthy Families or Medi-Cal; this form is included here as Appendix B. While the design of this form is colorful and engaging, and the form can be mailed in to either program for eligibility determination, the form itself does not necessarily simplify the eligibility determination process. Consequently, it was criticized by advocates inside and outside of the state, and another new, shorter form was developed, which is also included in Appendix B. Criticisms of the first new form centered on the following issues:

- **Length**. The packet was 28 pages long, including 16 pages of forms and 12 pages of instructions. The length of the form was partially due to the inclusion of a range of questions that may not be required, including three pages of questions about citizenship/immigration status. One page asked that the applicant identify and provide proof of the citizenship or immigration status of each child applying for Healthy Families, and another two-page section of the form asked similar questions regarding each pregnant woman or child applying for Medi-Cal. The detailed nature of these questions (and the documentation required) was widely reported to be a major barrier to enrollment of Latino children into Medi-Cal and Healthy Families.

- **The self-screening requirement**. Families were required to evaluate their own income levels and to select the appropriate program for which to apply for each of their children. This approach carried the risk that families would miscalculate their income, choose the wrong program, and delay or deny appropriate coverage for their children.

- **The permission box**. The form included a box the parent must check to give permission to forward the application to Medi-Cal or Healthy Families if a child was found ineligible for the other program. State officials chose this approach to allow families the "choice" to participate in each program or not, and to ensure that families knew for certain which program their child might be enrolled in. However, critics felt that this undermined the state's efforts to implement the "screen-and-enroll" provision of the CHIP legislation, which requires that those CHIP applicants who are eligible for Medicaid be enrolled in Medicaid.

In response to the criticism of the application form, state officials were at the time of the site visit developing a revised, shorter version. This form is included as Appendix C. These efforts will be described in the section below.

Application Assistants

A second major effort to encourage enrollment in Healthy Families and Medi-Cal for children focuses on the distribution of applications to community-based agencies and the provision of assistance by agency staff to families in filling them out. Because MRMIB is a statewide agency without a county-level infrastructure, a network of community-based agencies was necessary to facilitate enrollment in Healthy Families. Rather than hire county employees to perform this function, MRMIB officials chose to train staff of community-based agencies to help families complete the mail-in application form. These trained staff members are referred to as "application assistants."

A contract was let to Richard Heath and Associates to train and manage application assistants in community organizations to help families complete the Healthy Families/Medi-Cal application form. These assistants are housed in a variety of agencies, including physicians' offices and clinics, nonprofit social service agencies, schools, and community groups. The assistants were originally paid $25 for each application for Medi-Cal or Healthy Families that was submitted with the assistor agency's number and was subsequently approved; this payment was increased to $50 on 1 November 1998. In addition, assistor agencies will receive a bonus payment of $250 for every 10 successful enrollments between 1 July and 31 October 1998.

Future Plans

At the time of the site visit, the application form was in the process of being revised. In early October, the Director of DHS issued a clear directive that a revised form be developed within 45 days; work groups including representatives from both within and outside state government contributed to this revision. A revised, four-page application was released in late November 1998, with implementation to begin in early 1999. Issues that were considered by the work groups included:

- **Use of a single point of entry**. The current system relies on two organizations, one at the state level and one at the county level, to determine eligibility for the two insurance programs. The use of two points of entry into the system causes confusion among both applicants and Medi-Cal eligibility workers (EWs), as will be discussed in the section below. The use of a single agency to evaluate applications for the two programs and refer them appropriately would greatly simplify the application process. However, this strategy is complicated by the administrative structures and legal requirements of the two programs: counties must be involved in eligibility determination for Medi-Cal, so the entry point may have to be a county-level agency, not a single statewide entity, and MRMIB, the agency responsible for Healthy Families enrollment, does not have a county-level infrastructure.

- **Use of a true joint application**. The work group is also considering the development of a single application form that can be used to assess eligibility for both Medi-Cal and Healthy Families.

- **Revision of the application and instructions**. The group is working to shorten and simplify the application form and instruction packet. This effort is being conducted with the assistance of the federal Health Care Financing Administration (HCFA), which has facilitated conference calls with officials of other states with short application forms who can provide examples of their solutions to the problems California is facing. A draft of the revised application developed in late October is three pages long and omits the detailed questions about immigration status and the complex calculations of income included in the original mail-in application. In addition, it includes a box to check only if the applicant does *not* want the application forwarded to other programs.

- **Variation in county-level practices and attitudes**. Finally, the work group is considering the problems created by the inconsistency among California's counties in their approach to Medi-Cal eligibility determination. For example, counties are not consistently implementing the asset waiver for children, do not all use the same application forms, and have different approaches to assessing eligibility for children and families.

While the complexity of the application is without doubt a major barrier to accessing the state's child health insurance programs, it is a reflection of the administrative structure that created it. The problems with the application appear to be symptomatic of a complex bureaucracy, divided at the state level between two distinct entities and variably implemented across 58 autonomous counties. The implementation of the outreach and application process in one of these counties is the subject of the next section.

Local Implementation

Families may apply for Healthy Families or Medi-Cal for their children through a number of avenues. They may use the traditional method and apply in person at the county Social Services agency; they may fill out a mail-in application on their own and mail it to the appropriate agency; or they may work with an application assistant to complete the application. This section describes, first, the traditional system through which families apply for coverage for their children, followed by a discussion of the implementation of the network of application assistants trained to help with the new application form.

County Eligibility Determination Process

In San Jose, initial Medi-Cal applications are taken at two locations: the Assistance Application Center (AAC), located in South San Jose at 1919 Senter Street, and at Valley Medical Center.[4] The process for enrolling in Medi-Cal through the AAC is described below.

- **First visit**. During a first visit to the AAC, an applicant sees a member of the clerical staff and is asked to fill out a basic form giving the name and address of each family member applying for benefits. The applicant is given an application packet, which contains the following:
  - A brochure explaining beneficiaries' rights;
  - A brochure describing the Child Health and Disability Prevention Program;
  - A sheet listing documentation needed for eligibility for Food Stamps and documents needed for cash assistance or Medi-Cal;
  - A notice to Medi-Cal beneficiaries about the implementation of managed care for mental health services;
  - The 6-page MC-210 form;
  - A 4-page rights and responsibilities form;
  - A 2-page statement of citizenship, alienage, and immigration status;
  - A voter registration form;
  - A notice regarding equipment and supplies not covered by Medi-Cal for beneficiaries in nursing homes;
  - A notice regarding community property for persons in long-term care;
  - A notice regarding Medi-Cal general property limitations;
  - A notice regarding payment for share-of-cost Medi-Cal for beneficiaries in nursing homes;

[4] There are two other locations in Santa Clara County, one in Mountain View and one in San Martin. This case study focuses on the city of San Jose. Moreover, since the Valley Medical Center office primarily serves to enroll uninsured people while they are in the hospital, this study will focus on the process used at the AAC.

- A notice regarding the use of applicants' social security numbers to verify reported income and alien registration numbers to verify immigration status;

- A notice regarding the process for contacting an eligibility worker, access to family planning services, and confidentiality of personal information; and

- A flyer describing the WIC program.

The applicant is given an appointment to return with the completed application and the required supporting documentation. Currently, appointments are being made for one to two days in the future. This initial visit takes approximately one hour.

- **Second visit**. At the second visit, the applicant sees an eligibility worker (EW). The EW reviews the application brought in by the applicant, solicits any missing information, copies the applicant's documentation and assesses the family's Medi-Cal eligibility. Applicants are generally assigned to a specific worker for this visit, and they may request a workers who speaks their language; packets are distributed in English, Spanish, and Vietnamese, and workers are available that speak these languages plus several others. According to county officials, approximately 90 percent of applicants keep this appointment, which usually takes 45 minutes to an hour. An applicant may also wait 15 minutes or so for the appointment to begin.

  The application packet distributed at the first visit lists the following as "papers needed at your cash assistance/medical care appointment," although not all of this information is required for Medi-Cal applications. This list was developed by the Santa Clara County Social Services Agency and was last updated in 1984. The list includes the following:

  - A birth certificate, birth registration, baptism certificate or verification of alien status record for each family member;

  - Social Security cards for all persons in the home;

  - Marriage certificate, if applicable;

  - The address of an absent parent, the death certificate of a deceased parent, a doctor's statement about a disabled parent, divorce or separation papers or proof of separate residence from a spouse, or proof of application, award, or denial of unemployment benefits for an unemployed parent, if applicable;

  - The name of a child's school and grade, or a recent report card;

- If an applicant owns a house or land, the tax statement showing assessed value; a mortgage statement showing balance due; house insurance papers; statements showing property tax amount, amount of interest, and expenditures for repairs; and receipts for rental income;

- Current registration card for a car, motorcycle, boat, or trailer, and payment booklet showing current balance;

- Health insurance, life insurance, and burial insurance policies and most recent payment notices;

- Bank books, checkbooks, *and* the most recent statements showing the current balance for all savings, checking, or credit union accounts;

- Stock and bond certificates;

- Verification of income, including paycheck stubs, Social Security award letters, unemployment insurance benefits, state disability insurance benefits, VA benefits, strike pay, GI benefits, railroad retirement, child support, or alimony;

- For pregnant women, a letter from a doctor giving estimated date of delivery;

- Court order and verification of payment of child support;

- Any Trust Agreement to which anyone in the family is a beneficiary; and

- A rent receipt and utility receipts, or a letter from a landlord stating the amount of rent paid; and

- The full name of anyone other than a relative with whom the applicant lives.

Despite the new state policy waiving the asset test for children, the EWs interviewed in San Jose all appeared to be requiring proof of assets from most applicants, although this issue caused some confusion among them. One understood the policy to be a waiver of the asset *limit*, not the asset *test*, and thus he felt that the waiver could not be applied unless an applicant had assets over the limit (and the EW would not know about them unless he checked). Others reported that, even though the information on assets was not strictly necessary, if this information were not collected, the worker would risk having the application sent back by continuing EWs who have responsibility for the opened case file if it

appeared to be incomplete. These misunderstandings reflect the complexity of administering a program with different rules for each of 58 different aid categories. At this writing, significant confusion about those requirements is still apparent among those who are responsible for implementing the program.

Finally, at this visit, Medi-Cal beneficiaries who are required to choose a managed care plan under the county's two-plan model for Medi-Cal managed care would have the opportunity to meet with a Health Care Options counselor to assist with this choice.

- **Follow-up visit**. Approximately 90 percent of applicants have to return to the AAC a third time to bring in missing documentation. Most make a follow-up visit to drop off the required information for the EW; however, applicants can make arrangements to mail the information to the EW.

In addition to the EWs at the AAC, the county has out-stationed workers at four health centers: Gardner Health Center, CompreCare, O'Connor Center for Life, and Planned Parenthood. At Gardner, the site we visited, four out-stationed workers rotate coverage, so someone is there in the morning five days a week. When the clinic's registration clerks check their clients in, they ask about insurance status and income level (to assign a sliding fee level). Pregnant women and children who are potentially eligible for Medi-Cal are given an application packet (the same MC210 packet distributed at the AAC) and an appointment with the out-stationed EW. This appointment will generally be in about four days. The applicant will then come back to Gardner and meet with the out-stationed worker, who reports that he goes through the same eligibility determination process as the workers at the AAC.

After all information has been gathered from the applicant, the EWs are responsible for making the final eligibility determination. Determination must be done within 45 days, but administrators report that it actually takes only 7 to 10 days from the first face-to-face interview. The completed case file is then sent to a continuing EW at a local district office. This worker will be responsible for ongoing case management duties, including verifying income eligibility on a quarterly basis.

In evaluating a Medi-Cal application, EWs report that they first look to cover the entire family under full-scope, no-cost Medi-Cal. If the family does not qualify, they would then check to see if any members of the family, including children or pregnant women, qualify under the "percent of poverty" programs (Indeed, the computer program that is used to evaluate Medi-Cal eligibility reminds the workers to look to these programs to cover individual members of a family).

If the family is ineligible for no-cost Medi-Cal and the children do not qualify for the percent-of-poverty categories, the worker's next approach would be to enroll the family in "share-of-cost" Medi-Cal; state regulations require that Medi-Cal eligibility never be denied based on family income. Under this program, as described above, the family would pay a certain amount of their monthly income toward their medical bills until their "share of cost" is met. At that point, no-cost Medi-Cal would become available. Thus, the family would not pay if they did not use services, but if the family's income is significantly above the income maintenance level, the amount the family must spend before Medi-Cal becomes active could be substantial. Families may be offered the choice of enrolling all members in the share-of-cost program or enrolling only their children in the percent-of-poverty program.

Of particular note is the fact that EWs in Santa Clara County do not routinely evaluate applicants' eligibility for Healthy Families; they explained that this is because this is not a Medi-Cal program and the EWs have not been trained and are not required by their contract to perform Healthy Families eligibility determinations. In fact, if a parent wanted to apply for Healthy Families for her child, she would have to formally withdraw her Medi-Cal application. One EW, in discussing the difficulties that families face in enrolling their children in Medi-Cal, described the case of a family in which the younger children were eligible under the percent-of-poverty program but the family income was too high by two dollars to cover the oldest child. The EW enrolled this child in share-of-cost Medi-Cal, to the parent's confusion and frustration. The EW did not appear to be aware that this child was almost certainly eligible for Healthy Families.

Union rules require that the EWs process two new applications each day; the rest of their time is spent performing budget calculations, processing paperwork, researching regulation changes, and doing computer data entry. In addition to face-to-face applications, they also process the mail-in applications that are routed to their county. These are considered part of the quota of new applicants that each EWs works with each day. When these applications come to the county, they are assigned on a rotating basis to an EW within a week and are subject to the same 45-day limit for eligibility determination. The process for evaluating mail-in applications is similar to that for the MC210; if documentation is missing, the worker will call the family and ask them to bring or mail the missing information in. Although an in-person interview is not required with a mailed application, the workers and their supervisors report that they prefer to see applicants in person. They explain that this reduces the time needed to process an application (and that the county has established Saturday hours to accommodate working families), but its practical effect is still that the applicant must make a trip to the social services office.

Application Assistants

For families who want coverage only for their children, the alternative to the traditional Medi-Cal determination process is to use the state's new, "shortened" mail-in application form, which can be obtained from a wide range of community agencies. Many of these

agencies also have had staff trained to assist in completing the applications; at the time of our site visit, Richard Heath and Associates listed 47 agencies sponsoring application assistants in Santa Clara County, 33 of them in the city of San Jose. These include private providers' offices, community health centers, social service agencies, and grassroots community groups. We interviewed assistants from four agencies: Catholic Charities, the Indian Health Center of Santa Clara Valley, the Santee Community Group, and Santa Clara Valley Health and Hospitals.

The assistants we interviewed reported a mixed response to their efforts. Agencies that had not previously done extensive outreach to the community had not received large numbers of requests for assistance with the application and had in fact curtailed special efforts (such as classes and information sessions) to educate their clients about Healthy Families and Medi-Cal due to lack of participation. Other agencies reported higher levels of interest; Santa Clara Valley Health and Hospitals, which has outreach workers going door to door to promote the program, has assisted in completing 300 applications for 700 children.

Assistants report that, with some practice, they can help a family to complete the application in 30 to 45 minutes. Without assistance, they report that their clients would not be able to fill out the application correctly. However, the agencies have come to realize that the $25 fee is not sufficient to cover the time their workers spend on application assistance. Moreover, at the time of the interviews, the agencies had received few payments for successful applications: Catholic Charities had received one payment, Santa Clara Valley Health and Hospitals three, and Indian Health Services and Santee Community Group four each. (It is interesting to note that one of the most successful agencies is one that is not directly related to health care.) One agency reported giving a considerable amount of help with applications over the phone, assistance for which the agency cannot be paid; the assistor agency's number must be recorded on the application, and the agency cannot bill until the application has been mailed. Since they do not know what happens to these applications, they cannot be paid for telephone assistance. The agencies reported that increasing the fee to $50 per application will make the program more fiscally worthwhile.

The policy of paying assistants a "finder's fee" of $25 (now $50) was initially considered an innovative approach and was greeted with considerable excitement. However, based on early implementation experience, this system, in which agencies are essentially paid on a piecework basis, was itself described as a barrier to successful outreach. Assisting with applications is a time-consuming process, which agencies say they do not have the infrastructure to support. Because no start-up funding is available, and because payments cannot be guaranteed, agencies cannot hire new staff to act as application assistants; instead, this function must be added to the workload of existing employees. Therefore, unless other sources of funding are available (as was the case for Santa Clara Valley Health and Hospitals), agencies report that they are able to assist their existing clients but cannot be a resource for anyone in the community who needs help with the application.

The list of available assistants therefore overstates the resources available in the community for application assistance.

Knowledge and Attitudes of County Eligibility Workers and Application Assistants

For the most part, the county EWs interviewed took the job to help people in need, but over the years, some have become disillusioned with the welfare system. The provision of benefits such as cash support and Food Stamps do nothing to promote self-sufficiency, they said, and in fact may encourage dependence. However disenchanted with income support programs, they did see Medi-Cal (and health coverage in general) as an important benefit that people may not be able to get on their own. Therefore, even those who have become somewhat hardened to the needs of their clients support them in their efforts to obtain health coverage for their children. In fact, an out-stationed EW reported that he chose to be placed in a community health center so as to focus on Medi-Cal rather than the other programs.

Immigration issues are universally identified as a significant barrier to enrollment of Latino children, even those who are citizens, if their parents are not US citizens. The EWs interviewed, even those who are themselves immigrants, were divided on the legitimacy of immigrants' applications for assistance, with one expressing resentment that childless, non-disabled adult citizens, however poor, could not get Medi-Cal, while undocumented immigrants could get coverage for emergency services. This EW also finds it frustrating that confidentiality restrictions prevent him from reporting such "criminal acts" as the use of false social security numbers.

The EWs received approximately two hours of training about the Healthy Families program (less than the application assistants). It is therefore not surprising that they demonstrated considerable confusion and misunderstanding of the program; one thought that the family had to include a pregnant woman to be eligible (a mistake that may be attributable to the program's name), and another was unfamiliar with the co-payment structure and income limits. They pointed out that they are not paid to do Healthy Families eligibility determination and clearly do not feel responsible for enrolling children in the program.

The EWs expressed little confidence in the ability of application assistants in the community to help applicants to fill out the form correctly; for example, they assume that undocumented sources of income, such as tips, will go unreported. Some EWs may fear that the use of assistants is the beginning of contracting out their jobs and may therefore resent them.

The application assistants, in contrast, are quite willing to help clients to complete applications. The challenge they face is the balance between the competing demands of their jobs and the incentive (as well as their personal motivation) to enroll children in

Healthy Families and Medi-Cal. In addition, they report that their clients' perceptions about the programs pose a significant barrier to their enrollment. The specific issues they encounter most frequently are:

- **Dislike of Medi-Cal**. Some of the assistants report that families do not hesitate to check the box giving permission to forward the application to Medi-Cal or Healthy Families if they have applied for the wrong program. However, others report that many families do not want to participate in Medi-Cal, so they do not check the box (or check the box only to refer the application to Healthy Families). One assistant believed that families really could choose between the two programs.

- **Immigration issues**. The assistants almost universally reported immigration issues to be a major barrier to enrolling eligible children, particularly Latino children, in either Healthy Families or Medi-Cal. Families are concerned that enrollment in any public program will lead to their being considered a "public charge," a designation that could threaten the parent's citizenship application or require that benefits be repaid. In fact, potential applicants are being advised by immigration lawyers not to apply for any public benefit if they are in the process of applying for citizenship, even if the children are citizens. In this environment, application assistants do not feel that they can adequately reassure their clients that enrollment in Medi-Cal or Healthy Families will not threaten the family's immigration status.

  To resolve this issue, officials of both DHS and MRMIB have written to the INS for clarification of the circumstances under which aliens who receive public benefits may be considered a "public charge." The INS has responded that the receipt of benefits by an alien parent's U.S. citizen child is not counted against the parent (or other family member) for "public charge" purposes, unless the family relies on those benefits as its "sole means of support." The INS's letter did not clarify the agency's policy toward non-citizen children. A second letter has been submitted to the INS to address this issue specifically. [5]

Outreach

California's success at enrolling low-income children in Medi-Cal and Healthy Families depends on the state's ability to identify and attract these children's families to these programs. The state has developed a number of outreach efforts to inform the public about child health insurance programs and to make the application process accessible. In

[5] In response to publicity about this issue, the INS issued new guidance on May 26, 1999 clarifying its treatment of CHIP benefits. This guidance states that "the receipt of Medicaid and CHIP benefits, with the exception of institutionalization for long-term care, cannot be considered in making a public charge determination." However, considerable effort will still be needed to inform immigrant families of this policy.

addition, a number of efforts are under way on the local level in Santa Clara County to publicize the programs and locate and enroll eligible families. These efforts are described in turn below.

State Efforts

Within DHS, responsibility for promotion of Healthy Families/Medi-Cal for children has been assigned to the Medi-Cal Eligibility Branch, the same office that handles eligibility policy. Although this was traditionally a policy unit, in 1991, it was assigned responsibility for BabyCal, the state's public awareness campaign to promote early prenatal care and reduce low birth weight and infant mortality rates. Because of the success of that campaign, the Eligibility Branch was assigned responsibility for managing the Healthy Families/Medi-Cal for Kids outreach effort. To this end, the branch has implemented the following initiatives:

- **Media**. DHS has contracted with Runyon, Saltzman, and Einhorn to produce the state's media campaign. This campaign includes TV and radio spots, print ads, bus cards with tear-off flyers, and billboards in all media markets in the state, as well as a number of collateral materials, including pins, information cards in ten languages,[6] stickers, and posters with messages in a variety of languages and targeted at various ethnic groups. This campaign began in June 1998.

  All of these materials use the Healthy Families/Medi-Cal for Kids logo and promote the Healthy Families toll-free hotline, which is managed by EDS. The logo is intended to join the two programs in the public's mind; however, many informants reported that the joint logo confuses the public and links Healthy Families too closely to Medi-Cal, a program that many people distrust.

- **Corporate partnerships and sponsorships**. A variety of corporations are involved in promoting Healthy Families/Medi-Cal for Kids. Raley's supermarkets include information on the program on the sides of its paper grocery bags and has placed information cards at checkout stands; Edison International is enclosing a flyer in its bills in Southern California; and RiteAid pharmacies distribute program information, collect cash premiums, and offer a $10 coupon to enrollees who fill prescriptions at their stores. DHS has established a Corporate Council, headed by John Bryson, CEO of Edison International.

- **Public relations**. DHS has contracted with Hill and Knowlton to conduct the program's public relations campaign. This campaign includes press releases about the Healthy Families program and Medi-Cal enrollment

[6] These languages are English, Spanish, Armenian, Cambodian, Chinese, Farsi, Hmong, Laotian, Russian, and Vietnamese. The application will also be translated into Korean.

simplification efforts, public appearances by state leaders to promote the program, and community events across the state.

The state is currently devoting $21 million to this outreach effort, with $12 million coming from CHIP funds and $9 million from Medicaid administrative funds, for which the state receives a 50 percent federal match. The application assistant fees are paid with Medicaid administrative matching funds.

In designing its statewide strategy to promote Healthy Families and Medi-Cal for children, the state's emphasis was on mass media and public relations efforts rather than on community-based case-finding efforts. However, state-level public health officials questioned this as the sole strategy and expressed need for more county-level efforts to make families aware of the availability of the programs; specifically, they recommended that outreach efforts be based on local public health agencies' knowledge of their communities and the low-income families in them. Indeed, as will be described in the next section, several community-driven efforts are in place in Santa Clara County, using private funding rather than state or county support.

Local-Level Efforts

Much of the promotion of Healthy Families/Medi-Cal for Children in Santa Clara County was organized on the local level. In addition to the network of community-based agencies that house application assistants, door-to-door outreach is being coordinated by the Santa Clara County Health and Hospitals System and supported with grant funds, and the Santa Clara Family Health Plan has initiated a range of community outreach efforts, as described below.

Santa Clara Valley Health and Hospital System

The Santa Clara Valley Health and Hospital System (SCVHH) is the county's system of publicly funded hospitals and clinics. In 1996, SCVHH began a Medi-Cal outreach program known as Valley Community Outreach Services, which used county funds to support financial counselors located in county-funded clinics and to support outreach workers to promote Medi-Cal in the community. This initial effort was a response to declining Medi-Cal enrollment and increased eligibility denials at the outset of the county's Medi-Cal managed care program.

In January 1998, SCVHH received a grant from the California Healthcare Foundation and the Packard Foundation to coordinate an outreach effort under the *First Things First* initiative. This funding allowed the agency to support financial counselors in non-county-operated clinics. These workers assist clients with preliminary screening for Medi-Cal eligibility, assist with Healthy Families applications, answer questions, and schedule appointments with out-stationed EWs. They also schedule home visits by the outreach workers and follow up with clients about missed application appointments and

incomplete applications. These workers are now located in five sites: the four Valley Health Center sites (at Bascom, Silver Creek, East Valley, and San Martin) and Gardner Health Center, and workers will soon be added at CompreCare, Planned Parenthood, Mayview, and Indian Health Services.

The *First Things First* grant is also being used to expand the scope of the agency's four outreach workers. These workers are from the local community and are trusted by community members; three speak Spanish and one speaks Vietnamese. They focus on door-to-door canvassing in low-income neighborhoods and on organizing and educating community-based organizations, particularly in the Vietnamese community. This has allowed them to identify potentially eligible families who might not use county clinics. Most families contacted by the outreach workers are willing to complete an application, either right away or at a later date. Of the families reached through these outreach efforts, 75 percent apply for Healthy Families. (In contrast, most of the families identified by the financial counselors are eligible for Medi-Cal). The outreach workers have assisted in completing 300 applications while the clinic financial counselors have filed only 30.

The success of this effort highlights the importance of individual, community-based outreach to identify low-income families with uninsured children, educate them about the available programs, and assist them in completing applications.

Santa Clara Family Health Plan

The Santa Clara Family Health Plan is a managed care organization developed by the county's public sector providers to serve Medi-Cal enrollees under California's Two-Plan Model.[7] The plan is prohibited from directly recruiting Medi-Cal/Healthy Families members for conflict-of-interest reasons; however, the plan has invested considerably in outreach to the community, on the assumption that reaching people actively will be more effective than waiting for them to seek out coverage. The plan's outreach activities include the following:

- **Community Outreach Conference**. To introduce Healthy Families to the community, the plan held a conference in April 1998 for community-based organizations, which was attended by more than 200 representatives of schools, churches, providers, and community groups. At this conference, participants discussed methods for reaching the estimated 25,000 uninsured children in Santa Clara County.

[7] The commercial plan operating in Santa Clara County under this model is Blue Cross of Northern California. As the only plan involved in Healthy Families statewide, Blue Cross has been active in promoting public awareness of Healthy Families and Medi-Cal for children, primarily through training sessions offered to providers and community leaders in smaller, rural counties. The plan chose not to be actively involved in Healthy Families/Medi-Cal outreach in Santa Clara County, as other grass-roots coalitions had already formed for this purpose.

- **Facilitating application assistor training**. Although their staff cannot act as application assistants, the plan worked with Richard Heath and Associates to identify agencies that could house assistants and to sponsor training sessions. Through these sessions, 130 assistants from 35 agencies were trained.

- **Fact sheets**. The plan has developed fact sheets about Healthy Families in English, Spanish, Chinese, Vietnamese, and Cambodian. These are distributed through churches, food banks, schools, and child care centers. The plan is also working with PTAs to train parents to assist each other in filling out applications.

- **Community events**. The plan participates in health fairs and festivals throughout the county to distribute information and educate people about Healthy Families and Medi-Cal.

- **CalWORKS training**. The plan is working with CalWORKS, the state's Temporary Assistance for Needy Families program, to educate clients about their eligibility for transitional Medi-Cal and about how managed care works. This helps to reassure CalWORKS participants that they will not lose health benefits when they join the workforce.

- **Outreach through Chambers of Commerce**. The plan is working to educate employers about the availability of coverage for the children of low-wage workers, who may not be offered or may not be able to afford dependent coverage. Networking events have been held with temporary agencies and with the Hispanic, Filipino, and Vietnamese Chambers of Commerce. The plan also distributes packets to employers containing applications in several languages and information about Healthy Families.

- **Outreach through pharmacists**. The plan is working with pharmacists to identify uninsured children from among their customers. The plan received funding from pharmaceutical firms to conduct continuing education dinners on topics of interest, such as depression and drug therapies for heart conditions. At these sessions, they present information about Healthy Families and hand out materials, such as counter cards, that pharmacists can use to promote the program.

- **Outreach through physicians**. To reach children in specific ethnic communities, the plan is working with ethnic independent practice associations within their networks. This approach is based on the assumption that families will accept information from trusted sources within their communities more readily than from door-to-door outreach.

All of these efforts are financed through the plan's general revenues; although the plan is involved in the grant-funded *First Things First* initiative, it receives no funding from that program.

Future Initiatives

In addition to its investment in media and public relations, the state is currently soliciting proposals from the counties to do outreach for Medi-Cal using the $17 million in 1931(b) funds available to California under the federal Personal Responsibilities and Work Opportunity Reconciliation Act. These funds, which are financed through a match of 90 percent federal funds with 10 percent county funds, are to be used to target Medi-Cal eligibles, including those who have never enrolled as well as those who are eligible for Transitional Medi-Cal as they join the work force; these efforts are to be coordinated with Healthy Families outreach. Only one application will be accepted from each county. It is expected that counties will be the grantees, but the counties are required to collaborate with local community-based organizations.

Lessons Learned

As of 31 October 1998, a total of 24,301 Healthy Families applications had been processed by EDS and 33,052 children—approximately 8 percent of the estimated 400,000 uninsured children eligible for the program—had been enrolled in the program statewide. Of the 24,301 applications processed, 9,486, or just over one-third, were completed with the help of application assistants. The results of the applications completed with and without assistance are shown in Table II-1 below.

Table II-1
Results of Healthy Families Applications (as of 31 October 1998)

With assistance: 9,486			*Without assistance: 14,815*		
all children eligible	all children ineligible	some eligible, some not	all children eligible	all children ineligible	some eligible, some not
5,971 (63%)	1,985 (21%)	1,530 (16%)	8,775 (59%)	4,130 (28%)	1,910 (13%)

Of the children found to be ineligible for Healthy Families, 70 percent had family incomes that qualified them for Medi-Cal, and 12 percent had family incomes above the Healthy Families eligibility level. Other reasons for ineligibility include those relating to the date of entry into the U.S. (8 percent), lack of alien documentation (6 percent), and current enrollment in no-cost Medi-Cal (6 percent).

No similar tally is kept of the results of the Medi-Cal mail-in application. However, in the early months implementation of the mail-in form, Los Angeles County tracked the applications it received. As of 5 October 1998, 3,152 applications had been received at the processing center, and 1,371 of these had been screened. Just over half had been completed with the help of application assistants; of those that were completed with assistants, 67 percent had no errors, while of those completed without assistants, 2 percent had no errors. Major errors included lack of documentation, a Medi-Cal case already open, an incomplete application, or errors in reporting income. No information is available about the proportion of applicants who were determined to be eligible for Medi-Cal.

California's experience in the early months of implementation of Healthy Families and simplified Medi-Cal enrollment for children offers a number of important lessons about state- and local-level policies and procedures. On the state level, officials were faced with a paradox: the creation of a separate state program apart from Medi-Cal, while appealing both politically and to consumers, required the use of a separate structure for enrollment and administration, thus hampering the state's efforts to coordinate outreach and enrollment with Medi-Cal. Therefore, state officials designed an outreach strategy that attempted to link the two programs with a single logo and a combined application form. However, the connection with Medi-Cal is proving to be at best confusing and at worst counterproductive, as many families want to avoid all connection with a program they see as "welfare." The ultimate challenge, therefore, will be to distinguish Healthy Families/Medi-Cal for Kids as a state program separate from cash assistance. Given that challenge, many of those interviewed saw the state's enrollment of 30,000 children in Healthy Families in four months as an admirable achievement, considering that the program is entirely new.

Another critical lesson has to do with the effect of fears of INS enforcement on outreach efforts. State officials estimate that 60 percent of uninsured children eligible for Medi-Cal or Healthy Families are Latino. This is the population that is proving most difficult to enroll, as families are concerned about the effect of the use of public services on their efforts to become citizens or legal residents. The state has requested clarification from the INS on the circumstances under which the receipt of benefits by an alien child will be attributed to the parent for "public charge" purposes, and whether the use of these benefits will prevent the parent or other family member from sponsoring other relatives who want to enter the U.S. This clarification will allow all of those who are in a position to help attract Latino enrollees, including EWs, application assistants, outreach workers, and community-based organizations, to provide clear answers to their clients' questions and to offer their full support to the program.

On the local level, the major lesson that was apparent from this case study regards the difficulty of implementing a new program through a long-established county welfare bureaucracy. In California's counties, Medi-Cal eligibility is still closely tied to eligibility for cash assistance and Food Stamps, and a complex system of rules, forms, and computer software has grown around all of these programs, linking them inextricably

and hampering even the best-intentioned efforts toward change. For example, applicants for Medi-Cal in Santa Clara County are still being given a list, last revised fifteen years ago, of "papers needed at your cash assistance/medical care appointment." According to state officials, at least seven of these 16 items are not required for Medi-Cal eligibility determination or are needed only in specific, unusual circumstances (such as if an applicant owns more than one home). However, no attempt is made to inform applicants that they do not need to bring in all 16 items on the list.

In another example, while the asset test for children has officially been waived, EWs still request information about assets either because they do not understand the policy or because they are concerned that Continuing Eligibility Workers will send the case back to them if the documentation appears to be incomplete. Thus, despite efforts to separate Medi-Cal for children from the welfare system in the minds of the public, the operationalization of this policy will continue to be a challenge. This challenge is compounded by the fact that these program changes must be implemented by 58 county agencies individually.

The case study also emphasized the importance of locally-based outreach efforts tailored to the needs of individual communities. The state's media-based efforts, while well known within Santa Clara County, were not generally considered to have been effective in bringing families into the Healthy Families program. Rather, the efforts of local agencies, supported largely with private funds, appeared to have been critical in bringing the message about health insurance for children to low-income families. These efforts were coordinated with those on the state level, using materials and logos created by the state's media contractor, but generally used these only as a small element of a creative, targeted outreach strategy. This strategy, including door-to-door outreach by trusted community members as well as efforts tailored to reach professionals within all segments of the community, appears to be the most promising avenue to attract families to these programs.

The public health branches within DHS were not extensively used to promote Healthy Families on the community level. The Division of Primary and Family Health proposed an outreach model that emphasized partnerships with local public health agencies and community-based organizations that work with low-income families; these agencies would not only identify and enroll children in the programs but would work with their families to assure that they received health care services. This model would have required up-front funding rather than retrospective payments, but it would have allowed for the creation of new staff positions devoted to Medi-Cal/Healthy Families outreach, enrollment, and follow-up. This approach is not feasible under the current system, as the assistor fee cannot cover all of an employee's time and is only received for successful enrollments. Moreover, because outreach is financed with Medicaid administrative matching funds, the Title V agency cannot provide the state share and is unable to hire outreach staff on the local level.

Overall, nearly everyone interviewed, from those least familiar with the intricacies of Medi-Cal to those who know it best (the EWs) agree that the system of publicly-funded coverage for children is too complex to be easily accessible, and the programs would be much easier to promote if they were simpler and more unified. Several informants suggested that, for example, all children with family incomes under 200 percent of poverty should be eligible for coverage. In theory, that is the case in California. In practice, however, the use of two programs and two eligibility determination systems produces a reality that does not reflect the policy goal.

Chapter III

Georgia

Background and Overview

Current estimates by the Georgia Department of Medical Assistance of the state's uninsured population set the number of children without health care coverage at approximately 370,000. Georgia officials further estimate that between 113,000 and 140,000 children under age 19 who do not have insurance are eligible for PeachCare for Kids, the Georgia Children's Health Insurance Program (CHIP). Approximately 100,000 children are potentially eligible for Medicaid but are not currently enrolled and an additional 100,000 children are uninsured but not eligible for either Medicaid or PeachCare.

Prior to passage of Title XXI, Georgia's only public child health insurance plan was the Medicaid program, which is administered by the Department of Medical Assistance (DMA). Georgia currently covers children in the following income categories under its Right from the Start Medicaid (RSM) program:

- Pregnant women and infants to 1 year of age with family incomes up to 185 percent of the Federal poverty level (FPL);
- Children age 1 through 5 with incomes up to 133 percent of FPL; and
- Children age 6 through 19 with incomes up to 100 percent of FPL.

The phase-in of eligibility for children under 100 percent of poverty was accelerated in 1995 through a Section 1902(r)(2) expansion.

In addition to the Medicaid program, Georgia had two public-private programs that were designed to provide health care to uninsured children, although neither of the programs offered health insurance. The first, the Georgia Partnership for Caring, consists of a health care referral system for Georgians who cannot afford private health insurance but are not eligible for Medicaid or Medicare. Undocumented children are eligible for services through this program. The second, the Caring Program for Children, was designed to provide primary and preventive health care coverage to children of working Georgians at no cost to their parents or guardians. This program has been phased out with the implementation of Georgia PeachCare.

The state of Georgia has created a program with its Child Health Insurance Program funds called "PeachCare for Kids." Although not a Medicaid expansion, the program is considered

to be a Medicaid look-alike in that it offers the same services as the Georgia Medicaid Plan with the exceptions of non-emergency transportation and targeted case management, with all services subject to the same limitations and prior approvals as in the Georgia Medicaid Plan. Services covered under PeachCare are delivered through the existing Medicaid provider system. Children enrolled in either PeachCare or Medicaid use the state's primary care case-management program, Georgia Better Health Care (GBHC), or enroll in a managed care organization in those counties in which the state has contracts with managed care plans.

Children 0 to 18 years of age with a family income at or below 200 percent FPL, and not eligible for Medicaid, will be covered under Georgia CHIP. The breakdown of coverage is as follows:

- Children age 0 through 1 year, at 186-200 percent FPL;
- Children age 1 through 5 years, at 134-200 percent FPL; and
- Children age 6 through 18 years, at 101-200 percent FPL.

While there are no deductibles or co-payments, a premium is required for some children. There is no premium charge for children ages 0-5; for one child aged 6-18 there is a monthly premium of $7.50, and for two or more children the premium is set at $15.00 per month. A three-month waiting period applies to families who drop employer-based or other coverage to enroll in PeachCare. However, the waiting period does not apply if coverage under a parent's employer plan during the prior three months is terminated because the employer canceled the entire group plan; loss of eligibility was due to parent's layoff, resignation, or employment termination; leave of absence without pay or reduction of work hours; or because a COBRA or individual insurance policy was cancelled. A child born during the three-month waiting period is eligible for PeachCare. Children of state employees are not eligible for the program.

Statewide implementation of PeachCare began 1 December 1998 with benefits payable on 1 January 1999.

Administrative Structure of RSM and PeachCare

The Department of Medical Assistance (DMA), the state Medicaid agency, is responsible for the administration of both RSM and PeachCare. DMA has contracted with the Department of Human Resources to do outreach and eligibility determination for RSM. Eligibility determinations are conducted by state employees in each county through local Division of Family and Children's Services (DFCS) offices. Outreach is conducted by a separate cadre of RSM outreach workers, also state employees, housed in community agencies rather than in DFCS offices.

Using funds from the CHIP 10% administrative funding pool, DMA has also contracted for administration of PeachCare, including eligibility determination, claims administration, and outreach. Eligibility and claims administration are conducted by a private agency, Dental and Health Accounting Consultant Services (DHACS), the agency that administers the State of Florida's Healthy Kids program. Statewide media efforts are conducted through a contract with Prospect Associates, an Atlanta-based firm, and local-level outreach is conducted by the RSM outreach workers. DMA has established the position of PeachCare Project Coordinator to be responsible for the coordination of PeachCare activities at the state level.

Case Study Design

To understand state-level outreach and enrollment systems and policies, a two-person site visit team spent a day in Atlanta interviewing officials of the Division of Family and Children's Services, the Department of Medical Assistance, the Georgia Association for Primary Health Care, Georgia Legal Services, and Georgians for Children.

The local-level case study was conducted in Macon, the urban center of the seven-county region in Central Georgia where PeachCare enrollment was piloted beginning 1 September 1998. The counties included in this region are Bibb (which includes the city of Macon), Crawford, Houston, Jones, Monroe, Peach, and Twiggs. Benefits for this pilot area became effective 1 November 1998.

State officials estimate that the seven-county region houses approximately 7,000 children who are eligible for PeachCare, with more than 3,000 residing in Bibb County. In Bibb County, almost 40 percent of families have incomes below $25,000, and nearly 22 percent have incomes below $15,000. Just over one-quarter of the county's population is under age 18. The region has high rates of illiteracy, teen pregnancy, and youth crime. A map showing the location of Bibb County is presented at the end of the case study in Appendix A.

Eligibility Determination Process

State Policy

Following the passage at the federal level of the Children's Health Insurance Program, Georgia's Governor, Zell Miller, worked with the Health Policy Center at Georgia State University to examine the alternatives for Georgia's CHIP program. Ultimately, the Georgia General Assembly voted in their 1998 session to create the PeachCare for Kids Program. Policy issues influencing the choice of the separate state program model included the long-term financial implications of an entitlement program and a desire to develop a child health insurance program consistent with the state's welfare reform policy of emphasizing self-sufficiency. Therefore, Georgia's CHIP program was designed as a Medicaid look-alike program that requires the payment of premiums to maintain coverage.

Over the long term, state officials are interested in establishing a seamless eligibility process, moving away from categorical insurance programs and reducing confusion for families. At this time, however, the two programs have distinct eligibility determination systems. A comparison between the two eligibility determination systems is presented below.

- **Application forms**. For pregnant women who are determined to be presumptively eligible for RSM, a one-page application form is used. Children of the pregnant women may also be included on this form. For other children potentially eligible for RSM, a three-page form must be completed. For the PeachCare program, a separate one-page, two-sided application form is used and sent to the state's third-party administrator, DHACS, for processing. The premium in the required amount must be sent to DHACS before coverage can begin; however, the application can be processed before the premium is received. There are no asset test requirements for either the Right from the Start Medicaid Program or the PeachCare Program.

- **Application process**. Applications for the RSM Program may be mailed to DFCS, completed at the DFCS county office, or electronically transmitted by the RSM outreach workers using the DFCS SUCCESS computer system. PeachCare applications are mailed directly to DHACS, which is not currently connected to the SUCCESS system. On the PeachCare application parents may indicate that, if their child is found to be ineligible for PeachCare, the application may be automatically forwarded to DFCS to determine eligibility for RSM. Likewise, RSM applications are automatically sent for PeachCare eligibility determination if the child is found to be ineligible for RSM.

- **Verifications**. For RSM, income verification is required for families with incomes over the poverty level; self-verification is accepted for those with incomes below 100 percent of poverty. PeachCare applicants are not required to provide verification of income. With the permission of the applicant, income may be verified verbally with the employer. DMA policy is to eliminate as many requirements that could act as barriers to the enrollment of eligible children as possible. Verification of citizenship is a requirement for enrollment in RSM, although self-declaration is acceptable in most cases. For PeachCare, only legal aliens and those whose citizenship is questionable are asked to provide proof of a child's citizenship.

- **Retroactive coverage.** Children who are deemed eligible for RSM can obtain coverage for services received for the three months preceding the application date. Coverage for PeachCare does not begin until the first of the month following the month in which the application form was processed and the premium paid. If a PeachCare premium is not paid in a given month, the child will not be covered for that month; coverage may resume when a payment is received.

- **Re-certification**. RSM requires re-certification every six months; this may be done by mail, with telephone follow-up if necessary, or in person at the county DFCS office. A face-to-face interview is required once a year. As there is no continuous eligibility provision for children, parents of children eligible for PeachCare must confirm or correct their application information annually. In the future, the state will have the ability to perform a computer match of families with children enrolled in PeachCare with Department of Labor employment records. If the match indicates that the families' income is in excess of 200 percent of poverty, the family will be contacted to assess continued eligibility.

A policy of presumptive eligibility for children was discussed as the PeachCare program was being formulated but was ultimately not adopted. Policymakers felt that children, as opposed to pregnant women, are probably not in need of immediate coverage. In addition, since the current presumptive eligibility process uses a paper system, state officials were reluctant to overload providers with additional forms. However, the state has not abandoned the notion of presumptive eligibility; DMA has set aside funds to contract with the Georgia State Health Policy Center to continue to explore presumptive eligibility as PeachCare policy.

State officials are also interested in determining the level of utilization of health services by children enrolled in PeachCare. Since PeachCare enrollees use the same provider system as Medicaid enrollees, DMA plans to explore the feasibility of linking enrollee data with insurance and provider claims data to link enrollment status with utilization activity.

Local Implementation

Families can enroll their children in RSM or PeachCare through two major channels: the RSM outreach workers and the traditional eligibility determination system at DFCS.[8] This section summarizes the application process used in each of these systems in Bibb County; application forms for RSM and PeachCare are included in Appendix C.

Traditional Medicaid Application Process

Traditionally, Medicaid applications have been and continue to be taken at the Department of Family and Children's Services office on Oglethorpe Street in Macon. In addition to the workers at this site, two DFCS workers are out-stationed full-time at the Medical Center for Central Georgia to take applications from uninsured patients. Workers stationed at housing projects carry ongoing caseloads of the projects' residents but do not take new applications.

Filing a Medicaid application is a two-step process. In an initial visit, an applicant will pick up and complete an application for those programs in which she is interested using a four-page

[8] Families may also enroll their children using the mail-in PeachCare application.

form. The wait for this application can last from one to four hours. This form is used only to determine which programs an applicant is applying for and under which categories she may be eligible; it does not include income or other eligibility determination information. An appointment for a return visit will then be made; this visit generally takes place within a week to ten days.

At the second visit, the applicant will have an interview with a DFCS worker. No paper form is needed for this interview, as all information can be entered directly into the computer system. The interview has in the past taken only about half an hour; however, a new computer system has recently been installed, and appointments are taking much longer as DFCS workers learn their way around the new software. An application interview for only RSM will be much briefer than one in which a family is applying for TANF, Food Stamps, or other programs as well. If she is applying for only RSM, the applicant may pick up the three-page RSM application and mail it back or drop it off with the required verifications. The documentation required for RSM includes:

- A Social Security number and the child's date of birth (although a copy of the Social Security card and birth certificate are not required, workers report that they prefer to have legal documentation in the file whenever possible);
- Proof of income (in the form of four pay stubs) if the family's income is above 100 percent of poverty (if income is below the poverty level, proof will not be required unless a check with the Department of Labor's employment database shows a discrepancy); and
- Proof of citizenship if the client indicates that citizenship may be an issue. The workers indicated that they may pursue proof of citizenship based on applicants' names. Birth certificates and Social Security cards may be requested for citizen children of non-citizen parents.

Workers do not ask about the family's resources if they are applying for RSM only.

The information will be entered into the computer system, known as SUCCESS. This system evaluates the applicant's eligibility for those programs for which she is applying. However, if the family appears to be eligible for other programs as well, the system will generate a letter informing the applicant that she may be eligible for these programs and advising her to contact her DFCS worker for more information. Medicaid applications must be processed and eligibility determined within 45 days.

If a family's income is too high to qualify for RSM, the worker may first explore the family's eligibility for Medicaid under the Medically Needy category by asking whether the family has a chronically ill child or has (or anticipates) outstanding hospital bills. If the child does not seem likely to qualify under this category, the workers may refer the family to PeachCare by handing out the application and advising the family to fill out as much of it as they can and mail it in. The workers were not given any training on PeachCare, however, and cannot

provide detailed assistance with the application or information about program specifications, such as income limits.

The workers interviewed report that they complete approximately 75 RSM and Food Stamp applications each month, about 25 to 30 of which are for RSM only. They are currently overwhelmed because of the time it is taking to incorporate the new software into their routines and because of the additional work required to alert people going off TANF of the availability of Transitional Medicaid.

RSM Outreach Workers

Many of those interviewed report that families prefer not to go through the DFCS eligibility determination process, as they find the process time-consuming and demeaning and the workers unsympathetic. In that case, families can apply for RSM or PeachCare through the county's RSM outreach workers. Approximately 30 percent of the RSM workers' time is spent working directly with clients and 50 percent is spent doing outreach in the community. This section describes the process that these workers use to complete applications and determine eligibility for RSM and PeachCare. The workers' outreach and case-finding efforts will be discussed in detail in the following section.

Four RSM outreach workers cover Bibb County. Each is housed in a community-based agency: one at a Family Self-Sufficiency Center within a housing project, two at the county health department, and one at the Medical Center for Central Georgia. The workers have computers at these sites that they use to verify eligibility using the SUCCESS system.

The workers have traditionally used Form 247, the *RSM Medicaid Application/Interview Guide*, to assess Medicaid eligibility. The form is six pages long, with two pages for applicants to fill out, one page listing rights and responsibilities, and three pages for the workers to use to document that the necessary verifications have been received. The form requires a face-to-face interview, but applicants may fill the form out at home.

This form is currently being replaced by Form 256, the *Interview Guide for Cash, Food Stamps, and Medicaid Assistance*. This is a 20-page packet that replicates the information that is required by the SUCCESS software package and would not be filled out on paper by the applicant. Because the system is new and they are unused to the new form, the workers report that they usually have applicants fill out Form 247 and enter the information from the form into the computer system. RSM workers estimate that they spend approximately 20 percent of their time processing applications using the SUCCESS system. Once the information is entered, the system can then determine eligibility quickly, often delivering a determination the same day once verifications have been received. The only verification the workers report that they require is proof of income if the income is above 100 percent of poverty or if a discrepancy appears with the Department of Labor database. When necessary, the RSM workers will visit clients at home to collect this verification, and will give clients three chances to keep an appointment before they deny an application for noncompliance.

Once Medicaid eligibility has been established, cases are transferred to ongoing DFCS workers for monitoring and re-determination in six months. Technically, re-determination requires an in-person interview; however, enrollees are allowed one re-certification by mail, postponing the visit until they have been enrolled in the program for a year. The workers report that many of their clients simply let their eligibility lapse at six months so as to re-apply with the RSM worker rather than have any contact with DFCS.

The workers are expected to complete 40 to 50 applications a month. In fact, the workers interviewed report that they complete 30 to 50 a month (fewer in sparsely populated counties). They report only a two percent denial rate among completed applications. However, a substantial proportion of the applicants they work with (20 to 50 percent) are discovered to have an existing TANF or Food Stamp record in the computer system; these cases must be referred to DFCS and cannot complete an application through the RSM workers.

If a family appears to be eligible for PeachCare, they will give out the application and an envelope addressed to DHACS. They will also help clients fill out the mail-in application if necessary. If the client fills out a PeachCare application and appears to be eligible for RSM, they will keep the application and use it to process an RSM application on the SUCCESS system.

Knowledge and Attitudes of Eligibility Workers

The DFCS workers interviewed see their Medicaid-only clients as distinct from those who need cash assistance, describing them as "intact families" who only need health coverage for their children. They see a widespread need for health insurance in the community and feel that their clients appreciate the availability of PeachCare if Medicaid is not an option for them. However, they acknowledge the poor reputation that DFCS has in the community; people's reluctance to come to what is seen as the welfare office does create a barrier to access to benefits.

The RSM workers are clearly dedicated to helping their clients to qualify for the programs available to them, and described in some detail the reasons why they felt it was difficult for their clients to seek help. The perceived connection of Medicaid to welfare is, they believe, a major barrier to potentially eligible individuals seeking publicly financed health insurance. They felt that these attitudes were reinforced by the behavior of health care providers and other human services workers toward those who use publicly funded assistance programs. Therefore, the RSM workers are careful to distinguish themselves from DFCS workers and emphasized the importance of reaching out to potential clients in settings where clients will not feel stigmatized. They cited the obviousness of the current Medicaid eligibility document—a brightly-colored sheet of paper, rather than a discreet insurance card—as an example of a barrier to Medicaid acceptance.

The RSM workers report that their clients are appreciative of their efforts, and often keep up with them even after their cases have been transferred to continuing eligibility workers at

DFCS. The outreach workers stressed the importance of the personal connection with clients and that clients particularly appreciate the flexibility in RSM workers' hours and their availability at night and on weekends. The workers empathized with their clients' life situations and needs and felt that the state's emphasis on finding eligible pregnant women and children and helping them obtain health insurance was the best way to help families. They cited the lack of knowledge of the availability of publicly funded health insurance, fears related to a sense of personal failure and possible stigmatization by others, and a lack of trust in the public system, as the major barriers to enrolling in Medicaid and PeachCare.

When they begin their jobs, RSM workers receive two weeks of policy training and one week of training in giving presentations in the community. Refresher training is given to all workers once a year. Despite these updates, the workers report that they still have questions about complex cases: whose income to count in complex family situations, for example, or whether a child is eligible for PeachCare if the custodial parent is a state employee but the absent parent is responsible for health insurance. The workers and their supervisor also report that they would feel more comfortable if they had more information about other programs for which their clients may be eligible, such as Food Stamps and TANF. They call DFCS when they have questions, but do not feel that they are able to give their clients full information about the programs for which they may be eligible.

Outreach

Georgia's efforts to publicize RSM and PeachCare are based on a model that focuses on community-based outreach conducted within the context of a state-directed media campaign. The primary component of the local outreach effort is the trained community members known as RSM Outreach Workers. The state is also promoting PeachCare through a statewide media campaign and through collaborative efforts with such groups as the Georgia Association for Primary Health Care, community action agencies and the state hospital association. This section first describes state policies in these areas and then discusses the activities of the RSM Outreach Workers and other community agencies that are working to identify potential eligibles in Bibb County.

State Efforts

RSM Outreach Workers

Georgia is building on the Right from the Start Medicaid (RSM) Project outreach strategies to facilitate PeachCare enrollment. In response to the state's high infant mortality rate and to improve access to health services for pregnant women and children, the RSM project was initiated in July 1993. A total of 143 RSM outreach workers, all of whom are state employees, are stationed in health departments, hospitals, schools, Head Start centers, community action agencies, and other community-based locations throughout the state's 159 counties. The priority activities for the RSM workers are to locate uninsured children and pregnant women, to determine eligibility for Medicaid, and to provide information and assistance regarding enrollment in Georgia PeachCare.

A major feature of the program is the availability of staff during non-traditional work hours—each worker is required to work 12 non-traditional hours during each 40-hour work week. RSM staff also make presentations about the Medicaid and PeachCare programs to various consumer and community groups, health care provider organizations, and businesses. The RSM outreach workers are required to conduct 12 such presentations each month.

In addition to locally-centered efforts, the RSM outreach project has initiated a number of statewide efforts to publicize RSM and PeachCare. These include the following:

- Placing information in paychecks of workers at Kmart, Shoney's, and Waffle House;
- Passing out flyers at state Highway Patrol seatbelt road checks; and
- Including information in Sunday church bulletins.

The RSM outreach project makes a point of hiring workers from their communities, with the rationale that these workers will be familiar with the community and its resources and will be invested in helping their neighbors. This is the first job for many workers, and the project administrators find that turnover in this position is high, as other agencies hire the workers after the RSM project has trained them. During their three-day presentation training session, the workers learn a standard text so that they may present a consistent message across the state. In addition, the workers have unit meetings in which they practice their presentations and share ideas about presenting effectively. There is also an annual meeting of all the RSM workers in the state.

The RSM outreach effort is financed through the state's Indigent Care Trust Fund, which is, in turn, financed by a provider tax that is matched by the Federal government at the state's standard Medicaid matching rate. CHIP administrative funds are not used to support the RSM outreach workers.

Mass Media Efforts

The Georgia Department of Medical Assistance has contracted with Prospect Associates to spearhead statewide outreach efforts to encourage families with eligible children to enroll in the PeachCare program. The firm has developed a mass media campaign around the general theme of "PeachCare for Kids: All the Care Without All the Costs." Promotional messages emphasize the importance of parents' having health insurance for their children and the affordability of the insurance premiums. The identification of these themes resulted from marketing research undertaken by Prospect with working parents. The firm learned that it was important for parents to believe that they could afford PeachCare and that it was just like other insurance programs. Subsequently the marketing firm developed brochures, posters, billboards and transit ads in both Spanish and English and will implement a paid advertising campaign on broadcast television and radio in early 1999. Promotional kits have also been prepared that include samples of these materials; these have been sent to a wide range of organizations,

agencies and community groups encouraging them to act as PeachCare supporters and assist in the identification of eligible children. The media campaign focuses entirely on PeachCare; no mention is made of the availability of Medicaid.

In mid-December, a statewide PeachCare enrollment day was organized, creating many opportunities for press coverage. The marketing firm is working with statewide groups such as the Hospital Association and a range of community-based organizations.

A toll-free telephone number has been established through which callers may receive information about the PeachCare program. This hotline is staffed by DHACS workers who will send PeachCare applications to callers upon request and remind callers that they may mail in the application. The hotline is also used by PeachCare providers to verify the enrollment of children in the program. Some limited information about the Medicaid program may also be provided by hotline staff. While the hotline was reported by some to be helpful, others have found it difficult to get through on this line. In addition, in some rural areas, the hotline's toll-free 877 prefix is not yet operational, making the hotline completely inaccessible; the long-distance carrier is working with local telephone companies to correct this problem.

Local-Level Efforts

The major local outreach effort for RSM and PeachCare comes from the RSM Outreach Workers housed in community agencies throughout the county. In addition, however, several other community agencies have taken the initiative to incorporate promotion of these programs into their work with low-income families. These efforts are described in the following sections.

RSM Outreach Workers

The four RSM outreach workers in Bibb County spend approximately half their time in the community, giving presentations to businesses and community groups, and distributing information to the public at stores and community events. The workers have been promoting RSM in the community since 1993; since the PeachCare pilot began, they have incorporated PeachCare into their presentations and broadened their outreach strategies to reach working families. They are not, however, able to widely distribute PeachCare applications and instead encourage those who are interested to contact the toll-free hotline.

In general, the outreach team's strategy is to determine all the possible points of contact with families who may be eligible for Medicaid or the PeachCare Program. The outreach workers' emphasis is on the finding the family, rather than on the family's finding the outreach worker. To achieve this, the RSM outreach workers have compiled a list of all business and agencies that low-income families use and are trying to reach all of them between January and June 1999. To this end, the team has divided the target organizations into four phases: city government, churches and civic groups, local businesses, and small businesses and individuals. In addition to these efforts, the outreach workers have solicited radio time for public service

announcements and have received donated space for a billboard and for cards on Transit Authority buses. They also spend a considerable amount of time talking directly to families at grocery, discount and video stores, churches, and community events, such as a recent Christmas parade.

The outreach workers report a generally positive response from the community. Although sometimes people do not want to take brochures for fear that others will observe their interest in a publicly funded program, they are receptive once the programs are explained to them (and once they are reminded that they are actually paying for them through their taxes). They appreciate not having to go to DFCS to apply, and would rather pay a premium to enroll their children in PeachCare even if they are eligible for Medicaid.

Other Community Agencies

The RSM outreach strategy, while attempting to reach eligible low-income families in many of the places where they are most likely to be found, does not appear to include close partnering with several other potentially helpful community agencies that serve or advocate for this population. The site visitors interviewed four such agencies and found a sincere interest in helping to identify and inform families who may have children who are eligible for RSM and PeachCare. However, these agencies need additional training to be able to provide effective application assistance to these families. The efforts of these agencies are summarized below.

- **Child Care Information Services**. This agency, the child care resource and referral agency for Bibb County, offers information about child care resources to families and provides training and support to family child care providers and child care centers. In Bibb County, 57 family child care providers and 39 child care centers care for a total of 5,753 children, a large proportion of whom are likely to be from low-income families. After going to a regional training coordinated by DFCS, the agency director put information about PeachCare in the newsletter she sends to all child care providers and has offered to provide information about the program to all callers who need it, though no one has yet asked for this information. The agency director has also considered including information about PeachCare in her training course on starting a family day care business.

- **Resource Mothers**. This program is operated by the Bibb County Health Department and provides case management services to low-income pregnant women and mothers of children up to age two. Seven Resource Mothers carry caseloads of more than 100 families each. The service is not currently reimbursed by Medicaid, so although the program's clients have low incomes, they are not all enrolled in RSM.

  When a new case is opened, the Resource Mother asks about the insurance status of the woman and each of her children. If anyone in the family who is potentially eligible is not enrolled in Medicaid, they will be referred to the RSM outreach worker who is stationed at the health department. If the family does

not appear to be eligible for Medicaid (or if they report that they have applied before and been found ineligible), the Resource Mother will give the client the PeachCare application. The Resource Mothers have not received training on the PeachCare application and cannot provide assistance in filling out the form. Instead, they advise their clients to call the toll-free hotline if they have questions about the program or the form.

- **Georgia Legal Services**. This agency provides legal assistance in civil matters, including divorce, bankruptcy, housing, and public benefits, to people with incomes under 125 percent of the federal poverty level in 23 counties in central Georgia. Although Legal Services' attorneys and paralegals on the local level rarely work directly with Medicaid, they are interested in assuring that their clients receive all of the benefits to which they are entitled. During the client intake process, they gather information about all sources of income and are therefore in an excellent position to assess clients' eligibility for Medicaid and PeachCare.

  The agency has had no contact with the RSM outreach workers in Bibb County; rather, the agency's staff received training in the PeachCare program and the use of the application form from staff of Georgia Legal Services in Atlanta. Since that training, the agency has begun to distribute PeachCare brochures in its waiting room and its paralegals assist clients in filling out the application form if they report on intake that their children do not have health insurance. (They do not use the RSM application form or refer those with income levels below the Medicaid eligibility standard to RSM or DFCS; instead, they use the PeachCare application for all uninsured children.) The application takes about ten minutes to complete, and the paralegals report no major problems or questions in completing it. They received a list of primary care providers who participate in Georgia Better Health Care from which clients may choose.

- **Middle Georgia Regional Development Center**. This agency houses Challenge for Change, a collaborative of health and human services agencies, nonprofits, and businesses that aims to improve the health and well-being of children in Bibb County as well as the local Area Agency on Aging. One of the collaborative's objectives is to increase the proportion of children who have health insurance. The group's strategies to achieve this goal include a community awareness program, planned for April 1999, to promote PeachCare and build relationships with agencies that serve low-income families so potential enrollees can hear about the program from people they trust. However, the Challenge for Change coordinator and the partner agencies have received no training (beyond a brief orientation workshop attended by the coordinator) and cannot provide assistance with the PeachCare application form or answer detailed questions about the program.

  One agency that has become involved in the PeachCare outreach effort is the Area Agency on Aging that serves Bibb County and ten surrounding counties.

Because this agency is co-located with the Challenge for Change, the coalition's coordinator thought to pass information on PeachCare to the agency to be distributed to senior centers. Intact extended families are still common in rural Georgia, and many grandparents care for their grandchildren, so this approach may be a productive avenue through which to reach uninsured children.

The staff of both the Resource Mothers program and Georgia Legal Services report that their clients are quite receptive to the idea of low-cost health insurance for their children and are willing to take the PeachCare application and fill it out. However, they also report that clients generally had not heard of the program before they described it to them. They echoed the RSM workers' report that clients greatly appreciated not having to go to DFCS to apply for Medicaid or PeachCare and their feeling that the program would be much less well accepted in the community if it were administered by the welfare agency. In fact, even those who are likely to be eligible for Medicaid prefer to fill out the PeachCare form and have it referred to Medicaid.

Lessons Learned

Georgia's experience of identifying and enrolling eligible children in RSM and PeachCare as exemplified in Bibb County offers many important lessons in the implementation of a separate state CHIP program and the conduct of community-based outreach within the context of a statewide media effort. Georgia, like many states, is trying to move ahead as rapidly as possible with the implementation of its CHIP program and is therefore forced to plan, implement, manage and monitor simultaneously.

The Georgia policy mandate regarding CHIP is clear: insure children, provide comprehensive benefits, and require parents to contribute, if nominally, to the cost of insurance. This overarching policy is reflected in practices designed to eliminate many of the commonly recognized barriers to participation, such as arduous eligibility and enrollment requirements and extensive verifications. State officials also recognize the importance of working toward a seamless system of publicly-funded health insurance in which families can move, as necessary, between Medicaid and PeachCare and onto employer-based insurance when that is an option.

Georgia is just beginning to implement its statewide media campaign, which is based on market research and collaboration with a range of community-based organizations and agencies. Materials have been developed and are being distributed to those who are in direct contact with eligible population groups. Press events are being organized in recognition of the importance of wide distribution of information about the availability of PeachCare. Thus far, however, Georgia's principal strategy for identifying and enrolling eligible pregnant women and children in Medicaid, and now its main avenue for PeachCare enrollment, is the use of community-based RSM outreach workers. These workers, with their strong roots in the community, the trust of their clients, and their willingness to work at non-traditional times and in unusual places, provide an innovative, personal approach to promoting and explaining these

programs and assuring that eligible families are able to enroll. The flexibility of the outreach workers' strategies and the strong empathy they feel for their clients are critical elements in the effort to reach eligible families, who may have a strong distrust of public programs and the bureaucracies that accompany them.

This approach, while emphasizing local control, may have sacrificed state leadership in areas in which communities may have needed guidance. Specifically, some of the more institutionalized support systems that may be helpful in the identification of eligible families in Bibb County appear to have overlooked by state policy makers and the RSM outreach workers. These include the child care providers, county health department programs, and the Legal Services system. In Georgia, as in other states, many statewide, locally based public and private health and human service agencies and organizations are in direct or indirect contact with populations potentially eligible for Medicaid or PeachCare. Mobilizing these agencies at the state level might have helped to direct the efforts of local RSM workers and helped to secure the commitment of partner agencies.

Several other gaps in the state's approach to outreach were apparent as well. The major issues that arose during our case study are described below.

- **The need for thorough training of those involved in promoting the program.** Many of those interviewed expressed a need for introductory or additional training on PeachCare, Medicaid and other Georgia programs that can strengthen and support families. The training available appears to be sporadic, fragmented and limited in follow-up. Although many community agencies are interested in participating in the outreach effort, the only training opportunities that have been offered to date have come from outside the PeachCare/Medicaid system. Organizations such as the Georgia Primary Health Care Association are involved in providing PeachCare training to member health centers using support they received from a HCFA/HRSA grant, and staff from Georgia Legal Services are also providing some training to selected community groups. These efforts do not seem to be part of all overall state strategy, but rather are isolated attempts to inform specific interest groups.

  In addition, the RSM workers themselves indicated a need for training support not only to facilitate their direct work with clients but also in their capacity as resources for other community workers in contact with potentially eligible clients. This issue will be discussed further below.

- **The need to assure the effectiveness of the PeachCare hotline.** Although statewide PeachCare enrollment is only just beginning, experiences from Bibb County may be instructive as the state begins to assess and monitor the role of the hotline. Several of those interviewed identified problems in accessing the hotline. As statewide promotion of the hotline intensifies and the number of inquiries from both consumers and providers increases, it will be important to

assure the capacity of the hotline in order to maintain public trust and confidence in the program.

- **The challenge of coordination with Medicaid enrollment**. In Georgia, although families can theoretically choose not to have a PeachCare application forwarded to Medicaid, all applications that fall within Medicaid eligibility limits are forwarded to a special team of RSM outreach workers before the completed applications are sent to the appropriate county DFCS office for Medicaid eligibility determination. Thus, PeachCare can provide a new avenue for Medicaid enrollment that bypasses both the RSM outreach workers and the DFCS eligibility determination process. However, because of the poor reputation of Medicaid, the program is not advertised as being connected to Medicaid or as providing access to Medicaid for those who are eligible; therefore, this potential benefit may not be used to its full advantage.

  While the best approach to facilitating a seamless integration between Medicaid and PeachCare may be the promotion of the programs as separate from those perceived as linked to welfare, the Bibb County experience also pointed out drawbacks as well. A significant limitation of the RSM workers, and one that is acknowledged by the workers themselves, is that Medicaid and PeachCare are the only programs for which they can actively intervene. In fact, the workers find that if their clients need information about other benefits, such as Food Stamps or TANF, they are not able to answer their questions fully. Thus, while clients appreciate being able to apply for Medicaid without going to DFCS, they may be losing an opportunity to learn about and apply for other important benefits.

The structure of the PeachCare program may itself present a barrier to full enrollment. The state created a separate CHIP program to avoid the potential problems of establishing a new entitlement, to develop a program consistent with the state's welfare reform policies in which parents could contribute to the costs of the health insurance, and to counter public attitudes toward DFCS and welfare. While the rationale for the establishment of a separate CHIP program, using a distinct name, a unique and simple form, and a separate enrollment and claims administration system is understandable, it does create some challenges to the state's long-term policy direction of a seamless system. Some of these challenges became apparent in the experiences described by those working to implement the PeachCare Program in Bibb County.

Many people interviewed felt that the PeachCare premium, while nominal, may pose a challenge to those unused to or unable to pay a health insurance bill every month. Parents may not have a checking account and may not have ready access to money orders to pay the premium. Since enrollment will be canceled if the premium is not received, and re-enrollment will require the payment of two months' premiums, this may make it impossible to provide continuous coverage and health care for children. Another important provision is the exclusion

of state employees from PeachCare enrollment. Many state employees cannot afford dependent coverage and could benefit from the program, but their children are ineligible.

Another issue raised by those working in Bibb County was the option for families to select a primary care provider on the PeachCare application form. While the inclusion of this opportunity as part of the application process was seen as positive, concerns were expressed about the extent of families' knowledge of the primary care providers available and thus their ability to make an informed choice. Families that do not indicate a primary care provider choice are auto-assigned based on geography.

At the time of the site visit, the implementation of PeachCare was still in its early stages, and the media campaign had not yet begun, so it is impossible to evaluate the program's success at reaching eligible families. To assure access to these programs, Georgia officials must counter years of mistrust toward public-sector programs and must use its cadre of community-based outreach workers to effectively identify and educate low-income families about the programs available to them.

Chapter IV

New Mexico

Background and Overview

Twenty-one percent of children living in New Mexico are uninsured—the highest rate in the country.[9] Of the 122,000 uninsured children[10], approximately 94,500 of these children are eligible for Medicaid and live in families with incomes below 185 percent of the federal poverty level (FPL). To enroll these uninsured children in Medicaid, the Human Services Department (HSD) was appropriated an additional $10 million in state general funds in 1998. In the short term, the Department's goal is to enroll half of the 94,500 uninsured children who are eligible for Medicaid.

A number of changes have been made in New Mexico Medicaid policy in recent years. In 1995, the state expanded Medicaid coverage to 185 percent of the FPL for pregnant women and children under age 19 and waived the asset test. Medicaid managed care, called Salud! in New Mexico, was implemented statewide beginning in July 1997 through three HMOs—Presbyterian Salud, Lovelace Community Health Plan, and Cimarron Salud.[11] Presumptive eligibility (PE) and 12 month-continuous coverage for children were passed with little debate and became effective 1 July 1998. In addition to the recent passage of these mechanisms to streamline the Medicaid application process, New Mexico has been using a short Medicaid application form for over nine years.

The State's Child Health Insurance Program (CHIP) plan proposes to expand Medicaid eligibility for children up to 235 percent of the FPL, providing coverage for an additional 5,500 children. Compared to the high numbers of uninsured children eligible for Medicaid, relatively few children in the 185 percent to 235 percent income bracket are uninsured, because many of the state's working poor are low wage earners with insurance benefits, such as copper-mine workers and state employees. Children enrolled in CHIP would be served through Salud! HMOs. Children will be ineligible for CHIP for 12 months following the termination of other health insurance, unless a child involuntarily loses coverage.

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[9] The Henry J. Kaiser Family Foundation, 1998, *Child Health Facts: National and State Profiles of Coverage.*

[10] The Henry J. Kaiser Family Foundation, 1998, *Child Health Facts: National and State Profiles of Coverage.*

[11] Some specialized services are still provided on a fee for service basis.

The New Mexico CHIP program is divided into two "phases." Phase I expands Medicaid's eligibility limit from 185 percent to 235 percent of the FPL. Phase II, as proposed, would provide "wrap-around" services for all children under 235 percent of the FPL. Because only 5,500 additional children are projected to be eligible through the CHIP program, the architects of the New Mexico CHIP plan emphasized the delivery of health benefits that are not covered by Medicaid, such as behavioral health, school health, medical day care, early intervention, home visiting, and respite care. The CHIP plan was submitted to the Health Care Financing Administration (HCFA) on 19 May 1998. The plan had not yet been approved at the time of the site visit.[12]

Administrative Structure for Medicaid and CHIP

The Medicaid program is administered by the New Mexico Human Services Department (HSD), as will be the proposed CHIP program. The Human Services Department is composed of several Divisions—Medical Assistance, Child Support, and Income Support. The Medical Assistance Division's Client Services Bureau handles Medicaid policy and eligibility issues.

The Income Support Division (ISD) administers cash assistance, Food Stamps, TANF, and energy assistance, and it determines Medicaid eligibility through the state's 37 ISD offices run by state employees. There is at least one local ISD office in each of New Mexico's 33 counties, four in Bernalillo County, and two offices thirty miles apart in the expansive Doña Ana County.

HSD received input from the Children Youth and Families Division (CYFD), the Department of Health (DOH), and others in designing the CHIP plan, and it plays an active role in the Medicaid outreach efforts. Four district offices throughout the state oversee approximately 55 local health offices staffed by state employees. Staff at the local health offices serve as application assistants for families eligible for Medicaid.

Case Study Design

The case study conducted in New Mexico consisted of a one-day visit to Santa Fe, the state capital, to interview DOH and HSD staff regarding Medicaid and CHIP enrollment and outreach strategies adopted at the state level. The local-level case study was conducted in Bernalillo and Sandoval Counties, which include Albuquerque and a neighboring semi-rural area. Bernalillo County is the most populous county in New Mexico with approximately 510,000 people[13]. As of August 1998, Bernalillo County was estimated to have 60,020 Medicaid eligibles. Four ISD offices provide services to county residents.

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[12] The portions of the New Mexico CHIP plan to expand Medicaid eligibility and to implement cost sharing provisions was approved on 11 January 1999. New Mexico expects to expanded eligibility to 235 percent of poverty on 1 March 1999.

[13] http://www.unm.edu

Sandoval County is adjacent to Bernalillo County. The county's major population centers are Rio Rancho, with a population of 45,000; the county seat of Bernalillo, which has a population of about 8,000; and the smaller town of Cuba, with a population of just 1,000. The county is composed of a relatively high population of Native Americans and Hispanics. As of August 1998, Sandoval County was estimated to have 9,473 Medicaid eligibles. The ISD office is located in the county seat of Bernalillo. The map in Appendix A shows the location of the two case study counties.

Eligibility Determination Process

In an effort to increase access to medical care for infants and children, to reach out to adolescents (who typically do not use preventive services), and to minimize application processing time, New Mexico has embraced a community-based enrollment process. The state has aggressively pursued a strategy to use medical and social service providers as application assistants in order to create additional points of access through which families can obtain Medicaid coverage. To further simplify the process and de-link Medicaid from the traditional welfare system, applicants who initiate their Medicaid application through community providers do not have to go to the local welfare office. However, the local welfare offices are still responsible for processing applications and determining eligibility.

This section presents the new state policies and local practices that have been instituted in an attempt to make it more convenient for families to enroll in Medicaid, and outlines the Medicaid application process and documentation requirements. Not surprisingly, as in any new system, some challenges have arisen. In some instances, the philosophy of the application process does not coincide with the actual practice of provider and local ISD offices. The dilemmas presented by these new enrollment practices, as reported by providers who assist families in completing the applications and ISD workers who process Medicaid applications, are presented below.

State Policy

Over nine years ago, New Mexico implemented an important streamlining feature for pregnant women and children—Medicaid On-Site Application Assistance (MOSAA). This process allowed specific community-based providers to initiate a Medicaid application using a two-page application form, eliminating the requirement that families go to an ISD office for an interview. In an effort to enroll more eligible children in Medicaid and to reduce the time it takes to process an application, New Mexico recently expanded the types of providers who can initiate a Medicaid application and more rigorously pursued the recruitment and training of community providers to serve in this capacity. To further increase access to care and to facilitate the enrollment of still more uninsured children in Medicaid, New Mexico also instituted presumptive eligibility for children on 1 July 1998.

In the past, hospitals, federally qualified health centers, and Indian Health Services staff, among others, could serve as MOSAA providers. As of 1 July 1998, representatives from schools, the Department of Health, and the Division of Children Youth and Families' Child Care Bureau staff can opt to attend PE/MOSAA training and become certified PE/MOSAA providers. Starting in January 1999, the list of eligible providers will again be expanded to include Head Start and primary care providers who serve Medicaid clients.

After New Mexico's CHIP plan is approved, little will change. The eligibility process, including PE, will remain the same, except, of course, the income chart will be modified to reflect the upper limit of 235 percent of the FPL. CHIP will be marketed as part of the Medicaid program, so the demarcation between Medicaid and CHIP will be invisible to the community.

The state's approaches to increasing access to children's health insurance and simplifying the enrollment process—Medicaid On-Site Application Assistance and presumptive eligibility—are presented below. The operations and role of the ISD offices are described later in this section. The MOSAA and PE forms are included in Appendix D.

Medicaid On-site Application Assistance (MOSAA) Packet

The MOSAA application packet consists of a cover sheet, the two-page Medical Assistance for Women and Children (MAWC) application, and two additional forms that are not always needed—a "Third Party Liability Inquiry Form" and the "Absent Parent Information Form." Each of the application components is described below.

- Among other issues, the cover sheet addresses civil rights, confidentiality, child support, and fair hearings.

- The first page of the MAWC application includes information on the client and other household members (name, relationship to the applicant, date of birth, sex, race, citizenship status, alien status, whether or not the individual is in school, and each social security number). A few questions related to household members' medical needs and health insurance status are also included on the first page. The second page of the MAWC requests income information for all household members and child care costs.

- If the applicant has health insurance, they must complete the "Third Party Liability Inquiry Form" (MAD 009), which verifies an applicant's primary medical coverage. In addition to the forms for applicants, the application packet includes instructions for MOSAA providers on how to fill out the form.

- In cases when a child does not live with his or her parents, MOSAA providers must also complete the "Absent Parent Information Form" (MAD 333).

Applicants are required to submit the following documentation with the application:

- Four weeks' worth of pay stubs or a letter from their employer stating their earned income for the period preceding the interview date; [14]
- Social security number;
- A copy of a rent receipt or a statement that the client intends to remain in New Mexico; and
- If the applicant has insurance, a copy of the health insurance card.

In addition to submitting these forms and documents, MOSAA providers must complete a two-page interview guide (referred to as the "MOSAA narrative"), and submit it with the application. Described in the MOSAA training manual as "the provider's link to the (ISD) worker," the purpose of the narrative is to verify information and provide additional details on household composition, the applicant's pay schedule, and dependent care costs. If the provider does not submit the narrative with the application, the client will have to go to the ISD office to conduct an interview.

As short as the application form is, the state's policy is not to widely distribute the MAWC application at community sites. Rather, the application is only released to providers who have completed the PE/MOSAA training.

Presumptive Eligibility Application and Documentation

Unlike the MOSAA process, the presumptive eligibility application process is handled entirely between the PE/MOSAA provider and Consultec, the state's fiscal agent. ISD offices are not involved in PE enrollment or determination. The PE application package consists of five forms:

- The two-page Presumptive Eligibility application;
- A provider worksheet that determines eligibility and serves as the authorization form that is faxed to Consultec;
- A temporary Medicaid "card" in the form of a letter;
- An approval/denial notice; and
- A fax cover sheet.

[14] New Mexico uses gross family income to determine eligibility and applies a $90 earned income deduction and a child care deduction.

No verifications are needed to determine presumptive eligibility.

In order to serve as PE providers, agencies are required to sign a provider agreement stipulating that they will complete a MAWC application for all children for whom they have completed a PE application within ten days of PE determination. The agreement also says that if the provider fails to submit a MAWC application for at least 90 percent of its PE applicants or if 10 percent or more of the provider's MAWC applications are incomplete, HSD can terminate the agreement immediately. The provider agreement also requires PE providers to:

- Attend HSD trainings;
- Fax the fiscal agent the PE approvals on the day they are approved;
- Check with the state computer system (AVRS) before completing a PE application to ensure that applicants are not already covered by Medicaid; and
- Maintain client confidentiality.

The provider agreement allows the provider to "authorize temporary presumptive Medicaid eligibility for a child while the child's application is being processed, providing the child with full Medicaid coverage during the period between receiving treatment and final eligibility determination, a period of up to 60 days." To complete a PE application, families must seek the assistance of a credentialed PE provider.

Statewide PE/MOSAA Training Effort

To orient the new PE/MOSAA providers and to educate all providers on the presumptive eligibility process for children, HSD's Medical Assistance Division (MAD) launched an extensive training initiative in the summer of 1998. In the past, MAD had sponsored one-day trainings for MOSAA providers, in which they would cover the six categories of Medicaid for pregnant women and children. With the addition of presumptive eligibility for children and the expansion of the type of providers who can complete the MAWC application, HSD lengthened the training to two days and used it as an opportunity to refresh those providers who had been completing applications for nine years.

In April 1998, MAD sponsored a public forum in Albuquerque to kick off the presumptive eligibility process. Approximately 400 providers and field office representatives attended the forum. From June through September 1998, MAD sponsored 19 training sessions for over 500 providers. Many of these providers represented Children's Medical Services, local health offices, federally qualified health centers, Indian Health Services, and school district employees. In addition to offering training for providers, MAD trained 50 ISD workers who, in turn, trained local PE/MOSAA providers in their counties. ISD workers offered about 30 training sessions in their local areas in September and October.

Upon completion of the training and after PE/MOSAA providers have signed the "Presumptive Eligibility Provider Agreement," they are assigned a PE/MOSAA provider number. In 1998, MAD trained more than 800 providers; however, as of mid-December, only 475 providers had applied for their PE provider numbers. MAD's goal is to eventually enlist 1,000 PE/MOSAA providers. Primary care physicians and Head Start agencies have been targeted for PE/MOSAA training in early 1999.

Local Implementation

Families can initiate Medicaid and PE applications through community-based providers or at the local welfare office. The PE/MOSAA approach was envisioned to cast a broad net, supplying communities with multiple points of entry into the system. Though conceptualized by New Mexico as a singular process through which to enroll more eligible children in Medicaid, in reality, the PE and MOSAA processes are quite distinct and appear to be used by different providers for different reasons. Though many community agencies attended the HSD training session that covers both the MOSAA and PE processes, only a subset of these providers have elected to submit both PE and MOSAA applications for clients. This section describes the MOSAA and PE processes, and then reviews the steps taken by ISD offices to process applications submitted by walk-in clients. A discussion of implementation issues and challenges follows.

The MOSAA Process

At the time the case study was conducted, 84 individuals in Bernalillo county and 19 persons in Sandoval county were credentialed PE/MOSAA providers. The providers interviewed during the case study reflect the diversity of agencies authorized to act as application assistors. Among others, researchers met with staff from a school district, an early childhood education program, district and local health offices, and a children's psychiatric hospital. Providers that had been trained to complete PE/MOSAA applications included social workers, educators, nurses, case managers, and patient account representatives.

Before completing a MAWC application, the provider screens the applicant to determine whether or not he or she is likely to be eligible for Medicaid. The provider then assists the individual in filling out the application; however, providers may not actually complete the application for the client. In addition, the provider conducts an interview with the applicant, using the MOSAA narrative as an interview guide.

MOSAA providers estimate it takes from 20 to 45 minutes to complete an application, depending on the complexity of the household makeup and on the language of the applicant. Despite a very large proportion of Spanish-speaking Hispanics, the MAWC application is only available in English.[15] Providers report that it takes much longer to complete an application for

[15] After the site visit, a Spanish version of the MAWC application was created and disseminated.

Spanish-speaking applicants, as they must translate the form as they proceed through the interview.

After interviewing the applicant, the provider compiles the required documentation. If the application is not complete, the provider can hold onto the application so that the applicant can gather the necessary documentation and bring it back to the provider before the application is mailed to the ISD office. In this case, the MOSAA provider is instructed to give the applicant a "What You Still Need" form (ISD 160) and tell them to bring the documents back within 7 to 10 days. Once the application is complete, the provider forwards the application to the ISD office. MOSAA providers are not supposed to hold an incomplete application for more than 7 to 10 days before sending it to an ISD office. If a MOSAA provider sends an incomplete application to the ISD office, an eligibility worker will follow up with the family to obtain proper verifications.

When the MAWC applications arrive at the ISD office, they are entered into a log to document their receipt. Information from the application is then entered into the ISD computer system. If the application is incomplete, the caseworker will send the "What You Still Need" form to the applicant and a copy to the MOSAA provider. If the ISD office receives a complete application, staff can make an eligibility determination. Due to the simple nature of the MAWC form, the fact that clients do not have to participate in an interview at the ISD office, and the minimal documentation required, these applications are usually processed within two days to two weeks. A case is denied automatically after 45 days if an applicant fails to send in the required documentation. Depending on the determination, a denial letter or a Medicaid card is generated by the state HSD office and sent to the applicant.

The Presumptive Eligibility Process

Unlike the MOSAA process, PE applications are handled entirely by the PE/MOSAA provider and Consultec, HSD's fiscal agent. Local ISD offices do not play a role in the PE application review or the eligibility determination process.

Before completing a PE application, providers are supposed to call the Automated Verification Response System (AVRS) system using their PE provider number to ensure that the child is not already on Medicaid. The PE/MOSAA provider then describes the complete process to the applicant, makes the eligibility determination on site, and if approved, gives the applicant the temporary Medicaid card. As in case of the MOSAA application, gross family income is used to determine eligibility, though verification of income is not required for PE determination. The PE/MOSAA provider then faxes the application to the fiscal agent. If there are any problems with the application, Consultec can fax it back to the provider. The fiscal agent adds the child's Medicaid number to its data system within 24 hours.

Some providers choose to complete both the PE and the MAWC application at the same time, while others elect to complete the MAWC application a few days later, depending on their workload. Providers estimate that it takes 10 to 15 minutes to complete a PE application.

Medicaid Applications Initiated at ISD Offices

Having described the steps that are followed if a family elects to initiate an application through a community-based agency, we will now turn toward the traditional process of filing a Medicaid application in New Mexico. In this section, we outline the steps followed should a family walk in to the ISD office.

The case study included a site visit to three ISD offices, one in Sandoval County and two in the city of Albuquerque in Bernalillo County. The Sandoval office has 15 Income Support Specialists (ISS). Of these 15 eligibility workers, two are dedicated to processing MAWC applications received from MOSAA providers, and two other workers exclusively process applications for pregnant women and children that are initiated by applicants themselves at the ISD office. Sandoval County workers estimate that about half of the Medicaid applications they process for pregnant women and children are initiated by MOSAA providers and half are submitted by clients as walk-in appointments at the ISD office.

There are four ISD offices in Albuquerque. In the Southwest and Southeast offices, 30 to 35 eligibility workers manage caseloads of 400 to 500 at one time. As in Sandoval County, the Southwest office has two staff dedicated to processing applications initiated by MOSAA providers. Caseworkers in the Southeast office handle all types of cases—Medicaid, Food Stamps, and cash assistance.

Though ISD offices are administered by the Human Services Department, practices vary considerably across local ISD offices. Pregnant women and children applying for Medicaid at ISD offices are not consistently given the same application. At some offices, walk-in applicants are given the MAWC application—the short application used by MOSAA providers. In other offices, clients are made to fill out the "long form," which, in addition to determining eligibility for Medicaid, assesses an applicant's eligibility for Food Stamps and cash assistance. Not only are different forms used by the different ISD offices, but the procedures for processing applications also vary across ISD offices, as described below.

- **Completing the Application**. If a client initiates a Medicaid application at the Sandoval ISD office, he or she would be given the MAWC application by staff at the office reception desk. After the client fills out the MAWC application, they are seen by the staff member who is responsible for screening applicants for expedited Food Stamps. If, however, the client reports no income whatsoever on his or her application, a brief interview is conducted that day in

order to expedite the Medicaid application. In other cases, the client is given an appointment to return to the office for a group interview within ten days.[16]

The ISD offices in Bernalillo County appear to be distributing the eight-page application, referred to as the "long form," that determines eligibility for Medicaid, Food Stamps, and cash assistance. According to caseworkers, applicants who are given the long form are told to ignore the sections of the application that pertain to Food Stamps and cash assistance. All Spanish-speaking clients are given the long application, as the ISD offices do not have the MAWC application in Spanish. A client applying for Medicaid only is given the option of waiting for an interview that day. According to workers, about 90 percent of clients prefer to wait for an interview as opposed to returning 10 days later for an appointment. Reportedly, a client may wait from 30 minutes to two hours for an interview.

- **Client Interview.** Clients in Sandoval County return for a group interview with approximately 20 to 30 other applicants. The office schedules one group interview each week; some are conducted in English and others in Spanish. Navajo applicants who do not speak English are told to bring an interpreter to the interview. The group interview lasts about 30 to 40 minutes and is used as an opportunity to explain the Medicaid and Salud! programs to applicants. After the group interview, applicants are given the opportunity to speak directly to a caseworker.

  In Bernalillo County ISD offices, clients are interviewed on an individual basis. During the interview, the caseworker reviews the applicant's rights and responsibilities, reviews the application and covered benefits, and verifies the applicant's name, citizenship status (if required), and income. Caseworkers estimate it takes them about 15 to 30 minutes to process a MAWC application, and from 30 minutes to one hour to complete the long form.

After the interview is complete and all the verifications are collected, workers can determine eligibility. When applicants are missing documentation, caseworkers give them the same "What You Still Need" form that is distributed by PE/MOSAA providers.

Face-to-face interviews are required for all "walk-in" applicants. Unlike those clients who submit their applications through a PE/MOSAA provider and whose meeting with the PE/MOSAA provider fulfills the interview requirement, clients who initiate the application process through an ISD office may choose to mail in the forms but will eventually be called in for an interview with an ISD caseworker.

[16] The Sandoval ISD office will make exceptions for applicants who mail in complete MAWC applications. With their supervisor's permission, workers can conduct an interview with the applicant by telephone.

Knowledge and Attitudes of PE/MOSAA Providers and ISD Workers

As one might imagine, the new enrollment policies set forth by the state will take time to become part of the organizational culture of local ISD offices as hundreds of workers must be trained and educated and then monitored to assure the consistent application of these policies. Conducted just five months after the initial roll-out of PE and the expansion of the types of MOSAA providers, the case study uncovered areas in which the newly-trained community agencies have encountered difficulty in carrying out their new tasks. The actions of these providers both positively and negatively affect the work of the ISD workers who process these applications once submitted. The concerns and opinions of those initiating applications, as well as those determining eligibility, are addressed in this section.

Provider Observations and Concerns Regarding the PE/MOSAA Process

The knowledge and opinions of MOSAA providers seem to depend on the number of applications they are completing. Providers who completed many applications seemed to have a better grasp of the process and required documentation than did those providers who submitted applications only occasionally. Most providers interviewed felt comfortable with the process, but those who did not complete a lot of applications, or were new to the process, had some questions regarding the required documentation.

Providers raised concerns about the process, the application itself, and the inconsistency among ISD offices in how these new policies were being implemented. Each of these is addressed below.

- **Added Workload and Responsibility**. While the state's policy of training community providers to enroll families in Medicaid was greeted with excitement, as evidenced by the large numbers of providers who participated in the PE/MOSAA training sessions, the realities of actually implementing this policy have presented some interesting dilemmas for providers. Most evident to providers is the fact that even though a single application takes only 20 minutes to complete, having to submit numerous applications quickly creates a significant workload. While the MOSAA process was initially welcomed, district-level health staff have become less enamored with the process, as they are concerned about burgeoning staff workloads.

  Certain aspects of the application process were reported to take staff a relatively long time. According to providers, determining household composition can be challenging, especially for families living in pueblos, where 8 to 11 people can be living in one home. At the time the case study was conducted, the MAWC application was available only in English, requiring PE/MOSAA providers to translate the form anew each time they assist a family in applying for Medicaid. Staff claim that this can take up to 45 minutes for each application. Though New Mexico does not require many verifications, PE/MOSAA providers say they spend a lot of time explaining documentation requirements to clients, assisting them in obtaining proper verification, and compiling the documents to

be forwarded to the ISD office. Finally, PE/MOSAA providers report that there are many clients who cannot read or write. Because HSD does not allow community agencies to complete the application for an individual, PE/MOSAA providers must spend additional time coaching these individuals to complete the forms themselves.

Some providers perceive that the PE/MOSAA process represents a purposeful shift in responsibility for completing Medicaid applications out of ISD offices and into the community. Representatives from the Albuquerque district health office, in particular, are frustrated by the additional responsibility for local health office staff, as they are already charged with many other tasks. Some health offices have devised scheduling arrangements to handle the increased workload, such as assigning certain days to complete Medicaid applications. For example, clients presenting to the health office on Tuesday may be told to return to the office on Friday morning when a staff member can assist them in completing a Medicaid application. Such scheduling arrangements may undermine the intent of using community-based providers to enroll clients in Medicaid, thereby increasing access. District office representatives were also quick to point out that while they are dedicating staff resources to completing Medicaid applications, they are not reimbursed for their services—a policy that they would like changed.

It was also reported that PE/MOSAA providers will be held liable for information that is reported on the application. Again, some believe this is yet another example of a shift in responsibility outside the realm of ISD. They also fear that this policy will discourage agencies from becoming PE/MOSAA providers, ultimately acting as a barrier to access.

- **Potentially Limited Utility of PE Application for Many Providers**. After a few months of implementation, it appears that some providers who intended to complete presumptive eligibility applications for children, are not. It appears that the utility of PE application is minimal for children without emergency needs. Because providers who sign the PE Provider Agreement must agree to submit follow up MAWC applications for 90 percent of their PE applications, it was reported that many providers who attended the PE/MOSAA training are skipping over the PE process and are only submitting MAWC applications to avoid the extra workload of submitting two applications for each individual. Local health offices are not processing PE applications for children for this reason.

  On the other hand, some providers say the opportunity to have more control over their clients' Medicaid coverage is a benefit that is worth the time it takes to complete the applications. This is especially important for inpatient providers who provide high-cost services to children with urgent needs and require rapid reimbursement. For example, representatives from a children's psychiatric hospital said they would rather complete and submit the

PE/MOSAA applications themselves, even though it takes time, than refer families to the local ISD office and not know if they are found eligible. These providers especially appreciated their ability, as certified PE providers, to verify the status of a patient's Medicaid coverage using the AVRS phone system.

- **Inconsistency among ISD Offices**. According to some providers, the goals and philosophy of the PE/MOSAA process are not reflected in the practices of the local ISD offices. According to those interviewed, the smaller ISD offices outside of Albuquerque have been more successful in making the culture shift to de-linking the Medicaid application process from that of Food Stamps and cash assistance. However, great inconsistencies remain across ISD offices in Albuquerque, particularly related to the use of the MAWC application and the requirement of an interview.

  - *MAWC application not widely accepted at area ISD offices*. Even though in theory the "short application" has been in use for nine years, providers report that it was not accepted by the majority of ISD offices, because ISD staff didn't trust providers to inform families of all the services that were available to them. According to those interviewed, only the Sandoval ISD office allowed families to apply for Medicaid using the MAWC application. The other offices force clients to fill out the "long form" that simultaneously determines their eligibility for Food Stamps and cash assistance, but requires much more documentation, which may ultimately dissuade families from enrolling.

  - *Some ISD offices are still requiring a face-to-face interview*. The MOSAA application is supposed to replace the face-to-face interview at the ISD office, but some ISD workers are calling applicants in for an interview and reviewing the entire application.

- **Environment of ISD Offices and Attitudes of ISD Personnel.** Providers believe the PE/MOSAA concept is sound because it prevents clients from having to go to ISD offices, particularly those in Albuquerque, which providers describe as "industrial, oppressive, and cold." An armed security officer who guards the door to the ISD offices we visited in Albuquerque scans all who enter with a metal detector. The poor attitudes of certain ISD eligibility workers, some of whom are perceived as rude and unresponsive, were attributed to the fact that many offices are understaffed and their personnel overworked. Some PE/MOSAA providers had problems early in the process with the ISD offices losing their applications. As a result, some providers have resorted to hand-delivering the applications and requesting a receipt. The Sandoval County office, however, has a good reputation in the community for having the clients' best interest in mind.

- **Follow-up after PE/MOSAA Applications are Submitted**. Providers would like to know what percentage of the families for whom they initiate an

application are actually found eligible, so they can learn from their mistakes and follow up with their patients. However, because the state cannot differentiate between Medicaid applications originated by MOSAA providers and those initiated at the ISD office, they are unable to respond to providers' requests. Though providers submitting PE applications can use the AVRS phone system to check on a child's status, they report that it takes about 15 minutes to check on each child. As a result, they prefer to call the family directly to inquire about the status of their coverage. (HSD is in the process of creating a monthly report for PE providers that lists the clients for whom the provider submitted a PE application and whether or not they were subsequently found eligible for Medicaid.)

Opinions and Concerns of the ISD Workers

On the whole, the ISD Income Support Specialists interviewed understand the importance of medical coverage for children. They seem to support the aim of the PE/MOSAA process to streamline eligibility determination, eliminate the need for an interview with ISD workers, and increase the number of locations in the community where eligible families can initiate an application. ISD workers feel that some applicants, particularly Spanish-speaking applicants, may feel more comfortable dealing with their medical or public health provider, and therefore think the PE/MOSAA provider idea is a good one. For the most part, workers do not believe that families applying for Medicaid try to defraud the system, as they would not gain any tangible benefits by doing so. In fact, workers report that most families applying for Medicaid fall far short of the income ceiling. Some ISD workers empathize strongly with the families they serve and report being sincerely upset when they have to deny an application.

Despite their general support for the PE/MOSAA process, ISD workers are sometimes frustrated by the kinks in this relatively new initiative. According to ISD workers, many PE/MOSAA providers submit incomplete applications to the ISD office and make errors in completing the forms. Some ISD workers understand that these errors are the result of a new system, while others have grown impatient with providers and believe they are not learning from their initial mistakes. Workers estimate that between 25 to 50 percent of the applications they receive from MOSAA providers have problems requiring their intervention. One of the most common problems they encounter is duplicate applications being sent in for the same individual. In addition to making errors on the applications, ISD workers believe that MOSAA providers are holding the applications longer than the allotted 7 to 10 days before forwarding them to the ISD office. The caseworkers in Sandoval County that are responsible for processing MOSAA applications have started to keep a log of errors and are contacting MOSAA providers to inform them of the nature of their mistakes.

When asked their opinion about the prudence and feasibility of eliminating the face-to-face interview and widely distributing the short Medicaid application for pregnant women and children, caseworkers said that without an interview, ISD would witness an increase in fraud. Caseworkers believe that the interview adds a necessary layer of accountability and a mechanism for ISD to check the veracity of applications and verifications.

Outreach

Thus far, New Mexico's outreach efforts have been mainly invested in a statewide public information campaign with a small but growing emphasis on community-based activities. Though the current campaign includes some locally based activities, such as health fairs, these types of activities will be featured to a greater extent in the second phase of the campaign, to be implemented in 1999.

The New Mexikids campaign has been designed to target families of all eligible children, as opposed to specific audiences within the Medicaid-eligible population. The development and implementation of the campaign has been divided into two phases—one that began in July 1998 and will continue until the state's CHIP plan is approved, and one that will be implemented after the proposed CHIP plan is approved.[17]

The idea of sponsoring a statewide public information campaign enjoyed wide support in Santa Fe, as media was seen as "yet another tool in the state's tool box" to get eligible children enrolled in Medicaid. The New Mexikids campaign was designed to be a component of an already-existing *Say Yes to Kids* campaign initiated by the Department of Health in the spring of 1998. The *Say Yes to Kids* campaign is conceived of as an overarching campaign meant to feature various health issues. Since its inception, *Say Yes to Kids* has encompassed messages concerning immunization, teen pregnancy, and well-child care.

When asked to create a campaign to increase enrollment in the Medicaid program, DOH and HSD agreed that the Medicaid campaign should build upon on the *Say Yes to Kids* campaign instead of "reinventing the wheel." The Human Services Department and the DOH have tried to tie the campaigns together by featuring the *Say Yes to Kids* tagline on all the New Mexikids materials and by acknowledging DOH as a partner. Though envisioned as a spoke in the wheel of this larger campaign, New Mexikids has taken on an identity of its own.

In the early stages of campaign design, HSD personnel reviewed other state's Medicaid and CHIP media campaigns to gather ideas in general, and examples of other states' program names in particular. In order to minimize the stigma associated with the program by some eligible families, an explicit effort was made to avoid using "Medicaid" in campaign materials.

After reviewing the efforts of other states, some possible names were presented to high-level administrators at HSD and to Belinoff and Bagley, HSD's communications and marketing firm. Among the names presented was "New Mexikids," inspired by Arkansas' ArKids First. According to HSD, Belinoff and Bagley did not pre-test the name "New Mexikids" or conduct

[17] The second phase of the New Mexikids campaign will incorporate information regarding the program's cost-sharing features. The state must wait to launch the second phase of the campaign until the mechanics of cost-sharing are determined. Among the decisions to be made is whether the campaign materials will continue to feature "no cost" insurance coverage for children as opposed to "low cost" coverage.

any other research with the target audience. Nonetheless, HSD officials are reportedly very pleased with the name of the campaign.

Implementation of New Mexikids

The campaign includes community events, promotional materials, and print and electronic media. All of these materials feature the logo and slogan "New Mexikids—No Cost Health Coverage for Kids." All New Mexikids print materials and radio spots feature a toll-free phone number that families can call for more information. Each of the campaign's components is described below.

- **Community Events**. The New Mexikids campaign was launched at the "Children's Health and Fitness Safari" sponsored by Blue Cross and Blue Shield at the Albuquerque Zoo on 28 August 1998. Approximately 100 exhibitors and 6,000 people attended the day's events. In addition, HSD has participated in five health fairs.

- **Promotional Materials**. Promotional materials are a relatively large component of the New Mexikids Campaign. It is believed that colorful and useful promotional materials help attract parents and children to New Mexikids display tables at community events and fairs. HSD wanted to ensure that the promotional items would be of interest to parents, school-age children, and adolescents. Frisbees and water bottles were created for adolescents, and rulers, pens, pencils, magnets, growth charts, *Band-Aid* boxes and toothbrushes were distributed for younger children and their parents.

- **Print Materials**. The campaign's primary print materials include a flip card and poster with a pad of tear-off sheets. The flip card, which is printed in English on one side and Spanish on the other, touts "No Cost Health Coverage for Kids." This piece is being distributed at community events and is used in direct mail efforts, as it fits neatly into a letter-size envelope. A cornerstone of the campaign is a heavy, card-stock poster that includes an adhesive pad of informational tear off sheets printed in English and Spanish. Also, numerous ads were placed in various publications and all newspapers in the state.

- **Radio**. In addition to print materials, the campaign has featured radio spots in Spanish, English, and Navajo on several radio stations. Though the spots were only 30 seconds in English, proper translation required a 60-second Spanish radio spot, and a three minute and five second Navajo spot.[18] Due to the nature of the campaign, HSD was able to get radio stations to match their paid time with free spots at a 2:1 ratio. Though HSD only had to pay for 63 spots, 126 radio spots were aired.

[18] Native American members of the Medicaid Advisory Committee (MAC) volunteered to assist HSD in developing Navajo radio spots. These committee members worked closely with Belinoff and Bagley to translate and produce the Navajo spots.

Distribution Channels

Campaign materials are disseminated through a distribution team that works in the Client Services Bureau of HSD in Santa Fe. The team has maintained a list—now 20-pages in length—of all the agencies that have requested and/or received New Mexikids materials, such as the state pediatrics association, hospitals, managed care organizations, Native American community centers, and Salud! partners. Beginning in July, the team sent posters and adhesive coupon books to all county ISD and local health offices. However, several providers interviewed during the case study had never seen or not yet received New Mexikids materials, pointing to gaps in the distribution process.

Schools were also one of the campaign's primary channels of distribution. HSD sent supplies of posters and coupons to the schools that responded to an initial letter requesting their cooperation in educating parents about the program. According to HSD, about half of the state's 750 schools have requested materials to date, with the small and rural schools responding more quickly than schools located in metro areas.

New Mexikids Phone Line

All the outreach materials feature one phone number for people to call to get more information. The phone line was created two years ago to field questions regarding Salud!, the New Mexico Medicaid managed care program. Each phone bank staff member attended the PE/MOSAA training so that they can answer callers' general questions about the program. Seven full-time HSD staff members respond to approximately 300-350 New Mexikids calls each week, as well as a number of grievance calls and those concerning Salud! The phone bank staff do not complete PE/MOSAA applications over the phone. HSD staff use the list of credentialed PE/MOSAA providers to refer callers to local providers in their town that can initiate a Medicaid application for them. Beginning in October, HSD instituted a tracking system for these calls. Each caller is now asked where he or she heard about the phone line so HSD can use this information to determine the most effective channels of distribution. Some of the most common places that callers heard about the New Mexikids program to date are schools and the newspaper.

New Mexikids Campaign After CHIP Expansion

After New Mexico's CHIP plan is approved, the New Mexikids campaign will be implemented more broadly by using additional communication channels. However, HSD recognizes the fact that they will need a new "hook," especially for those families who may have already responded to the campaign and determined that they were over income for Medicaid. HSD plans to revise New Mexikids materials to contain information about cost-sharing. Instead of the slogan being "No Cost Health Coverage for Kids," it will read "Low Cost Health Coverage for Kids." In addition, HSD will purchase more television and radio spots for the campaign. The community-based efforts of the campaign will be enhanced by sponsoring health fairs with on-site assistance by ISD workers, and building partnerships with "corporate citizens," such as Wal-mart, that can aid in disseminating campaign materials.

Lessons Learned

Given the relative numbers of children in New Mexico who are eligible for Medicaid compared to those eligible for the CHIP program, policymakers concentrated their efforts on enrolling families under 185 percent of the FPL. In order to make the Medicaid program attractive to eligible families, particularly those who work and have not previously participated in publicly funded programs, the state attempted to separate health care coverage from the receipt of welfare benefits in the eyes of the target audience. Toward this end, HSD more aggressively implemented the MOSAA process, which had technically been in operation for nine years, enabling families to apply for Medicaid without ever having to go to the ISD office. The adoption of presumptive eligibility was also an attempt to get more children into the health care system, by making it easier to obtain coverage. HSD also created a new name and image for the New Mexico Medicaid program for pregnant women and children.

By mid-December 1998, all of these efforts had resulted in 1,859 approved PE applications. However, at the time of the site visit, the state did not have a system in place to track the percentage of PE enrollees for whom a Medicaid application is submitted, or, of these, how many are determined to be eligible for Medicaid. (Subsequently, New Mexico implemented a system to track the number of children found eligible for PE who go on to Medicaid after their PE expires.) However, HSD was able to track the total number of enrollees in the Medicaid categories for infants and children. As of mid-November 1998, it was estimated that approximately 6,000 additional children have been enrolled in Medicaid since 1 July 1998.

The aggressive implementation of the PE/MOSAA process required a massive effort on the part of HSD, particularly related to the statewide training effort, which was well-received by all interviewed. It has been suggested, however, that more training sessions are needed in remote areas of the state that serve Native American populations.

Upon examining the local implementation of the state policies, some missed opportunities and stumbling blocks were identified. These issues are present beginning with distributing applications, to adequately staffing and paying PE/MOSAA providers, to inconsistent practices in the local ISD offices. As discussed, the New Mexico application is not widely distributed at community locations, and clients must complete an interview. New Mexico has opted not to distribute Medicaid applications at community sites in order to: 1) reduce the number of incomplete applications being sent to the ISD offices that would require follow-up by ISD staff; 2) lighten the burden on ISD offices that are understaffed and overworked as a result of changes related to welfare reform; and 3) to insure that a greater percentage of applicants ultimately attain coverage. It appears that in a state with such a high number of uninsured children, this represents a missed opportunity.

In addition, overwhelmed community providers, particularly local health offices, which are charged with many tasks, have created a variety of scheduling arrangements to handle the increased workload of initiating PE and MOSAA applications for clients. While some MOSAA providers make it possible for walk-ins to complete an application immediately,

others give those wishing to apply for Medicaid the application packet and a list of the verifications they will need, and make an appointment for them to return another day to fill out the application. Such arrangements run counter to the purpose of instituting a policy of using community application assistors and jeopardizes client access, as some may not return for the second appointment. Also, only about half of the community providers who attended the PE/MOSAA training sessions have opted to apply for a PE provider number. It appears that the added value of PE coverage is not great enough for non-emergent providers to commit to processing the required number of follow-up MAWC applications.

The state's current policy not to pay application assistors affects providers' ability to make staff available to assist clients with Medicaid applications. It was thought that the enthusiasm of the provider community for the PE/MOSAA process, coupled with the simplicity of the form and the short time it takes to complete, made a payment to the providers unnecessary. HSD administrators have acknowledged that this streamlining strategy is in its early stages; the state has not yet formally solicited providers' opinions regarding the need for payment. According to HSD representatives, they have not ruled out the possibility of reimbursing PE/MOSAA providers should the provider community be dissatisfied with the current system.

Local-level implementation of the Medicaid enrollment process varies widely across county ISD offices. The two most significant areas of inconsistency relate to the type of application given to clients (the Medicaid-only MAWC form versus the long form that also determines eligibility for Food Stamps and cash assistance), and whether or not they are obligated by an ISD worker to come to the office for a face-to-face interview. Though New Mexico has opted to increase the number of points in the community through which an application can be processed, a face-to-face interview is, in effect, still required by some ISD offices. Though it can be expected that policy shifts such as the PE/MOSAA process can take time to trickle down to the front-line worker, some Albuquerque providers were pessimistic about the possibilities for a smooth and far-reaching cultural shift within area ISD offices, especially since some offices only recently began to accept the MAWC applications nine years after the application was simplified.

When asked to describe the profile of families who are eligible for Medicaid but not enrolled, many could not offer a clear picture of the approximately 100,000 children currently being targeted by HSD. It has, in fact, been confirmed that these data do not exist in New Mexico. The absence of this information makes it challenging, if not impossible, to target outreach messages to the intended audience. However, responses from individuals, when pieced together, created a mosaic of the groups in New Mexico who have been reluctant to enroll in Medicaid. According to interviewees, the untapped Medicaid population consists of immigrant Hispanic families living in the Southern region of the state; transient ethnic groups living in Southeast Albuquerque, particularly Vietnamese families; and Native American families, who for geographic and cultural reasons do not see the benefits of enrolling in Medicaid.

Respondents offered their opinions as to why these families and others have not enrolled in Medicaid. Differences in language and culture were reported to be a significant barrier to

Medicaid enrollment. Language barriers, access to IHS services, and the lack of Medicaid managed care providers on reservations make it difficult for some Native American families to see the value in participating in Medicaid. Some believe that Hispanic families living in the southern part of the state near the Mexican border are concerned about the implications of accepting public assistance on their efforts to become legal residents or citizens. Others believe that some families, particularly those who have never had health insurance, do not see the need for medical coverage for their healthy children. Finally, some families are reluctant to enroll in Medicaid program as it is perceived to be welfare or because they may have had negative experiences with public assistance in the past.

Those who have seen the New Mexikids outreach materials reacted positively to their design and believed the campaign's message to be clear and concise, though a few individuals questioned the cultural appropriateness of the term "New Mexikids" for Native American and Hispanic families who do not speak English. It appears, however, that the state missed some opportunities to solicit feedback from the target audience when developing the campaign, as they did not pretest messages or materials and only recently implemented a monitoring system to determine the efficacy of their various dissemination strategies. In fact, a fairly large number of the individuals that were interviewed had not yet received New Mexikids materials, nor had they seen them or previewed them in any way. This issue was particularly problematic for the providers that were listed on the materials as points of contact.

All respondents believed that a statewide media campaign is a step in the right direction and an effective means of getting the word out about the program, but believe there are still many families unaware of the program, its benefits, and income guidelines. Some said the state must continue to pursue culturally appropriate outreach strategies for Native American families. In general, New Mexico should consider the benefits of a more balanced outreach strategy that incorporates a greater emphasis on community-based activities. Some suggested that HSD should form partnerships with more community organizations, such as churches and work sites. While the mass media campaign will likely achieve greater awareness among the target population, additional community outreach activities, such as those planned for the second phase of the campaign to begin after the CHIP expansion, are needed to help audience members act upon their new knowledge and actually enroll in Medicaid.

Overall, the simplicity of the New Mexico program is its strongest feature: one income ceiling for all children, one program name, one phone number, a short application, a long eligibility period, minimal documentation, and the option to apply for PE. The challenge lies in the consistent application of these policies at the local level. Still early in its implementation process, New Mexico shows great potential for attracting eligible families to the program. The state must, however, monitor the ability of the provider community to absorb the increased workload resulting from completing PE/MOSAA applications, as well as the practices of local ISD offices to insure that a system that was designed to be simple remains so in its day-to-day application.

Chapter V

Ohio

Background and Overview

The latest data from the Current Population Survey reveal that approximately ten percent of children under the age of 19 living in Ohio are uninsured. This figure represents between 250,000 and 400,000 uninsured children, about half of whom live below 150 percent of the Federal Poverty Level (FPL). Roughly 43,000 of Ohio's uninsured children live in families with incomes between 151 and 200 percent of the FPL. Compared to privately-insured children, uninsured children in Ohio are more likely to live in single-parent families, have only one parent who works, or have parents who work part-time.[19]

Prior to January 1998, Ohio's Medicaid program for children, called Healthy Start, provided coverage for children up to age six under 133 percent of the FPL and for children through age 14 up to 100 percent of the FPL. In July 1997, the Ohio legislature granted authority to expand Healthy Start's eligibility limits to 150 percent of the FPL for all children up to 19 years of age. The legislature's action allowed state officials to incorporate this expansion into Phase I of Ohio's Children's Health Insurance Program (CHIP) after the passage of the Balanced Budget Act and to submit a Title XXI state plan promptly (Ohio was one of only five states to submit state CHIP plans to HCFA in 1997). The expansion was implemented in January 1998, and HCFA approved the plan in March, providing retroactive approval to January.

Under the expansion, all uninsured children with family incomes between the Medicaid eligibility limits and 150 percent of the FPL are eligible for either the CHIP program or what is known as the "Healthy Start expansion." Those with no insurance are eligible for CHIP, while those who have another source of insurance are eligible for the Healthy Start expansion, which provides Medicaid coverage for services not covered by their insurance; for these children, the state is reimbursed at the regular Medicaid matching rate.

In January 1998, Governor Voinovich requested that the Ohio Department of Health form an Advisory Task Force to make recommendations on how to best design and implement Phase II of the CHIP program. The Task Force has suggested that Phase II be a Medicaid look-alike, but a separate state program. As the newly-elected Governor has not yet delivered his budget to the legislature, plans for CHIP Phase II are not yet final at this writing.

[19] Report of the Children's Health Insurance Program Advisory Task Force. July 1, 1998.

Administrative Structure for Medicaid and CHIP

Healthy Start is administered by the Medicaid Division within the Ohio Department of Human Services (ODHS). The Division's Consumer and Program Support Bureau (CPS), a relatively new bureau that initially focused on the transition to managed care, is responsible for fostering consumer awareness and responsiveness and taking the lead on state-level outreach for the Healthy Start program. Most of Ohio's social service programs are administered at the 88 county DHS offices.

The Ohio Department of Human Services and the Ohio Department of Health (ODH) have enjoyed a long-standing, positive working relationship at the state level. ODH is represented by 150 local health departments, all of which operate autonomously and are run by either county or city employees. At the state level, ODH has been involved in a number of Healthy Start/CHIP-related eligibility and outreach workgroups, including a committee charged with revising the Healthy Start application. Despite the involvement of ODH at the state level, implementing the Healthy Start expansion and the CHIP program has largely been the responsibility of ODHS and Ohio's 88 county DHS offices.

Case Study Design

The local case study was conducted in northeast Ohio in Cuyahoga County, which includes the metropolitan area of Cleveland, and has roughly 1.4 million inhabitants. Cuyahoga's citizenry is racially diverse due to migrations of African-American and Appalachian families at the beginning of the century and post-World War II infusions of Eastern Europeans, Asian, and Middle Eastern populations. A significant Spanish-speaking population of mixed origin also lives in the county. The Cuyahoga River divides the city into eastern and western sections, a division that historically represented a divide between the African American and white communities, although the racial boundary has broken down in recent years. Also of note is the strong medical community in Cleveland, a mid-size city, with three major tertiary hospitals and additional specialized clinics. Presented in Appendix A is a map showing the location of Cuyahoga County.

Eligibility Determination Process

Though the local DHS offices operate relatively autonomously, the state has instituted a number of changes in eligibility and enrollment policies and procedures to increase access to coverage for Ohio's uninsured children. Ohio officials continue to explore the feasibility of additional streamlining options available to states under Title XXI as well. Also, efforts are underway at the state level to further simplify the short Medicaid application for pregnant women and children that has been used for ten years. This section addresses state and local efforts in the realm of eligibility and presents some of the challenges faced by Cuyahoga County in implementing state policy.

State Policy

To streamline the eligibility determination process, Ohio designed a two-page, mail-in application, removed the asset test for children, and eliminated the need for a face-to-face interview. In addition, Ohio has emphasized the local control by counties of outreach and enrollment strategies to best serve their communities.

Healthy Start has used its Combined Programs Application (CPA) since 1989, when it was developed jointly by ODH and ODHS. The CPA is a two-page shared medical and nutritional benefits application form for pregnant and postpartum women, infants, and children wishing to apply for Medicaid, WIC, the Child and Family Health Services Program (CFHS), and the Children with Medical Handicaps Program; this form is included in Appendix E. The application is available in WIC clinics, CFHS clinics, county welfare offices, and through the state ODHS Healthy Start hotline. Applicants can send the application and required documentation to their county DHS office—they are not required to complete a face-to-face interview.

Though Ohio has made great efforts to simplify the Healthy Start application process, and continues to do so, the state has not implemented some Medicaid options made available through the Balanced Budget Act, namely presumptive eligibility (PE) and twelve-month continuous coverage. The rationale for not opting for PE appears to be both philosophical and technical. For some, PE is viewed as a "provider entitlement" that benefits providers more than families. It was also argued that PE resembles a government handout, and may therefore tarnish the new image ODHS has tried to fashion for Healthy Start. Instituting PE would also require ODHS to create a new Medicaid eligibility category, a technological challenge of considerable cost. For the time being, Ohio has decided against PE, and believes instead that families will be better served by:

- Further simplifying the application;
- Reducing processing time; and
- Conducting more targeted outreach.

Currently, Healthy Start participants must go through the reapplication process every six months. However, ODHS is considering the possibility of twelve-month continuous coverage and is now running economic models to predict the cost implications of such a policy change.

Combined Programs Application

When the CPA was originally conceived, the aim of the application was to expedite Healthy Start eligibility and to screen applicants for as many other health-related programs as possible. The recent effort to de-link Medicaid from other programs has presented a reversal in this policy, as local DHS offices are encouraged to allow families to apply only for selected programs, even if they may be eligible for more benefits. Overall, the CPA has been well received, though some county agencies reportedly still make families applying for Healthy

Start and cash assistance use the Common Application Form, a generic application used for all programs. If families apply for the *Ohio Works First* program and are found ineligible for cash assistance, the ODHS computer system, known as CRIS-E, automatically determines Healthy Start eligibility.

ODHS and ODH are currently meeting to revise the CPA to ameliorate some of the problems with the form. Perhaps the sharpest criticism is that the form is not available in Spanish. The committee has decided to design a bilingual three-part carbon paper form that is printed in Spanish on the top page for the applicant and in English on the attached sheets for the DHS worker. The revised form will also eliminate the need for applicants to sign the application three times on three separate pages, as is now required. The legal language regarding rights and responsibilities, which is now printed on the back of the application, will be recorded on a separate form. Currently, applicants are required to submit:

- A copy of their social security card;
- Proof of identity, such as a driver's license, state identification card, voter registration card, school identification card, or school report card;
- Proof of age, including a birth certificate, baptismal record, school record, or driver's license;
- Proof of citizenship or alien status;
- Proof of residence;
- Proof of income, including paycheck receipts or a letter from an employer and any other source of income.

In addition, applicants who have left a job in the past 12 months might be asked to confirm through an employer verification process that they no longer work or earn income from these previous employers.

As Ohio's welfare offices operate fairly autonomously, they do not all distribute the CPA application in the same way. Some counties widely distribute the application, while other counties prefer "to control the process" and only make the application available through the programs for which it determines eligibility. According to ODHS, widely distributing the application results in the generation of multiple applications for one individual, as different agencies simultaneously submit applications for the same client. Also of concern is the state's 30-day performance standard for determining eligibility. Applications that are incomplete or erroneously filled out require more work on the part of DHS staff, which causes offices to become backlogged with pending applications and slows the approval time for all applications.

Allocation of Enrollment and Outreach Funds to Ohio's Counties

In November 1997, the Director of the ODHS sent a memo to all County Commissioners, County Departments of Human Services, and Child Support and Children Services Agencies informing them of the newly available federal matching funds from Section 1931 of PRWORA for Medicaid outreach related to welfare reform. The state of Ohio was approved for up to $16.9 million in federal matching funds at a matching rate of 90 percent for activities related to community eligibility outreach, training, out stationing, and PSAs and new materials regarding eligibility. The state also received a matching rate of 75 percent for activities related to hiring new eligibility workers, identifying individuals whose Medicaid enrollment status may be affected by welfare reform, and tasks related to state and local organizational changes. While the state earmarked a portion of these matching funds to finance changes in the Medicaid eligibility computer system, the majority of these funds ($13.1 million) were made available to counties that were willing to provide local matching funds.

Counties were required to submit a "PRWORA Eligibility Outreach Consolidated County Plan" that detailed how the county intended to increase enrollment in Medicaid and how the county planned to secure funds to draw down the enhanced federal match at either the 75 percent or 90 percent rate. Because the enhanced matching funds are a one-time opportunity and will expire in September 1999, counties were required to propose activities that would end on 30 June 1999. Plans were due to ODHS by 31 March 1998.

Many of the county plans used the funds to sponsor enrollment drives at community locations, such as schools and child care programs, during which Medicaid applications were completed on-site. At least one metropolitan county plans to pay community providers a fee for each successful Medicaid application they submit. Other county plans centered around the development and distribution of outreach materials through the mail and at various community locales. The following section will present the ways in which the local case study area used these funds for enrollment and eligibility processes. Cuyahoga County's outreach initiatives stemming from these funds will be discussed in a later section.

Local Implementation

Cuyahoga County Department of Human Services (CCDHS) has made internal changes and initiated new activities with community providers in an effort to implement state enrollment and eligibility policies. The county HSD office has gone through an extensive reorganization in an attempt to de-link Medicaid from welfare in the eyes of the public. This valiant effort has resulted in a separate department within DHS that processes Healthy Start applications. However, this new department is still very much a part of the county welfare infrastructure and, in fact, relies upon the county's most senior caseworkers—those who are likely to be the most entrenched in traditional enrollment practices, created to provide as many benefits as possible to clients, which run counter to the goal of streamlining and de-linking Medicaid enrollment from welfare. The county has also instituted the use of application assistors in two area hospitals and health centers in an effort to enroll more uninsured children in Healthy Start. This section describes the enrollment and re-determination processes at the county welfare office, as well as the activities of the application assistors. This section concludes with a

discussion of the challenges facing counties, the greatest of which involves operating within the parameters of state infrastructure.

The Cuyahoga County Department of Human Services (CCDHS) comprises four separate departments, two of which were recently created from one single department. In July 1998, the Board of County Commissioners reorganized the Department of Entitlement and Employment Services into two separate departments—Cuyahoga Health and Nutrition (CHN) and Cuyahoga Work and Training (CWT). The reorganization was an effort on the part of the county to de-link the receipt of health care benefits through Medicaid from other welfare programs, such as Food Stamps and cash assistance. CHN administers the Healthy Start program and other programs for the working poor, the elderly, and the disabled who do not receive cash assistance. CWT focuses on benefits for those subject to the welfare reform work requirements and time limits, and administers *Ohio Works First*, the TANF program, and transitional Medicaid. The CWT caseworkers manage all the cases in a household, even if some members do not receive cash assistance. Both CWT and CHN Departments determine eligibility for the Food Stamp Program. The reorganization required an enormous effort, which moved 1,300 employees and reassigned 85,000 cases.

In April 1998, the Board of County Commissioners began to create eleven Neighborhood Family Service Centers, where families could more easily access representatives from programs administered by CWT and CHN. While these two departments are administered and staffed independently, they have an "integrated front door" and the division between the two departments is invisible to the public. Workers screen families when they come in to determine which caseworker they should see.

Cleveland comprises just one of the county's six health districts, each with its own health department. The CCDHS interacts with the local health departments primarily at the policy level through the local Joint Advisory Council and the Families and Children First Council. The local health departments have also participated in some Healthy Start outreach activities.

Processing Healthy Start Applications at the County Office

The Healthy Start Unit is housed within the central location of the CHN department and is staffed by three supervisors and eleven full-time staff who process only Healthy Start applications. As face-to-face interviews are not required, the staff interact with applicants over the telephone. When the Department was reorganized, new positions were assigned based on staff preference and seniority. Many of the Healthy Start Unit staff are veteran caseworkers who asked to be placed in the new unit.

This section describes the steps that caseworkers follow from the time they receive a new application to the end of the 30-day enrollment period. This section also includes a discussion of the problems created by the state's computer system at the Food Stamp and Healthy Start re-determination periods and what the caseworkers must do to compensate for these system-wide errors.

Initial Application

Healthy Start applications can be mailed in, completed at one of the program offices listed on the CPA, or compiled with the help of one of the four agencies contracted to serve as application assistants. When CPA applications first arrive at the central CCDHS office located at 1641 Payne Street, they are "cleared" through the CRIS-E system to determine whether or not the applicant already has an active file. If the applicant or a household member is already in the system, their application is routed to their existing caseworker in the CWT or CHN Department.

If the applicant is determined to be new to the system, their Healthy Start application is entered into the "Healthy Start Tracking System." This system was devised to track the origin of applications in order to reimburse the Healthy Start vendors for their application assistance services. After the information is entered into the county-maintained database, an administrative assistant logs the application in the statewide CRIS-E system. The application is then assigned to a Healthy Start caseworker. All of these activities are completed within 24 hours.

To make an eligibility determination, caseworkers must proceed through a number of steps:

- **Review application**. Caseworkers review the CPAs to ensure they are complete and have been signed and dated in all three places.

- **Review verifications and send checklist and employment form**. Next, caseworkers determine whether or not the verification is complete. If the documentation is not complete, caseworkers use the special Healthy Start component of the CRIS-E system to determine which verifications are still needed. At this time, the system runs a crosscheck with the IVES/JOBS system to determine if and where the applicant has worked in the last 12 months. The applicant is responsible for verifying that they no longer work for any of their past employers.

  The caseworker then fills out a verification checklist for the applicant and sends it to them in the mail, mostly likely the first day they are assigned the case. The letter requests that applicants return the missing documents within ten days. To assist them in obtaining verification of past employment, caseworkers send an employment form that applicants can take to their employer, as some require written permission from the client to divulge this information. Some caseworkers contact the employer directly and ask them to fax verification of the applicant's current employment status directly to CHN.

- **Send reminder letter**. After 20 days, if the caseworker still has not received the required documentation, a follow-up letter is sent to the applicant. If they need clarification or additional paperwork, caseworkers often contact the

client's authorized representative—often a health center or hospital that helped the applicant to submit the application and which the applicant has authorized to receive confidential eligibility information—instead of the client. The authorized representative will then follow up with the client.

- **Make eligibility determination**. Once the paperwork has been received and the application is complete, the worker makes the eligibility determination. If a client fails to respond within 30 days from the date the application is received, a denial letter is generated and mailed. Some caseworkers also make an attempt to call the applicant before the 30-day period expires to remind them to send in their documents.

  In an effort to address the county's high denial rate (50 percent) and to facilitate a customer service orientation among caseworkers, the Healthy Start Unit instituted a supervisory review process. Supervisors must now review all denials before they are processed. The reviews have revealed a wide range of caseworker practices, with some requiring verification that is not necessary when applying only for Healthy Start.

Re-determination

Healthy Start participants must go through the re-determination process every six months at one of the county's 11 field offices or through the mail. Once eligibility has been determined, cases are transferred from the main Healthy Start Unit to the field offices. The statewide CRIS-E system creates extra work for field office caseworkers at both the Food Stamp re-determination period and the Healthy Start re-determination period. An individual's Food Stamp Program application and Healthy Start application are linked in the CRIS-E system. If an individual misses his or her Food Stamp re-determination interview and is dropped from the Food Stamp Program, a letter is generated by CRIS-E and sent to the applicant directly from Columbus informing them that their benefits have been terminated. Therefore, for all Healthy Start clients who also receive Food Stamps and miss their three-month food stamp re-determination interview, caseworkers must remember to send letters to these clients telling them that they have *not been cut off* the Healthy Start program. This is, of course, an administrative challenge as the manual system, which has had to be created to combat the automated CRIS-E system, hinges on individual caseworkers remembering to send this important letter to the client. Though this problem could be ameliorated to some degree through intensive and ongoing training at the local level, CCDHS staff believe the state must step in and assume a leadership role in order to solve the problem statewide.

Another problem that occurs after an applicant is determined to be eligible for Healthy Start is that the CRIS-E system automatically schedules a face-to-face interview at the end of the six-month re-determination period, even though a face-to-face interview is not required. Again, the Healthy Start caseworker must compensate for the scheduling mechanism in the state's computer system by calling clients to tell them not to come in for an interview. They must also send clients a packet of information, complete with the required forms that they can send in by mail to one of the county's eleven field offices to reapply for Healthy Start benefits.

Cuyahoga Healthy Start Vendor Activities

As suggested by the state, Cuyahoga County utilized the Joint Advisory Council for Cuyahoga County as a forum to develop the county's PRWORA eligibility outreach plan for Section 1931 funds. The county's "PRWORA Eligibility Outreach Consolidated County Plan" was submitted in January 1998. For the period ending August 1999, the plan included proposed expenditures just over $1 million.

To mitigate the barriers enumerated during the planning process, and to attain the plan's goals of increasing community awareness of the program and increasing the number of children enrolled in Healthy Start, CCDHS conducted many activities and let a number of contracts. Those activities related to eligibility and enrollment are discussed in this section. The county's outreach activities are discussed in the following section.

The county funded four vendors, two hospitals and two health centers, to serve as application assistants: University Hospital, MetroHealth, Northeast Ohio Neighborhood Health Services, and North Coast Health Ministry to assist eligible families in completing the CPA. Three of the four agencies responded to an RFP issued in the Spring, operate under performance-based contracts, and are paid for submitting complete applications (including all verifications). They also receive a bonus for each person who is subsequently found eligible. Also, outside the RFP process, CCDHS contracted with MetroHealth, the county hospital, to assist families in enrolling in Healthy Start. During the case study, three of these four vendors were interviewed. They are each discussed, in turn, below.

Northeast Ohio Neighborhood Health Services, Inc. (NEON)

The last remaining FQHC in Cleveland, NEON has been providing comprehensive health care services for over 30 years. Its five centers serve a predominantly African-American population on Cleveland's East Side.

NEON's contract with CCDHS began in June 1998 and will expire in June 1999. Their approach to completing CPA applications for clients has been to involve all health center staff in recruitment. At registration, office managers identify clients' insurance status, and fill out a Healthy Start application when appropriate. NEON also hired a part-time outreach worker to initiate Healthy Start applications at the main site, follow-up on those originated at the health center's other five locations, and to conduct outreach for Healthy Start.

When responding to the RFP, NEON estimated they would submit 6,000 Healthy Start applications in one year. After six months, their staff completed 302 applications, but only actually submitted 146 of them. The balance of the applications were not sent to CHN because they were determined to be open cases or they had not yet been fully completed. When asked why they believe they have fallen so far short of their enrollment goal, NEON representatives cited time constraints, lack of staff resources to follow up on all the incomplete applications, and overambitious goals. The outreach worker reportedly spends more then 50 percent of her time tracking down documentation from applicants.

NEON is paid $3.00 for each application that is submitted with documentation, $5.00 for each initial person who is determined to be eligible, and a separate fee for each additional family member. The health center is not making nearly enough money to support the outreach worker's position, but say they are "not it in for the money." They believe it is in the health center's best interest to secure Medicaid coverage for their clients, though they were noncommittal when asked if they would continue to fund the outreach worker's position after the grant period ended.

MetroHealth

MetroHealth, the county's public hospital, is a large tertiary care hospital with four satellite centers in West Cleveland and approximately 12 Centers for Community Health on Cleveland's East Side. MetroHealth representatives estimate that 90 percent of their clients from Cleveland's East Side are on Medicaid and many are uninsured.

MetroHealth has been helping clients apply for Healthy Start in some capacity since 1991 and currently submits the greatest number of Healthy Start applications to the county of all the vendors. The hospital received a $150,000 grant from CCDHS to support five full-time employees from August 1998 to October 1999 to assist clients in applying for Healthy Start. The hospital has four "Healthy Start outreach workers," two in the hospital and two in the satellite centers. These women are responsible for initiating applications and gathering documentation. In addition to these workers, another Healthy Start representative, located in the hospital's inpatient billing office, reviews all MetroHealth-generated Healthy Start applications, makes a copy for the hospital's records, and sends it to CHN. MetroHealth Healthy Start staff routinely ask their clients to sign forms designating them as their authorized representative, allowing MetroHealth staff to call CHN Healthy Start caseworkers to inquire on the status of their applications. After the CCDHS contract expires, the hospital hopes to absorb the salaries of at least two of the outreach workers.

In addition to their efforts to enroll their clients in Healthy Start, MetroHealth has developed and sponsored an extensive internal and external marketing campaign using hospital funds. Beginning in the Spring, the hospital organized a number of educational programs for staff and patients, particularly those in family practice and pediatrics. The hospital's marketing department has also written articles about Healthy Start for the MetroHealth newsletter, developed a brochure which has been placed on all the hospital's registration desks, developed news releases and six radio PSAs, created transit ads for the buses that run within a five-mile radius of the hospital, sent direct mail letters to self-pay pediatric patients, and included information about Healthy Start on the hospital's telephone hold recording. All of these materials promotional materials feature the county's Healthy Start Hotline phone number.

University Hospital

University Hospital is associated with Case Western Reserve University and its campus is located in the East Side of Cleveland. Officials estimate that 20 to 30 percent of the hospital's clients are on Medicaid and about ten percent are listed as self-pay.

The hospital has its own customer service phone line, which responds to roughly 700 calls each month, and is staffed by ten people and is funded entirely by the hospital. In recent months, the hospital has added an "844-CHIP" phone line. To market the phone line, they created flyers and mailed them to uninsured patients under age 19.

Eight of the ten phone line staff are responsible for filling out Healthy Start applications. The other two phone line staff are full time Healthy Start specialists. They review the applications initiated by their colleagues and gather required verifications. Hospital officials reported that these workers often ask applicants to come in to the hospital to fill out their Healthy Start application, as they have had poor experiences in getting patients to complete applications through the mail. Since receiving the grant from CCDHS, the hospital has added two full-time financial counselors to assist with the Healthy Start applications. Housed in Admitting and the children's outpatient center, these women screen clients, inform them about the program, fill out applications, and compile documentation. Like MetroHealth, University Hospital staff act as the authorized representative for all clients applying for Healthy Start.

University Hospital, like NEON, is paid on a performance basis, although they are reimbursed at a higher rate. The hospital receives $50 for each person found eligible. Officials estimate that they have sent in about 375 applications and 250 have been found eligible.

CHN staff provided trainings for all the vendor agencies before they began working with clients. The county has also provided vendors with outreach materials created by the marketing agency and has allowed them to put their name and contact information on the materials. From July through November, CHN had received:

- 133 applications from Northeast Ohio Neighborhood Health Services;
- 129 applications from University Hospital;
- 1045 applications from MetroHealth; and
- 73 applications from North Coast Health Ministry.

As of December, CHN had also received 1823 applications from other sources, most of which came from clients themselves, the Healthy Start Hotline, clinics, the WIC program, and from Healthy Start Unit outreach events.

Knowledge and Attitudes of Healthy Start Workers and Vendors

As discussed, Cuyahoga County has put a new structure in place that attempts to streamline eligibility and de-link Medicaid from welfare. In talking to those who initiate and process applications, it is apparent that a new organizational culture and state infrastructure have been slower to develop and evolve in response to the changes related to the Medicaid expansion and CHIP. As Cuyahoga County continues their enrollment efforts, it will be important that they monitor some of the challenges presented below so that families will benefit from the state's forward-thinking enrollment policies.

Opinions and Concerns of Healthy Start Workers

On the whole, caseworkers have positive feelings about Healthy Start and believe "it is a very easy program" to apply for and work with. Many felt strongly that every family should have health insurance coverage for their children. The workers were particularly enthusiastic about their role in outreach activities and think the one-on-one outreach approach is effective.

It is important to note that the caseworkers that were interviewed for the local case study had between 12 and 20 years of experience at CCDHS. When asked why, as senior staff with the choice to be placed anywhere in the agency during the reorganization, they chose to work for Healthy Start, caseworkers said they had grown tired of the face-to-face interviews required by other programs and dealing with rude clients. Others wanted to avoid having to learn about the myriad changes in the TANF program brought about by the federal welfare reform legislation.

Though they had all processed CPA forms in their previous positions, caseworkers claim they were not given adequate training when they began working for CHN. They believe refresher training would have been beneficial, as each worked for different supervisors in the old Department of Entitlement and Employment Services and had therefore been trained differently regarding the Healthy Start program. Some say they were "over verifying" when they began determining eligibility for Healthy Start. It appears that, as veteran caseworkers, these women may be accustomed to requiring additional documentation and the least likely to be flexible and receptive to simplifying enrollment procedures.

Workers prefer to receive applications from the four Healthy Start vendors rather than from WIC or other agencies, as the vendors have a vested interest in sending in complete applications that include the necessary documentation.

Healthy Start caseworkers discussed a number of problems they encounter in their jobs. These are described below:

- **Issues Related to the CPA and CRIS-E System**. Caseworkers described some of the problems they commonly confront when processing Healthy Start applications and using the state's Medicaid computer system.
  - The requirement that applicants must verify their work history for the last 12 months is burdensome. As mentioned, Cuyahoga County has an extremely high denial rate. All caseworkers agreed that this is the single biggest barrier to enrollment. They report that it is especially difficult when the IVES system is incorrect, when the applicant works full time and cannot take time off work to visit their previous employers, when the applicant worked for several places in the last twelve months, and when they worked for temporary agencies, who are not cooperative when it comes to verifying employment status.
  - The CPA application is not printed in Spanish, requiring extra work for Spanish-speaking caseworkers who must spend additional time on the

phone explaining the program, the application, and the required documentation to applicants.

- The reminder letter that is sent to clients at 10 and 20 days is not clear, especially concerning verification of citizenship.

- Caseworkers recommend that a universal verification checklist be developed for the Healthy Start program.

- Some applicants have low literacy skills, and as a result send in incomplete or erroneous applications. For example, some clients put "N/A" for income.

- **Inconsistency of Caseworker Supervisors**. Caseworkers are troubled when supervisors enforce rules loosely, inconsistently or differently from one another. Workers feel vulnerable when a supervisor overrides policy and fear they may ultimately be held accountable for the decision. They say these decisions invariably cause problems for them and field office staff at the re-determination period.

- **Extensions**. Caseworkers complained that some agencies acting as authorized representatives continually request extensions one or two days before the 30-day enrollment period expires. The three CHN supervisors reportedly approve an unlimited number of extensions, which caseworkers believe encourages the agencies to move slowly when working with a client to complete their application packet. These requests most frequently come from two hospital collection agencies, HRS and Unicare.

- **Policies Related to Caseload and Distribution of Work**. Each caseworker generally receives three to five new cases a day and is expected to have no more than 60 open cases at any time. Healthy Start workers spend their time processing paperwork they receive in the mail for pending applications, talking on the phone with Healthy Start vendors and applicants, and sending follow up letters and re-determination packages to applicants. Caseworkers report that they find it difficult to prioritize their work during the day with the phone "always ringing."

  Though they are allotted overtime hours intermittently to catch up on their backlogged cases, workers are not allowed to work late. As a result, some particularly dedicated workers skip lunch to try to get more work done.

Vendor Observations and Concerns

Overall, vendors are content with their role in the enrollment process and seem dedicated to obtaining insurance coverage for their clients. Some of the common problems they have encountered are discussed below.

Vendors did not believe there had been a culture change at CCDHS as a result of the separation of the Healthy Start Unit from more traditional welfare programs. Some vendor staff say they have difficulty interacting with and enlisting the support of Healthy Start caseworkers, who they believe could benefit from improved customer service skills and a better understanding of some of the more uncommon situations that arise when determining eligibility, such as grandparents who have custody of their grandchildren. Vendor representatives also commented that Healthy Start applications are extremely backlogged. Finally, some vendor staff experience inconsistencies from worker to worker in how they calculate clients' monthly income.

When asked what their greatest challenges were in compiling and submitting Healthy Start applications, vendors responded similarly. Many said they didn't expect to encounter so many open cases. The NEON outreach worker says she spends a lot of her time checking with CHN to see if an individual already has an open case. Vendors were also frustrated by the amount of time it takes to track down verifications. Like the Healthy Start caseworkers, vendors mentioned job verification as a major barrier to enrollment.

Another surprise for some of the smaller vendor agencies was having to compete with other vendors and Healthy Start staff when conducting outreach at community events. One particular staff person said she became discouraged and stopped attending these events, because her agency did not have flashy promotional items to attract people to their exhibit booth, and it was therefore not a good use of her time.

Also explored were the pros and cons of becoming an "authorized representative." Both MetroHealth and University Hospital routinely ask clients to fill out a form identifying the hospital staff as their authorized representative. This allows them to interact with Healthy Start caseworkers on their clients' behalf and receive confidential information. NEON, a much smaller agency, has elected not to ask clients for this designation as they believe it would result in more work for their employees.

Of particular import is the fact that none of the vendors are meeting the goals they set for themselves. Most are falling far below the number of applications they expected to submit each month. While all the vendors said they did not respond to the RFP for financial gain, it is likely that all the vendors will not be able to retain all the staff they have currently dedicated to enrolling families in Healthy Start. This issue, of course, may affect the county's ability to continue to increase the Healthy Start caseload after the federal Section 1931 monies are discontinued.

Outreach

The lion's share of Healthy Start outreach is conducted at the county level. Of late, several months after initial implementation, the state has been mobilized by advocates to play a more prominent role in the Healthy Start outreach effort. Though it has been argued that locally-driven campaigns have the potential to be more tailored to the audience, and can therefore be more effective, the state can still serve an important unifying role. This section provides an overview of the state and local outreach efforts.

State Efforts

ODHS has not yet created a statewide overall logo, message, or slogan for the Healthy Start program. However, ODHS has recently formed a state-level theme, art and logo advisory committee comprised of representatives from a variety of agencies. The state's primary outreach strategy is to build relationships with local groups and county DHS offices. ODHS describes their target audience as frontline workers in programs like Planned Parenthood, WIC, and CFHS.

In an effort to spread the word about Healthy Start, ODHS has partnered with a number of government agencies, non-profits, and private associations to educate frontline clinic staff about the new Healthy Start income guidelines, share information and promotional materials, make presentations at conferences and key meetings, and sponsor joint mailings to eligible families.

Allocation of Funds to Counties to Develop Outreach Plans

As mentioned, most of the Ohio Medicaid outreach activities are conducted by counties. In response to the ODHS memo concerning PRWORA outreach funds, 62 of Ohio's 88 counties submitted outreach plans. Most of the counties that did not submit plans are rural counties, many located in the Appalachian region in Southeastern Ohio, where the Medicaid enrollment is already quite high. Most of the plans include local media campaigns, each with their own county-specific logo and slogan. Some counties have called Medicaid for children "Healthy Start," others named it "CHIP," and still other refer to it as "Healthy Start Plus." When asked to comment on the potential for confusion and countervailing messages resulting from 62 separate marketing campaigns, ODHS representatives said they try to be sensitive to problems arising from fragmentation and consider it when making decisions concerning state outreach initiatives.

Print and Electronic Materials

While the bulk of the outreach effort is based at the county level, ODHS has created a few print materials for Healthy Start, including a business card printed with information about the "Medicaid consumer hotline" and a couple of flyers, which are distributed at health fairs and through the county DHS offices. In the Spring, ODHS worked with ODH to send 80,000 flyers in a single mailing to WIC households that did not have health insurance.

Ohio also received a grant from the Health Care Financing Administration (HCFA) to purchase television time across the state for a 30-second public service announcement (PSA). The ad shows images of children receiving medical care and encourages families to call the toll free phone number to see if their children are eligible for "basic health care" and to fill out an application with a phone line representative. The ads ran in the Youngstown, Cleveland, and Columbus media markets during the first two weeks in November. ODHS also purchased radio time for a 30-second English and Spanish radio commercial that was run during drive time hours. When developing the spots, ODHS solicited feedback from local groups, but did not formally pretest the ads.

Medicaid Consumer Hotline

The Medicaid Consumer Hotline was created in July 1996 to provide an information and referral source for Medicaid consumers. Families can initiate a CPA application through the hotline or simply request that it is mailed to them. From January to September 1998, the hotline received a total of 78,669 calls, sent out 14,200 blank Healthy Start applications, and completed 10,125 applications. The hotline is required to handle all languages and uses the AT&T Language Line for translation services. Hotline staff ask callers where they heard about Healthy Start (e.g., radio, TV, friend) so that the state can monitor responses to various media and outreach strategies. Also, the state can track applications that are initiated through the hotline.

Local-Level Efforts

As mentioned in the previous section, Cuyahoga County developed its county eligibility and outreach plan with the input of several provider and community groups. In addition to issuing contracts with the four vendors to act as application assistants, the county plan outlined steps to partner with labor unions and schools to raise awareness of the program, hire a marketing firm to create a social marketing campaign, and contract out the existing Healthy Start hotline. In so doing, the county has utilized a variety of outreach strategies—mass media, community-based activities, and even one-on-one efforts through its vendor contracts. Each of these activities is discussed in this section.

In addition to the activities stipulated in the plan that involve outside agencies, the Healthy Start Unit conducts their own outreach activities. Cuyahoga Health and Nutrition and the local health department started a Kids Health Mobile in February 1998. Healthy Start caseworkers use the Kids Health Mobile to conduct outreach and attend special community events at nights and on the weekends where they help people fill out applications. Between February and November, the van participated in over 160 events.

Outreach Conducted Through Labor Unions

CCDHS often partners with the Universal Health Care Action Network of Ohio (UHCAN), a statewide organization that works for justice in health care by increasing access, quality, and public accountability. Though they do not receive funds directly from CCDHS, Healthy Start staff sponsored trainings for labor representatives on the Healthy Start program.

UHCAN works with four unions, but it works most closely with the Service Employees International Union (SEIU), representing roughly 8,000 union members who work for hospitals, nursing homes, hotels, and sports venues. UHCAN and SEIU coordinated with Healthy Start staff to host events at six nursing homes, three hotels, and the SEIU union hall where caseworkers filled out applications on site. The unions have submitted about 170 applications since September, although UHCAN does not have a mechanism to track the status of these applications.

Outreach Conducted in and through County Schools

Approximately $50,000 of the county's plan was allocated for school-based outreach, all coordinated through the Families and Children First Council (FCFC). These councils were initiated in every county across the state in 1993 as a mechanism to foster communication among the state boards of education, mental health and retardation, health, human services, and developmental disabilities.

The Council's primary Healthy Start outreach activity is a mass mailing of brochures to approximately 16,000 special education students in five urban schools. In conjunction with CHN staff, the council has also hosted four open-house events in the evening when parents can come to the school to fill out applications. They are beginning to train school personnel, particularly nurses, about the program.

Social Marketing Campaign

Adcom, a 35-person marketing firm specializing in health care, received a $200,000 contract from CCDHS in late spring to develop a Healthy Start outreach campaign. Adcom's marketing strategy is to keep the campaign's message simple: Healthy Start is a health care program, not a welfare program. The target audience was described as families in general, and working families specifically. Adcom did not conduct any primary research or pre-testing with the target audience, but reviewed focus group data and caseload statistics provided by CCDHS.

The Cuyahoga County Healthy Start campaign is in its incipient stages, though Adcom has produced a number of materials to date:

- **Logo/slogan**. The logo consists of a graphic design of a child holding a yo-yo. The tagline, "Healthy Start: Free Health Insurance for Kids" is written around the logo. When developing the logo/slogan, Adcom conducted two rounds of pre-testing with Healthy Start staff to solicit their feedback on the color and various proposed taglines.

- **Fact Sheet/Brochure and Tabletop Display**. Adcom also developed a fact sheet for direct mail purposes. The piece outlines the program's benefits, mentions the county's four Medicaid HMOs, includes an income chart, and the county's "Healthy Start Hotline" phone number. Adcom is currently developing a brochure based on the fact sheet, and has created a tabletop display

to hold the brochures. The displays will be placed at neighborhood locations based on scatter-plot graphs of Healthy Start clients being created by CCDHS.

- **Television Spot**. Adcom designed a 30-second television spot that is currently airing on cable television. Paid television time has been purchased for the first quarter of 1999 on broadcast stations. The up-beat spot features children of different ethnicities playing with yo-yos and then shows a nuclear, White family. At the end, the ad encourages people to call the Healthy Start Hotline for more information and to fill out an application.

  The television spot could be used by other counties as it does not specifically identify itself as a Cuyahoga initiative. However, because the Cleveland media market includes 11 counties, the television spot could generate a lot of calls to the Cuyahoga Healthy Start Hotline from neighboring counties inquiring about coverage. Adcom plans to work with CCDHS to ensure that phone line staff are trained in how to field calls from other counties.

- **Radio Spot.** Sixty-second radio spots have been produced in both English and Spanish to reinforce the television spot and to provide additional information about Healthy Start benefits. Radio spots will be played on predominantly urban stations, also in the first quarter of 1999. The radio spot mentions the county twice, which may make those living outside the county believe they do not qualify for the program.

- **Promotional Materials**. Adcom produced yo-yos and water bottles printed with the Healthy Start logo/slogan. These materials are distributed at community health fairs and other events attended by the Kids Health Mobile.

Once the television and radio ads begin showing in 1999 and other collateral materials are in place, the campaign will be evaluated on the number of calls to the local hotline. Adcom envisions public relations as a future focus of the campaign. In particular, supermarkets and schools are being considered as potential information channels to reach eligible families.

Healthy Start Hotline

MetroHealth holds an additional $150,000 contract with CCDHS to administer the Healthy Start Hotline for one year. MetroHealth has had its own hotline since 1980, so they merely expanded staff when they assumed responsibility for the Healthy Start line in October 1998. The line is staffed by a total of nurses between the hours of 9 a.m. and 9 p.m. Voice mail is activated after hours. Adcom, the county's marketing agency, reportedly alerts MetroHealth about upcoming marketing activities so they can staff the phone line accordingly.

Phone line staff take the names and addressed of callers who request Healthy Start applications. The hospital generates mailing labels and sends them to CHN on a biweekly basis. Applications and information packets are sent to hotline callers directly from CHN. Approximately 30 percent of callers have detailed questions and are transferred to the Healthy

Start outreach workers stationed at the hospital. Callers who want to check on the status of their application can be transferred directly to CHN.

MetroHealth is paid based on a percentage of phone line staff time that is spent fielding Healthy Start calls. In October, MetroHealth handled 972 calls and billed CCDHS roughly $6,000. MetroHealth had estimated that their monthly billing would average $12,000.

Lessons Learned

Ohio has adopted many policies to simplify and streamline the Medicaid enrollment and eligibility process. The state has used a short, mail-in Medicaid application for ten years, and eliminated the asset test and need for a face-to-face interview. Each of these efforts on their own is an important step toward reducing barriers to access; together they are a laudable achievement in the effort to provide coverage to Ohio's uninsured children. Also, ODHS's sophisticated and precise data system is a valuable asset, as it can track the enrollment of new cases, as well as those previously enrolled in Medicaid and welfare programs, by county and by funding source. This system will be instrumental in monitoring the successes and pitfalls of the Medicaid expansion.

Because Ohio got out of the starting blocks quickly compared to other states, it has more implementation experience from which to learn. To evaluate their progress, Ohio officials have analyzed the enrollment and disenrollment patterns across the state. It appears that the new policies and the various county outreach strategies have been effective in *enrolling* clients in Healthy Start. Based upon analyses conducted in 1997, Ohio set the goal of enrolling 133,000 children in the Medicaid expansion and CHIP program by June 1999. The October 1998 caseload demonstrates that the state has identified approximately 34 percent of the expected caseload increase to date.[20] However, a closer examination of the caseload figures reveals an alarming problem with retention. From January 1998 to September 1998, approximately 64,000 children were enrolled in the Healthy Start expansion and CHIP program. However, only 42,095 children were enrolled in these programs in September. Thus, approximately 22,000 of the newly enrolled children had already dropped off the program—most of them from the expanded Healthy Start program, meaning that they had another source of insurance coverage. ODHS estimates that roughly 55 percent of the children who have fallen off the rolls are no longer eligible either because of an increase in family income or because they did not re-apply for the program at the six-month re-determination period. The other 45 percent are said to now qualify for "regular Healthy Start," and other Medicaid programs, due to a decrease in family earnings.

It also appears that most of the efforts in 1998 to enroll more children in Healthy Start have identified families previously involved in the welfare system. The September Caseload Bulletin shows that of the new year-to-date eligibles, about 63 percent were previously

[20] Caseload Analysis Bulletin. Ohio Department of Human Services, September 1998. Caseload Analysis Bulletin Ohio Department of Human Services, October 1998.

enrolled in Medicaid, through either TANF, the aged, blind, or disabled categories, or Healthy Start, and approximately 14 percent had siblings who were previously eligible for Medicaid. The remaining 23 percent of the new recruits were truly new to the Healthy Start system.

On the local level, Cuyahoga County officials are pleased with the increase in their caseload achieved to date. According to ODHS data, Cuyahoga County is one of the state's metropolitan areas that has experienced the greatest caseload increase since January. As of October 1998, Cuyahoga County had enrolled 4,885 *new* eligibles in the Medicaid expansion, representing roughly 55 percent of the county's projected population of children eligible for the Medicaid expansion and CHIP programs.

County officials believe the contracts with area hospital and health centers to help clients fill out Healthy Start applications was a "good first move," as these agencies have the most contact with the uninsured, and because one year ago, the county denied 50 percent of the applications it received, mostly due to a lack of verification. Unlike many states, the CPA form is not the problem in Ohio—verification is the greatest barrier. Partnering with these agencies has helped to increase the number of complete applications arriving at CCDHS, saved precious staff time previously spent entering incorrect applications in the CRIS-E system and sending out letters requesting documentation, and contributed to a decrease in the county's denial rate from 50 to about 30 percent. County officials report that it is too early to tell what the effects of the DHS reorganization have been.

Given the state's mixed success with recruiting and retaining Healthy Start clients, it is crucial that the CRIS-E system be amended to limit the degree to which it drives the Healthy Start re-determination process. Though Cuyahoga County DHS has made a valiant effort to de-link Medicaid from cash assistance programs through outreach and enrollment, we have learned that the two are inextricably linked at the state level through the CRIS-E system at the back end, that is, at the re-determination period. As a result, five percent of the entire Medicaid population in Cuyahoga County falls off the rolls each month, undoing their effort to identify these families and determine their eligibility only a few months before.

Those interviewed during the Ohio case study enumerated a number of barriers to initial enrollment in the system, as well as barriers to retention. A lack of awareness about the program, and how streamlined the application process has become, and misperceptions about who is eligible for Healthy Start, were mentioned as reasons that families do not even fill out Healthy Start applications. Though Medicaid for pregnant women and children has been called Healthy Start in Ohio since 1989, the culturally entrenched Medicaid stigma has persevered. Also, as mentioned, the CPA is not printed in Spanish, presenting a significant obstacle for Spanish-speaking families interested in enrolling in Healthy Start. Barriers to retention mentioned by state and local officials include the complexity of the managed care system and the decreasing pool of Medicaid HMOs in some areas. Also, questions remain as to whether or not *Ohio Works First* caseworkers are informing families about the availability of transitional Medicaid and Healthy Start. And, finally, the Medicaid computer system is still linking Healthy Start and food stamp benefits, causing many to lose Healthy Start three months into their enrollment period.

Ohio's county-based outreach strategy has been commended by some for drawing upon counties' knowledge of their own communities and criticized by others as being disjointed and uncoordinated. However, the state's strategy could certainly benefit from increased coordination between the state and the counties and among counties. Several months after the counties have launched their own outreach efforts, the state has convened a committee to create a statewide Healthy Start logo. While there are many positive aspects to locally based outreach efforts, it appears that the state has not fostered cross-pollination of ideas at the county level. By funding 62 individual outreach campaigns, each with its own identity and consumer information line, the state has missed the opportunity to benefit from economies of scale related to conducting formative research, developing print and electronic outreach materials, and buying paid media time. Within Cuyahoga County itself, officials have opted not to coordinate the outreach activities of their vendors who work independently in different areas of the city. In an effort to obtain medical coverage for their client base, the four vendors have created their own media campaigns and hotlines, independent of the county-funded initiative.

After more than half of the period for which the state has access to federal PRWORA funds, an unparalleled one-time resource for enrollment and outreach, Ohio has recruited and retained 34 percent of its projected net caseload increase. While Ohio's simple application and ability to apply through the mail without completing a face-to-face interview makes it relatively easy for families to gain access, many lose their coverage just as quickly. To fix its problem with retention, the state must address problems of the CRIS-E system and revisit their quality assurance and monitoring role with the county DHS offices.

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