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**NATIONAL  
HEALTH  
POLICY  
FORUM**

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**Insuring Virginia's Children:  
Local Outreach and  
Enrollment**

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August 3, 2000  
Northern Virginia

The  
George  
Washington  
University  
WASHINGTON DC



**S I T E V I S I T R E P O R T**

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# Acknowledgments

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“Insuring Virginia’s Children: Local Outreach and Enrollment” is the second in a series of site visits focusing on children’s health issues made possible by the generosity of the David and Lucile Packard Foundation. The Robert Wood Johnson and W. K. Kellogg Foundations provided core funding in support of this as all other Forum activities.

The Forum is grateful to all the speakers who gave their time and expertise to the site visit program. They, along with some who were unable to appear on the program, were also helpful in collecting information and giving behind-the-scenes tutorials to Forum staff. Especially helpful in designing the site visit were Ron Carlee of the Arlington County Department of Human Services and Sherrie Smith of Partnership for Healthier Kids, both of whom agreed to host site visitors on their premises. Robert Hurley, Ph.D., of Virginia Commonwealth University, was a valued source of knowledge and advice.

Judith Moore and Lisa Sprague, assisted by Wakina Scott, organized the site visit and wrote this report. Forum Director Judith Miller Jones provided counsel. Dagny Wolf served as site visit coordinator. Moira Muccio Secrest and Diane Harvey offered financial and administrative support, while Michele Black edited and managed publication of the report. Federal site visitors generously contributed their thoughts and perceptions to its content.

# Insuring Virginia's Children: Local Outreach and Enrollment

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## BACKGROUND

Virginia's State Children's Health Insurance Program (SCHIP), known as the Children's Medical Income Security Program (CMSIP), has been in operation since 1998. Overall responsibility is vested in the state's secretary of health and human services, with specific tasks divided between the Department of Medical Assistance Services (the Medicaid agency) and the Department of Social Services. Outreach, enrollment, and eligibility determination occur at the county level.<sup>1</sup> Overall, of 63,000 Virginia children believed to be eligible and targeted by the state, approximately 25,000 had been enrolled by July 2000. Having determined that Northern Virginia counties led the state in enrollment, the National Health Policy Forum sponsored a one-day site visit to examine CMSIP in Northern Virginia.

The one-day format, enabled by the close-at-hand venue, was an experiment by the Forum to test whether a shorter duration would enable additional federal staff to participate and also whether a single day (as opposed to the two or three days of a typical site visit) would allow sufficient time to gain understanding of a state/local program. In evaluating the event, participants said they would have liked to pursue some topics that the one-day schedule did not permit, but several also noted that they could not have committed the time to a longer visit.

## PROGRAM

On the morning of August 3, site visitors were presented with an overview of health care in Virginia, followed by a presentation on CMSIP by the state Medicaid director. Also discussed was the projected Family Access to Medical Insurance Security (FAMIS) program, approved by the state legislature as a replacement for CMSIP. (A state plan amendment to implement FAMIS was undergoing review by the Health Care Financing Administration at the time of the site visit.) A panel

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<sup>1</sup> For purposes of this report, the term "county" should be understood to include independent cities, such as Alexandria.

representing community organizations and providers shared their experience with the group, touching on provider concerns, coordination of outreach at the regional level, and assistance for clients after they have been approved for enrollment.

Following lunch with the morning's speakers and other invited local guests, site visitors traveled to the Arlington County Department of Human Services, whose director described the county's approach to implementing CMSIP. Outreach and enrollment staff explained their processes and walked visitors through a step-by-step review of numerous critical forms. A second stop was Inova's Partnership for Healthier Kids in Fairfax County, where visitors heard from county officials, a school superintendent, and partnership staff.

## IMPRESSIONS

■  
*Political considerations played a major role in CMSIP's design, development, implementation, and projected replacement by the FAMIS program.*

The Virginia Coalition for Children's Health and a majority of the legislature had supported a Medicaid expansion model for CMSIP. Newly elected Gov. James S. Gilmore was opposed to this approach and modified the design. The CMSIP program model as implemented has satisfied neither side, as attested by the Gilmore administration's proposing FAMIS as a substitute. FAMIS, too, is a compromise, but expansion advocates hope that, with the governor's taking ownership, its goals will be more ardently pursued at the state level than CMSIP's have been.

■  
*Outreach partnerships between local agencies and community organizations are successful in Northern Virginia.*

Success in enrolling children in CMSIP has been most notable in small rural counties and in Northern Virginia. In

the former case, this is a matter of “everybody knows everybody.” Factors contributing to Northern Virginia jurisdictions’ success are greater engagement on the part of county governments, a strong pattern of regional cooperation, and willing community partners. The region’s leading health care system, Inova, is notable for its commitment of staff and resources to CMSIP.

The Northern Virginia Access to Health Care Consortium provides a forum for coordinating outreach programs across the region. A regional outreach committee comprises representatives of CMSIP programs in the city of Alexandria and in Arlington, Fairfax, Loudoun, and Prince William Counties.

Arlington County made a strong commitment to CMSIP outreach and enrollment, allocating some \$150,000 in county funds to the effort, on top of the \$50,000 received from the state. The Department of Human Services (DHS) established an interdisciplinary team encompassing members with bilingual fluency as well as with expertise in eligibility, social work, school health, and child care. The county has achieved 95 percent of its enrollment target, though site visitors reported some confusion as to what projected eligibility figures were based on. Some questioned an overall expenditure of \$200,000 to enroll 1,130 children, but others calculated that a figure of \$177 per enrolled child was reasonable, considering the level of individual attention given to client families.

■

***The intersecting roles of state and county in administering CMSIP add an additional layer of complexity.***

There is little state oversight of county administration of CMSIP. County agencies are not held accountable for meeting enrollment targets. The state relies on local agencies and community partnerships to do outreach and enrollment, contributing only modest funds to the effort. A state official explained that, because Virginia put a cap on administrative expenses for CMSIP, outreach funds, categorized as part of administration, are necessarily constrained as well.

Counties feel the state could provide more feedback, particularly in terms of regular county-specific reports on the status of CMSIP applications. As it is, phone inquiries are necessary. Officials in Fairfax county pointed out that one component of community partnerships is allowing the partner organization to know that their efforts are paying off in the form of benefits to families. Fairfax has a consent form that clients sign to permit a copy of the determination letter to be shared with community partners.

■

***The paperwork involved in completing an application and obtaining the necessary verifications for Medicaid or CMSIP can be overwhelming for caseworkers, community advocates, and clients.***

A two-page enrollment form is not necessarily “simple.” While Virginia’s application has been whittled to two pages, required verification documents add considerably to its heft. Every applicant must provide a Social Security number and birth certificate (or similar documentation) and must verify wages and benefits and school and child care expenses with back-up documents, including statements from employers and child care providers. Certain immigration classifications, pregnancy, or an absent parent entail further paperwork.

The enrollment process is so complex that community partners without staff dedicated to CMSIP efforts may be more successful at getting the word out than actually doing enrollment. A key issue is knowing when an entry triggers the need for another form to be completed. The Northern Virginia Regional Commission has developed software to guide screening and application completion.

Mandatory coordination with the child support enforcement program can be a deterrent to CMSIP enrollment. The absent parent paternity information form is detailed, and some clients are reluctant either to get a former partner “in trouble” or to create any reason for further contact with him or her.

■

***The availability of one-on-one assistance is critical, both during the application process and later in negotiating the health care system.***

Eligibility workers feel it is imperative to meet with families to offer hands-on help in completing a Medicaid or CMSIP application. Given that many clients in Northern Virginia speak English as a second language (if at all), there often are language and culture barriers. But in addition to translation services, the clients may need help to understand what other documents are required and to grasp the basic rules of the program. Many also need reassurance. This is particularly true with respect to the possible involvement of the Immigration and Naturalization Service, since many clients fear (incorrectly) that applying for medical assistance through Medicaid or CMSIP will jeopardize their immigration status or citizenship prospects.

Once an application has been approved, clients still may need assistance in finding an appropriate, convenient physician who is accepting Medicaid and/or CMSIP patients.

They may need to be educated about the importance of check-ups and immunizations. They may also need help finding transportation or making arrangements with an employer for time off to take a child to the doctor.

Past the enrollment stage, counties do not follow up on clients in the community. Social service agencies, such as Northern Virginia Family Services, fulfill some of this function, but there is no systematic way of tracking how clients are faring.

■

***Sketchy Medicaid and CMSIP enrollment data, as well as a dearth of information on those remaining uninsured, make gauging CMSIP's effectiveness difficult.***

The number of Virginia children remaining uninsured is unknown. A leader of the Virginia Coalition for Children's Health believes that CMSIP enrollment has in part offset a decline in Medicaid enrollment following welfare reform. But, while published CMSIP enrollment figures are disappointing in many parts of the state, these numbers do not reflect the number of children who were found eligible for and enrolled in Medicaid rather than CMSIP.

County agencies and community outreach programs have not yet focused on redetermination, so there are few available data on this segment of program operation.

■

***Partnering with schools can be an effective enrollment strategy with the right leadership.***

Schools in Fairfax County have become enthusiastic partners in CMSIP outreach and enrollment, working with the Inova-sponsored Partnership for Healthier Kids (PHK). An elementary school principal agreed to allow her school be the setting for PHK's outreach program pilot in 1996. (PHK was already active in some schools with a prevention program and, even before CMSIP, had tried to match children with safety-net providers.) PHK will operate in 70 of the county's 134 elementary schools in the 2000-2001 school year. The Fairfax County School District has been involved in the planning process from the beginning, and support for PHK begins at the superintendent level.

In a participating school, school personnel review emergency care forms to identify parents who have recorded no regular doctor and/or health insurance for their child. The parents are then contacted, usually by letter from the principal or other school official. Since the emergency care form also asks for the language spoken at home, standard letters have been prepared in Spanish, Farsi, Korean, Vietnamese, and Urdu. Free and reduced-

lunch program applications now ask families if they want to receive CMSIP information. Schools distribute CMSIP flyers and health newsletters. Interested families are referred to PHK. So far, the schools' work with PHK has been in elementary schools, but there is interest in pursuing outreach at the middle and high school level as well.

■

***Medicaid and CMSIP have no managed care contracts in Northern Virginia, but provider recruitment and retention is a perpetual challenge.***

Managed care is not a powerful factor in Northern Virginia Medicaid or CMSIP programs. A primary care case management program is in place, but managed care organizations have not responded to the state's overtures toward an HMO-based alternative. (This is a contrast to the Richmond and Tidewater areas of the state, which have enrolled all their CMSIP children in HMOs.) Reimbursement to providers remains almost wholly fee-for-service. Counties may provide some health care services directly in county-run clinics.

Maintaining an adequate network of physicians willing to accept Medicaid/CMSIP patients is an ongoing challenge. Physicians surveyed by Fairfax County cited low, slow, unpredictable payment; complex and ever-changing regulations; excess paperwork; and patient failure to keep appointments as drivers of their disgruntlement with these programs. Some have formed the erroneous impression that participating in Medicaid puts them at risk of a practice audit. Physicians fluent in the languages spoken by their clientele are chronically in short supply.

■

***FAMIS is designed to look and operate more like a private health insurance plan than like Medicaid.***

The timing of FAMIS implementation and, indeed, its approval at the federal level are uncertain. Because children enrolled in CMSIP will be grandfathered into FAMIS, Northern Virginia agencies and partnerships are keeping outreach and enrollment activities at full throttle. When FAMIS begins, current CMSIP beneficiaries will be permitted to qualify under old CMSIP or new FAMIS rules.

A feature particularly appealing to the administration is that FAMIS will permit beneficiaries to enroll in their employer-sponsored plan and receive a state subsidy. Small employers are said to welcome the prospect.

State officials believe that centralizing the application and eligibility determination process will produce faster

turnaround and greater consumer satisfaction. Caseworkers and enrollment counselors at the local level fear that centralization will lead to delay and a greater percentage of denials, since no one will be assigned to help families assemble the various required verification documents.



***Outreach and enrollment success is a critical first step—still to come in some parts of Virginia—but ensuring that children receive appropriate care is the necessary corollary.***

Once children are enrolled, there is little ability to track their progress. None of the speakers during the day indicated that post-enrollment follow-up (other than for redetermination of eligibility) is in process or even planned. The Virginia Medicaid director, who exhorted federal policymakers to “judge states by their results,” did not offer data on delivery and quality of care in Virginia.

Site visitors agreed (as an earlier group had done in Indiana) that information on children’s health status as well as enrollment status is necessary to weigh SCHIP’s overall success. Questions that might be pursued include the following: How many children find a medical home, and how quickly? Is there a linkage between enrolling for insurance and seeing a doctor? How can county agencies shift their emphasis from enrollment to health care? Would contracting with managed care organizations rather than individual physicians alleviate provider participation problems?

# Agenda

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**Thursday, August 3, 2000**

8:30 am Background and introductions [*Marshall Room, Hyatt Regency Arlington*]

9:00 am OVERVIEW OF HEALTH CARE IN VIRGINIA

**Robert Hurley, Ph.D.**, *Associate Professor*, Department of Health Administration,  
Virginia Commonwealth University

- How do state and local jurisdictions administer health and welfare programs in Virginia?
- How does Virginia's Medicaid program compare with other states in the region and nationally?
- What tensions surrounded the enactment of the Children's Medical Security Insurance Plan (CMSIP), Virginia's State Children's Health Insurance Program?
- What is the extent of health insurance coverage among Virginians, generally? Among children?
- What differences exist between Northern Virginia and other parts of the state with regard to health insurance coverage, health services delivery, and safety net services?

9:45 am VIRGINIA'S CHILD HEALTH INSURANCE PROGRAM: CMSIP AND FAMIS

**Dennis Smith**, *Director*, Virginia Department of Medical Assistance Services

- What are the eligibility and financing characteristics of Virginia's Medicaid program?
- What are the parameters of Virginia's existing children's health insurance program, CMSIP?
- How are Medicaid and CMSIP administered? How does the state relate to local jurisdictions in the administration process?
- How has outreach been undertaken by the state to enroll children in CMSIP? Does the state provide financial or other support to local outreach efforts?
- What changes in Virginia's children's health insurance program are contemplated under the Family Access to Medical Insurance Security (FAMIS) program?
- Will outreach activities change under FAMIS? What about relationships between state and county administrators?
- What features of FAMIS make it a better approach to providing health insurance to children?

10:45 am Break

11:00 am PERSPECTIVES ON ACCESS AND DELIVERY

**Chris Bailey**, *Senior Vice President*, Virginia Hospital and Health Care Association

**Kim Burson**, *Project Manager*, Northern Virginia Regional Commission

**Carol Jameson**, *Director*, Loudoun County Services, Northern Virginia Family Services

**Patricia Stevens**, *Services Integration Manager*, Department of Systems Management for  
Human Services, Fairfax County

- What are provider views of the strengths and weaknesses of Virginia's CMSIP and Medicaid programs?

- How did the difficulties between the governor and the General Assembly around enactment of a children’s health insurance program affect the implementation of CMSIP?
- Will the FAMIS program provide a better vehicle for access and service delivery? If so, how?
- In Northern Virginia, what collaborative activities have cities and counties undertaken across the region? How have these activities contributed to high CMSIP program enrollment in the area?
- Are provider systems and attitudes different in Northern Virginia from other areas of the state? If so, in what ways?
- What CMSIP outreach activities have been particularly successful statewide? In Northern Virginia jurisdictions?
- Are there barriers to access to health care beyond lack of insurance? That is, once enrolled in Medicaid or CMSIP, what challenges remain for beneficiaries?

noon Lunch

1:00 pm Bus departure for Arlington County

1:15 pm ARLINGTON COUNTY: OUTREACH AND ENROLLMENT

**Ron Carlee**, *Director*, Arlington Department of Human Services, and staff

- How does the eligibility and enrollment process for Medicaid and CMSIP work in Arlington County?
- How does Arlington County administration of human services programs differ from that of other Virginia jurisdictions?
- To what do you attribute Arlington County’s success in enrolling previously uninsured children in Medicaid and CMSIP?
- What activities were instituted to reach out to children and their families to assure optimum enrollment in CMSIP? Were these activities prescribed or governed by state requirements or mandates?
- How does CMSIP enrollment interact with other county programs and with private human services programs? How are schools and the education department involved?
- Are special initiatives undertaken to reach out to minority populations in the county?
- How would the implementation of FAMIS change Arlington County’s CMSIP operations?

2:45 pm Bus departure for Inova Health System in Fairfax County

3:15 pm OUTREACH AND ENROLLMENT PARTNERSHIPS

**Alan Leis, Ph.D.**, *Deputy Superintendent*, Fairfax County Schools

**Sherrie Smith**, *Director*, Partnership for Healthier Kids and Children’s Prevention Services, Inova Health System

**Shelby Gonzalez**, *Outreach Coordinator*, Partnership for Healthier Kids and Children’s Prevention Services, Inova Health System

**Yolanda Sharifi**, *Program Coordinator*, Healthy Kids Connection, St. Anthony’s of Padua Catholic Church

- What activities do community partners undertake to enroll children in CMSIP? Are these coordinated with county, state, or regional groups?
- How do Fairfax County Schools participate in CMSIP and children’s’ health activities? What philosophies guide the county’s commitment to working actively in outreach and enrollment in children’s health insurance programs?

- What is the history of Partnership for Healthier Kids and its involvement in CMSIP and Medicaid outreach?
- How did the Healthy Kids Connection come into being and how has it evolved?
- How do community groups work with multiple jurisdictions? Are there major differences between Fairfax, Arlington, and Loudoun Counties, for example? Is there a great deal of mobility of clients among jurisdictions?

4:45 pm Wrap-up for federal participants

5:15 pm Bus departure for Rosslyn Metro

# Federal Participants

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**Rhoda Abrams**

Director  
Center for Managed Care  
Health Resources and Services Administration  
Department of Health and Human Services

**Debra Cohan**

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Domestic Social Policy Division  
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*Fellow*  
Committee on Ways and Means  
U.S. House of Representatives

**Kate Kirchgraber**

*Program Examiner*  
Office of Management and Budget

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*Senior CHIP Analyst*  
Family and Children's Health Programs Group  
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**Jean Maldonado**

*Regional Outreach Coordinator*  
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**JoAnn Martinez**

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Office of Senator Dubin  
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Health and Human Resources Division  
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Office of Senator Robb  
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*Legislative Assistant*  
Office of Senator Robb  
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Health Education and Human Services  
General Accounting Office

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Office of Management and Budget

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*Senior Advisor*  
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*Senior Health Policy Analyst*

American Public Human Services Association

**Dan Steinberg**

*Policy Specialist*

National Conference of State Legislatures

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**Karl Polzer**

*Senior Research Associate*

**Moira Muccio Secrest**

*Financial Analyst*

## Biographical Sketches— Northern Virginia Participants

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**Christopher Bailey** is senior vice president with the Virginia Hospital and Healthcare Association, with responsibility for financial policy issues, health data programs, and spearheading the association's efforts with Medicaid. He came to Virginia from Illinois, where he spent ten years with the Illinois Hospital Association. He holds a master's degree in health services administration from the University of Michigan.

**Kim Burson** is project manager of the Children's Health Care Connection, a regional outreach project of the Northern Virginia Access to Health Care Consortium administered by the Northern Virginia Regional Commission and funded by the Arlington Health Foundation. Burson is a master's-level mental health professional with more than ten years' experience in health and human services. She previously worked for the Metropolitan Washington Council of governments.

**Ron Carlee** has been director of the Department of Human Services in Arlington County since 1987, having served the county in a variety of positions since 1980. Earlier, he had stints as a congressional press secretary and assistant to the mayor of Birmingham, Alabama. Carlee holds an adjunct faculty appointment at George Washington University. He is a founding member and past president of the Virginia Association of Local Human Services Officials.

**Shelby Gonzales** is the outreach coordinator for the Partnership for Healthier Kids, a program established under the auspices of Inova Health System's Community Health Division. She works closely with schools and medical providers to ensure that children have access to a source of ongoing health care. Gonzales joined Inova in 1997, following her graduation from George Mason University.

**Robert Hurley, Ph.D.**, is a faculty member in the Department of Health Administration at the Medical College of Virginia, Virginia Commonwealth University. He has been studying and writing about Medicaid managed care since 1985 for a variety of sponsors across the country.

**Carol Jameson** is director of community services for Loudoun County for Northern Virginia Family Service, where her focus is on developing programs to increase access to health care for underserved populations. She is a founding member and past chair of the Northern Virginia

Access to Health Care Consortium and currently chairs the Loudoun Health Partnership. Last year, the Richmond-based Virginia Health Care Foundation presented her with its Unsung Hero Award.

**Alan Leis, Ph.D.**, is deputy superintendent of the Fairfax County Public Schools. He has been with the system for over 25 years, serving in a variety of positions, including elementary teacher, curriculum specialist, and assistant superintendent for human resources.

**Dennis Smith** is director of the Virginia Department of Medical Assistance Services, which administers the state's Medicaid and SCHIP programs, as well as other indigent health and related programs. Before being appointed to this position by Gov. James S. Gilmore in July 1998, Smith served as a professional member of the majority staff of the U.S. Senate Committee on Finance. Earlier, he was staff director, in turn, of the Select Committee on Children, Youth, and Families and the Committee on the District of Columbia, both under the chairmanship of Rep. Thomas J. Bliley (R-Va.)

**Sherrie Smith** is director of the Partnership for Healthier Kids (PHK) and of Children's Prevention Services at Inova Health System. She has been with PHK since its inception more than five years ago, having joined Inova initially in 1989 to work on community health initiatives. Smith, who has combined degrees in community health and clinical social work, has spent more than 15 years working with diverse populations as she managed and developed programs in community health and health care settings.

**Patricia Stevens** is the services integration manager in the Fairfax County Department of Systems Management for Human Services. She provides research, analysis, and project management for a variety of interagency human services activities, including school-based service delivery, long-term care services, and access to health care. Before joining the county in March 1999, Stevens was a policy analyst with the Office of the Assistant Secretary for Planning and Evaluation in the U.S. Department of Health and Human Services. She joined the federal government as a presidential management intern in 1993, after completing her M.P.A. at the University of Central Florida.



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