

# ISSUE BRIEF

## CHIP and Medicaid Outreach and Enrollment: A Hands-On Look at Marketing and Applications

Tuesday, October 19, 1999  
Washington, DC

A discussion featuring

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## CHIP and Medicaid Outreach and Enrollment

All over the nation, on bus cards, posters, flyers, t-shirts, and baseball caps, messages appear about children's health programs. In what seems to be an infinite variety of ways, states are marketing health insurance programs for children. Since its enactment in 1997 as Title XXI of the Social Security Act in the Balanced Budget Act (BBA), the State Children's Health Insurance Program (CHIP) has been the hottest new public policy program in decades, and the outreach programs launched throughout the country are a central and highly visible component of this new program. Sometimes the outreach efforts are specifically designed to reach children or families potentially eligible for both CHIP and Medicaid; more often, expanded Medicaid enrollment is a desirable but not targeted outcome of the new outreach efforts.

Getting services to children through CHIP begins with outreach—providing information about the existence of the program to target families and educating those families about the need for children to receive health care and have the insurance coverage that finances it. The next and equally critical step is enrolling children—providing applications that are simple to understand, uncomplicated to fill out, and easy to submit. Such applications require a minimum of verification and supporting documentation and can be submitted by mail, fax, or Internet. And they are optimally provided in a user-friendly atmosphere that welcomes families and encourages rather than discourages questions and requests for assistance—an atmosphere of customer service that anyone, rich or poor, would appreciate in the administration of health insurance programs. Anecdotal evidence suggests that most states are trying very hard to provide just such an environment for families with uninsured children.

The federal government has joined the effort in a variety of ways—through a nationwide toll-free number connected to state-specific information, encouragement of education officials in every state to get involved, presidential involvement, and strong congressional support. In one of the first pronouncements on CHIP, DHHS officials communicated to states their strong support for innovative outreach programs, provided examples of successful outreach activities, and described federal funding programs available to pay for them. They urged simplifying the Medicaid and CHIP

applications, suggested use of a single application, and provided model applications.<sup>1</sup> In 1999, DHHS provided states with guidance about how to expand Medicaid eligibility programs to support low-income families making a transition from welfare to work.<sup>2</sup> All this is quite a reversal for a department that, following explicit congressional directions, spent significant resources in the 1970s and 1980s on assuring that only those who met the letter of the law were eligible for Aid to Families with Dependent Children (AFDC) and Medicaid.

All of this new attention was warranted, however. Concurrent with the expansive marketing activity to attract children and their families to new CHIP programs, headlines appeared announcing declining Medicaid enrollments, including lower numbers of enrolled children. Since CHIP is a small program in comparison with Medicaid, this is particularly troubling. Data from 1997, the latest available from the Health Care Financing Administration (HCFA), indicate a Medicaid enrollment decline for children to 21.0 million, from a high of 21.6 million in 1995.<sup>3</sup> Widely assumed to be the result of significantly declining welfare rolls following the imposition of strict work requirements, diversion programs, and time limits authorized by the 1996 Temporary Assistance to Needy Families (TANF) welfare reform program (under the Personal Responsibility and Work Opportunity Reconciliation Act [PRWORA]), these declines in adults and children on Medicaid raise concerns about the interaction among CHIP, Medicaid, and welfare

### ISSUE BRIEF/No. 748

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programs. Enrollment declines produce questions about states' attention to providing benefits in a seamless way to assure optimum access to care and continuity of coverage. Issues abound about the interaction of CHIP, Medicaid, and welfare: whether states' efforts to attract CHIP enrollees have diminished their Medicaid efforts or complemented them; whether the bright new CHIP program has brought a fresh and positive luster to Medicaid or whether the welfare stigma often associated with Medicaid has rubbed off on CHIP; whether TANF requirements have discouraged Medicaid enrollment; and just how the new CHIP program with its higher federal matching rate is administered within the context of the larger constellation of state health, social services, insurance, and welfare programs.

This Forum session will focus on outreach, enrollment, and application processes for CHIP and Medicaid. Representatives from California, Kansas, Maryland, and Pennsylvania will provide information on specific problems and issues, and participants will be able to see a variety of outreach materials from around the country. In addition, some participants at this session will be able to go through a mock-application process with eligibility workers from one of the featured states.

## OUTREACH

Developing, implementing, and marketing a new program for children "has been a blast," according to one state official, who goes on to note that, with most legislators and governors vying for credit and seeking photo opportunities with cute kids who need insurance, it has been easy to get strong support for innovative outreach activities. Hailed as the most significant new federal health program since the enactment of Medicaid and Medicare in the 1960s, CHIP had widespread support but was the subject of intense congressional debate and negotiation over federal versus state roles and responsibilities. In the end, states were given considerable flexibility in designing and implementing their programs and in deciding whether to develop a separate program, a Medicaid expansion, or a combination of the two.<sup>4</sup> Among states and the District of Columbia, there are currently 16 separate programs, 23 Medicaid expansions, and 12 combination programs. A constructive relationship, uneasy at times, has developed between state and federal officials in the two years since enactment. All states and territories now have CHIP plans approved by HCFA. Recent estimates count 1.3 million children enrolled in June 1999, up a significant 57 percent since December 1998.<sup>5</sup>

The Title XXI statute recognized outreach, placing a specific emphasis on it by mandating its inclusion in state plans that must be submitted to the federal government. Funding for outreach is available from the state's CHIP allotment, but only as part of the 10 percent of CHIP money allowed for administrative expenses. This limitation has produced strong criticism from states, who note that it is difficult to get new programs up and running when such a small percentage of expenditures is allowed for all administrative costs, including outreach and systems development. However, if a state is using a Medicaid expansion under CHIP, that state can also opt to use regular Medicaid program money for outreach or can use Medicaid funds when its CHIP allotment is exhausted.

A \$500 million federal Medicaid matching fund created in the welfare reform legislation to smooth the transition and administrative change between Medicaid and TANF is also available for outreach related to Medicaid and can be used in conjunction with other CHIP and Medicaid outreach activities. Efforts supported by the administration and a number of other groups are under way to extend this funding, which is scheduled to sunset this October for most states. The lack of state use of this fund, which could have been used to assure that potential Medicaid beneficiaries are maintained on the program, even if they lose welfare eligibility, has produced significant criticism from a number of advocates for the poor and others. States assert, however, that federal limitations and technical requirements made the money difficult to use. Nevertheless, the money does represent a significant largely untapped source of funding for outreach activities.

The specific list of outreach activities undertaken by states is endless and fascinating. It runs the gamut from traditional approaches, such as hiring outreach workers (sometimes recent welfare recipients who are community-based, sometimes state caseworkers dedicated specifically to reach out to children, sometimes contracted private-sector companies, and sometimes community-based advocates), to slick, professionally produced television, radio, and billboard advertising. Partnerships with other state agencies, community organizations, hospitals, and businesses are common. Celebrities and politicians have lent their support in a variety of ways. Employers and health care providers are sometimes involved, and schools are often a vehicle for providing information, brochures, and applications. There are toll-free lines (some say too many) and cute new names like HUSKY, HealthWave, Healthy Families, CubCare, Check-Up, PeachCare for Kids, and MI Child, to mention a few. In a recent study by

the American Public Human Services Association to elicit information about state outreach and enrollment activities, 32 of 33 responding states reported significant outreach activities: 29 were using pamphlets, posters, fact sheets, and other overview materials; 29 were using radio advertising; 23 were using television advertising; 23 had sent direct mailings to potential beneficiaries; and 25 had used flyers in other kinds of community mailings. All 33 states had toll-free hot lines and 23 had Web sites.<sup>6</sup>

A variety of sponsors have made significant contributions to state efforts to develop CHIP and Medicaid outreach activities. “Insure Kids Now”—1-877-KIDS-NOW—is the federally sponsored national toll-free telephone number that transfers callers to a state’s CHIP program. This program was announced with much fanfare by the president in February 1999 and is administered by the Health Resources and Services Administration at DHHS. A huge national program sponsored by the Robert Wood Johnson Foundation, “Covering Kids: A National Health Access Initiative for Low-Income, Uninsured Children,” was expanded after the enactment of CHIP to a \$47 million commitment over three years. The Covering Kids program, with current grants to 49 states and the District of Columbia, requires the development of state-community coalitions that are broad-based and represent major public and private entities involved in children’s health and advocacy activities. Covering Kids’ primary goals are to design and conduct outreach programs to assure children’s health coverage, simplify enrollment processes, and coordinate existing coverage programs for low-income children.<sup>7</sup>

Often funded by foundations active in children’s advocacy, other national organizations are also sponsoring CHIP-related advertising and outreach activities. These include the Children’s Defense Fund, the Center on Budget and Policy Priorities, the March of Dimes, and Families USA. The National Governors’ Association, National Conference of State Legislatures, American Public Human Services Association, and Association of State and Territorial Health Officers are state-based organizations that have been active in sponsoring national outreach projects. National companies such as McDonald’s, Kmart, and Wal-Mart have lent support.

In addition to the more advertising-oriented approach to outreach, states have employed a host of additional strategies to assure that the program is made known to those who are potentially eligible. Eligibility workers who operate from nontraditional settings such as schools, day care centers, hospitals, even shopping malls—places other than welfare offices—have been

popular with states as well as beneficiaries. Focus group participants in several studies have suggested community-focused outreach. A report for the Kaiser Family Foundation, based on a series of focus groups, noted that “personal contact is critical. Many feel they have never had a chance to talk with an informed, responsive, sensitive person about the program itself and whether they or their children might be eligible.”<sup>8</sup> Underscoring the importance of personal interaction and of the use of appropriate language and cultural mores, case studies by Renee Schwalberg and colleagues have concluded that “interviews at the local level highlighted the importance of personal approaches to outreach, based on face-to-face encounters with people who speak families’ language and can directly address their fears and concerns.”<sup>9</sup> Some states are providing families access to eligibility information and help during evening and weekend hours. And, in a significant departure from Medicaid procedures, many states have provided a mail-in application, often as part of brightly colored and attractive educational materials or a flyer.

All of these outreach activities, while interesting, creative, and often exciting, received scant pre-testing and little formal follow-up evaluation. These shortcomings, while acknowledged by many, have not been systematically addressed. Considering CHIP implementation in three states, Trish Riley and Cynthia Pernice have observed that

all expressed a desire for more accurate measures of the success of their efforts. In addition, all three states voiced concerns about the mixed messages sometimes sent by the various players involved in promoting health coverage for children, specifically, state government, the Federal government, and the Robert Wood Johnson Foundation Covering Kids Initiative.<sup>10</sup>

As the CHIP program matures and its relationship to Medicaid is clarified within states, market research, pretesting of materials and messages, and evaluation will become increasingly important.

## APPLICATION AND ENROLLMENT

All the enthusiasm and information in the world is not worth much if people do not apply for coverage and get enrolled in the appropriate program. In its original communications with states, HCFA stressed the need to simplify application forms. Indeed, simplification of application forms was a high priority in many states from the beginning of their CHIP programs, and simplification has come to be a high priority for other states as they learn more and begin program operations.

The critical task is simplifying not only CHIP but also the Medicaid application and enrollment processes, as well as engineering both to make them work together in a seamless way that is best for potential beneficiaries of both programs. This is particularly difficult, since most beneficiaries will not understand the complexities involved or even understand that two programs exist. Further complicating the picture is the fact that both applications are usually computer-based and that the systems used to process and assess Medicaid applications are often different from those used for CHIP.

### **Policy Underlying Procedures and Decision Making**

The initial and fundamental policy decision that must be made by states is whether to expand their existing Medicaid program, develop a free-standing CHIP program, or produce a combined approach. As complex and significant as this fundamental decision is, the administrative procedures that implement that decision are at least as important.

For example, the question of what is required on an application form reflects state policy and oversight rules—and decisions about whether the same policies, rules, and approaches will be used for both CHIP and Medicaid. Will a state streamline the application and the eligibility process of either or both programs by adopting policies that require minimal documentation, or will verification be required of a whole host of facts, such as employment, family income level, bank accounts, car or property valuation, birth certificates, and Social Security numbers? Some verification may be appropriate, but how much is really necessary? When does verification become a demeaning and excessively demanding process? Will a state drop the complicated welfare-based system of income disregards and set income standards that are easier to understand and administer or will the disregard system be maintained for one or both programs? Are mail-in applications allowed, or must face-to-face interviews be conducted for CHIP or for Medicaid? If interviews are required, what procedures are in place regarding missed appointments? Are deadlines for submission of verification too short, not explained, or arbitrary in other ways? Are eligibility workers available in person—or by telephone—and required to actively assist beneficiaries? All of these questions can be answered by reviewing specific state and local policy and practice.

In PRWORA, states were given not only vast new discretion to change welfare policy but also extensive discretion to modify Medicaid eligibility policy under section 1931. Although states have been slow to take

advantage of this authority, it has great potential. More states are beginning to use this new tool to provide expanded access to Medicaid; one important by-product is the opportunity to streamline the eligibility process. Most states have made clear decisions to streamline and simplify CHIP application and enrollment processes, often when they have stand-alone CHIP programs, but this decision is not always mirrored in the state's Medicaid program.

### **Eligibility Disregards: A Potential for Simplification?**

The use of eligibility criteria based on a percentage of poverty is an instructive example of how policy “simplification” may not be simple. In a recent Urban Institute paper on eligibility determination, the authors noted, for example, that basing eligibility on a percentage of poverty is easy to understand, apply to different size families, and adjust for inflation. They went on to note:

However, the actual poverty-related eligibility criteria are usually more complicated than they might seem. States have discretion in how to count income, particularly about what types of income or expenses should be “disregarded” (subtracted from gross income to compute net income, which is then compared to the poverty standards). Moreover, some states also limit the amount of assets (e.g., savings, or the value of cars) that participating families may have, although most do not. These seemingly minor differences mean that a child might be declared eligible in one state, but not another, even if both states use 100 percent of poverty as the maximum income level.<sup>11</sup>

They concluded that most state Medicaid programs use disregards for poverty-related eligibility and, since disregard policies differ somewhat from state to state, the state policy variations are also larger than generally thought.<sup>12</sup> Another policy simplification finds fewer states using assets tests for Medicaid eligibility for women and children. The authors found that these were usually relatively high, but that the administrative hurdles related to asset declaration do exist in a significant number of states.<sup>13</sup>

### **Simplified Applications**

Application forms, once tied by law to welfare, are often used for several programs. CHIP programs have placed heavy emphasis on easy, short, understandable forms. This goes hand in hand with requiring less verification and fewer requirements for things like face-to-face interviews but is counter to some fairly recent history in the Medicaid program. In efforts in the 1980s to make welfare-related programs more efficient, the

federal government provided incentives to integrate applications for welfare, food stamps, and Medicaid. These successful efforts produced integrated eligibility systems that still tie programs together in most states. Now, with the statutory delinking of Medicaid and welfare and the enactment of CHIP, states must not only develop new applications for CHIP but also rethink the overall Medicaid eligibility processes and policy. For Medicaid, this means states have to contemplate redesigning forms, delinking systems, and untangling bureaucracies with close existing ties.

The critical concern about application simplification may be exemplified by the California experience with CHIP. The original CHIP application was 28 pages long, required many financial calculations, and provided little help for applicants. After extensive criticism and scant enrollment in the first months of the program, the state took a variety of actions. In addition to shortening the application to four pages and providing community-based assistants to help families apply, the state created a central processing unit, so that state staff could channel children into MediCal or Healthy Families, the California CHIP program—thereby relieving families of the burden of trying to figure out which program they are eligible for. But while it has simplified some parts of the process, the state still requires substantial documentation and thus has not gone as far in simplification as some advocates would suggest.<sup>14</sup>

While these changes in the California CHIP program seem to have brought an upswing in enrollment, the Medicaid application remains problematic. In April 1999, the Health Consumer Alliance released a report decrying the complication of the MediCal application form, which they claim requires 443 items of information and takes a college reading level to understand.<sup>15</sup>

As noted, simplification has to leap a host of hurdles beyond the paper document that must be filled out and the state's policy on applications. The verification process can be easy or horrendous. Requirements for proof of income are difficult for people whose income is paid in cash, who do not get "check stubs," or who are reluctant to ask employers for written letters of income verification. And the subject of immigration status, which has plagued CHIP and Medicaid for some time, has become infinitely more complex because of substantial restrictions on the provision of assistance to legal immigrants in PRWORA.

### **Immigration: A Special Issue**

The number of immigrants in the United States has increased dramatically over the past decade, and one out of every five children under the age of 18 is an

immigrant or the child of immigrant parents.<sup>16</sup> Immigration issues have compounded the complexity of public programs since PRWORA enacted tough restrictions on eligibility for TANF, food stamps, Supplemental Security Income, and Medicaid. Although many benefits have been restored since the 1996 PRWORA enactment, some restrictions remain, especially for low-income families and those who arrived after 1996. States have broad authority to set rules, and most immigrant families retain an extremely fearful attitude toward dealings with government programs. This is true even in families where parents are legal residents and children are U.S. citizens. Community Catalyst, a national advocacy organization, describes the situation:

The dizzying array of restrictions, conditions, and categories under the welfare reform law would bewilder the most seasoned bureaucrat. Advocates and community groups report that sheer confusion about eligibility requirements has discouraged many immigrants from applying even for benefits to which they may be entitled.<sup>17</sup>

Many of these immigrant families are fearful about accepting public programs benefits, including Medicaid or CHIP, believing that doing so might later subject them to restrictions on future citizenship or residency status, place them in a category of person who would become a "public charge," or require them to pay back expenditures incurred under the program. The complexity of the post-welfare-reform immigration rules compounds already difficult language and cultural barriers for immigrant families.

The Immigration and Naturalization Service (INS) clarified at least part of the problem in May 1999 when it issued guidance to its field offices as well as a proposed regulation clarifying its definition of public charge and specifically excluding Medicaid and CHIP from computations for public charge (one exception for Medicaid relates to people institutionalized for long term care support). But the earlier misunderstandings and fear are reflected in children's enrollment data in Los Angeles County for 1996 to 1998: enrollment was down 48 percent for children of noncitizens but up 6 percent for children of citizens.

The INS clarifications should be helpful. Ann Morse, program manager for the National Conference of State Legislators' Immigrant Policy Project has written that the release of the new INS policy "will be a critical tool in states' outreach and enrollment arsenal, giving them a way to assure the parents of immigrant children that they won't suffer negative repercussions by applying to CHIP or, for those with lower incomes, to Medicaid."<sup>18</sup>

## Systems Issues

Another major problem in many states relates to systems issues. With Y2K looming, state resources—including both funds and staff—for systems enhancement have been targeted at assuring that the computers continue to run after January 1. As mentioned, states rely heavily on automated eligibility systems, which handle applications for multiple programs. Changes that would complete the delinking of welfare, Medicaid, and food stamp procedures, streamline interactions between Medicaid and other programs, including CHIP, or provide seamless administration of Medicaid and CHIP, have often taken a back seat to other Y2K priorities. Commenting on these systems issues, Marilyn Ellwood has noted that the existing systems

are inadequate, primarily because they are designed and operated to meet welfare, not Medicaid, needs. In every state, staff complained that these systems inadequacies contribute to confusion with Medicaid applicants and recipients, and occasionally, erroneous terminations in Medicaid coverage. . . . Medicaid staff reported that the management of the automated eligibility systems is beyond their control.<sup>19</sup>

In addition, most states have not been able to fully develop efficient systems support for their CHIP programs, including the collection of important data. The short implementation time for developing and beginning CHIP programs left little time for careful systems development. Riley and Pernice noted that “all three [case study] states report the need for further refinements to their data collection and processing systems, and all three are working to ensure that those refinements are made just as quickly as possible.”<sup>20</sup>

With regard to Medicaid application processes, systems concerns have been extremely problematic for beneficiaries in some states where old linkages to welfare programs have terminated thousands of Medicaid enrollees. These problems are rooted in automated systems not appropriately modified since new state TANF programs were begun. In Pennsylvania, for example, the State Department of Public Welfare is reinstating health insurance for at least 32,000 uninsured residents—including 24,000 children—who lost Medicaid eligibility after welfare reform, often due to computer-generated actions.

## Retaining the Enrolled

Systems can also play a key role in assuring that those who are enrolled in CHIP or Medicaid are appropriately continued on the programs. Even after successful out-

reach and enrollment, huge administrative issues arise related to maintaining and retaining children on the programs. Sometimes, these issues relate to requirements for “redetermination,” the process of reapplying the eligibility rules to individual cases on a periodic basis. Requirements for continued verification of the information in an original application often call for the resubmission or updating of all or some of the backup materials required in the original application process. The time periods, systems, and interpersonal requirements applied to these processes can also determine whether children stay in a program after they have been enrolled. Policies center on factors such as mail versus face-to-face interaction, availability of transportation or translation, and timing requirements for production of documentation. Systems issues again may be critical, and ties to other welfare, social service and health programs through systems links or otherwise can provide outcomes that are either positive or problematic for clients.

Critical state policy decisions also relate to the length of enrollment before recertification of eligibility. States may require recertification quarterly, twice a year, or annually. They may require formal recertification only upon a change in circumstances. Or they may allow 12 months of continuous eligibility, regardless of changing circumstances. BBA provisions allow this 12 months of continuous eligibility for both Medicaid and CHIP, affording yet another point where the eligibility process can be streamlined and simplified if states choose to adopt this policy. In addition, continuous eligibility for 12 months is good for providers and managed care organizations, who can provide much more comprehensive preventive services. Research from the Center on Budget and Policy Priorities indicates that as of July 1, 1999, five states had 12 months’ continuous eligibility in both programs, and 14 states provided this policy in Medicaid or CHIP.<sup>21</sup>

## Medicaid and CHIP Applications: Integration

So, with all these issues to consider, can states that choose a separate CHIP program take steps to make their CHIP and Medicaid application processes seamless? That is, can states design one application for both programs or process two applications that are somehow interchangeable, so that families who do not qualify for one will be automatically screened for the other? Can such seamless processes avoid the stigma of a welfare association?

At the most sophisticated level, an automated search for CHIP and/or Medicaid eligibility designed for all

who apply for any social program would encourage a seamless benefit package. Thus, recipients of benefits under programs such as TANF; food stamps; and the Women, Infants, and Children nutrition program might learn of their CHIP or Medicaid eligibility through a systems-based prompt to caseworkers. However, in some states the level of automation necessary to accomplish this efficiency is likely to be years away.

In the meantime, the most popular step with states appears to be a central processing point for both Medicaid and CHIP eligibility determinations, with simultaneous screening and enrollment for both programs. Kansas and California have taken this step. In the case of California, the same worker reviews each application and decides which program is correct. In Kansas, co-located workers review applications and pass them back and forth as appropriate.

The difficulty of layering incremental new program reforms like CHIP on an existing eligibility system and bureaucracies that are complicated, large, and well-established cannot be understated. Existing state and local agency policies and organizational structures move ever so slowly, even in the wake of a popular health program for children. The need for state officials to thoughtfully re-examine all of their health and welfare programs and organizations could become more apparent as CHIP matures, evolves, and fails or succeeds.

### **OTHER CRITICAL CONCERNS: WELFARE LINKS, DIVERSION, AND STIGMA**

Before welfare reform and CHIP, the primary route to health coverage for low-income families and children was through AFDC cash programs and the welfare office. Delinking Medicaid and cash welfare programs has caused confusion and upheaval among needy families, among caseworkers and community activists, and among state administrators. In the long term, this could result in a Medicaid program that is viewed as a health insurance and support program. In the short term, it has caused major problems in many states. As discussed earlier, the number of Medicaid enrollees has fallen dramatically, and a variety of studies as well as anecdotal information suggests that many families simply do not understand that they may be eligible for Medicaid, even if they are not receiving welfare.

#### **Diversion Programs**

Diversion programs—efforts designed to keep families from ever applying for or receiving a TANF

grant—are active in many, perhaps most, states. Although not addressed specifically in the PRWORA statute, diversion is a natural outgrowth of welfare reform's strong emphasis on work and personal responsibility.

In the first national study of diversion, conducted by the Center for Health Policy Research at George Washington University (GWU), Kathleen Maloy and colleagues described three types of formal programs: mandatory job search before applying for welfare, lump sum payment programs to meet a particular need that makes work difficult or impossible, and exploration of alternative resources to seek other forms of community for family support instead of welfare.<sup>22</sup> Resulting from program rules and requirements that discourage families who might well be eligible from applying, informal diversion programs are much harder to define, measure, or describe. The GWU study and a more recent follow-up case study in five states concluded that

formal strategies to divert families from the welfare rolls are becoming an increasingly common component of states' efforts to transform their cash assistance systems into systems that promote and support work. . . . There is substantial potential for diversion programs to reduce families' access to Medicaid.<sup>23</sup>

Other observers have described the vast differences between states' diversion activities.

Diversion varies enormously depending on the activities included, their context, their duration, their combination, and how they are used in specific cases. Some states use diversion proactively as a service-assessment and service referral system. Others use it to erect a fortress-like welfare system instead of expanding the service options available to families.<sup>24</sup>

The likelihood that diversion can seriously limit Medicaid enrollment is one of the factors suggested to explain the striking declines in Medicaid enrollment and, by association, lower-than-anticipated enrollment in CHIP programs. Thus it is a subject worthy of continuing attention, since CHIP and Medicaid outreach and enrollment programs designed to elicit positive responses from families may run head-on into formal or informal diversion. At the least, CHIP and Medicaid messages must be very carefully crafted and need to take account of other programs and messages that can interfere.

#### **Stigma and Mixed Messages**

Welfare to work, personal responsibility, self-sufficiency—Democrats and Republicans alike embraced these concepts to enact welfare reform in 1996. Clearly,

the receipt of government-sponsored welfare benefits has negative connotations. The overwhelming goal of welfare reform was to limit governmental support for cash welfare payments in favor of work and personal responsibility, but the statutory language carefully protects the Medicaid program.<sup>25</sup> Section 1931 requires states to continue to provide Medicaid to families who were eligible prior to PRWORA and, as discussed, allows much more flexibility in serving a greater number of poverty-level families. But because Medicaid and cash assistance programs share such a long history, this delinking and the potential expansion of Medicaid have not been altogether successful, particularly if measured by the rapidly falling Medicaid rolls. Thus the real and perceived links among CHIP, Medicaid, and welfare have been of great concern to those who wish to see the maximum number of children enrolled in health insurance programs.

Recent studies have provided interesting information about the problems associated with CHIP and Medicaid enrollment and these programs' perceived linkages to welfare. In focus groups with parents held in 1998, Lake Snell Perry and Associates noted that many parents with little experience with Medicaid believe that the program is only for those on welfare, not for working people, and that their incomes are too high to qualify.<sup>26</sup> "For many of these parents, there is still a stigma attached to Medicaid/Medi-Cal. For some, Medicaid goes hand-in-hand with welfare. They see themselves as 'workers' and not as 'welfare recipients.'"<sup>27</sup> Focus group participants noted significant shortcomings in the Medicaid and Medi-Cal programs: "The eligibility criteria are confusing and, in some cases, unfair. The enrollment and re-enrollment processes are cumbersome, degrading and invasive."<sup>28</sup> If these findings are widespread, as many believe they are, the welfare identity of the Medicaid program and CHIP presents a real obstacle to full enrollment of children.

But is Medicaid welfare or health insurance? And what about CHIP? In the past, Medicaid was welfare—it was born a welfare program tied to the AFDC program from the 1965 enactment and was administered at both the state and the federal level as a welfare program for many years. In 1977, with the formation of HCFA, the federal government began an on-again, off-again approach to Medicaid as a health insurance program. Only in the last decade have some states begun to seriously move toward a nonwelfare orientation for Medicaid.

Riley and Pernice noted that the three case study states had gone to considerable lengths to avoid CHIP

association with Medicaid or to overcome what they saw as welfare stigma.

Some core elements of CHIP programs have been designed specifically to avoid this association, among them outreach and marketing efforts, enrollment procedures and materials. . . . Even the decision to expand Medicaid or create stand-alone CHIP programs is not infrequently based on the desire to avoid the Medicaid/government assistance stigma.<sup>29</sup>

The General Accounting Office noted that its contacts cited concerns that many low-income families believe that Medicaid carries the same negative image of dependency and inability to provide that is attached to welfare.<sup>30</sup>

Several studies of stigma, especially as it relates to Medicaid, are nearing completion. They suggest that stigma does indeed present a impediment to applying for Medicaid. Preliminary data compiled in a GWU survey indicate that stigma continues to be an important barrier to participation in the Medicaid program and that many respondents to the survey do not perceive the Medicaid program to be delinked from TANF.<sup>31</sup>

So, a critical issue in assuring appropriate coverage for children is the identification of the CHIP and Medicaid programs and new approaches to describing and informing people about them. One Medicaid director, commenting on the success of CHIP at the same time Medicaid rolls are declining, noted that "Medicaid has 30 years of baggage to undo." Is CHIP the way to undo it? Is it the vehicle for moving Medicaid toward less stigma and welfare identification, or not? Julie Hudman has suggested, for example, that if a single caseworker is the gate keeper for Medicaid and TANF, the administrative structure itself creates obstacles to smoothly enrolling families and may mute the message that Medicaid and CHIP are not welfare programs.<sup>32</sup> Clearly, the full potential for CHIP and Medicaid enrollment cannot be realized unless these effects of welfare policy and stigma are minimized.

CHIP is a program in its infancy, but while states try to design family-friendly CHIP procedures, they are operating tough welfare programs. The interaction of the Medicaid entitlement program and the CHIP block grant approach, complicated by welfare reform, brings a new level of complexity and mixed messages to state health financing programs. There is not a national CHIP program, there are individual state programs that interact and work with Medicaid, and sometimes welfare, in ways that differ, state to state. This is federalism and devolution in action—and the jury is out on most questions.

## THE FORUM SESSION

This Forum session will review the issues surrounding Medicaid and CHIP outreach, enrollment, and application processes in a multi-faceted way. First, some of the interesting and entertaining marketing materials that have been produced by states to inform and educate people about CHIP and Medicaid, including some videos, will be on display. Also provided will be an overview of outreach from the national perspective. Representatives from California, Kansas, Maryland, and Pennsylvania, including state officials, advocates, and caseworkers from these states, will describe their outreach and enrollment processes. Application forms and materials from each state will be available, and some participants will go through the application process. There will be time for all participants to talk with state staff and advocates about how the application and enrollment process works from the standpoint of the client family. Finally, policy issues related to both the outreach and the enrollment process will be discussed. The aim is to give participants a hands-on, bird's-eye view of what it takes to learn about and apply for Medicaid and CHIP. A session planned for November will look more closely at the potential effects of diversion and stigma on Medicaid and CHIP.

### Key Questions

Key issues to be discussed will include the following:

- What is the nature of the outreach activities under way in states? Is there too much diversity in these outreach activities, or does this diversity provide a localized strength? Are pretesting and evaluation programs given enough attention as states move beyond their first-year operating CHIP programs?
- Are outreach and enrollment activities reaching needed populations? Should different programs be designed to meet needs of different groups?
- Should the federal government just stay out of the outreach marketing area? Is their Insure Kids Now national campaign yet another complicating factor for states? Or should they provide greater guidance or technical assistance to promote consistency across states? How best can the federal government help?
- What barriers remain to streamlining the application and enrollment process? What are successful ways to streamline?
- What type of difficulties do states encounter when many different agencies administer portions of CHIP, Medicaid, and welfare programs? How can

multiple agencies define and achieve goals in child health coverage?

- Is there any chance to make systems modifications over the short-term period of the next year, or must meaningful changes await long-term redesign long after Y2K has come and gone?
- What kind of education and outreach programs will identify CHIP and Medicaid as health, rather than welfare programs? Is this an appropriate goal of outreach and education?
- What actions are states taking—or not taking—to review their approach to Medicaid? Is it seen in many or most states as a work support, to be encouraged, or is it still viewed by many politicians and administrators as a welfare program? Is there a role for federal action in encouraging or discouraging the image of Medicaid as a health support service rather than as a welfare program?

After opening remarks, speakers will engage in a facilitated roundtable discussion of these questions and issues, as well as of participant questions. During part of the meeting, a subgroup of participants will go through a mock application process with a caseworker from one or more of the featured states. (Please let us know when you register for the meeting if you would like to take part as a mock applicant.)

### Speakers

This session will open with comments by **Sarah C. Shuptrine**, director, Covering Kids National Program Office, and president of the Southern Institute on Children and Families in Columbia, South Carolina. Ms. Shuptrine will concentrate her remarks on outreach and enrollment activities of the 49 state Covering Kids grantees. She will particularly highlight national policy and legislative barriers to outreach and enrollment reforms. **Donna Cohen Ross**, director of outreach for the Center on Budget and Policy Priorities, will provide an overview of CHIP and Medicaid outreach activities, as well as basic descriptive information about the programs in the four states featured at this forum: California, Kansas, Maryland, and Pennsylvania.

The first featured state, California, has recovered momentum after a very slow start with CHIP, or Healthy Families as it is called in California, having redesigned outreach and application processes quite substantially after the first six months. California's Healthy Families program is a CHIP-Medicaid combination and is administered by a private-sector contractor. Application assistants in community-based organizations are a key

element of the application process. The state will be represented by **Richard Figueroa**, deputy legislative secretary to Gov. Gray Davis.

Kansas has a separate CHIP program, with a centralized private-sector contractor processing mail-in CHIP applications. These processors are physically co-located with state-employee eligibility workers to ease the application review and provide optimum interaction between Medicaid and CHIP application processing. The state will be represented by **Susan Kannarr**, HealthWave implementation director, and **Dennis Priest**, manager, economic support, both with the Department of Social and Rehabilitation Services, as well as by **Sandy Praeger**, chair of the Senate Public Health and Welfare Committee. In addition to his state duties, Mr. Priest serves as director of the federal and state Technical Advisory Group on Eligibility, which provides specialized advice to HCFA on Medicaid eligibility issues.

Maryland enacted a Medicaid expansion program for CHIP. Administration of the program is complicated by the state's decision to assign the CHIP application processes to the health department while Medicaid and welfare eligibility remain a responsibility of the Department of Social Services. Maryland will be represented by **Debbie Chang**, deputy secretary for health care financing of the Department of Health and Mental Hygiene. Ms. Chang is a familiar Washington face, having served on Senate staff and as director of HCFA's Office of Legislation before directing HCFA's implementation of CHIP at the federal level.

Finally, Pennsylvania, a state with a child health program that predates enactment of the federal statute, will be featured. Pennsylvania chose a separate CHIP program. Along with most other states, Pennsylvania has seen falling welfare and Medicaid caseloads and has responded to concerns of advocates in attempting to preserve Medicaid for a number of adults and children who lost eligibility during the implementation of their TANF program. Representing the state will be **Patricia Stromberg**, executive director of the Children's Health Insurance Program in the Commonwealth's Department of Insurance, and **George Hoover**, director of the Division of Health Services in the Department of Public Welfare. A Medicaid eligibility expert, Mr. Hoover also serves on HCFA's Technical Advisory Group on Eligibility. Joining them will be **Patricia Redmond**, an advocate who is health director of Philadelphia Citizens for Children and Youth.

All the states will also be represented by an eligibility caseworker or expert to further help participants

understand the application and enrollment processes in each of the featured states.

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## ENDNOTES

1. Nancy Ann Min DeParle, administrator, Health Care Financing Administration, and Claude Earl Fox, acting administrator, Health Resources and Services Administration, in a letter addressed to chief health and welfare officials in each state, January 23, 1998. A second letter, dated September 10, 1998, provided additional suggestions and a simpler model application.
2. Health Care Financing Administration and Administration for Children and Families, "Supporting Families in Transition: A Guide to Expanding Health Coverage in the Post-Welfare Reform World," Department of Health and Human Services, Washington, D.C., April 1999.
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4. For a full discussion of the CHIP program, see Richard E. Hegner, "The State Children's Health Insurance Program: How Much Latitude Do the States Really Have?" Issue Brief No. 725, National Health Policy Forum, Washington, D.C., October 1, 1998.
5. Vernon K. Smith, "Preliminary Estimates: Enrollment Increases in State CHIP Programs: December 1998 to June 1999," prepared for the Kaiser Commission on Medicaid and the Uninsured, June 30, 1999.
6. Michelle Mickey, "CHIP Outreach and Enrollment: A View from the States," American Public Human Services Association, Washington, D.C., June 1999.
7. See Web site ([www.coveringkids.org](http://www.coveringkids.org)) for full description of the program.
8. Michael Perry, "Barriers to Medicaid and MediCal Enrollment: Findings from 14 Focus Groups with Parents of Potentially Eligible Children," paper prepared by Lake Snell Perry and Associates for the Henry J. Kaiser Family Foundation and presented at the National Academy for State Health Policy Annual Conference, August 2, 1999.
9. Renee Schwalberg, Ian Hill, Hilary Bellamy, and Judith Gallagher, "Making Child Health Coverage a Reality: Lessons from Case Studies of Medicaid and CHIP Outreach and Enrollment Strategies," report prepared for the Kaiser Commission on Medicaid and the Uninsured, September 1999, 6.
10. Trish Riley and Cynthia Pernice, "If You Build It, Will They Come? Case Studies on CHIP Implementation," National Academy for State Health Policy, Portland, Maine, August 1999, 9.

11. Leighton Ku, Frank Ullman, and Ruth Almeida, "What Counts? Determining Medicaid and CHIP Eligibility for Children," a discussion paper (99-05) developed under the Assessing the New Federalism project, Urban Institute, 1999, 1.
12. Ku, Ullman, and Almeida, "What Counts," 11.
13. Ku, Ullman, and Almeida, "What Counts," 8.
14. "California Officials Overhaul Outreach Efforts for Healthy Families CHIP, Medicaid Programs," *State Health Watch*, January 1999, 3-4.
15. Stan Dorn, "Red Tape Epidemic: Health Coverage for Working Families at Risk," Health Consumer Alliance, Los Angeles, April 1999.
16. Donald J. Hernandez and Evan Charney, eds., *From Generation to Generation: the Health and Well-Being of Children in Immigrant Families* (Washington D.C.: National Academy Press, 1998).
17. Community Catalyst, "Unfinished Business: The Restoration of Immigrant Health Access after Welfare Reform," *States of Health*, 9, no. 2 (July 1999).
18. Ann Morse, "CHIP and the Immigrant Community: Getting the Word on 'Public Charge,'" *State Health Notes*, 20, no. 308 (September, 13, 1999).
19. Marilyn Ellwood, "The Medicaid Eligibility Maze: Coverage Expands, but Problems Persist," Urban Institute, Washington, D.C., forthcoming.
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21. Center on Budget and Policy Priorities, "Selected Simplification Criteria: Medicaid for Children and CHIP-funded Separate State Programs," chart prepared for the Kaiser Commission on Medicaid and the Uninsured based on a telephone survey of state officials, July 1, 1999.
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26. Perry, "Barriers to Medicaid."
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30. General Accounting Office, "Demographics of Non-enrolled Children Suggest State Outreach Strategies," GAO/HEHS 98-93, March 20, 1998, 3.
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