Enrolling Eligible People in Medicaid and the State Children's Health Insurance Program

Robert Wood Johnson Foundation

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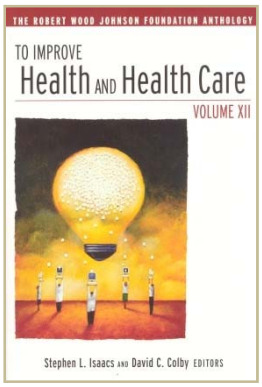

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Editors' Introduction

Although Congress has never been able to agree on legislation that would provide insurance coverage to all, or virtually all, Americans, it has been able to enact laws that provide piecemeal coverage. Medicare, passed in 1965, covers 44 million people over sixty-five and those of any age with disabilities.[1] Medicaid, also passed in 1965, covers the medical care of 59 million low-income people.[2] The State Children's Health Insurance Program (SCHIP), passed in 1997, covers 6 million children from low-income families.[3] SCHIP became something of a political football in 2007: it was extended in 2008 only after President George W. Bush vetoed two bipartisan bills to expand the program and after the Department of Health and Human Services had issued a regulation that made it difficult for states to raise eligibility limits.

Passage of a law making coverage available is not enough; six out of every ten uninsured children are eligible for Medicaid or SCHIP coverage but are not enrolled.[4] There are many reasons that individuals and families do not take advantage of health insurance benefits to which they are entitled. Probably the most common is that they are simply not aware that they or their children might be eligible. But even when families do recognize their eligibility and try to sign up, they face significant barriers. Forms are often long and complicated; eligibility requirements vary among programs and change frequently; documentation requirements can be onerous; legal immigrants face both language and cultural problems; and intake workers, concerned about fraud, can make the enrollment process difficult. Once enrolled, benefits last only for a limited period of time before eligible people have to go through the whole enrollment process again. Moreover, the greater the number of people enrolled in Medicaid and SCHIP, the greater the strain on state budgets, giving state governments an incentive to keep enrollment low, especially in hard economic times.

Since 1997, the Robert Wood Johnson Foundation has made substantial investments in a variety of programs to make families aware that their children might be eligible for SCHIP or Medicaid benefits and to address the practical obstacles to enrollment and renewal. In this chapter, the journalist Irene Wielawski, who is a frequent contributor to *The Robert Wood Johnson Foundation Anthology* series, examines the major Foundation-funded programs with this focus. Through her visits to two sites, she offers an on-the-ground look at the way different locales have worked to enroll eligible people and what the programs have and—not surprisingly, given the many practical challenges to enrollment—

have not accomplished.

The editors note with sadness the death in April of Sarah Schuptrine, the program director of the programs discussed in this chapter. We wish to recognize her many contributions to the field.

Notes

1. Centers for Medicare & Medicaid Services. *Data Compendium, Population*, 2007. (http://www.cms.hhs.gov/DataCompendium/17_2007_Data_Compendium.asp#TopOfPage)

2. Centers for Medicare & Medicaid Services: *MSIS Table FY 2004*, June 2007. (http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/msistables2004.pdf)

3. The Kaiser Commission on Medicaid and the Uninsured. "President's FY 2009 Budget and SCHIP." *Fact Sheet*, February 2008. (http://www.kff.org/medicaid/upload/7758.pdf)

4. Dorn, S. *Eligible but not Enrolled: How SCHIP Reauthorization Can Help*. Washington, D. C.: Urban Institute, September 2007.

Hey there," Angie Huval says brightly to the cashier as she bounds over to the deli counter at Guidroz's Food Center in Lafayette, Louisiana, to order *boudin*—a Cajun delicacy made of "dirty" spiced rice and fried pork innards stuffed in a loop of pig intestine. Huval, a serious foodie, wants details on Guidroz's recipe, and her curiosity gets the cook out from the kitchen, hooks the counterman, and draws several other customers into a discussion of seasoning and simmer time.

It's all in a day's work for Huval, who deploys her natural effervescence and gift of gab for serious purpose: finding poor and low-income families whose children qualify for Louisiana's combined Medicaid and State Children's Health Insurance Program, called LaCHIP.

Like a traveling saleswoman, Huval cultivates the relationships needed to get literature on LaCHIP and other state health programs prominently displayed among the businesses that ring Lafayette's low-income neighborhoods—family-owned markets like Guidroz's, convenience stores, gas stations, and luncheonettes. In the process, she adroitly extends her personal reach by converting store workers to the cause of getting this information into the hands of poor families.

"A lot of people here are related, and they know who the families are even if I don't, so I need them on my side," Huval says. "It's not just about getting people signed up; it's making sure the kids stay in the program. So when they're up for renewal and the phone's shut off or the mail gets returned, I've got people I can ask to find where those families are at so I can get the paperwork to them. The point is not to lose the kids."

In her attitude, no less than her hands-on proselytizing, Huval represents the leading edge of efforts across the United States to reach more than 6 million children eligible for government-sponsored health insurance but not enrolled.

The work, spanning more than a decade, utilizes a wide range of strategies to promote the benefits of health insurance and make it easier for families to sign up. It was significantly aided by three Robert Wood Johnson Foundation initiatives: the $43 million Covering Kids (1997–2001), the $65 million Covering Kids and Families (2001–2007), and the $5.9 million Supporting Families after Welfare Reform (2000–2004). Collectively, these programs reached into all fifty states and the District of Columbia, offering technical assistance to simplify enrollment as well as strategies to engage

community leaders, schools, businesses, churches, and civic groups in getting the word out to eligible families.

The result has been a dramatic shift in the attitude and function of government vis-à-vis needy citizens—a far cry from Medicaid's early days, when eligibility workers like Huval got more credit for denying benefits than for helping applicants clear procedural hurdles.

How states revitalized the Medicaid workforce while launching community-based ventures to build public trust and operational efficiency is worth examining as much for the stimulus of unforeseen events—an ill wind called Katrina, for instance—as for the incremental steps grantees took to make Medicaid and SCHIP more user friendly. The uneven road they traveled illustrates both the complexity of changing institutional mindsets and the creativity unleashed by doing so—lessons with applicability well beyond the health care sector.

How We Got Here

Almost from the day it was signed into law in 1965, Medicaid took heat for an unwelcoming attitude toward the very people Congress set out to help.

Critics compared the thick application packet used by most states to the Internal Revenue Service's onerous 1040 long form. Designed to weed out undeserving applicants and safeguard taxpayers' money, the application also discouraged eligible families who found the instructions confusing or didn't grasp the value of health insurance for their children. Michigan's program, for example, had a twenty-eight-page application that tiered eligibility in a way that left some family members insured, others not. If family income came in at or below 185 percent of the federal poverty level, pregnant women and babies qualified for coverage, but children ages one to fifteen didn't. The older children got in only if family income fell to 150 percent of poverty. Coverage for children sixteen to eighteen years old commenced at or below 100 percent of poverty.[1]

Proving eligibility was also daunting. States required many corroborating documents—birth certificates, pay stubs, utility bills, bank statements, residency proofs, and asset evidence such as car titles, deeds, and mortgage documents—as well as in-person interviews at government offices. The sometimes multiple visits needed to satisfy requirements deterred applicants who couldn't spare the

time from work, observers say. Treatment by state workers discouraged others.

"It was a you-go-get-it-and-bring-it-to-me system," said the late Sarah Shuptrine, former president of the Southern Institute on Children and Families in Columbia, South Carolina, and a long-time advocate for Medicaid reform, who led the Robert Wood Johnson Foundation's effort to change this situation.* "The eligibility worker just gave them a list of things they wanted—documentation, verification, and often a list of things that was more than the law required them to ask for. If the applicant couldn't find something, the worker had grounds to deny them for failure to comply. The system was biased in favor of denials, because eligibility workers were reviewed and rewarded for how many people they kept out. You were never asked how many people you helped get coverage." Another deterrent was a widespread public perception of Medicaid as a welfare program, even though Congress in 1986 opened it to working, low-income pregnant women and their children. Some working parents simply assumed that their children were ineligible. Others feared stigma and shunned Medicaid because they didn't want to be seen by their neighbors as charity cases. Still others worried that government officials would misuse the personal information required on Medicaid applications.

Lori Grubstein, a program officer at the Robert Wood Johnson Foundation, who has worked on Medicaid-related initiatives, said the wariness was justified. "There were some intentional efforts over the years by state governments to use the information on the application to push people off Medicaid in a low-budget year," she said.

All of these factors contribute to Medicaid-eligible children remaining uninsured and vulnerable to health consequences from delayed or inadequate care. Studies have shown that parents of uninsured children are slow to take them to the doctor because of cost concerns. Uninsured children also are less likely than insured children to have a regular doctor or dentist or place of care. Well-child visits and preventive care get short shrift, but in cases where parents repeatedly seek crisis care in hospital emergency rooms, overall costs to the health care system may actually be higher than the cost of Medicaid coverage.

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* Sarah Shuptrine died on August 18, 2008, after having been interviewed for this chapter.

Such analyses of both the human and systemic consequences of inadequate insurance coverage fueled national momentum in the early 1990s to overhaul the health care system. President Clinton devoted the first two years of his presidency to shepherding an ambitious universal insurance proposal. Its failure in 1994 fundamentally changed the conversation about ways and means to improve conditions for uninsured Americans. The wiser course politically became "incremental reform," through which existing sources of coverage such as employer-sponsored insurance, Medicaid, and the Medicare program could be adjusted to benefit more Americans.

With political emphasis shifting to incremental reform, the Foundation intensified its focus on improving access to existing public insurance and health assistance programs. In July 1997, the Foundation's board authorized a $13 million experiment to improve Medicaid enrollment in fifteen states; it was called Covering Kids: A National Health Access Initiative for Low-Income Uninsured Children. At the time, an estimated 10.6 million children in the United States lacked health insurance, of whom 5 million were believed to be eligible for Medicaid.[2]

With Covering Kids, the Foundation hoped to stimulate improvements in Medicaid outreach and administrative practices so that states could "max out," meaning enroll 100 percent of eligible children. The means to achieve this was through community-based coalitions made up of key government (including Medicaid) officials and community leaders and organizations. Specific strategies included making paperwork and proof of eligibility less onerous for applicants, accelerating the process of approval, and reducing the chances of children falling off the rolls solely for procedural reasons.

Congress and the Clinton administration were on a parallel track, honing in on better coverage for children as a means to redirect the political energy of health reformers. Their focus became children of the working poor, whose parents earned too much to qualify for Medicaid but not enough to buy private insurance. The proposed State Children's Health Insurance Program (SCHIP) shrewdly sidestepped the contentious issues that had undermined support for universal reform three years before, notably administration and cost. The mechanism to expand coverage—state Medicaid programs—was already in place, and children, studies showed, were relatively inexpensive to insure. The political strategy worked. Barely a month after the Foundation authorized Covering Kids, Congress passed SCHIP, tucking it into the Balanced Budget Act of 1997 with an allocation of $48

billion in new money for states over ten years. Like Medicaid and other health programs that are jointly funded by federal and state governments, SCHIP's federal share would be distributed through block grants. States could use it to expand Medicaid eligibility, to create an adjunct SCHIP insurance program, or to combine SCHIP insurance with Medicaid expansion.

Covering Kids was suddenly a very hot program. Medicaid officials scrambled to submit applications, hoping to garner ideas and expertise that would aid their states' rollouts of SCHIP. Foundation staff members scrambled in turn, hoping to reposition Covering Kids to take maximum advantage of the SCHIP platform. The program's scope was quickly deemed too modest, given SCHIP incentives to imbue coverage expansions with stigma-free, client-friendly features. A revised proposal was approved, swelling Covering Kids from a targeted $13 million experiment to a $44 million national investment covering all fifty states and the District of Columbia.

In May 2001, the Foundation continued Covering Kids through a $65 million successor program called Covering Kids & Families (2001–2007). The added emphasis on families aimed at taking advantage of new coverage options for low-income parents under Medicaid and SCHIP and at responding to research showing that when parents are insured, they're more likely to seek timely care for their children. Simultaneously, the Foundation authorized $5.9 million for Supporting Families after Welfare Reform to combat a national trend in which families moving from welfare to work automatically lost health insurance and other public benefits, even though some of them were still eligible.

Searching for Common Ground

The task of managing these gigantic, multistate programs—Covering Kids, Covering Kids & Families, and Supporting Families after Welfare Reform—fell to the Southern Institute on Children and Families. Shuptrine, its president at the time, became national program director for all three. Since in some way they all targeted Medicaid and SCHIP administrative processes, it seemed logical to group them under one roof.

"It was very, very important that we put Medicaid and SCHIP out there in a way that people could accept them without feeling ashamed," Shuptrine said. "We needed to open the door, reduce the barriers, get rid of the hoops that we were requiring them to jump through, and give them a chance

to come in."

But the leap from the conceptual to the practical was a big one. The administrative landscape that the Foundation sought to tame was kaleidoscopically diverse. Unlike Medicare, which covers everybody over age sixty-five and is administered according to a common set of federal rules, Medicaid eligibility and benefits vary from state to state and fluctuate from year to year, reflecting the myriad economic and sociopolitical forces that shape policy decisions at state and local levels of government. People can be eligible one year and, with no change in household income, lose benefits the next. A fifty-state jurisdiction for a program like Covering Kids translates into at least fifty different histories, health care delivery systems, population characteristics, and Medicaid benefit packages.

Despite these differences, there are many regional similarities. The New England states, for example, generally have low numbers of uninsured residents, high enrollment in public health and assistance programs, an easily accessible primary care and hospital infrastructure, relatively homogeneous populations, and liberal social policy, especially toward children. Deep Southern states, on the other hand, have extensive rural poverty, some of the nation's worst population health statistics, relatively low levels of employer-sponsored health insurance, and governments heavily focused on economic development as the means to improve living conditions. A similar bootstrap mentality underlies public policy in many Western states.

Yet even with such similarities, these were difficult programs to manage regionally. Unlike broad-brush policy initiatives, Covering Kids and its companion programs targeted the details of procedure and the demeanor of workers taking applications. This requires exhaustive knowledge of individual state systems in order to creditably address problems in procedure, forms, training, performance incentives, even office design. The Southern Institute's Covering Kids staff—all five of them—embraced a workload that included monitoring federal regulations, the rollout of new SCHIP programs, state Medicaid changes, and community outreach activities at 170 local sites.

"We didn't have the staffing that we got later with Covering Kids & Families," Nicole Ravenell, the Southern Institute's current president and CEO, said ruefully. Ravenell came on board in 2000 as deputy director for policy and research and, among other duties, worked to get Medicaid chiefs and

community leaders talking across state lines. The idea was to stimulate idea trading about common challenges, whether it was enrolling children of new immigrants, tracking homeless and other transient populations, or reaching families in isolated rural areas. "We quickly realized that, first, there isn't one single way of dealing with enrollment and retention problems, and second, that what worked in one area did not work in another."

Covering Kids and Covering Kids & Families required grantees to organize and work through coalitions that included state and local government representatives as well as leaders from relevant community organizations such as schools, churches, and civic groups. By structuring the initiatives in this fashion, the Foundation hoped to engage a broad cross section of knowledgeable people in each state who could cross-fertilize the public and private sectors with fresh ideas about how to bolster Medicaid and SCHIP enrollment. A subtler goal was to disrupt the age-old pattern of finger-pointing between government and private sector child welfare entities and build rapport for future collaboration.

"Covering the uninsured is a social issue and requires social change," said John Lumpkin, a Foundation senior vice president, who has grappled with problems of health care access from both sides, having served as state public health director in Illinois. "Our investment in the coalitions was part of initiating that social change."

In the process of working with the coalitions, which included state government representatives, the Robert Wood Johnson Foundation underwent a social change of its own and came to better understand the challenge of reorienting complex programs in the context of austere and often volatile state budgets. The insights, spurred notably by complaints from Supporting Families after Welfare Reform grantees about unrealistic Foundation expectations, led to significant changes in that program and helped foster better working relationships generally between Foundation and Southern Institute staff and state government partners. (Like Covering Kids and Covering Kids & Families, Supporting Families sought to improve administrative processes and retain people eligible for state aid.)

Supporting Families (the full name of the program was Supporting Families After Welfare Reform: Access to Medicaid, SCHIP and Food Stamps) focused on families moving from welfare to work as a

result of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, otherwise known as "welfare reform." In many states, these families were automatically losing Medicaid, SCHIP, and food stamps as soon as they left welfare, even though some were still eligible. To get benefits restored, the families had to reapply to each program. Some didn't, surveys showed, believing that their loss of health insurance or food stamps meant they no longer qualified. Halting such "procedural" denials required extensive administrative retooling and new links between social service and medical assistance agencies. Eight states and three large counties successfully applied for grants under Supporting Families to undertake this work, but they became disenchanted with what they considered unreasonable pressure to show coverage improvements quickly, especially in the harsh budgetary environment in which grantees worked after 2000, according to a midterm report of the program evaluator, Carolyn Needleman of Bryn Mawr College.[3]

"Extracting key facts from state administrative data—a step that everyone had assumed would be a fairly simple starting point—was actually a major undertaking in itself," Needleman wrote in her January 2003 report. "The National Program Office wanted very much to believe that it wasn't really that difficult after all, and continued to urge grantees to try harder and drill down into their data." Foundation staff members revised these assumptions as evidence mounted of both the difficulties of the task and the harsh budgetary environment in which grantees worked. Needleman recounted the experience of one grantee who got a phone call at a regional Supporting Families meeting in late 2002 to alert her to an unexpected $1 million cut in her agency's budget. Another grantee said she faced staff cuts as high as 40 percent because of the impact on state budgets of a growing national recession. In response, the Foundation dropped the goal of large-scale reform and refocused Supporting Families on laying the groundwork for incremental improvements in service to needy families. To this end, grantees were offered training in team-based learning and problem solving, using the model developed by the Institute for Healthcare Improvement of Cambridge, Massachusetts, to enhance medical care quality.

Turning the Supertanker

As the rocky course of Supporting Families illustrates, the job of retooling government administrative systems is neither quick nor easy. Nor is it solely a matter of having sufficient money and technical know-how. Fundamentally, the job requires an attitude shift that establishes children's health and well-being as a priority and then systematically organizes each unit in service of that mission.

Congress twice established the priority—in 1965 with Medicaid and in 1997 with SCHIP. Making that priority a reality has been the harder task, given constraints of budget, law, and the ever-shifting politics of charity in the United States. Public support for health coverage expansions is closely tied to the U.S. economy; polls typically measure strong support for health reform in prosperous times but not during periods of high unemployment, credit stress, and low consumer confidence.

In authorizing Covering Kids, Covering Kids & Families, and Supporting Families after Welfare Reform, the Foundation recognized these constraints but nevertheless sought to stimulate innovation in state administrative practices and capitalize on both SCHIP and the flush national economy of the latter 1990s to improve children's access to timely medical care. The Covering Kids request for proposals identified three goals for Medicaid agencies and their community partners:

- Improve outreach to find children eligible for public health insurance or other coverage
- Simplify the enrollment process
- Improve the coordination of programs so that children are comprehensively evaluated for eligibility and don't miss out on coverage simply because they applied to the wrong program.

The Foundation awarded grants ranging from $500,000 to $1 million to statewide coalitions in all fifty states and the District of Columbia, as well as to 172 coalitions in local communities. It also launched a $26 million communications campaign, beginning in 2000, to increase awareness of Medicaid and SCHIP among eligible families and encourage them to enroll their children. The effort included annual Back-to-School enrollment events and television, radio, and print advertisements to increase the number of people calling a federal hotline (1-877-KIDS-NOW) that connected them with eligibility offices in their states.

Covering Kids & Families, the successor to Covering Kids, continued the communications campaign, repeated the goals and broadened their scope to improve renewal procedures and include eligible adults. The Foundation awarded four-year grants averaging $830,000 to coalitions in all fifty states and the District of Columbia, and these, in turn, distributed half of their money to at least two local grantees, for a total of 173 local projects. In addition to continuing the work begun under Covering Kids, grantees also were asked to make sure that Medicaid and SCHIP patients had access to doctors, clinics, and other health care providers. The Foundation's initiatives weren't the only game in town, since many private organizations and government agencies had been similarly energized by SCHIP's

passage to pursue better coverage for children.

Among specific activities carried out by the states in collaboration with coalitions sponsored by Covering Kids and Covering Kids & Families were development of more appealing and readable program literature and a simplified application process. The latter includes the move by many states to combine Medicaid and SCHIP into a single application. The programs also tried to improve outreach, including decentralized and, in some states, online enrollment options that ease travel burdens on applicants and increase administrative efficiency, and reductions in the number of documents families must provide to prove their eligibility.[4] States have also worked to change the traditional "policing" mindset of staff via incentives that reward successful outreach, enrollment, and retention of health insurance coverage for eligible children.

A closer look at two very different states—New Hampshire and Louisiana—helps to show the many variables in play over the course of Covering Kids, Covering Kids & Families, and Supporting Families after Welfare Reform. Many of these variables—notably, shifting economic forces at the federal, state, and local levels—will continue to influence the process of reform.

New Hampshire

"GREAT HEALTH AND DENTAL BENEFITS FOR YOUR KIDS! LESS WORRY FOR YOU!" screams a headline on the red, white, and blue brochure for New Hampshire's combined Medicaid and SCHIP insurance program, called Healthy Kids. Inside are easy-to-read descriptions of medical and dental benefits, guidelines on how to apply, and eligibility requirements. The text is simply written, using encouraging, positive phrases and short declarative sentences. There's a small section titled "Why Is Health Insurance Important?" that talks about the expense of medical care, the importance of having a regular doctor, and the relationship between a child's health and school performance. Pictures of smiling children at the beach or showing off their new front teeth break up the type. Information phone numbers are listed as well as a Web site with easily downloaded application forms in English and Spanish. The application itself is eight pages, with instructions pegged to a fifth-grade reading level.

These are some of the visible changes in New Hampshire's public insurance programs for children, undertaken through a partnership between the state Department of Health and Human Services and

a community-based nonprofit organization called New Hampshire Healthy Kids. Healthy Kids, in turn, has developed partnerships with Anthem Blue Cross Blue Shield, the state's dominant private insurer; Northeast Delta Dental, a dental insurer; and hospitals, community health centers, physicians' offices, schools, and social service agencies to create a comprehensive health plan for children from low-income families.

The president and chief executive officer of Healthy Kids is Tricia Brooks. Her title reflects the business model New Hampshire has embraced to sell poor families on the benefit of insurance and overcome the stigma associated with government assistance. The approach, combined with eligibility expansions made possible by SCHIP, has contributed to coverage for more than 70,000 New Hampshire youngsters over the last decade, reducing the proportion of uninsured children in the state from 10 to 5 percent.

"We like the business model because we're essentially marketing a product," Brooks said. "Many families qualify for Healthy Kids Gold, which is free up to 185 percent of the federal poverty standard. But we also have a subsidized product called Healthy Kids Silver, which has a low premium and co-pays for families up to 300 percent, and a buy-in program for higher income families (between 300 and 400 percent of federal poverty). So we have to demonstrate the value of our product to our customers, which means our outreach workers have to operate like a sales force. We're counting on them not only to help with enrollment but also to work on building relationships of trust with our families."

How this customer service philosophy manifests itself varies from community to community. In the state capital, Concord, one step was relocating Healthy Kids' headquarters from offices that emphasized employee security to an attractive corporate building that offered a more businesslike ambiance.

"Our previous office had bulletproof glass that separated staff from applicants," Brooks said. "There also wasn't any way you could get to us from the lobby unless you were buzzed in. The message of that office was 'We don't trust you.' And yet that's exactly what we were asking them to do with us."

A very different kind of office awaits prospective families in the hard-up coastal town of Seabrook, an

hour's drive southeast of Healthy Kids' Concord headquarters. Here, clients climb a steep and narrow staircase to reach the cramped local office of SeaCare Health Services, a nonprofit medical access project for uninsured patients that works with Healthy Kids on outreach. If more than one person shows up, as on the day Kim Charland came in with her children, Alexis, fifteen, and Alex, ten, an application assistant named Karen Rowell quite literally has to climb over people in chairs to get around her desk. Yet the rundown nineteenth-century wood-framed building that houses her office, sandwiched between big box stores on commercial Lafayette Road, is a fitting place for Rowell's work. Locally known as the former Seabrook-Sanborn School, it is a fondly regarded landmark where generations of Seabrookers attended first through twelfth grade, including Rowell's father and grandmother.

The Charlands, owners of a small appliance business, typify the dilemma of low-income and some middle-income working families: lack of affordable private health insurance. Yet the Charlands did not think of themselves as people eligible for government aid and waited more than a year to apply for Healthy Kids.

"We had our own insurance ever since the kids were born, but then we had to close one of our stores and we couldn't keep it any longer because it was too expensive, $1,200 a month," Kim Charland said. "I never really thought about it that much—our children are basically healthy—but one day Alexis was practicing cheerleading handstands and fell over. She didn't tell us right away, because she wasn't supposed to be practicing on the driveway; it's concrete. But she didn't look too good when she came in, sort of pale, and when I asked if she was OK, she told me what happened and that she'd gotten the wind knocked out of her. I checked on her a few hours later in her room and she looked really bad and said her side hurt. I took her to the emergency room and the next thing she was in intensive care with a ruptured spleen. She was in there for five days, then home on bed rest with an attendant for one month. The bill was $17,000. Thank goodness we still had our insurace, but they took it away a couple of months later because we couldn't keep up the payments."

The experience, Charland said, left her a "nervous wreck," because she "realized what could happen." One day she confided her fears to Mary MacInness, a school nurse at Seabrook Middle School and one of Rowell's many community contacts. MacInness handed Charland a Healthy Kids brochure, but Charland didn't immediately follow up.

"I never really asked the state for anything, and it was really hard," she said. "We have only two employees at the store and everyone wants health insurance but, geez, we can't give them that—we can't even afford it for ourselves!" Charland's fears of the financial consequences of another random accident like Alexis's overcame her hesitancy, but it was another few months, she said, before she could convince her husband.

Unlike some states where computerized data and Internet links between agencies have reduced duplicative paperwork, New Hampshire's government records remain largely paper-based, with each social welfare agency maintaining its own client files. Applicants for Healthy Kids have a big job assembling birth certificates, Social Security cards, paycheck stubs, tax returns, immunization records, utility bills, and so on. Any irregularity can cause delay. The Charlands' application, for example, was held up because the obstetrician had forgotten to sign Alexis's birth certificate fifteen years before. "I had the original and it had her footprints on it and everything, but they wouldn't accept it without a signature," Charland said. "So my husband had to drive down to Gloucester, Massachusetts, where she was born, and get a verified copy from City Hall."

Rowell helps applicants fill out the forms and assemble required proofs of eligibility. The Charlands were unusually well-organized compared with most of her clients. "It's very rare that our families have their birth certificates," Rowell said. "If they don't, we'll write a letter for them, help them get it notarized, and send it to the town where the child was born. Otherwise they'd just say, 'Oh, forget it, I can't do this.'" Poor reading and writing skills underlie some of the reluctance, program officials say. Other applicants are ashamed and worry about disapproval from friends, relatives, and employers.

Seabrook's relative poverty shows up in student body statistics at Seabrook Elementary and Middle School. Of 900 students in pre-kindergarten through eighth grade, one-third qualify for Healthy Kids, one-third have private insurance, and the rest have no insurance, according to MacInness, the school nurse responsible for elementary-age youngsters. Her colleague, Helen Cataford, who's in charge of the older, middle school students, noted that roughly 40 percent of the students at the school qualify for federally funded free or reduced-cost lunch. Broader economic indicators are consistent; unemployment in Seabrook is more than twice the statewide average.

Such statistical measures of poverty translate medically into long waits at the three local hospital emergency rooms—two in New Hampshire and one just across the border in Massachusetts. There's only one pediatric practice in Seabrook, and those in adjoining towns are crowded, even for patients with insurance. Some uninsured families get around the cost of a doctor or an emergency room visit by sending sick children to school with the instruction to "go down and see Mrs. Mac," according to MacInness. Alternatively, they will take them to the Seabrook fire station, which has paramedics on duty twenty-four hours a day.

MacInness and Cataford have tried in ad-hoc fashion to fill in the health care gaps. For example, MacInness joined the local Lions Club so that she could have an inside track on the international civic group's vaunted free eyeglasses program. She and Cataford also are well known at the local WalMart and Sam's Club outlets because of the retailers' charitable optometric exam and eyeglasses programs. But dealing with disparate charity programs is neither efficient nor reliable, necessitating many phone calls and much time spent coaching parents on how to apply.

"If I have to figure out who to call, where to get the information, wait for the return call, then try to reach the parents—well, I just don't have the time," Cataford said. Moreover, the local WalMart and Sam's Club, which each used to provide thirty free eye exams and glasses annually to children at Seabrook Elementary and Middle School, recently cut their programs, as did the Lions Club. The nurses, therefore, are as grateful for their link to Rowell as she is for their help with Healthy Kids outreach, affirming the win-win business model advocated by CEO Brooks—and the Foundation's strategy of moving public health insurance programs into the mainstream of community life.

Louisiana

Much of New Orleans' once-teeming Lower Ninth ward is a weed lot today, many of its homes swept away by the storm surge that collapsed the levees during Hurricane Katrina in August 2005. Often, the only visible signs of what used to be are rows of cement slab foundations alongside the rubble of what once were streets.

Derrick Edmond, a community health care worker, regularly visits these desolate acres to remind himself of the importance of finding poor children eligible for Louisiana's combined Medicaid and

SCHIP program, called LaCHIP.

"I used to ride my bike over here after school to visit friends," Edmond said as he walked through the underbrush. "The hurricane wiped out a whole way of life—you don't even know where the people are now. We've estimated that 66,000 kids lost their Medicaid coverage due to Katrina and the evacuations, and we know some have come back. But you don't necessarily know where they are and which ones came back and who's gone for good, so you have to start all over at the places where you can find them—the schools, the laundromats, Chuck E. Cheese, local -markets."

Edmond works for the nonprofit organization Agenda for Children, which collaborated with the state Department of Health and Hospitals on efforts to improve LaCHIP enrollment. The Foundation's Covering Kids and Covering Kids & Families programs aided ongoing reforms in Louisiana's Medicaid program to double the number of low-income Louisiana children with insurance. Relative to other states, Louisiana also advanced during this period from the nation's fifth highest to the tenth lowest in percentage of uninsured children in families below 200 percent of the federal poverty standard.[5]

The devastating one-two punch of Hurricane Katrina and Hurricane Rita in 2005 killed more than 1,800 people, erased neighborhoods, caused economic losses estimated at more than $80 billion, and upended business as usual throughout Louisiana. In New Orleans, the main source of medical care for the poor, 2,680-bed Charity Hospital, was wrecked and remains closed today. State offices were destroyed, records were lost, and personnel were scattered.

But the disaster also spurred Louisiana's Medicaid agency to turn wreckage into opportunity and leapfrog one of the nation's poorest states into twenty-first-century health systems management.

The Medicaid agency is a division of the Department of Health and Hospitals. It had already been considering ways to make its public insurance programs more appealing when the Foundation's initiatives got under way. In addition to LaCHIP, these include LaMOMS, which covers prenatal, lab, and delivery services for pregnant women, and Take Charge, which covers family planning services. Leading this internal reform effort—and point person on Louisiana's Covering Kids and Covering Kids & Families grants—is LaCHIP Director Ruth Kennedy, who is also deputy director of

Medicaid in Louisiana.

Kennedy did not need to be enlightened about the need for better outreach to overcome enrollment deficits. She knew the problems first hand, having started her career in Louisiana Medicaid as an eligibility worker. It was July 1980, and Kennedy was fresh out of college.

"We were told we were not social workers," she recalled. "There was a toughness to it. You were more like an investigator, and your supervisors valued you for how many cases you closed." This never sat well with Kennedy, and in every new position she looked for ways to improve the agency's relationship with poor families. "The question was how to redirect the energy to keeping people enrolled," she said. "We shouldn't want to close a child who is financially eligible for the program just because of actions of parents who fail to return paperwork."

Participating in Covering Kids and Covering Kids & Families gave her staff access to "tremendous technical assistance," Kennedy said, as well as opportunities at conferences to hear from leading thinkers and to network with counterparts in other states. Program-wide strategies, such as creating a universal application to cover multiple aid programs, also were helpful, as was a communications consultant who helped her agency fine-tune press conference technique and move beyond billboard ads and other static messages to more effectively promote LaCHIP.

But Kennedy's deepest bow acknowledges what the Robert Wood Johnson Foundation did not do: micromanage. The grant requirements and the Southern Institute's direction were loose enough to let states work through the nitty-gritty of reform in their own ways. Said Kennedy: "I was leary of depending on external sources of funding, because it is my experience that when the grants go away, the program goes away. So we were pleased that the leadership fundamentally realized the importance of state CHIP and Medicaid programs as the foundation of outreach."

In contrast to New Hampshire, whose history of collaboration between state and private sector agencies dovetailed neatly with the Foundation's coalition approach, Louisiana largely looked to its state workforce for outreach innovation. Angie Huval's method of chatting up *boudin* in order to forge a link to uninsured families shopping at Guidroz's market was multiplied and revised many times over by eligibility staff members working out of forty-five local Medicaid offices, according to

Kennedy. Structurally, that meant relaxing the administrative hierarchy typical of government agencies.

"The attitude is always that caseworkers have too much to do and therefore are not capable of creative thinking," Kennedy said. "Believe me, my caseworkers have a heavy workload, 1,100 to 1,200 cases each. But we had no money for new outreach people, so I told my eligibility workers to set up a committee and develop an outreach plan. They came up with far more than I ever imagined, and in the ten years we've been working on this, they have never ceased to exceed our expectations."

Among the ideas was better use of the Internet so that eligibility workers could verify income, citizenship, immunization records, and other qualifying criteria electronically. This would make it possible to decentralize outreach operations even further. Instead of merely talking up LaCHIP and passing out promotional literature, eligibility workers could take their laptops to schools, health fairs, and other convenient locales, download applications, and enroll families on the spot.

The idea got support at the highest level of the Health and Hospitals Department. Indeed, Roxane Townsend, then the department's Medicaid medical director and later its chief, had already been exploring the possibility of moving Medicaid operations from paper to virtual, with links to other aid programs to eliminate duplicative effort. For example, families who had already been found eligible for, say, food stamps could be exempted from supplying identical income proofs to LaCHIP. Vital records could verify citizenship. And the quarterly wage information filed by employers with the state Labor Department could be used to back-check income declarations of new applicants.

Conceptual work segued to action in May 2005. Medicaid clerical staff undertook the tedious work of scanning documents into the agency's newly designed electronic database. Kennedy, a skeptic at the time, recalled, "I was not optimistic that we would be able to pull this off, but I didn't have the heart to say anything. We had employees whose sole job was pulling files. It was a staggering amount of work."

The Medicaid pilot project became part of a broader health information technology summit in July 2005. "We had everyone in the room for a day-long event, and it was a really productive meeting with lots of great ideas kicked around," Townsend recalled. Among them were how to link public

databases like Medicaid's with hospital and physician office records so as to begin to address medical care quality in line with emerging federal mandates. "We were supposed to have a follow-up meeting in September," Townsend said. "But, needless to say, we never did. Katrina took care of that."

The New Orleans Medicaid office, located in the low-lying suburb of Metairie, was inundated by ten feet of water. "We had loads of paper files in there, and everything was ruined," Kennedy said. "Even after the water receded, you could barely read them, the mildew was that bad. But we had them all scanned already. Now, we're building replacement offices that don't even have a file room—that's how electronic we are now."

Louisiana today relies for the majority of eligibility proofs on so-called ex-parte review—confirming information through other sources than the applicant. Through electronic links to state and federal databases, eligibility workers can confirm citizenship, household composition, Louisiana residency, children's ages, vaccine records, child support and wage income, and participation in other programs with comparable eligibility standards such as food stamps, federal Supplemental Security Income, and Temporary Assistance for Needy Families (TANF, the program that succeeded welfare in 1996). To speed coverage approval, enrollment and reenrollment standards have been relaxed to accept eligibility workers' "reasonable certainty" that the applicant qualifies. These measures, combined with sleuthlike tracking of families who have changed addresses or phone numbers, reduced the rate of procedural case closures—shorthand for children dropped from coverage because of a paperwork glitch—from 28 percent in 2001 to 1 percent in 2007.

"I'd hoped to get it to 10 percent," Kennedy said. "I never dreamed we'd get it to 1 percent."

Conclusion

Cementing these gains will be the harder challenge. The celebratory mood at Covering Kids & Families' wrap-up gatherings in mid-2007 darkened as SCHIP's reauthorization ran into trouble. Advocates expected easy renewal and expansion of eligibility criteria. Instead, Congress and the administration were at loggerheads, with every bill to expand SCHIP meeting a presidential veto. An intensive lobbying campaign to push for congressional override drew advocates from around the country. Ruth Kennedy flew to Washington in early December to participate in an informational Web cast sponsored by the National Academy for State Health Policy.

Kennedy's role was to narrate a series of slides showing Louisiana's progress under SCHIP, including a reduction in the proportion of uninsured poor children from 31.6 percent to 12.5 percent, and enrollment momentum that by 2007 had built to more than 1,000 new children a month. Kennedy expressed worries that the Bush administration's proposal to hold SCHIP funding to current levels would undermine Louisiana's progress.

"We are very reluctant to make that move to cease and desist outreach because we know how hard it is to get that momentum going," she said.

Yet that is the state of things today. Congress's third override attempt failed in January 2008, in a week that saw the stock market plunge more than four hundred points on fears of global recession. SCHIP was reauthorized—through March 2009—but with funding sufficient only for currently enrolled children.

However painful this political result may be for Medicaid officials and citizen activists who participated in Covering Kids, Covering Kids & Families, and Supporting Families after Welfare Reform, it's neither surprising nor fatal, despite the hot rhetoric of last December's reauthorization fight. Social welfare programs have always had to contend with larger political and economic forces. And just as these forces favored health insurance expansion for children, spawning SCHIP in the late 1990s, so they combined to restrain SCHIP growth a decade later. There's no question that a protracted economic downturn will increase the number of uninsured children from historic lows achieved by states such as Louisiana and New Hampshire. But this is not the sole measure of the last decade's achievement.

The federal government's $48 billion investment in SCHIP and philanthropic contributions through programs like Covering Kids, Covering Kids & Families, and Supporting Families after Welfare Reform have enabled states to put in place a culture favoring enrollment over disqualification. This is a huge social change, and not one easily undone by recession. Ruth Kennedy's personal dismay at the health consequences for children whose parents messed up paperwork has become the social norm. The degree to which states can act to safeguard children fluctuates with their budgets. But the foundation laid by retooling the mission of public health insurance programs to one of proactive

assistance makes it more likely that fiscally driven retrenchments will be transient.

The last decade saw measurable progress in children's access to health care in the United States, partly as a result of better coverage. The proportion of uninsured children dropped from 14 percent to 11.7 percent, the health status of low-income children with chronic conditions improved, and racial and ethnic disparities in access moderated.[6]

Covering Kids, Covering Kids and Families and Supporting Families after Welfare Reform contributed to these gains by helping states and local communities improve outreach and simplify administrative procedures. While cautious about attributing cause and effect numerical results to these strategies because of the many factors influencing enrollment, evaluators said that grantees were overwhelmingly positive in their assessments of the utility of specific program goals, such as coordination of Medicaid and SCHIP applications and simplified enrollment procedures. Covering Kids and Covering Kids & Families grantees also responded favorably to the state and local coalitions approach as a means to build constructive partnerships between government administrators of Medicaid and SCHIP and community organizations with closer ties to eligible families. At the same time, the trio of evaluators of Covering Kids & Families—Mathematica Policy Research, Health Management Associates, and the Urban Institute—noted the discouraging influence of economic downturn on outreach and enrollment, citing the example of the 2001–2003 recession in California. The state cut the budget for statewide media announcements, eliminated its training program for application assistants, and stopped paying for application assistance at schools and community organizations. "These cuts seem to have blunted enrollment growth," wrote Judith Wooldridge of Mathematica in a February 2007 evaluation report.[7]

Table 3.1. Percentage Change in Uninsured Children by State, 1997–1999 and 2004–2006

Uninsured Children	1997–1999* (%)	2004–2006**(%)	% change
Alabama	9.6	4	-5.6
Alaska	8.3	4.9	-3.4
Arizona	19	11.6	-7.4
Arkansas	14.7	6.2	-8.5
California	12.8	8.2	-4.6
Colorado	7.8	9.3	1.5
Connecticut	5.9	3.3	-2.6
Delaware	8.9	6.6	-2.3
D.C.	11.1	5.2	-5.9
Florida	12.2	10.7	-1.5
Georgia	10.7	8.2	-2.5
Hawaii	5	2.2	-2.8
Idaho	13.5	6.3	-7.2
Illinois	8.1	6.4	-1.7
Indiana	7.5	4.8	-2.7
Iowa	5.4	3.4	-2
Kansas	7	4.6	-2.4
Kentucky	9.8	5.8	-4
Louisiana	15.5	7.4	-8.1
Maine	6.3	3.6	-2.7
Maryland	7.1	5.2	-1.9
Massachusetts	4.4	2.8	-1.6
Michigan	5.5	3.3	-2.2
Minnesota	4.4	3.9	-0.5
Mississippi	14.1	10.9	-3.2
Missouri	5.2	5.4	0.2
Montana	12.8	9.5	-3.3
Nebraska	4.6	4.8	0.2
Nevada	14.1	9.5	-4.6

New Hampshire	3.1	2.6	-0.5
New Jersey	6.2	5.3	-0.9
New Mexico	15.9	11.6	-4.3
New York	9	4.8	-4.2
North Carolina	10.2	7.7	-2.5
North Dakota	10.6	6.5	-4.1
Ohio	5.8	4.5	-1.3
Oklahoma	10.6	8.4	-2.2
Oregon	8.5	7.6	-0.9
Pennsylvania	4.5	5.3	0.8
Rhode Island	4.8	3.2	-1.6
South Carolina	12.3	5.7	-6.6
South Dakota	6.1	4.9	-1.2
Tennessee	4.9	5.4	0.5
Texas	17.4	14	-3.4
Utah	6.6	7.4	0.8
Vermont	2.8	2	-0.8
Virginia	7.6	5.3	-2.3
Washington	4.2	3.6	-0.6
West Virginia	8.1	4.8	-3.3
Wisconsin	4.4	3.5	-0.9
Wyoming	8.7	4.2	-4.5

*U.S. Census Bureau, Housing and Household Economic Statistics Division. Low Income Uninsured Children by State, December 7, 2004.

**U.S. Census Bureau. Current Population Survey, 2005, 2006, and 2007 Annual Social and Economic Supplements, 2008.

In an evaluation survey of sixty-five state officials representing Covering Kids & Families activities in forty-six states, sixty-one of the respondents said the programs had influenced state policies and procedures and that half of them would not have occurred without the programs.[8] Procedural reforms in Medicaid and SCHIP promoted by the Robert Wood Johnson Foundation's initiatives included the following:

- Elimination in virtually all states of the requirement of face-to-face interviews for enrollment or renewal
- Elimination in most states of the asset test for eligibility
- A combined Medicaid and SCHIP application adopted by thirty-three states
- Coverage for children under age nineteen expanded to at least 200 percent of federal poverty in forty-one states
- Most states also have simplified program documents and literature to make their Medicaid and SCHIP programs more visible and accessible. Covering Kids & Families played a role by sponsoring workshops, bringing in design experts, and commissioning a guidebook, *The Health Literacy Style Manual,* which describes how to design brochures, create appealing logos, simplify prose, select easy-to-read typeface, and convert intimidating documents into friendly invitations.

Sexy? Hardly. But in the survey of state officials by the evaluators of Covering Kids & Families, the majority credited this sort of technical assistance with helping them fine-tune enrollment and retention processes, coordinate benefits, invigorate outreach, and improve policy. Moreover, the respondents characterized nearly two-thirds of these changes as permanent.[9]

That in itself speaks to the attitude shift at the heart of Covering Kids, Covering Kids & Families, and Supporting Families after Welfare Reform. *Permanent* is not a word you hear often from state officials; the culture of government work tends to discourage predictions beyond the current political administration. The greatest expression of this bolder outlook in Medicaid and SCHIP is found among the outreach workers that New Hampshire's Tricia Brooks called her "sales force" and Louisiana's Ruth Kennedy described as "my incredibly dedicated eligibility staff." No longer deskbound, this mostly young workforce seems to thrive on the freedom to innovate, pinched budgets notwithstanding.

No money for consultants? That didn't stop New Hampshire's April Purinton from making friends

with a computer savvy co-worker so that she could program Microsoft Access to track her applicants. Nor did it keep Trene Jenkins from buttonholing strangers in New Orleans' public libraries to ask for feedback on the ease of using LaCHIP's online application, which went live at the end of 2007.

As for Angie Huval, it's hard to imagine a bureaucracy capable of holding her back. The young woman who washed out of her first career as a prison guard because she was too chatty with the inmates is having the time of her life promoting LaCHIP.

"It's not that I don't take my work seriously," Huval said. "It really kills me if my supervisor finds one of my families that I didn't track down first. But I was just a watchdog in that guard job. This one lets me be a compassionate being."

Notes

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