

Outreach to Children: Moving from Enrollment to Ensuring Access

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Executive Summary

To reduce the number of uninsured children in this country and improve children's health status by providing access to health care, Congress recently created, and states are now implementing, the State Children's Health Insurance Program (CHIP). The program encourages states to provide subsidized health insurance to low-income children, by either expanding state Medicaid programs, establishing new programs to buy health insurance for children, or a combination of both approaches. This new program builds on the Medicaid expansions for children and other children's health insurance programs that have been implemented over the past decade to reduce the number of uninsured children in this country.

Although these are all welcome developments, without effective outreach these well-intentioned efforts will fail. Simply making coverage available does not guarantee that all, or even most, eligible children will receive health coverage. No children's health insurance program has been able to insure more than half of the eligible children. In 1994 nearly two-thirds of Medicaid-eligible children who were not receiving cash assistance (which conferred automatic eligibility for Medicaid) failed to enroll in the program. This experience suggests that, as welfare reform reduces the cash assistance rolls, many more children are likely to become uninsured.

If the new state CHIP programs are to reverse this trend, we must use effective outreach strategies to reach low-income families, encouraging them both to apply and, once covered, to use appropriate preventive and primary care services to keep their children healthy. Unfortunately, outreach services all too often have been an afterthought for

Without effective outreach to find, enroll, and ensure services for these children, the well-intentioned efforts of CHIP will fail.

policymakers, program designers, and providers. Outreach campaigns have not been well evaluated and are not well funded. However, these problems may soon be resolved. Since the passage of the CHIP legislation, those who understand the importance of outreach have succeeded in making outreach a top priority for federal agencies that administer children's health programs and for states as they design their CHIP plans. We must not miss this opportunity to identify successful outreach programs, build on their strengths, and disseminate the effective strategies as broadly as possible.

Fortunately, a wealth of experience is available from a variety of sources. This paper summarizes these experiences and presents what is known about the barriers that prevent children from enrolling in health coverage programs, the barriers that keep them from accessing care, and what works to overcome these problems. Highlighted barriers and outreach strategies are briefly presented below and discussed in more detail in the body of the paper.

We must first understand the barriers that discourage parents from enrolling their children in health coverage programs and then devise

effective strategies to overcome those barriers. Parents may not come forward to enroll children because

- they do not know they are eligible,
- they want to avoid the stigma of “welfare” associated with Medicaid,
- they cannot complete the burdensome application process, or
- they may not believe that health insurance coverage is important.

We also must understand and overcome system barriers that include

- difficulties in navigating the complex Medicaid system,
- increased chances of losing Medicaid coverage with changes due to welfare reform, and
- the lack of local data describing uninsured children so that outreach efforts can be appropriately targeted.

Strategies for overcoming these barriers include

- developing marketing strategies that are driven by consumer needs and preferences,
- making applications readily available and allowing them to be mailed in rather than filled out in a welfare office,
- simplifying and shortening applications and eliminating asset tests,
- outstationing Medicaid eligibility workers to take applications in community settings frequented by low-income families,
- establishing presumptive eligibility for children so that services can be rendered while a formal application is being processed, and
- establishing 12-month continuous eligibility for children so that they do not lose their eligibility and then have to re-enroll as their family circumstances fluctuate during the year.

Once a child has a Medicaid or insurance card in hand, that child must have a regular source

of high-quality preventive and primary health care. Barriers that prevent children from having such a health home include both personal and system-based issues, such as

- lack of transportation,
- clinic hours that conflict with work schedules,
- lack of child care for siblings,
- overcrowded clinics with long delays,
- doctors’ unwillingness to see Medicaid or other low-income patients, and
- concern that care is unresponsive to medical needs or interpersonally disrespectful.

Successful strategies for overcoming these barriers have included the following:

- financial incentives to enrollees,
- public awareness campaigns regarding the importance of preventive health care and where to get it,
- grassroots outreach through home visiting and community health advisors,
- transportation services,
- improving provider participation and training,
- making clinics, provider sites, and staff more user-friendly,
- care coordination for children, and
- information systems that permit regular review of encounter data.

Effective outreach requires collaboration and creativity between families, community organizations, businesses, health plans, public health and Medicaid agencies, foundations, and policymakers. These players share a common mission of ensuring that children have access to high-quality, cost-effective health care.

Outreach strategies must be carefully designed to meet the target population’s needs, but they also must be flexible and adaptable as these needs or the population changes. Information systems should be developed and used to track the strategies’ effectiveness. The strengths of

the information systems used by managed care plans and public agencies should be combined for this task. Collaborating and making outreach a top priority will help fulfill the promise of CHIP to improve children's health.

Introduction

It is well known that many low-income children lack health insurance and that lack of health insurance significantly reduces access to care. To address these problems, Congress has recently created, and states are now implementing, the State Children's Health Insurance Program (CHIP), which encourages states to provide subsidized health insurance to low-income children, by either expanding state Medicaid programs, establishing new programs to buy health insurance for children, or a combination of both approaches.

It also is well known that low-income children face many barriers to obtaining health coverage and to accessing health services, especially preventive and primary care. Simply making coverage available does not guarantee that all, or even most, eligible children will obtain health coverage. Experience with expanded Medicaid eligibility for children has shown that, despite the expansions to date, most children do not enroll unless they are also applying for cash assistance.¹ This experience suggests that, as welfare reform reduces the cash assistance rolls, many more children are likely to become uninsured.

These children are in working poor families and are similar to children targeted by CHIP and other children's health insurance programs. Outreach is the key to surmounting the barriers they face in obtaining coverage and services. Outreach can be thought of as a continuum: first, identify the target population and barriers they face to enrollment and services; second, develop strategies to facilitate enrollment; and third, ensure that they have access to a high-

***Outreach can be thought of as a continuum:
Identify the population,
facilitate enrollment, and ensure access to services.***

quality primary care provider, a health home. If all of these steps are not completed, the well-intentioned efforts of CHIP will fail, and the Medicaid expansions and other children's health insurance programs will not realize their goals. If trends are to be reversed, we must find effective ways of getting the message to low-income families and encouraging them both to apply and, once covered, to use appropriate services to keep their children healthy. Unfortunately, outreach services have all too often been an afterthought for policymakers, program designers, and providers. Such efforts have not been well evaluated and are not well funded. However, this may be about to change. Since the passage of the CHIP legislation, outreach has become a top priority for the federal agencies that administer children's health programs and for many states as they design their CHIP plans. Private-sector organizations are taking notice and identifying roles they can play in outreach. Such attention and understanding is unprecedented and offers an opportunity that must be taken *now*: to find successful programs, build on their experience, and broadcast the strategies that work. Parents, health plans, public agencies, foundations, policymakers, community organizations, employers, and others who insure and serve children must collaborate on these efforts to cover children and ensure their access to care.

Fortunately, a wealth of experience is available from a variety of sources, including public health findings in case management and home visiting, lessons learned from recent state Medicaid expansions, Blue Cross and Blue Shield plans' Caring Programs for Children, state initiatives in child health insurance programs, and many community-based outreach efforts.

The purpose of this paper is to summarize this experience and present, as concisely as possible, what is known about both the barriers that prevent children from enrolling in and accessing care and what works to overcome these barriers. We first present trends in health care coverage for children and why outreach services are needed to improve coverage. We then review the barriers that prevent children from enrolling in care and what works to overcome these barriers. Lastly, we present barriers that prevent children from accessing care and strategies for overcoming those barriers. An appendix gives descriptions of Web sites that may help in designing and implementing outreach initiatives.

Trends in Health Care Coverage for Children

Although most children are in excellent health, lower-income children are more likely to be in fair to poor health than are children in higher-income groups, and children without health insurance are more likely to be in poor health than those with insurance.² Most uninsured children (close to 70 percent) have family incomes below 200 percent of the federal poverty level.³

A lack of health insurance has frequently been cited as one of the most important barriers to health care, if not the most important.⁴ To improve children's access to and use of health

A Snapshot of Children's Health and Access to Insurance Coverage

Health Status

- Most children are in excellent health.
- Lower-income children and uninsured children are more likely to be in fair or poor health.

Insurance and Access to Services

- A lack of health insurance has frequently been cited as one of the most important barriers to health care.

Employer-Based Coverage Declining

- Most children are covered by private health insurance, usually offered through their parents' employers.
- Between 1987 and 1995, employment-based coverage of children fell from 67 to 59 percent.

Medicaid Coverage Increasing

- In 1996, Medicaid covered 22 percent of all children under 18.
- As of June 1997, 15.3 million Medicaid beneficiaries, mostly families with children, were enrolled in some form of managed care.

States and Private Sector Have Stepped In

- As of May 1997, eight states had state-funded insurance programs, and 24 had privately-funded or mostly privately-funded programs, such as the Caring Program for Children, to try to fill the gaps between employer-based coverage and Medicaid.

Children Remain Uninsured

- Over 14 percent of all children, more than 10 million, remain uninsured despite private insurance coverage, Medicaid coverage, and special children's health insurance programs.
- The State Children's Health Insurance Program (CHIP) encourages states to provide subsidized health insurance to low-income children, by expanding Medicaid, establishing new programs, or both.

care services, federal and state policymakers expanded children's eligibility for Medicaid in the mid to late 1980s. By 1996, 22 percent of all children younger than 18 were covered by the program.⁵ In addition, increasing numbers of these children are enrolled in managed care as states strive to reduce their Medicaid costs and increase children's use of appropriate primary and preventive care. As of June 1997, 15.3 million Medicaid beneficiaries, most of whom were families with children, were enrolled in some form of managed care.⁶

States and the private and nonprofit sectors have tried to further close the gap between insured and uninsured children by creating health insurance programs specifically for children. As of May 1997, eight states had state-funded insurance programs, and 24 had privately-funded or mostly privately-funded programs, such as the Caring Program for Children sponsored by Blue Cross and Blue Shield plans.⁷

While most children are covered by private health insurance, usually offered through their parents' employers, such coverage has been declining. Although many economic factors are at work, the decline seems to be due largely to employers' shifting of rising premium costs onto workers, who may decline coverage, including dependent coverage, because of its cost.⁸ Between 1987 and 1995, employment-based coverage of children fell from 67 to 59 percent.⁹ Thus, despite private insurance coverage, Medicaid coverage, and special children's health insurance programs, over 14 percent of all US children, more than 10 million, remain uninsured.¹⁰

Because of the continuing gaps in coverage and the powerful link between insurance, children's

access to care, and their health status, Congress passed and President Clinton signed into law the State Children's Health Insurance Program (CHIP) in August 1997. This law created Title XXI of the Social Security Act and is the largest federal commitment to child health since the enactment of Medicaid over 30 years ago. The program is authorized for \$24 billion for the first five years. States can either expand their Medicaid programs, create a private health insurance plan, or apply a combination of both approaches.

The Key to Enrolling and Serving Children Is Effective Outreach

The mere existence of Medicaid, CHIP, or other health insurance programs doesn't mean that families will come forward to enroll and get services for their children. These initiatives present opportunities for children, but they also include challenges that are all too familiar to those who work to ensure children have the health care they need. The challenges are to *find eligible children, facilitate their enrollment, and ensure access to services* for as many children as possible. For these challenges to be met, leadership and commitment are needed from Medicaid and public health agencies, health plans, policymakers, foundations, community organizations, businesses, families, and others to initiate and maintain effective outreach strategies that respond to the needs of children in their communities.

Challenges to Enrolling Children

Helping families to enroll their children in health insurance is the first step to ensuring access to a health care system that is readily available and of high quality. One of the most important, if not ominous, problems that states and others must surmount is that eligibility

does not guarantee enrollment. Despite Medicaid expansions since the mid 1980s and some degree of outreach efforts to inform families of the program and where and how to enroll, eligibility has not translated into coverage for millions of children. As of 1994 (the most recent year for which data are available) one-fifth of all children eligible for Medicaid, or 2.7 million, were not enrolled, nor were they covered by any other form of insurance. More importantly, for children in families *not* eligible for cash welfare (TANF [formerly AFDC]), which conferred automatic eligibility for Medicaid, nearly two-thirds were not enrolled in Medicaid.¹¹ These non-cash-assistance children are similar to those targeted by CHIP and other children's health insurance programs. The fact that most children who are eligible do not enroll in Medicaid is a key indicator of the enrollment barriers that families face and the limited amount or limited effectiveness of previous outreach efforts.

Even in states that have developed special children's health insurance programs, enrollment lags behind expectations. Several states experience program-penetration rates (i.e., program enrollment compared with total uninsured child population) of less than 10 percent, while the highest rate is for Hawaii's QUEST program, which has a 52 percent penetration rate.¹²

Barriers Facing Families

Why do eligible families not enroll their children in Medicaid? Research is limited, but experience across the country has shown that there are many reasons. Some barriers are unique to Medicaid, while others are more general and may apply to families eligible for but not enrolled in children's health insurance programs. When designing enrollment systems for CHIP, it will be important for states, health

plans, providers, and others who serve low income children to keep these barriers in mind and identify others that may be unique to their targeted populations of children. Parents may not come forward to enroll children because

- they do not know they are eligible;
- they want to avoid the stigma of “welfare” associated with Medicaid;
- they cannot complete the burdensome application process;
- they do not believe health insurance coverage is important;
- they cannot complete the application process because information is not available in their language; or
- they are undocumented residents, even if their children are citizens and therefore eligible for services.

System Barriers

Medicaid is a complex program to navigate. Medicaid is a very complicated program to understand, and it is difficult to simplify the program enough so that a typical low-income family will know how to apply and what benefits they will receive. Families—as well as community organizations who work with them—may lack information or have erroneous information about the availability of coverage and benefits. In one study, women already receiving Medicaid were asked questions about benefits in five different programs: Medicaid, child care, food stamps, cash welfare (AFDC), and housing. The program least understood was Medicaid.¹³

For health plans and the providers who serve these children, the simpler the program the better. A family with a sick or chronically ill child naturally has greater incentives to navigate a complicated maze of paperwork to insure

their child. For families with healthy children, they may not perceive insurance as worth their effort. To prevent adverse selection of only the most ill or most needy children as well as to insure as many children as possible, states need to simplify Medicaid and not repeat the mistakes of the past as they design and implement CHIP.

Welfare reform makes outreach even more urgently needed. When a family is eligible for only Medicaid, and not also cash assistance (which is usually the main incentive for coming to the welfare office) they usually do not apply. Yet, as more and more women leave welfare for work, as required by welfare reform, they and their children may continue to be eligible for Medicaid, or the children might be eligible for coverage through a new CHIP program in their state. States are already experiencing downturns in their Medicaid caseloads but, for lack of data and tracking systems, do not know why.¹⁴ Mothers may be obtaining health insurance through work, although that is doubtful. It is more likely that women are not being told that they or their children are still eligible for Medicaid.

Finding families and helping them to enroll has long been a challenge facing Medicaid agencies, and welfare reform has increased this challenge. Similar difficulties will face the CHIP program and efforts must be made to identify working poor families and effectively encourage them to enroll.

Local descriptive data about uninsured children are not readily available. Outreach to enroll children should be tailored to meet the needs of different target groups. The characteristics of a community's working poor population and the types of jobs they hold, what percentages live in rural and urban areas, and the needs of different racial and cultural groups are important

information upon which to design targeted outreach and service strategies.

Unfortunately, although national information (collected mainly through surveys) is available, it is general and does not capture variations between and within states. Nationally, it is known that

- uninsured children are most likely to be 6 to 19 years of age (probably because many low-income, younger children are covered by Medicaid);
- they are likely to live in low-income families where the head of household works in a small company or is self-employed;
- health insurance through the parents' work is either unavailable or unaffordable and the children are not eligible for Medicaid or are eligible but are not enrolled; and
- the children may have special health care needs for which coverage is not available or is too expensive for the family.¹⁵

Local-level data need to be collected to ensure that outreach efforts are appropriately targeted to local needs.

What Works to Enroll Children

To reduce barriers to children's health care coverage, most states have responded to some degree and have simplified the administrative and application processes for Medicaid, developed outreach programs, and passed laws to facilitate enrollment. Public health programs, particularly state Title V agencies that administer the Maternal and Child Health Block Grant program, have collaborated with state Medicaid agencies, community health

centers, and others to develop and run outreach initiatives. Public health programs are key partners for these efforts because they have programmatic experience and data sources that can be very useful in designing and operating outreach initiatives and appropriate health care services for Medicaid and child health insurance programs.

Funding for Outreach is Growing

Medicaid administrative funds have long been available to states for outreach to find and enroll eligible individuals. These monies plus Title V Maternal and Child Health funds and other private financing have been combined for a variety of initiatives. The CHIP law allows funds to be used for outreach and other administrative expenses, but it limits the amount a state can spend to 10 percent of the total federal and state dollars the state spends on insuring children.

Since the passage of the CHIP legislation, outreach has gained high-level attention. In his budget proposal for 1999, President Clinton included a plan to expand and clarify the use of a \$500 million outreach fund that was established in the 1996 welfare reform law, but has not been well used yet, to help states locate and enroll children in Medicaid. The funds can also be used to steer eligible children to CHIP. The president also called upon the Health Care Financing Administration and other federal agencies with jurisdiction over children's programs to develop intensive outreach strategies to help enroll children and identify barriers to enrollment that can be addressed.¹⁶ At the same time, private-sector efforts are intensifying as well. For example, a nationwide, toll-free number for families to call for information has been promised by Bell Atlantic; drug store chains and pharmacies plan

With their experience and resources, public health programs are key partners in outreach initiatives.

to distribute information about children's health programs in local pharmacies; and the Robert Wood Johnson Foundation and Kaiser Family Foundation have dedicated new funds to identifying effective methods of outreach.¹⁷

Research is limited as to what outreach and related strategies are most effective, for what types of children, in what settings, and at what cost. Nonetheless, available evidence suggests that the following strategies are promising and have helped children and families obtain health coverage.

Develop Marketing Strategies Driven by Consumer Needs and Preferences

In many states, Medicaid agencies have teamed up with others who are familiar with low-income and working poor families to develop a more coherent and appealing program. Similar collaborations have occurred in the design and implementation of other children's health insurance programs, resulting in strategies such as clearly worded brochures or videos in various languages that explain a program and how to apply for it. Many states have renamed their Medicaid program to help de-stigmatize its welfare image, such as Vermont's Dr. Dynasaur and Rhode Island's RItEStart. Other state-level children's health insurance programs have

names such as Florida Healthy Kids, ARKids First in Arkansas, and the more than 20 Blue Cross and Blue Shield plans' Caring Programs for Children. Ideally, the programs are broadly and frequently advertised on or in television, radio, billboards, sides of buses, and libraries. The Right from the Start Medicaid Project in Georgia even distributes flyers in children's shoe boxes, as tray liners in fast-food restaurants, in employees' paychecks, and with report cards sent home from school.¹⁸

Applications and information are available in locations such as pharmacies, schools, health clinics, hospitals, child care centers, and relevant county social service agencies in several states. Toll-free hotlines are staffed, sometimes at all hours of the day and night, with people knowledgeable about Medicaid, health insurance, public health programs, available pediatric providers, and other information. States are also realizing that how people are treated has a great impact on how they perceive and use a service and whether they recommend it to friends and neighbors.

Simplify, Shorten, and Allow Mailed Applications and Eliminate Asset Tests

It does little good to revamp, rename, and advertise a Medicaid program for children without also simplifying the application forms and process. Simplification is crucial to the success of any effort to enroll children. In addition, families with higher incomes will not be attracted to a program that resembles public welfare in any way. If a program wants to attract healthy children, the program needs to be simple and attractive. Lengthy forms and processes are holdovers from the days when the only people who qualified for Medicaid were those who had to provide documentation to prove they were eligible for cash assistance. This is no longer the case, and states need to reevaluate their application and eligibility

Outreach in Action

In Florida, a collaboration between the University of South Florida, the Walt Disney Company, and others will soon initiate a program called Friendly Access. One of the program's goals is to provide training in customer service and leadership skills to front-line staff and health care providers who work directly with children and families.

processes to reflect only what is needed by Medicaid. To target higher-income (non-cash-assistance) families for Medicaid, 31 states have shortened application forms to some degree and have dropped questions about an applicant's assets.¹⁹ Eliminating asset tests alone goes a long way to shortening application forms. This has been done for pregnant women applying for Medicaid for many years and now can be done for children as well. Twenty-five states also allow their Medicaid applications to be mailed in,²⁰ eliminating the need for a trip to the welfare office for a face-to-face interview. States implementing CHIP programs must be aware of the barriers that application forms, procedures, and questions present and must be careful to only ask questions that are absolutely necessary to ascertain a child's eligibility.

Outstation Medicaid Eligibility Workers

One way states use Medicaid administrative funds to find and enroll individuals is to place eligibility workers or train others to take applications in community settings frequented by low-income families, such as federally qualified health centers, which are predominant sources of preventive and primary care for low income children. Not only does outstationing increase children's enrollment in Medicaid, it improves the health centers' financial condition

because it reduces their uncompensated care costs. In some locations, these workers do much more than just take applications. They also are care coordinators who perform risk assessments, develop a plan of care, coordinate referrals to other providers, and follow-up and monitor to ensure that services are received.²¹ In implementing CHIP, states should make it a point to educate staff and provide them with program materials at local health clinics, WIC clinics, schools, Head Start sites, and other locations where eligible children can be found.

The Aaron E. Henry Community Health Services Center in Clarksdale, MS, provides comprehensive primary care for four rural counties in northern Mississippi. In February 1990, a state-employed, outstationed eligibility worker (OEW) was placed at the center. The center pays for half of the OEW's salary. The OEW conducts the initial processing of Medicaid applications and makes the eligibility determination. In addition, the OEW assists families applying for cash assistance and food stamps. Medicaid applications, which normally took a month or more to process, can be processed by the OEW in two to five days. This is due to the OEW's use of a shortened application form and to spending time with applicants to be sure they provide the necessary information in a timely and accurate manner. Patients perceive the OEW as sensitive to their needs and concerns. The OEW has helped increase the percentage of center patients enrolled in Medicaid and has thus also helped improve the center's fiscal condition.²²

Establish Presumptive Eligibility for Children

Initially allowed for pregnant women only, but now also allowed for children, presumptive eligibility is a process by which a pregnant woman, or parents on behalf of a child, can

apply for temporary Medicaid eligibility at the location where they receive health care or other services (such as federally qualified health centers, pediatricians' offices, WIC programs, and Head Start programs). States that choose to expand Medicaid with their CHIP funds can use presumptive eligibility for children, and many have indicated that they will do so. Providers who see CHIP patients could become presumptive eligibility sites. Like outstationing Medicaid eligibility workers, the presumptive eligibility process moves the initial eligibility intake point to the location where children receive health care.

Although families must follow presumptive eligibility with a formal application, such eligibility allows a child to be immediately enrolled and the provider assured of payment for services rendered. Presumptive eligibility for pregnant women is used by 25 states²³ and has been found to be effective in boosting enrollment. A 1991 study by the US General Accounting Office found that states that both implemented presumptive eligibility and dropped asset tests for pregnant women experienced the fastest growth in enrollment.²⁴ The president's fiscal year 1999 budget proposes to expand the range of organizations that can establish children's presumptive eligibility to include child care resource and referral agencies, schools, and child support agencies.

Establish 12-Month Continuous Eligibility for Children

Continuous eligibility is important both to enrolling children and to ensuring that children receive care. The law that established CHIP gave states the option of providing 12 months of continuous coverage for children under Medicaid regardless of changes in family circumstances that would otherwise render the

children ineligible. Once ineligible, families often do not reapply. Having coverage for a full year improves the likelihood that children will establish a relationship with a provider and receive preventive as well as acute care in a timely manner. Continuous coverage is particularly important for children in managed care plans because it gives their families time to understand the system and use it appropriately, the children can receive scheduled health supervision visits and immunizations, and the managed care organizations have an incentive to ensure that the children get needed care. This may also make it easier for other children's programs with 12-month eligibility (such as Head Start) to coordinate their outreach and enrollment efforts with those for Medicaid.²⁵ As states design and implement CHIP, ensuring a reasonable amount of time for continuous enrollment in that program will also be important for the same reasons.

Challenges to Ensuring Children Receive Care

Although the primary—and crucial—goal of the Medicaid expansions, CHIP, and other health insurance initiatives is to remove financial barriers to health care, children face numerous other barriers to care. Outreach to find and enroll children is the first step, but similar attention must be paid to ensuring that, once they have a Medicaid or insurance card, children actually get the services they need.

Determining Appropriate Cost-Sharing Mechanisms and Levels is Difficult

Although enrollment gives a child an insurance card, financial issues do not end there. One of the major decisions in program design is whether to impose cost-sharing, what kind to impose (premiums, deductibles or co-

Finding and enrolling children are important goals, but similar efforts have to be made to ensure that children are actually receiving services.

payments), and how to adjust these according to a family's income. Cost-sharing affects both program participation and utilization rates.²⁶ Determining the appropriate level of cost sharing is difficult. Federal Medicaid law prohibits cost-sharing for children's services.²⁷ Among state children's health insurance programs, some charge nothing while others charge amounts that increase with income. Because of the generality of these guidelines and the limited research available, program administrators tend to rely on budgetary limitations, anecdotal evidence, and small-scale testing of price sensitivity.²⁸ Although some research supports the argument that any cost-sharing deters families from seeking care, anecdotal evidence, such as that from the Florida Healthy Kids program, supports that cost-sharing has provided an incentive for parents to use services in order to "get their money's worth." Whatever cost-sharing a plan imposes, care must be taken to monitor its effects on enrollment and utilization of services, and states must be prepared to make adjustments along the way.

Reaching Diverse Populations Is a Challenge

As the immigrant population in the United

States is increasing and immigrants are enrolling in Medicaid and children's health insurance programs, outreach targeted to these groups is becoming more important. Outreach must be culturally competent and responsive to their special needs and characteristics.

Although many of the barriers discussed here also apply to recent immigrants and minority cultures, unique reasons for why they do not access care must also be identified, and methods to reach them need to be developed.²⁹

Low-Income Children in Managed Care May Differ from Commercial Members

Children and families in different income strata differ in ways that affect their ability to negotiate the health care system and appropriately use health care services. As more lower-income children enroll in managed care, health plans are discovering the differences between these groups of children and their commercial members. Compared with commercial members, low-income children are more likely to

- be in poorer health;
- live in communities with fewer health care sites, making it difficult for them to get to a provider and also difficult for a health plan to form networks of providers needed by this population;
- live in isolated communities that lack adequate transportation;
- have parents who are poorer and have less education;
- have complex needs requiring services of public agencies such as child welfare, WIC, and public health³⁰; and
- be accustomed to relying on emergency rooms or walk-in clinics for acute care needs and not accustomed to having a regular provider/health home.

Effectively serving these children takes special effort. As more of them become insured and enrolled in managed care, health plans need to develop outreach methods and materials that will draw them into preventive and primary care and enable them to appropriately use services.

In states where Medicaid eligibility has been raised significantly above the federal poverty level, health plans have experience with these children in working poor families, who are less like the traditional Medicaid population that also receives welfare and more like children targeted by CHIP and those served through existing children's health insurance programs. They also are more like the commercially insured in terms of health care utilization.³¹ Plans experienced with these populations, such as the Blue Cross and Blue Shield plans' Caring Programs for Children, are already aware of many of the access issues, and some have developed strategies for outreach and services to these children. Some have adapted materials and methods from their commercial business, while others have created materials especially for this population. These plans' knowledge could help inform states as they design and implement CHIP.³² This collaboration would make the program more effective and attractive for children and the plans that enroll them.

Barriers Are Both Personal and System-Based

Unfortunately, barriers to care are numerous, and they emanate from personal and system issues. Barriers include

- lack of transportation,
- lack of understanding or denial of the child's health problems,
- clinic hours that conflict with work schedules,

- no child care for other children in the family,
- overcrowded clinics with long delays in getting appointments or long waits in the waiting room, often with more than one child in tow,
- competing family or personal issues and priorities,
- doctors' unwillingness to see Medicaid patients, and
- patients' concern that the care received is either unresponsive to their medical needs or interpersonally disrespectful.³³

Personal barriers. Personal barriers depend on a family's specific situation, their experiences with the health care system, their health beliefs, their culture, and their ability to make getting to the provider a priority. Children targeted by Medicaid and CHIP are typically from lower-income families that face more obstacles in their daily lives than do families with more means. The level of education of a child's mother is an important predictor of well-child visits and is generally lower for low income children.³⁴ To be effective, outreach strategies must take into account these and other characteristics of the target population.

System barriers. Health care system barriers have their source in individual clinics and physician offices, Medicaid policies and procedures, the medical profession, and the capacity and structure of the health care delivery system. Targeted approaches that address specific concerns—like a clinic's hours of operation, a need for improved health education materials, and the availability of child care on site—can be handled locally and potentially without great expense. Issues such as providers who do not accept Medicaid patients or the maldistribution of pediatricians are much larger and require the attention of state and federal officials, provider groups, community leaders in affected areas, and others.

Outreach in Action

After focus groups told them that preventive health services were not a priority for their families, Pennsylvania's Love 'Em with a Checkup program planners developed messages that emphasized the importance of preventive health care and provided a toll-free number for additional information. The Western Pennsylvania Caring Program was told by their program participants that they did not initially apply for the program because they thought that it was "too good to be true." Caring Program managers realized that they needed to repeat the advertised messages about the program several times so parents would understand that their children actually might be eligible and would apply.

What Works in Ensuring Children Receive Care

Getting children timely and appropriate health care requires parents who are knowledgeable about their children's health, what their health coverage does and does not pay for, how to make and keep an appointment, how to communicate effectively with providers, and how to follow through with instructions received. It requires a system that has providers who will see Medicaid and low-income patients; that has reasonably short waiting times for appointments; that is relatively close by, welcoming, friendly, and supportive; that has hours of operation that are responsive to working parents and providers who are available by phone after hours; that has staff knowledgeable and helpful about other services a child may need; and that provides monitoring and follow-up.

Regardless of the financing mechanism that enables a family to pay for care, the system that they enter should meet these sorts of criteria. The appropriate use of preventive and primary care is a shared goal among the public health profession, Medicaid, managed care plans, community health centers, and others who are part of the health care network used by children. Collaborations between these players can create effective and aggressive strategies to reduce barriers, increase access, and ultimately result in healthier children. To increase their likelihood of success, the collaborations should also include the consumers of care: low-income families with children.

Strategies to Reduce Personal Barriers

Financial and other incentives. Many of the lessons learned about the components of an effective incentive program have come from prenatal care programs' efforts to encourage pregnant women to come in early and consistently for care. One example for encouraging prenatal care is offering women coupon books that are full of free gifts and discounts from area merchants. Women who make their prenatal visits can get their coupons validated for use. Although some coupon books include primarily products and services needed by the baby, books with products and services for the mother as well seem to have more impact. Learning from the women themselves what products and services are most attractive is important in setting up an incentive program. An evaluation of the Healthy Beginnings program in Alabama showed the incentive program to be effective in motivating women to seek early and continuous prenatal care.³⁵ There is also some evidence of similar programs targeting parents to encourage them to bring their children in for well-child care.

Outreach in Action

Mercy Health Plan in Philadelphia had success in using a gift-certificate incentive program to increase the immunization rates of their enrollees. Parents were offered certificates for diapers or shoes when a needed immunization was obtained.³⁶

Desirable health education classes. Designing, marketing, and holding health education classes on topics of interest is an effective way of getting a wealth of information to a target audience. Low-income parents often do not have accurate and complete information to make good health and health care choices for themselves or their children. Childbirth education classes can be a vehicle for informing soon-to-be parents about healthy behaviors and lifestyles, prenatal care, newborn care, the importance of well child check-ups and immunizations, and useful resources. Throughout Florida, outreach childbirth education classes for low-income families have been well received by parents. Parents have expressed the ability to make more informed, positive choices for their and their families' health.³⁷

Public awareness campaigns. Not only are public awareness or media campaigns used to inform families about the availability of a health insurance or Medicaid program, they also are used to inform the public about healthy behaviors and the importance of preventive health care services and how to obtain them. Public awareness campaigns need to be flexible and modified as additional information about the campaign's effectiveness is gathered from current and potential program participants.

The messages about program availability and

the importance of preventive health care can be spread simultaneously through television, radio, billboards, and newspaper advertisements.

Brochures and flyers can be placed in locations frequented by the targeted children and families. Toll-free numbers can be advertised and staffed with people knowledgeable about coverage and service issues. Public awareness campaigns are an ideal project for partnerships between public health and local community organizations and health plans, combining the local community's knowledge of low-income populations with health plans' expertise in marketing strategies.

Grassroots outreach through home visiting and community health advisors. Although a public awareness campaign can spark interest and provide limited information, backing up the campaign with effective outreach at the grassroots level is important. Home visiting or community health advisor programs use nurses, social workers, or trained lay workers to go into clients' homes or neighborhoods to screen family members for health and social services needs, develop a plan of care, directly provide health services, provide linkages to needed services, and educate parents about the importance of preventive health care. Programs differ considerably in their intensity, duration, and scope of services. Medicaid funds can be used for home visiting under certain circumstances, and community health centers administer home visiting programs for children and families. Foundations and Title V MCH funds are the primary sources of funding for many home visiting and community health advisor efforts.

Public health nurses have provided home visiting for many years. Several other countries have had national systems of home visiting for decades, and although the United States does not have one, home visiting is experiencing a

Outreach in Action

The Franciscan Children's Hospital and Rehabilitation Center in Boston, after assessing its community's health needs, determined that a mobile clinic, dubbed the "Kids' Care-Van," would be started. Staffed by a pediatric nurse practitioner, a WIC representative, and a dentist, the Kids' Care-Van stops at neighborhood schools, a Head Start program, two day care centers, and a Boys' and Girls' Club. The van stays at each site for three to four days and provides basic screenings, which are often accompanied by referrals to the children's health care provider or a local clinic. Age-appropriate health education is also given to the children on topics such as mental health, nutrition, bicycle safety, smoking cessation, pregnancy prevention, AIDS, immunizations, and fire prevention. The Kids' Care-Van works closely with other local service providers and businesses to get the children and families the

renaissance of sorts. Home visiting and community health advisor programs are growing, and they often operate out of hospitals, community-based clinics, and local health departments. Some managed care plans have begun to see the value in reaching their members with these techniques. Plans may hire home visitors or contract with agencies that provide these services.

Especially as the US population grows more diverse, reaching new citizens and improving their access to services will grow more important. Community health advisors can address cultural barriers to care and help their neighbors get the services they need.³⁸ Evaluations of home visiting programs are limited, but programs that use specially trained registered nurses, target high-risk families, and

employ other proven criteria have demonstrated positive effects on the families.³⁹ Other evaluations have found home visiting to be a promising means of reaching at-risk families; educating them about healthy behaviors, good nutrition, and the importance of prenatal care and well child care; and assisting them in obtaining the services they need.⁴⁰ Health plans have combined outreach strategies with sophisticated data-management systems that include claims data, out-of-plan immunization data, records for member notifications and home visits, and evaluation components that analyze the effectiveness of the home visits in improving immunization compliance and provide cost data for the intervention.⁴¹

Transportation. Because getting to and from appointments is a frequent barrier for low-income families, Medicaid covers transportation expenses under certain circumstances. However, many beneficiaries do not know this, and the benefit is not well used. Other programs and providers have addressed their clients' transportation problems by purchasing a van to bring patients to care or to take the care to them. Such initiatives are often the brainchild of community and religious hospitals, but others, including managed care plans and providers who target hard-to-reach children, can replicate these successful programs. Plans serving high-risk populations sometimes choose to supplement existing Medicaid-supported transportation systems in order to link members to care.⁴²

Strategies to Reduce System Barriers

The health care system that has developed over the years to serve low-income populations is well known to be fragmented and difficult to negotiate. In areas where low income families usually live, the capacity of the health care system and infrastructure are limited.

Outreach in Action

The Arkansas ConnectCare Medicaid Program received a 1997 "Innovations in American Government" award for its efforts to encourage provider participation by streamlining the payment and billing system. Through the use of a patient's magnetic card, the Automated Eligibility Verification Claims System (AEVCS) verifies Medicaid eligibility, checks benefit limit status, and edits the claims online. The claims are transmitted immediately and payments can be deposited directly into providers' bank accounts. The program has dramatically increased provider participation in Medicaid and has resulted in physician visits nearly doubling over a 17-

Addressing these problems is part and parcel of ensuring that children have access to care once they have an insurance card in hand. Many states and communities have worked to reduce these barriers for children and families and thus have experience to draw on as CHIP is implemented and more uninsured children enroll in health plans.

Improve provider participation. Experience with Medicaid has shown that access to care is limited by providers' willingness to care for Medicaid patients and providers' locations relative to where Medicaid beneficiaries live. Medicaid payments are typically lower than private insurance payments, the paperwork is burdensome, and providers often view families on Medicaid as difficult and noncompliant compared with their commercially insured patients. The percentage of pediatricians limiting their Medicaid caseloads has been growing.⁴⁴ This makes ensuring access to care difficult for Medicaid and has implications for children enrolling in CHIP, especially if states

opt to expand Medicaid with CHIP funds.

In response, some states have raised payment rates and streamlined the billing process systems for providers. In North Carolina, the Medicaid agency, Title V MCH agency, rural health office, and the pediatric societies joined together to improve provider participation in Health Check, the state's EPSDT (Early and Periodic Screening, Diagnostic and Treatment) program. They improved payment rates and procedures, including financial incentives to providers who agreed to accept significantly more Medicaid children into their practices.⁴⁶

How states determine capitation rates for Medicaid managed care plans and what is included in those rates can influence plans' extra efforts to ensure that children receive well-child and sick care, especially children with chronic conditions such as asthma and diabetes. Financial incentives can be used by managed care plans to encourage certain provider behaviors and outcomes.

HealthPartners in Minneapolis has an incentive program for their clinics called the "Outcomes Recognition Program." This program makes monetary awards to clinics that meet children's immunization and prenatal care goals. They plan to add additional goals for the clinics in the near future.⁴⁷

Improve system capacity and infrastructure

Regardless of payment levels and administrative simplifications, families living in remote rural areas and inner cities need infrastructure development to obtain health care. To improve the distribution of primary care providers, many federal and state programs target these areas. The longstanding federal National Health Service Corps program identifies areas throughout the country with shortages of health professionals and provides medical, dental, and nursing students with scholarships

or loan repayment plans that are tied to their agreement to work in these underserved communities for a certain length of time after graduation. Many state health departments have similar programs. The federal Health Centers program gives grants to local entities to develop and operate community and migrant health centers and health centers for the homeless. These centers are primarily located in underserved areas and are knowledgeable, important partners for states and managed care plans as they reach out to serve at-risk populations.

Improve provider training. Managed care plans have important roles to play in improving their providers' ability to work with Medicaid and other hard-to-serve groups. They can train providers and others on the frontlines, contract with traditional providers, such as community health centers and local health departments who know these populations well, or both. Gateway Health Plan in Pittsburgh has used a combination strategy. They have contracted with traditional providers and established a provider relations department that helps sensitize their providers to patient needs and utilization patterns.⁴⁸ The chief goal of any of these strategies is to ensure that networks include providers who are familiar with the needs of children, and of low-income children in particular.

Providers should also be encouraged to use every opportunity to provide preventive health services and teach parents about their importance. For example, a provider should check a child's immunization status and give immunizations when the child presents for sick care. Every staff member in an office can share this responsibility. For instance, checklists of preventive health and other topics to cover in a visit can be flagged on the outside of a child's chart as a reminder to providers and staff.⁴⁹

Make clinics, offices, and staff user-friendly. If a mother brings her child in for care and is met with a long wait in a crowded waiting room, is treated with disrespect or disinterest by the front office staff, has nothing with which to entertain her other children whom she brought along because she could not or did not make other arrangements, or is told that she will need to come back because the one doctor is backed up due to an unforeseen emergency, she may leave and never come back again. If she tries to get an appointment and cannot make one within a reasonable amount of time, she may not call back again. These barriers are specific to a particular clinic and need to be addressed at that level, but these types of problems can occur anywhere. To ensure access for children, providers, program managers, and health plans need to be aware of these issues at the point of service and take steps to reduce or eliminate them.

Offer care coordination for children. Although most children are healthy and their health care needs are very basic, some children face chronic conditions, such as asthma or diabetes, that require special attention. Care coordination, also often called case management, can ensure they get the range of services they need and is a valuable aspect of quality care. To reduce inappropriate emergency room use and to prevent asthma-related hospitalizations, health plans have initiated innovative case management programs. They have developed asthma-management programs that at the most basic level include education on asthma triggers, how to manage an attack, and when to go to the doctor. More comprehensive programs also include home assessments for triggers, developing a plan with the primary care physician, and assistance in finding specialty items such as hypoallergenic pillow cases. Several asthma-management programs

Outreach in Action

To reduce emergency room usage and make primary care a more attractive alternative, the Florida Health Care Plan (FHCP), the provider for the initial Florida Healthy Kids demonstration site, provided a walk-in clinic and extended clinic hours. As noted by one FHCP manager, “long waits in an ER or doctor’s office are the real co-payment” for parents, particularly working parents. By making the office environment more user friendly than the emergency room, FHCP provided an easier point of access for enrollees.⁵⁰

have shown some promise in reducing emergency room use and in preventing asthma attacks requiring hospitalization.⁵¹

Care coordination also can be used for children with social, economic, and other risk factors that make it difficult for them to get the health and other services they need. Care coordination is a powerful service-organizing strategy that can surmount the barriers and fragmentation that typically exist between the health and related services these children need. Care coordinators identify a child’s needs, plan what services are necessary, link their clients with those services, educate parents about their child’s health condition and needs, and review progress toward goals for the child’s care.⁵² Medicaid will pay for care coordination, and over half of the states use this strategy for pregnant women and/or children.⁵³

The North Carolina Baby Love Program, a care-coordination model for high-risk pregnant women, has been shown to improve pregnancy outcomes in a high-risk population. Lessons learned from this program have been applied to the state’s EPSDT program, called Health

Check, to help Medicaid eligible children enroll in Health Check and get the preventive, primary, and other services they need. Health Check built on the care coordination and marketing strategies used with Baby Love to place Health Check coordinators in county health departments and develop a toll-free hotline, logo, and tag line (“Health Check—Check It Out”). The same hotline staff and information databases are used. Staff have been cross-trained, and bilingual staff have been added. The Medicaid agency’s automated claims data system is used to identify and track enrolled children. Information is then given to the Health Check coordinators, who contact families by phone, letter, or home visit. The state will be expanding the number of counties with Health Check coordinators and the marketing and public awareness campaign for Health Check with CHIP funds.⁵⁴

Implement continuous quality improvement.

One of the greatest challenges in ensuring access to services is the development and maintenance of quality assurance systems. Measures of access include provider contract language that clearly states the expectations of purchasers and providers, and the regular use of information systems to examine enrollees’ utilization patterns and health outcomes. Many states are now providing more specific language in Medicaid managed care contracts regarding requirements for access to care, including listing the maximum time or distance that enrollees should have to spend or travel in order to access care.⁵⁵

Health plans have much more sophisticated data systems than are traditionally available through public agencies. Regular reviews of encounter data can help plans and state agencies determine which children are appropriately accessing services and where there are gaps in services. Plans can review this data on their own, and they and their oversight

bodies can analyze the data to monitor compliance with contract requirements, develop coordinated health care delivery systems, and implement more effective outreach strategies.⁵⁶ Outreach strategies can be markedly improved when they are informed by data from these information systems. Both individuals’ and health care systems’ issues of access become more readily apparent through these analyses. Once particular issues are pinpointed, mailings, follow-up telephone calls, or home visits can be targeted to children who are not adequately immunized, to particular neighborhoods where enrollees are not accessing preventive care, or around particular services that are not being provided.

Conclusion

Families, health plans, public health and Medicaid agencies, foundations, policymakers, community organizations, and employers share a common mission of improving access to primary and preventive care for children through the highest-quality, most cost-effective means possible. Outreach is critical to identifying eligible children, facilitating their enrollment in health coverage programs, and ensuring they have access to a high-quality health home.

To date, outreach initiatives have not been well funded or evaluated. Information about effective strategies has not been broadly disseminated across states and communities. These problems may soon be resolved with the heightened awareness of outreach since the passage of CHIP and with the new federal and state funds dedicated to outreach.

Outreach efforts require careful research of the target population’s needs and the barriers they face to accessing health care. Strategies must be designed to address these needs and issues, and

the strategies must be flexible and adaptable as needed to reach those who do not respond to initial outreach efforts. Creative partnerships should be forged with community organizations and groups that know the target population and can help link families to care. Information systems must be developed that track the effectiveness of outreach strategies on health access and health outcomes wherever possible. These kinds of concerted, broad-based efforts to devise effective outreach strategies are needed throughout the states so that the promise of health insurance coverage to improve the health of children can be realized.

Notes

- ¹Summer, Laura, Sharon Parrott, and Cindy Mann, *Millions of Uninsured and Underinsured Children Are Eligible for Medicaid*, Center on Budget and Policy Priorities, Washington, DC, April 1997.
- ²Coiro, Mary Jo, et. al., "Health of Our Nation's Children," *Vital Health Statistics*, vol. 10, no. 191, December 1994, 1-61; and Employee Benefit Research Institute, "Health Insurance and Characteristics of the Uninsured," *EBRI Issue Brief*, no. 170, Washington, DC, February 1996.
- ³The 1997 federal poverty level for a family of three was \$13,330. Income for a family of three at 200 percent of federal poverty was \$26,660.
- ⁴Holl, Jane L., et. al., "Profile of Uninsured Children in the United States," *Archives of Pediatrics & Adolescent Medicine*, vol. 149, no. 4, April 1995, p. 398-406; and Aday, LuAnn, et. al., "Health Insurance and Utilization of Medical Care for Children with Special Health Care Needs," *Medical Care*, vol. 31, no. 11, 1993, p. 1012-1026.
- ⁵US General Accounting Office, *Health Insurance: Coverage Leads to Increased Health Care Access for Children*, GAO/HEHS-98-14, Washington, DC, November 1997.
- ⁶Health Care Financing Administration, *Medicaid Managed Care Enrollment Report*, Office of Managed Care, HCFA, Washington, DC, June 30, 1997.
- ⁷National Conference of State Legislatures, *State Options for Expanding Children's Health Insurance*, Washington, DC, May 1997.
- ⁸*Paying More and Losing Ground: How Employer Cost-Shifting is Eroding Health Coverage of Working Families*, Lewin Group, Inc., Fairfax, Virginia, 1998.
- ⁹Employee Benefit Research Institute.
- ¹⁰*Ibid.*
- ¹¹Summer, Parrott and Mann.
- ¹²Gauthier and Schrodel.
- ¹³Shuptrine, Sarah C., Vicki C. Grant, and Genny G. McKenzie, *A Study of the Relationship of Health Coverage to Welfare Dependency*, The Southern Institute on Children and Families, Columbia, SC, March 1994.
- ¹⁴*Poverty Rate Fails to Decline as Income Growth in 1996 Favors the Affluent*, Center on Budget and Policy Priorities, Washington, DC, October 14, 1997.
- ¹⁵Johnson, Kay A., and John E. McDonough, *Expanding Health Coverage for Children: Matching Federal Policies and States Strategies*, Milbank Memorial Fund, New York, 1998.
- ¹⁶American Health Line: National Journal's Daily Briefing, February 19, 1998.
- ¹⁷*Ibid.*
- ¹⁸Shoaf, Becky, Project materials from *Right from the Start Medicaid Project: Georgia's Outreach for Uninsured Children*, February 1998.
- ¹⁹National Governors' Association.
- ²⁰National Governors' Association, *MCH Update: State Medicaid Coverage of Pregnant Women and Children*, Washington, DC, September 1997.
- ²¹Hill, Ian T., and Trude Bennett, *Enhancing the Scope of Prenatal Services*, National Governors' Association, Washington, DC, 1990.
- ²²Henderson, Tim M., *Outstationing Medicaid Eligibility Workers at Community and Migrant Health Centers*, National Governors' Association, Washington, DC, 1992; and communication with Arlia Taylor, Aaron E. Henry Community Health Center, March 1998.
- ²³National Governors' Association.
- ²⁴US General Accounting Office, *Prenatal Care: Early Success in Enrolling Women Made Eligible by Medicaid Expansions*, Washington, DC, February 1991.
- ²⁵Cohen Ross, Donna, *New Medicaid Funding for Outreach and Enrollment Activities*, Center on Budget and Policy Priorities, Washington, DC, Aug. 18, 1997.
- ²⁶Gauthier and Schrodel.
- ²⁷The law that established CHIP allows some cost

- sharing, based on a family's income, if a state chooses to create an insurance program for children rather than expand Medicaid.
- 28 "Children's Health Insurance Programs Move to Reduce and Simplify Cost-Sharing," *State Health Watch*, vol. 5, no. 1, January 1998.
 - 29 Uba, Laura, "Cultural Barriers to Health Care for Southeast Asian Refugees," *Public Health Reports*, vol. 107, no. 5, September-October 1992, p. 544-548; and Moore, Patricia, and Joseph T. Hepworth, "Use of Perinatal and Infant Health Services by Mexican-American Medicaid Enrollees," *Journal of the American Medical Association*, vol. 272, no. 4, July 27, 1994, p. 297-304.
 - 30 Rosenbaum, Sara, et. al., *Negotiating the New Health Care System: A Nationwide Study of Medicaid Managed Care Contracts*, Center for Health Policy Research, The George Washington University Medical Center, Washington, DC, February 1997.
 - 31 Shenkman, Elizabeth et. al., "Children's Health Care Use in the Healthy Kids Program," *Pediatrics*, Volume 100, No. 6, December 1997.
 - 32 Carolyn Palakowski, Georgia Caring Program, personal communication, March 1998.
 - 33 US General Accounting Office, *Prenatal Care: Medicaid Recipients and Uninsured Women Receive Insufficient Care*, GAO-HRD-87-137, Washington, DC, September 1987; and Riportella-Muller, R, et. al., "Barriers to the Use of Preventive Health Care Services for Children," *Public Health Reports*, January-February, 1996, vol. 111, no. 1, p. 71-77.
 - 34 Short and Lefkowitz.
 - 35 Ingram, Jerry, Robin D. Rawls, and H. Dean Moberly, "Using Incentives to Motivate Women to Seek Prenatal Care: An Effective Outreach Strategy," *Journal of Health & Social Policy*, 5(1) 1993, p. 23-32.
 - 36 Kennedy, Kathleen M., and Kevin Browngoehl, "A 'High-Tech, Soft-Touch' Immunization Program for Members of a Medicaid Managed Care Organization," *HMO Practice*, September 1994, Volume 8 Number 3, p. 119.
 - 37 Jeffers, Delores F., "Outreach Childbirth Education Classes for Low-Income Families: A Strategy for Program Development," *AWHONN's Clinical Issues*, vol. 4, no. 1, 1993, p. 95-101.
 - 38 Rosenthal, E. Lee, *The Final Report of the National Community Health Advisor Study*, The University of Arizona, Tuscon, Arizona, 1998 (at press).
 - 39 Kitzman, Harriet, et. al., "Effect of Prenatal and Infancy Home Visitation by Nurses on Pregnancy Outcomes, Childhood Injuries, and Repeated Childbearing," *Journal of the American Medical Association*, vol. 278, no. 8, August 27, 1997, p. 644-652; and Olds, David L., "Home Visitation for Pregnant Women and Parents of Young Children," *American Journal of the Diseases of Children*, vol. 146, June 1992, p. 704-708.
 - 40 US General Accounting Office, *Home Visiting: A Promising Early Intervention Strategy for At-Risk Families*, GAO/HRD-90-83, Washington, DC, July 1990.
 - 41 Kennedy and Browngoehl, pp. 117-119.
 - 42 Mona Jordan, Gateway Health Plan, Personal Communication, March 1998.
 - 43 Paine, Brigitte, "A Kids' 'Care-Van': Hospital's Mobile Health Program Provides Screenings for Neighborhood Children," *Health Progress*, Oct. 1994.
 - 44 Chang, R., and Neal Halfon, "Geographic Distribution of Pediatricians in the United States: An Analysis of the Fifty States and Washington, DC," *Pediatrics*, vol. 100, no. 2, August 1997, p. 172-179.
 - 45 ASTHO, "Arkansas' ConnectCare Medicaid Program Improves Access," *ASTHO Report*, Volume 6, Number 11, January/February 1998, p. 3
 - 46 Marsha Roth, Division of Women's and Children's Health, North Carolina Health Department, personal communication, March 1998.
 - 47 Donna Zimmerman, Director of Government Programs, HealthPartners, personal communication, March 1998.
 - 48 Mona Jordan, Gateway Health Plan, personal communication, March 1998.
 - 49 Margolis, Peter A., et.al., "The Rest of the Access-to-Care Puzzle: Addressing Structural and Personal Barriers to Health Care for Socially Disadvantaged Children," *Archives of Pediatrics and Adolescent Medicine*, Volume 149(5), May 1995, pp. 541-545.

- ⁵⁰Coulam, Robert F., et.al., "Managing Access: Extending Medicaid to Children Through School-Based HMO Coverage," *Health Care Financing Review*, Spring 1997, Volume 18, Number 3, p. 163.
- ⁵¹Moe, E.L., et al. "Implementation of Open Airways, an Educational Intervention for Children with Asthma in an HMO," *Journal of Pediatric Health Care*, 6(5), 1992, pp. 251-255; Mona Jordan, Gateway Health Plan, personal communication, March 1998; Wissow, Lawrence S., et.al., "Case Management and Quality Assurance to Improve Care of Inner-city Children with Asthma," *American Journal of Diseases of Children*, Volume 142, July 1988, pp. 751-752,
- ⁵²Berkowitz, Gale, Neal Halfon, and Linnea Klee, "Improving Access to Health Care: Case Management for Vulnerable Children," *Social Work in Health Care*, vol. 17, no. 1, 1992.
- ⁵³National Governors' Association.
- ⁵⁴Marsha Roth, Division of Women's and Children's Health, North Carolina Health Department, personal communication, March 1998.
- ⁵⁵Rosenbaum, et.al.
- ⁵⁶Children's Health Council of Connecticut Program Materials, February 10, 1998.

Appendix A

State Children's Health Insurance Program (CHIP) Web Sites

This list of web sites with information about CHIP was prepared by the National Center for Education in Maternal and Child Health for the January 1998 PIC Briefing Book: Title XXI, State Children's Health Insurance Program. Sites include summaries of the CHIP legislation and other related legislation; policy and program analyses; implementation guidelines; states' progress in implementing CHIP; benefits and coverage information, including managed care issues; and technical assistance publications and resources on outreach and enrollment.

Agency for Health Policy and Research

www.ahcpr.gov

The Agency for Health Care Policy and Research (AHCPR), a part of the U.S. Department of Health and Human Services, is the lead agency charged with supporting research designed to improve the quality of health care, reduce its cost, and broaden access to essential services. AHCPR's research programs bring practical, science-based information to medical practitioners, consumers, and other health care purchasers. The AHCPR Web site contains research on managed care, quality assurance, guidelines, and medical outcomes; results from the Medical Expenditure Panel Survey; press releases; and grants announcements.

Alpha Center

www.ac.org

The Alpha Center is a nonprofit, nonpartisan health policy center that provides objective information, analysis, and strategic planning to both the public and the private sectors. This Web site includes access to Alpha Center publications, selected State health care policy developments and data, links to other policy resources, and information on the State Initiatives in Health Care Reform program, sponsored by The Robert Wood Johnson Foundation.

American Academy of Pediatrics

www.aap.org

The American Academy of Pediatrics is a membership organization committed to the attainment of optimal physical, mental, and social health for all infants, children, adolescents and young adults. Activities of the AAP: include advocacy for children and youth; public education; research; professional education; membership service and advocacy for pediatricians. The AAP Web site includes sections on Washington and State Government Updates, press statements and testimonies, as well as a number of documents related to the CHIP program.

Assistant Secretary for Planning and Evaluation

aspe.os.dhhs.gov

The Office of the Assistant Secretary for Planning and Evaluation is responsible to the secretary of the U.S. Department of Health and Human Services (DHHS) for policy analysis and advice, policy development, strategic and implementation planning, and the coordination and conduct of evaluation and policy research. This Web site contains information on health care financing, children and youth policy, DHHS poverty guidelines, and State efforts to integrate health information.

Association of Maternal and Child Health Programs

www.amchp1.org

The Association of Maternal and Child Health Programs (AMCHP) is a national non-profit organization principally made up of the directors and staff of state public health agency programs for maternal and child health, and children with special health care needs in all 50 states, the District of Columbia, and eight additional jurisdictions. This Web site includes information on membership, discussion groups for state MCH and CSHCN directors, fact sheets and Issue Briefs on topics such as collaboration between Title V and children's health insurance programs.

Association of State and Territorial Health Officials

www.astho.org

The Association of State and Territorial Health Officials (ASTHO) represents the public health agencies of each of the States and U.S. territories. ASTHO is involved in a number of legislative, scientific, educational, and programmatic issues and activities on behalf of public health. This site provides links to State public health departments and information on ASTHO's public health projects. It also includes ASTHO's periodic publication, ASTHO Access Brief, which provides useful resources and contact information about outreach and enrollment issues under CHIP.

Bazelon Center for Mental Health Law

www.bazelon.org

The Judge David L. Bazelon Center for Mental Health Law provides legal advocacy for the civil rights and human dignity of people with mental disabilities. This Web site provides publications and alerts on issues which affect children with mental disabilities and mental retardation, including SSI, welfare reform, Medicaid managed care, mental health parity, and the CHIP program.

Census Bureau

www.census.gov

The goal of the U.S. Census Bureau is to collect and provide timely, relevant, and quality data about the people and economy of the United States. The Bureau's Web site contains an alphabetical listing by subject area for easy access to data and publications, including the health insurance status of adults and children. The site also includes information on surveys, statistical activities, software, and Web links to other data collection agencies.

Center for Health Care Strategies

www.chcs.org

The Center for Health Care Strategies, Inc. is a non-profit, nonpartisan policy and resource center affiliated with the Woodrow Wilson School of Public and International Affairs to promote the development and implementation of effective health and social policy. Through grants from the Annie E. Casey Foundation, the Center provides technical assistance and information on issues related to managed care for vulnerable children and low-income families. Since September 1997, this work has included a Web site on Children's Issues in Managed Care.

Center for Studying Health System Change

www.hschange.com

The Center for Studying Health System Change is a Washington-based research organization dedicated to studying how the country's health care systems are changing and how those changes are affecting people at the community level. This Web site includes information on conferences, seminars, research, and issue briefs. Topics included health care costs, hospital report cards, access to care, and the 'crowd out' effect.

Center on Budget and Policy Priorities

www.cbpp.org

The Center on Budget and Policy Priorities is a nonpartisan research organization and policy institute that conducts research and analysis on a range of government policies and programs, with an emphasis on those affecting low- and moderate-income people. This Web site provides access to publications on numerous topics, including outreach and enrollment of children in health coverage programs and analyses of CHIP.

Children's Defense Fund

www.childrensdefense.org

The Children's Defense Fund (CDF) is a private, nonprofit organization dedicated to educating people about the needs of children and encouraging preventive investment in children. This site provides information on all the current CDF activities, including its Child Health Information Project. The CDF Web site includes recent analyses of the new children's health insurance legislation, State-by-State estimates of the number of uninsured children, and approximate State allocations provided by the new program, as well as links to other children's advocacy organizations. The site also includes information about CDF's state offices and activities.

Employee Benefit Research Institute

www.ebri.org

The Employee Benefit Research Institute (EBRI) is a nonprofit, nonpartisan organization committed to original public policy research and education on economic security and employee benefits. The Web site includes access to EBRI publications and issue briefs, including the annual "Sources of Health Insurance and Characteristics of the Uninsured," which analyzes the Current Population Survey.

Families USA

www.familiesusa.org

Families USA is a national nonprofit organization advocating high-quality, affordable health and long term care for all Americans. Families USA issues reports and analyses, and works extensively through a variety of media, to educate the public, opinion leaders, and policymakers about problems consumers experience in the health care marketplace and what should be done to solve them. This Web site includes publications and advocacy information on Medicaid, Medicare, children's health care reform, and managed care.

Federal Employee Health Benefits Program

www.opm.gov/insure/html/openseas.htm

The Web site of the Office of Personnel Management includes information on the Federal Employee Health Benefits Program (FEHB). This site includes FEHB information organized alphabetically and by State and the 1997 FEHB Guide. This information may be downloaded.

Florida Healthy Kids Corporation

www.healthykids.org

The Florida Healthy Kids Corporation was created in 1990 by the Florida Legislature to address the problem of the State's uninsured children. The project uses school districts to create large health-insurance risk pools that bring affordable, accessible, quality private-sector health care to uninsured children. The Healthy Kids Web site includes an overview of the local and national projects, annual reports, research and evaluation activities, enrollment information, grant opportunities, and links to other relevant sites.

The Future of Children

www.futureofchildren.org

This site includes the full text of The Future of Children, a journal that summarizes current research and policy issues relating to the well-being of children. The journal is developed by the Center for the Future of Children at the David and Lucile Packard Foundation.

General Accounting Office

www.gao.gov

The US General Accounting Office (GAO) acts as the investigative arm of Congress. This Web site provides access, with searching and downloading capabilities, to GAO reports and testimony. The site also includes Comptroller General Decisions and Opinions, reports on the major rules of Federal agencies, GAO policy and guidance materials, and special publications. GAO has issued a number of reports on Medicaid, private insurance reforms, health insurance for children, and other health policy issues.

HCFA/Children's Health Insurance Program

www.hcfa.gov/init/children.htm

This site, run by the Health Care Financing Administration, includes informational materials for various audiences relating to CHIP. It includes letters sent from the Administration to state officials, Federal Register notices, a draft template and instructions for the submission of CHIP plans, a series of Frequently Asked Questions and Answers, status report on state plan submissions, and a direct link to ask questions of Administration officials via e-mail.

Health Resources and Services Administration

www.hrsa.dhhs.gov

The Web site of the Health Resources and Services Administration (HRSA), the branch of the U.S. Department of Health and Human Services charged with providing health resources for medically underserved populations, provides an overview of and information about HRSA programs, news and public affairs, a staff directory, and a list of upcoming events. This site also allows subject searches of HRSA's Bureau of Primary Health Care, Bureau of Health Professions, Bureau of Health Resource Development, and Maternal and Child Health Bureau.

Henry J. Kaiser Family Foundation

www.kff.org

The Web site of the Henry J. Kaiser Family Foundation includes information on its work in health care policy and innovations. The site includes fact sheets and publications on State health policy, the uninsured, and the Kaiser Commission on the Future of Medicaid. Documents may be downloaded from organizations that receive Kaiser funding, including The George Washington University Center for Health Policy Research, the Alpha Center, the Urban Institute, and the National Governors' Association.

House of Representatives Committee on Commerce

www.house.gov/commerce

The Committee on Commerce is responsible for public health, Medicaid, and health insurance issues in the US House of Representatives and is currently chaired by Congressman Tom Bliley of Virginia. Rep. Bliley has recently released the first in a series of CHIP implementation guides for states, which may be downloaded from the site.

Institute for Child Health Policy

www.ichp.ufl.edu

The Institute for Child Health Policy is dedicated to improving the health status of infants and children in the state of Florida and the nation by integrating the resources of the universities in the state to assist in the formulation and evaluation of health policies, programs and systems. Starting in 1988 the Institute developed the concept of school enrollment based health insurance. These efforts culminated the establishment of the Florida Healthy Kids Corporation in 1991. This Web site includes information on Institute work on both policy and program development and research and evaluation.

National Academy for State Health Policy

www.nashp.org

The National Academy for State Health Policy (NASHP) is a multidisciplinary forum of and for state health policy leaders from the executive and legislative branches. NASHP helps policymakers to exchange insights, information and experience, and to develop practical, innovative solutions to complex health policy issues confronting states. The NASHP site contains information on ordering publications, including a status report on CHIP.

National Association of Child Advocates

www.childadvocacy.org

The National Association of Child Advocates (NACA) is a membership organization comprised of child advocacy organizations working on the front lines to ensure the safety, security, health and education of America's children. The NACA Web site includes information on current projects (including their Child Health Advocacy Project), membership materials, a publications list, and links to a number of related Web sites.

National Association of Insurance Commissioners

www.naic.org

The National Association of Insurance Commissioners (NAIC) is the organization of insurance regulators from the States and U.S. territories who are appointed to protect the interests of insurance consumers. The NAIC Web site provides consumer and regulatory information, access to publications and data base products, model laws and regulations, and State health insurance department contacts.

National Association of State Medicaid Directors

medicaid.apwa.org

The National Association of State Medicaid Directors (NASMD) is a bipartisan, professional, nonprofit organization of representatives of State and territorial Medicaid agencies. The primary purposes of NASMD are to serve as a focal point of communication between the States and the Federal government and to provide an information network among the States on issues pertinent to the Medicaid program. This Web site includes position papers and legislative memoranda, specific information on State waiver activity, and general information on upcoming conferences and membership.

National Center for Education in Maternal and Child Health

www.ncemch.org

The National Center for Education in Maternal and Child Health (NCEMCH) is a resource center dedicated to improving the health of children and families. NCEMCH serves maternal and child health (MCH) practitioners—including health professionals, researchers, policymakers, program administrators, business leaders, and health officials—to help them make more informed decisions to improve the health of the Nation's children and families. This site provides a searchable database on MCH organizations and issues, publications available for downloading, information on conferences and projects, and links to other MCH Web sites.

National Center for Policy Analysis

www.ncpa.org

The National Center for Policy Analysis (NCPA) was established to develop and promote private alternatives to government regulation and control, solving problems by relying on the strengths of the competitive, entrepreneurial private sector. NCPA works on a number of health policy issues, in particular the use Medical Savings Accounts. The health section of NCPA site includes information on MSAs, managed care, managed competition, Medicaid, and health care reform. Issue Briefs, including those on uninsured children, are available on this site.

National Conference of State Legislatures

www.ncsl.org

The National Conference of State Legislatures (NCSL) is dedicated to improving the quality and effectiveness of State legislatures, fostering interstate communication and cooperation, and ensuring legislatures a strong, cohesive voice in the Federal system. NCSLnet, the organization's Web site, provides electronic information for State legislators and their staff. NCSL's health program has posted information on accessing books, LegisBriefs, and State Legislative Reports on a wide range of health-related issues, as well as a detailed analysis of the new State Children's Health Insurance Program.

National Governors' Association

www.nga.org

The National Governors' Association (NGA) is the only bipartisan organization of, by, and for the Nation's Governors. NGA provides assistance in solving State-focused problems, information on State innovations and practices, and a bipartisan forum for Governors to establish, influence, and implement policy on national issues. The NGA Web site provides direct access to information on Governors and shares the best ideas of the States via electronic means. Policy statements, Issue Briefs, StateLines, and access to publications on children's health are available through the Health Division of the Center for Best Practices. This site also includes information on CHIP implementation plans in the states and links to other related publications.

National Health Law Program

www.healthlaw.org

The National Health Law Program (NHeLP) is a national public interest law firm that seeks to improve health care for America's working and unemployed poor, minorities, the elderly and people with disabilities. NHeLP serves legal services programs, community-based organizations, the private bar, providers and individuals who work to preserve a health care safety net for the millions of uninsured or underinsured low-income people. The NHeLP Web site includes many of their publications, including a detailed summary of CHIP and other Medicaid provisions enacted by the Balanced Budget Act of 1997.

National Parent Network on Disabilities

www.npnd.org

The National Parent Network on Disabilities is a national organization that shares information and resources to promote and support the power of parents to influence and affect policy issues concerning the needs of children, youth, and adults with disabilities and their families. This Web site includes legislative updates on changes in the Supplemental Security Income program, welfare reform, and CHIP.

Policy.com

www.policy.com

Policy.com is a comprehensive public policy information service and Internet/online community. This Web site provides news and issues analyses through its diverse membership of think tanks, advocacy organizations, universities, associations, businesses, government agencies, and the media. Discussions and links are available on a variety of health issues.

Robert Wood Johnson Foundation

www.rwjf.org

The Web site of The Robert Wood Johnson Foundation (RWJF), the Nation's largest foundation devoted exclusively to health and health care, provides the latest news on health policy from American Health Line, information on programs and publications funded by RWJF, and the new Health Tracking Program that is designed to measure the effects of health system changes on the American people.

THOMAS

thomas.loc.gov

Operated through the Library of Congress, THOMAS provides access to Congress. The site includes searchable data bases on current congressional activity; the text, summaries, and current status of legislation; Congressional Record text and indices; committee reports and Web sites; historical documents; information on the legislative process; and other government Internet resources.

Urban Institute

www.urban.org

The Urban Institute is a nonprofit policy research organization that investigates social and economic problems confronting the Nation and analyzes government policies and the public and private programs designed to alleviate them. The Web site has reports and analysis on a variety of topics, including health care and devolution to the States, which may be downloaded.

