



**Pennsylvania  
Partnerships for Children**

# Covering Kids and Families PA

*News on Covering Kids and Families-Pennsylvania, a project to reach and enroll uninsured children in children's health insurance programs*

**Pennsylvania Partnerships for Children**

## **Self-declaration, outreach assistance a strong pair**

Children whose families could self-declare their income and who received intensive outreach enrolled in CHIP and Medicaid enrolled at two and three times the rate of children whose families were left on their own, a Philadelphia-based study of enrollment methods found.

Working with the state departments of Insurance and Public Welfare, the Delaware Valley Healthcare Council (DVHC) of the Hospital and Healthsystem Association of Pennsylvania worked in four of Philadelphia's school clusters, each containing one high school and its feeder elementary and middle schools. Other participants in the study were the Philadelphia County Assistance Office, the School District of Philadelphia's Family Resource Network, Philadelphia Citizens for Children and Youth, and Philadelphia's Promise. Hospital partners working within each cluster were

Temple University Children's Medical Center, Albert Einstein Healthcare Network, Holy Redeemer Health System, and Jefferson Health System. Funding was provided by the departments of Public Welfare and Insurance and the Centers for Medicare and Medicaid, with additional support from the U.S. Department of Health and Human Services Region III, the Dolfinger McMahon Foundation, and the DVHC.

Enrollment and outreach were handled differently in each of the four groups, where families would:

- Apply for health coverage without providing income verification documents – also known as self-declaration – but without receiving additional outreach efforts.
- Apply without providing income verification in an area with intensive out-

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## **Year Three lessons from pilot sites: Outreach through lunch applications, small business, health sites**

Building on previous years' lessons, Pennsylvania's Covering Kids pilot sites honed their outreach approaches in Year Three, tackling more complex challenges and learning valuable lessons about how families approach and navigate the children's health insurance enrollment system.

Strategies were developed and tested to reach families through three new venues: the school lunch program, small business and health care sites. The Delaware Valley

Hospital Council also partnered with the departments of Public Welfare and Insurance and the School District of Philadelphia and the Departments of Public Welfare to test the effects of self-declaration of income on enrollment (see "Self-declaration," above).

### **Consumer Health Coalition: School lunch application**

Allegheny County's pilot site, the

## Self-declaration, outreach assistance work well

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reach activities.

- Apply using routine income verification in an area with intensive outreach activities.
- Apply using routine income verification in an area with no additional outreach activities. This cluster, applying in the normal manner, was the study's control group.

Outreach help and self-declaration, followed by post-authorization verification, proved effective in answering a key question behind the study – whether enrollment could be correctly and significantly increased for children in schools in high-poverty areas. In the outreach clusters, outreach workers participated in school events such as health fairs, report card conferences, graduation ceremonies, and Home and School Association meetings. They contacted each family who did not list health coverage on emergency information cards. If the family could not be reached by phone, an outreach worker visited the home, leaving a letter if no one was available.

In the end, 554 applications were submitted, and more than 900 children and adults were enrolled in CHIP or Medicaid. The tally was most dramatic when self-declaration and outreach were combined, resulting in more than two and a half times the applications completed and submitted in the cluster with outreach workers and routine income verification requirements.

The importance of outreach in providing families with information and support was evident in returns showing that in the cluster with self-declaration of income and no additional outreach efforts, the number of applications was significantly fewer than either cluster with outreach workers. Self-declaration of income simplifies the process but by itself does not result in a significant increase in enrollment:

- The two clusters without outreach workers yielded 64 applications in one year. The cluster with outreach and income verification generated 133 applications, while self-declaration and outreach brought in 347 applications.
- Enrollment also rose with the level of ease and

assistance, from 113 enrollments in the non-outreach clusters, to 212 enrollments in the income verification/outreach cluster, and to 583 enrollments in the self-declaration/outreach cluster.

The applications distributed through the project were coded to reflect their distinct status and handled by a special processing unit in the County Assistance Office. At the special processing unit, applications received special handling based on whether they utilized self-declaration of income with post-authorization verification or the routine income documentation method. Applications were logged and tracked, and statistical reports were developed on the volume of applications and their status: approved, denied, or forwarded to CHIP.

Overall, the most common reason for Medicaid application rejections was that the family's income was too high, and the applications were then forwarded to CHIP. However, within the cluster that used routine income verification, "failure to verify income" was the most common reason for Medicaid denial.

### Recommendations

The DVHC concluded that the project findings support the feasibility of statewide and permanent implementation of outreach combined with self-declaration of income with post-authorization verification to increase enrollment in children's health insurance. The council recommended that a work group be convened to develop a timeline and rollout strategy across the state. The effort should identify appropriate locations, collaborative partners, and effective methods for identifying the uninsured, the council recommended.

For more information, contact Joan Apt, Delaware Valley Healthcare Council, [japt@dvhc.org](mailto:japt@dvhc.org).

### New site manager in Philly

The Covering Kids and Families Coalition welcomes Alisa Simon, the new Health Director at Philadelphia Citizens for Children and Youth. She will take over the project management of PCCY's Covering Kids and Families Pilot project.

## Year Three lessons from pilot sites

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Consumer Health Coalition, worked with three school districts and the departments of Education, Insurance and Public Welfare to test a combined school lunch-health coverage application.

Beginning in fall 2001, the project probed several key questions:

- Could a form be developed to let families apply for both programs?
- Could a completed health coverage form move from the school lunch program to the local County Assistance Office?
- Would families applying for health coverage submit the appropriate verification documents?
- How would school district staff be affected?
- Would fewer children apply for school lunch?

In the end, success – as indicated by 1,300 health coverage applications – mingled with unintended consequences, and the results are still being reviewed.

But even this early, participants can say with certainty that the process, particularly the start-up phase, was not an easy task.

- Schools' receipt of federal and state funding for critical education programs such as Title I, the federal reading assistance program, often hinges on the extent of participation in free and reduced-price lunch, so school lunch staff were wary about altering a process that brings in education dollars and feeds hungry children.
- The additional questions and directions needed for health coverage purposes lengthened what had been a one-page form.
- Separating the school lunch pages and re-collating the health coverage pages proved to be burdensome to the school districts.
- Since schools used different distribution methods – some mailed the forms home before school started, others sent them home with children on the first or second day – delivering the 40,000 applications created logistical challenges.

In some cases, families returned the forms without the income verification needed for health cov-

erage (school lunch applications don't require immediate income verification), or proof of income did not travel with the form from the school to the County Assistance Office.

Administrators are studying whether a slight but not significant drop in school lunch enrollment is linked to the new application, or whether other factors, such as employment status, played a part.

Currently, stakeholders are being interviewed, the process is being evaluated, and plans are being made for a second test in 2002-03, which could include self-declaration of income, a simpler application, and earlier distribution of the forms.

For more information, contact Geoff Webster of the Consumer Health Coalition, [websterchc@star-gate.net](mailto:websterchc@star-gate.net).

### York: Small business outreach

Wellspan Health and the Healthy York County Coalition were working to engage the small business community in outreach to families with uninsured children.

Their first contacts – hotels and motels who, they thought, could reach out to hourly employees – were not interested or didn't see the need.

Not to be deterred, HYCC collaborated with the York Chamber of Commerce, mailing an offer of CHIP paycheck stuffers, CHIP posters, speakers, and KIDS NOW brochures to the Chamber's small business list of 900 companies with 25 or fewer employees. The response was substantial, with 175 companies requesting CHIP information, and by the end of December, HYCC had provided 5,500 paycheck stuffers, 5,300 KIDS NOW brochures, 260 CHIP posters, and two speakers.

For more information, contact Carole Register of Wellspan Health, [cregister@wellspan.org](mailto:cregister@wellspan.org).

### Cornerstone Care: Health care sites

Cornerstone Care, the Southwestern Pennsylvania pilot site, wanted to test two theories arising from its Covering Kids experience: that families seeking a health care procedure for a child are more motivated for apply for coverage, and that the

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## Year Three

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availability of free care could outweigh the perceived hassle of applying for coverage.

So, Cornerstone Care is now testing whether families can be convinced to apply for coverage when they visit the program's clinic and the fee for that visit is waived once the application is completed.

Cornerstone Care received approval from the Center on Medicare and Medicaid to substitute the Application for Health Care Coverage (the "walking families form") for the sliding fee scale application. Families with a scheduled appointment are contacted in advance and asked to bring income documents and Social Security numbers. Cornerstone's Community Health workers help families complete and submit the application.

As the test progresses, Cornerstone Care will also work with clinic walk-ins, designing a data collection system that compares the results among families with advance notice to those who seek care without a prior contact.

For more information, contact Cyndy Holcomb at [cholcomb@cornerstonecare.com](mailto:cholcomb@cornerstonecare.com).



### Pennsylvania Partnerships for Children

**Covering Kids and Families PA is published quarterly by Pennsylvania Partnerships for Children. PPC is the statewide voice for the health, early education, and well-being of Pennsylvania's children, Joan L. Benso, President and CEO; Ann Bacharach, Covering Kids and Families Project Director. Funded by the Robert Wood Johnson Foundation.**

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## Bush: Offer tax credits to help families get health insurance

The Bush administration has proposed refundable tax credits and other strategies to help low-income Americans access health insurance.

The tax credit plan will use \$89 billion over 10 years to provide tax credits for workers who do not have employer-sponsored health coverage. Under the proposal, families with annual incomes less than \$25,000 would qualify for a \$3,000 tax credit, while income between \$25,000 and \$60,000 would qualify families for a smaller tax credit. Individuals with annual incomes less than \$15,000 would qualify for a \$1,000 tax credit, and those earning between \$15,000 and \$30,000 would qualify for a smaller credit.

The proposal also would help states establish purchasing pools to reduce the cost of health insurance premiums for low-income residents who use the tax credits to purchase health coverage.

Other components of the plan include:

**Community Health Centers:** Bush will propose \$1.5 billion, a \$114 million increase, for community-based health centers. The funds would support 170 new and expanded facilities and provide services to 1 million additional patients.

**Provider Training:** Bush will propose \$191.5 million, a \$44 million increase, for a program that provides loans and scholarships to doctors and other health care professionals who are willing to work in underserved areas.

**Medical savings accounts:** Bush will propose to loosen the rules to make MSAs available through all employers, rather than only small businesses, and make the accounts, which Congress approved as an "experiment," permanent.

**Transitional Medicaid assistance:** Bush will propose \$350 million to extend a program that provides Medicaid coverage for families in transition from welfare to work.

*Source: The Kaiser Health Network. For more information, visit [www.kaisernetwork.org](http://www.kaisernetwork.org).*