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Building Healthy Partnerships: Supporting Community Based Outreach

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Topics: The Southern Regional Initiative to Improve Benefits for Low-Income Families with Children

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It is such a pleasure to be here with you today to be part of this impressive gathering.

Most of your sessions are focused on outreach to help individuals and families gain access to health services.

I have been asked to share with you the experiences and lessons learned by the Southern Institute on Children and Families as we've worked across 17 states and the District of Columbia to improve children's access to health coverage. Our focus has been centered on coverage, rather than service delivery.

You know, many people don't know what difference it makes for a child to have health coverage. Study after study have shown that — whether through public or private insurance — children who are insured have better access to preventive and primary care. Such care improves their overall well being and increases their potential to become healthy, productive adults.

The flip side is that children without health coverage are less likely to have a regular source of medical care, and are more likely to receive care in a hospital emergency room. They are also less likely to seek care for injuries or to be immunized.

Given the recent findings on early brain development — and the importance of preventive care and development in early childhood and beyond — it is hard to imagine a cause more compelling than helping poor and low-income children to gain health coverage and health care.

We have an unprecedented opportunity at this point to move and move aggressively to see that millions of low-income uninsured children have what their families have only dreamed of – and that is for their children to have the advantages that come with having health coverage.

With all the Medicaid expansions over the past 12 years and now the passage of the State Child Health Insurance Program, we are well positioned to make it happen. We certainly have our work cut out for us. Many low-income working families don't have a clue that Medicaid benefits are available to their children. And a recent national poll found that only **26%** of parents with uninsured children had read or seen anything about the new child health insurance program which became reality almost a year ago.

We also know that even if families learn of the opportunity, it does not mean that they will apply for public child health coverage, and that they will have the perseverance to stay with the application process to the point of enrollment.

And beyond enrollment, we know that many become overburdened with the reports required to maintain coverage. When they fail to file reports on time — the result is eligible children losing public coverage.

The question is:

What can we do to help low-income children get and keep health coverage?

Through our outreach an enrollment initiatives, we have worked with families, communities and states to identify strategies to reduce bureaucratic and informational barriers that impede access to child health coverage.

In 1994, prior to welfare reform, the Southern Institute conducted personal interviews with 69 AFDC and Transitional Medicaid recipients in Charlotte, North Carolina and Nashville, Tennessee. We were attempting to determine the extent to which the loss or perceived loss of Medicaid was a disincentive to leaving welfare.

We asked a number of questions to determine their level of knowledge of what happened to health and other benefits when they left welfare for work. We discovered a serious lack of information and misconceptions about the availability of Medicaid benefits for children and families outside of the welfare system.

Following this study, the Southern Institute worked to develop creative and innovative information outreach strategies that effectively communicate messages about health coverage opportunities for low-income children. With support from North Carolina and Georgia, we conducted 27 focus groups in nine counties, both rural and urban. We tested three brochures for readability and acceptability among three different target groups: (1) Recipients, (2) Community Organizations and (3) Employers. The recipient focus groups included AFDC and Transitional Medicaid families.

At the beginning of each focus group session, we conducted a pretest to measure the level of participant knowledge prior to showing them the brochure targeted to their group. I want tell you about some of the Georgia pretest results which are very similar to the North Carolina results.

Georgia Recipients:

- 55% did not understand that if parents get off welfare because of work, their children would be able to get Medicaid
- 57% did not understand that even if a child's parents live together, a child can get Medicaid
- 59% did not know about the availability of Transitional Medicaid Assistance for up to one year

- 78% did not understand that children under age six are eligible for Medicaid at higher income levels than older children

Georgia Employers:

- 21% did not know that children do not have to be on welfare to be eligible for Medicaid coverage

- 43% did not know about the availability of Transitional Medicaid coverage for up to one year

- 78% did not understand that children under age six are eligible for Medicaid at higher income levels than older children

Post test results showed dramatic improvement in percent of correct answers. Recipients went from 38% to 81% for Medicaid and employers went from 61% to 96% for Medicaid.

We have also developed videos to reinforce the messages contained in the brochures. The videos have also been produced in Spanish and we are now developing a Spanish version of the brochures.

The videos and brochures are currently in use in 11 southern states (Delaware, Florida, Georgia, Kentucky, Maryland, Mississippi, Missouri, North Carolina, South Carolina, Tennessee and Virginia.) And the Southern Institute is currently working on drafts of the outreach brochures with Alabama, Arkansas, Oklahoma and Texas to develop them for use in those states.

Why is it that families who are connected to the welfare system are so ill informed about Medicaid benefits for low-income, working families?

We know that the lack of knowledge on the part of families wasn't because they had not been given any information. The problem is that they are inundated with information and much of it is written in "bureaucratese and legalese" and is buried in rights and responsibilities language, which more often than not isn't read by families.

Few resources have been allocated to educating families on or off welfare on the extent to which Medicaid is available to children outside of the welfare system. Very little has also been done to educate employers of low wage workers and community organizations about the availability of Medicaid coverage for children in low-income working families.

The result is that there are thousands of families struggling to make ends meet on low wage salaries who cannot afford to purchase health insurance – even if their employer offers it – and who do not know that help is available.

We can and must be more effective at communicating with families about opportunities for child health coverage. Whether it is Medicaid or a state child health coverage program, we owe it to these families to get the word out.

Let's look at some of the information we have on other reasons why children are eligible, but not enrolled in Medicaid.

- Eligibility rules are confusing and often illogical (Age difference/assets tests)

- The application process is complicated and demeaning

- Verification requirements are excessive

- Automatic searches for other eligibility categories are not always conducted before closing children's cases

Adopting the continuous eligibility option can help with this problem, but it will still be an issue at the end of the continuous eligibility period when the child comes due for redetermination.

Numerous studies document the "user friendliness" of the application process. Before I review some of the reasons the process is burdensome for families, I do want to mention that families are not the only ones frustrated by the application process.

It is critical that we devote attention and resources to do everything we can to simplify the eligibility rules and the application process so that families who hear about child health coverage and apply are not turned off by the experience.

Word is out that the application process is intrusive and complicated.

Unless simplification is made a priority at the state, local and federal levels, many of the families who respond to the outreach initiatives will not complete the application process, and many will never apply again, regardless of outreach efforts.

Our studies document that a major problem with the application process is the **excessive amount of verification** requirements encountered by families during the application process. Too often, reducing the size of the application is the singular focus of simplification efforts. If an agency reduces the size of the application process without reducing verification requirements, little will have been accomplished toward simplifying the eligibility process from the perspective of the family.

As most of you are aware, when families apply for health coverage, it is typical for them to be required to produce numerous documents to verify personal statements made on the application. Because most eligibility workers are not actively involved in assisting families to obtain verification information, the application process can generally be described as a "**You go and get it and bring it to me"** type of process for the applicants. The time and cost involved in providing such verification can be substantial for families.

And families frequently face obstacles from third parties who do not want to be involved in their application, or who do not understand the urgency of meeting the deadlines imposed by the agency for return of the verification documents. Such uncooperative third parties can include employers, relative and noncustodial parents.

Wage verification is often a problem for applicants and this underscores the need for outreach to employers, as well as the development of alternative forms of wage verification.

Age verification is an area where more use of self declaration will remove eligibility barriers for children. Another remedy is for state systems to take greater responsibility for accessing birth verification through their vital statistics data, rather than asking families to pay for birth certificates.

Verification requirements are a particular problem for undocumented parents with citizen children.

Although advocates have pushed for reductions in verification for years, states usually take a rigid position due to a resistance developed during years of intense federal attention to reducing eligibility error rates.

Now, it certainly sounds like a good objective for agencies to assure that accurate eligibility decisions are made. The problem is that throughout the 1980s and into the early 199s, the federal "quality control" system focused almost solely on reducing errors that resulted in *in*eligible families receiving benefits – without concurrent attention being given to errors that kept *eligible* families from receiving benefits or to providing resources to assist applicants to produce required verification.

As a result, in most state and county eligibility agencies, little or no attention or resources have been allocated to helping eligible families to receive benefits. In our studies of the eligibility process, eligibility workers have told us they feel more like *in*eligibility workers.

Although there have been some minimum efforts in recent years to bring attention to the need for balance in the federal quality control system, the mindset is prevalent among local eligibility workers that it is more important for the agency to keep *in*eligible families out, than to help eligible families gain benefits.

Without some action by the federal and state government to change this mindset, it will remain a serious barrier to enrollment.

State eligibility process reviews can produce results in reforming the application process, especially if the federal government is willing to be a full partner in such efforts. States have flexibility in deciding the rules regarding such important factors as to what extent mail in applications are utilized – without face-to-face interview requirements – and to what extent verification is required versus allowing self declaration under penalty of law. States are also in the driver's seat on decisions regarding which documents are acceptable for verification.

However, even though error rates are within tolerance in most or all states, they remain convinced that the federal government is going to "come back and bite" them if they don't maintain a rigorous effort at quality control. Eligibility workers agree that much of the activity involved in verification is questionable from a cost effectiveness standpoint, but there is a comfort level to continuing on as they have been in the past.

One action that can alleviate some of the pressure on states and free them to try some new strategies related to verification would be for the federal government to allow a grace period on eligibility errors for child health coverage. This would mean that states would not be at risk when attempting to design systems that reduce barriers.

An action states can take is to conduct a state eligibility process assessment to determine precisely what needs to be done to reduce barriers to child health coverage. The components of such an assessment are:

- Differentiate federal verification requirements from additional state and local requirements. Then pursue solutions accordingly.

- Review the need for verification, item by item, giving special attention to the value of specific documents from a quality control standpoint.

- Identify alternative documents for verification.

- Identify verification that can be obtained through federal, state or local systems rather than requiring the family to provide it.

Such assessments will go a long way toward creating a new mindset among local eligibility agencies that it is important to have a process that is conducive to helping families gain benefits. Eligibility assessments will, however, present a significant challenge to current eligibility practices, which is one reason why the policy must be clear at the outset that state leaders want eligible children to receive coverage.

A state verification assessment should also examine what role outreach workers can play in helping families obtain required verification. Where such workers have been funded through Medicaid match arrangements, there have been clear results. There are examples of successes with hospital based outreach workers and outreach workers at social services agencies. In both cases, outreach workers become extensions of desk bound eligibility workers.

Outstationed workers are often referred to as outreach workers. Outstationing is a form of outreach, but most outstationed workers are as desk bound as their eligibility agency colleagues, and they often do not have the computer capabilities to tie in to agency databases that can provide client information.

Another subject I'd like to discuss is applications for multiple programs.

Due to President Clinton's directive, there is long overdue attention being given to identifying ways to unifying the application process across programs. One word of caution – in looking at the potential for combining eligibility for multiple programs – care must be taken to not confuse families who want only child health coverage.

A multiple program application can backfire. A very real barrier to integrated eligibility approaches is that many of the federal rules that govern the major programs for poor and low-income families are different, often for no logical reason.

Although mind boggling, it is not impossible to bring some uniformity to the federal rules and regulations that govern the major programs for poor and low-income families, and thus make it much more feasible to do integrated eligibility determinations. Several reports that could facilitate that process were produced in 1993 and 1994.

But until significant cross program policy reform has been achieved, we have to be very clear about what is needed for child health coverage only. We simply can't risk losing families by asking for demeaning and hard to obtain information that is not required for a determination for children's health coverage.

One action that can be taken along multiple program lines is to examine ways to allow applications for various programs to be accepted by other programs, at least to the extent that the same information can be used to determine or expedite an application for child health coverage. Or, at a minimum, allowing various program applications to activate a referral contact from one agency to another.

For example, why shouldn't applications for the school health program, WIC, Food Stamps, housing, low-income energy assistance, and other low-income programs contain a statement by the applicant granting permission to provide the information to the eligibility agency that determines child health coverage?

Confidentiality can't be used as a reason not to do it. Experts in this area point out that if the applicant gives permission to share information for specific purposes, there is no issue of confidentiality.

I would like to mention a couple of areas where federal statutory changes would simplify eligibility and help maintain coverage for children. These changes were identified during a recent 18 state project conducted by the Southern Institute where we asked states for ideas on improving access to child health coverage.

Consensus on three changes

1) On the subject of linkages to Medicaid for TANF families, allowing states the option to create a Medicaid category that is a mirror image of their TANF programs – without requiring a waiver – will help states to provide Medicaid coverage for TANF families.

2) Also, for families who are eligible for Transitional Medicaid, eliminating reporting requirements during the second six months of Transitional Medicaid will reduce barriers to continued eligibility. Very few families are going to earn their way out of Transitional Medicaid during the second six months. Eligibility workers tell us that the major reason for case closures during the second six months is failure to file required reports.

3) Not requiring families to be on welfare for three out of the previous six months:

- ***Covering Kids***
- **RWJ/SICF**
- **Three goals**
- **45 applications**

It's likely that many of you know what you want to do in the area of outreach. But I hope I've convinced you that you need to also invest your energy in understanding the eligibility policies and procedures in your state and community so that you can help develop ways to help families get through the application process.

Otherwise, your outreach efforts will be impeded. Involve yourselves.

Let's get that card in their hands.

I realize that getting children health coverage won't resolve the many important issues we need to address with regard to improving access to health care. But let's get this one

on the way while there is support to do it, so we can focus on the issues of improving access to care.

Timing is everything and the time is now to act on the issue of child health coverage.

It’s a very exciting time. Thank you again for the opportunity to be here with you.