The Future of Outreach: A Call for Action
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As we celebrate the most recent step toward providing low-income children with the opportunity to gain health coverage, it is sobering to recognize that past experience has taught us that it will be a mistake to assume that families who can benefit by the new opportunity - know what has happened - and what it means to them.

A recent national poll found that only 26% of parents with uninsured children had read or seen anything in the newspaper - or on television - about the new child health insurance program (CHIP).

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 - or they fail to file reports on time - resulting in eligible children losing public coverage.

This time around, we should all take a personal oath to see that the track record for implementing CHIP is better than the track record for implementing previous Medicaid expansions. If this one doesn't move with greater efficiency and sensitivity, we may find the funding that makes it all possible decreased due to a perceived lack of need.

Translating a policy triumph into an implementation success will require every ounce of energy and ingenuity that all of us can muster. We will be a lot more successful if we allow ourselves the liberty to believe that just because we have done things one way in the past does not mean that we have to do them that way in the future.

It was 12 years ago that the nation's governors asked Congress to give states the option to provide Medicaid coverage for low-income pregnant women, infants and young children without requiring them to be on welfare. Congress responded and a few years later mandated Medicaid coverage at certain levels, but this was one federal mandate that most states had already implemented. In succeeding years, Congress increased the mandated age and income levels and gave states additional options so that more children in working families could receive Medicaid benefits.

While millions of children have gained coverage due to this progressive public action, today there are approximately three million children who are eligible for Medicaid, but who are not

enrolled. These currently eligible but not enrolled children and the newly eligible CHIP kids place us at a historic point in our efforts to see that poor and low-income children have access to health coverage.

The cause has been joined, the funds have been allocated and now comes the hard part - making it happen. Our willingness to work hard and think anew will determine whether the intent of both the previous Medicaid expansions and the new state child health insurance program will finally become a reality for low income children and their families.

You know, many people don't know what difference it makes for a child to have health coverage? Study after study has 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.

Access to health coverage for low income children is a major issue with welfare reform. It is critical for federal and state policy makers to understand the necessity of providing some stability of child health coverage for families that are leaving welfare for work.

In 1994, the Southern Institute conducted personal interviews with 69 AFDC and Transitional Medicaid recipients. We were trying to determine the extent to which the loss or perceived loss of Medicaid was a disincentive to leaving welfare.

We learned a lot by talking with these parents and other caretakers. Fully one third of these families listed health coverage for their children as the benefit they needed most in order to hold down a full time job.

We asked them 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 that the program they understood best was Food Stamps (only 6% incorrect responses). The program they understood the least was Medicaid (76% incorrect responses).

We know that their lack of knowledge was not because they had not been given any information. The problem is that much of the information given to families about opportunities is written in "bureaucratise and legalise" and is buried in rights and responsibilities language and usually in small print.

Outreach

What can we do to see that families know about and take advantage of the opportunity for health coverage that will give their children greater access to preventive and primary health care?

And how can we better understand why children who are income eligible are not enrolled in available health coverage programs?

Viewing the system through the eyes of a low income family and involving families in exploring these questions, will place us leaps and bounds ahead in identifying ways to make Medicaid and other coverage programs more accessible and family friendly.

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

- Families lack information or are misinformed about the availability of coverage for children in working families and two parent families.
- Eligibility rules are confusing and often illogical.
- The application process is complicated and demeaning.
- Verification requirements are excessive.
- Automatic searches for other eligibility categories are not always conducted before closing children cases.

The lack of information is unconscionable. We have done far too little to counter the pervasive and inaccurate belief that children have to be on welfare in order to be eligible for Medicaid coverage.

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 Medicaid is a source of health coverage for their children. 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 that help is available.

Following the study I referenced earlier where we discovered the serious misconceptions of families about Medicaid and other benefits, the Southern Institute - with support from the states of North Carolina and Georgia - worked to develop creative and innovative information outreach strategies that effectively communicate messages about health coverage opportunities for low income children. We conducted 27 focus groups in nine counties, rural and urban. The result is three user friendly brochures that are an example of the kind of colorful and easy to read

communication materials that are needed to inform low income families about health coverage and other benefits for children.
Before I briefly show you the information outreach brochures, I would like to share with you the pretest results of the Georgia focus groups conducted in 1996. 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. There were three groups: 1) Recipients (welfare and Transitional Medicaid); 2) Community Organizations; and 3) Employers. The pretest results clearly demonstrated the need for information outreach.

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.

Community Organizations

- 12% did not understand that even if a child's parents live together, a child can get Medicaid.
- 31% did not know about the availability of Transitional Medicaid coverage for up to one year.
- 92% did not understand that children under age six are eligible for Medicaid at higher income levels than older children.

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.
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RECIPIENTS
PERCENTAGE OF CORRECT ANSWERS
ON THE PRETEST and POST TEST, BY PROGRAM

Program	Pretest	Post Test
Earned Income Tax Credit	41%	86%
Medicaid	38%	81%
Child Care	76%	93%

Source: Southern Institute on Children and Families, 1996. Data collected for the Georgia Information Outreach to Reduce Welfare Dependency Project.

COMMUNITY ORGANIZATIONS
PERCENTAGE OF CORRECT ANSWERS
ON THE PRETEST and POST TEST, BY PROGRAM

Program	Pretest	Post Test
Earned Income Tax Credit	71%	96%
Medicaid	61%	98%
Child Care	81%	100%

Source: Southern Institute on Children and Families, 1996. Data collected for the Georgia Information Outreach to Reduce Welfare Dependency Project.

EMPLOYERS
PERCENTAGE OF CORRECT ANSWERS
ON THE PRETEST and POST TEST, BY PROGRAM

Program	Pretest	Post Test
Earned Income Tax Credit	38%	100%
Medicaid	61%	96%
Child Care	50%	100%

Source: Southern Institute on Children and Families, 1996. Data collected for the Georgia Information Outreach to Reduce Welfare Dependency Project.

Subsequent support from The Robert Wood Johnson Foundation made it possible for us to produce videos to reinforce the messages contained in the brochures and the videos were also produced in Spanish.

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. While the technical assistance to adapt the brochures is provided by the Southern Institute with support from The Robert Wood Johnson Foundation, the states are responsible for printing (which in this case is not cheap) and dissemination. And, of course, they know that the use of these outreach brochures will result in the enrollment of more children and increased expenditures.

A report published by the Southern Institute in February 1998 outlines these and other enrollment outreach initiatives underway in the southern region, including the aggressive outreach initiatives in Arkansas, Georgia, South Carolina, Tennessee and West Virginia. I brought a copy of the report along with a sign up sheet for those who would like a copy.

These actions on the part of the southern states are solid evidence of their commitment to reaching out and enrolling more children. A number of states outside of the southern region are also taking actions to outreach to low income families. I think it is clear that states are serious about conducting outreach.

Funding for these state outreach initiatives and the outstationing has come from administrative match. I have to tell you that I am concerned that the proposed reduction in the administrative match rate will adversely affect these and other outreach efforts. To my knowledge, there is no exemption for outreach in this reduction.

Simplification

Concurrent with designing information outreach campaigns, we must do everything we can to simplify the eligibility rules and the application process so that families who hear about child health coverage and come in to apply are not turned off by the experience.

Another reason why the application process must become more user friendly is that the word is out that the process is intrusive and complicated and many families are not going to even come in to apply, especially if their children are not sick.

Frankly, my greatest fear at this point is that most of the attention will go to outreach and too little will go to eligibility simplification. 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.

A major problem with the application process is the excessive amount of verification requirements encountered by families during the application process. Reducing the size of the application is too often the singular focus of simplification efforts. If an agency reduces the size of the application 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, relatives and noncustodial parents.

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

eligibility workers tell us that the current wage match requirements are mostly irrelevant since the wage information they are able to access on line is out of date.
On the subject of the noncooperation of absent parents, there is evidence that one of the major barriers to child health coverage under Medicaid is the federal requirement that applicants must cooperate in establishing paternity - not just that they cooperate in identifying and verifying third party payment available through an absent parent. There is federal precedent for not requiring paternity establishment. The Food Stamp program does not require it for purposes of eligibility. I expect shortly to be able to provide more information on the subject of paternity establishment and Medicaid eligibility barriers affecting children.

Age 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.

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 l980s and into the early 1990s, the federal "quality control" system focused almost solely on reducing errors that resulted in ineligible 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 ineligibility 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 ineligible 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 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. They will 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.

Despite these fears, there is interest on the part of many states in reducing verification and a few are even willing to put themselves at risk in order to reduce application barriers. That shouldn't be necessary at this point, given the commitment of the President and Congress to enroll children.

One idea for alleviating some of the pressure on states and to 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 at risk when attempting to design systems that reduce barriers.

The Southern Institute recommends that states conduct eligibility process assessments to determine what can 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.
- 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.

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.

Attempting to design a process with multiple programs on the same 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 so 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 such action takes place at the federal level, both in Congress and the Administration, a multiple program single application won't result in simplification. Although it might sound better, it is not likely to simplify the application process for either the family or the eligibility agency.

So, once again, from someone who would love to see real application integration, until significant cross program 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 lunch 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?

Using confidentiality as a reason not to do it doesn't hold water. 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.

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.

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.

Coordination

Coordination among child health coverage programs is another area I'd like to discuss. By making it clear that children who are Medicaid eligible must be enrolled in Medicaid rather than a state coverage program, CHIP has moved the coordination issue from rhetoric to the front burner.

Coordination will be a tremendous challenge in states that create or already have separate child health coverage programs that are not administered by a single entity.

Thorny issues involving eligibility decisions will have to be dealt with to assure that the yet to be simplified Medicaid application process does not stand in the way of children's access to health coverage under other programs.

In the past, Medicaid denials for procedural reasons - such as failure to return all verification documents or failure to keep an appointment - have resulted in access barriers for eligible children. The issue is how will a procedural denial be treated in defining Medicaid ineligibility.

One way to avoid the procedural denial bottleneck is to allow states to screen for income and age by accepting self declaration in order to make an initial finding of ineligibility for Medicaid. If the declared information indicates that a child is not eligible under Medicaid, the application could then be considered under the non Medicaid program.

Another potential coordination problem could be the refusal of some families to apply for Medicaid when they have heard about a state coverage program and want to enroll their children in that program. Every effort should be made to avoid talking about funding streams with families.

The last issue I would like to discuss is the lack of credible state by state data on the health coverage status of children. Everyone turns to the Current Population Survey for data. The CPS sample sizes are too small to provide the type of information needed to design children's health coverage initiatives.

From a planning and budgeting standpoint, the CPS comes up short. This is an issue for the federal government to resolve. It is not feasible or desirable for each state to have to develop their own numbers. This is an area where I believe that HCFA can provide leadership and resources and I certainly hope you will do so.

Covering Kids

Before I close, I did want to mention a specific outreach and enrollment initiative supported by The Robert Wood Johnson Foundation with direction provided by the Southern Institute on Children and Families. Covering Kids is a $13 million national health coverage access initiative to improve access to health coverage for low income, uninsured children. (Since this speech was presented, Covering Kids was expanded to $47 million and opened to all states.)

The three goals of Covering Kids are:

- Design and conduct outreach programs that identify and enroll eligible children into Medicaid and other coverage;
- Simplify enrollment processes; and
- Coordinate existing coverage programs for low-income children.

A major part of Covering Kids is the emphasis on involving private sector organizations, such as churches, businesses, health plans and providers, in addition to traditional child advocacy organizations. Covering Kids will award grants to conduct state/local coalitions over a three-year period.

Covering Kids will also seek to be a national resource for public and private organizations working to help low income children access health coverage.

Closing Remarks

I very much appreciate the invitation to share my thoughts with you on outreach and enrollment issues. You are in an incredibly important place at this point in time. Your leadership and your partnership are pivotal.

Working together as a team with states will greatly expedite the progress that can be made in helping low income children to actually join the ranks of the insured - and by doing so to have better access to preventive and primary health care.

That’s not to say that the many issues that affect access beyond the point of insurance are not still there. But what it does mean is that we can get this one behind us so that we can work hard on the issues that restrict access beyond enrollment.

Thank you.