

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**Federally Funded Health Centers and  
Low Income Children's Health Care**

**Improving SCHIP Enrollment and  
Adapting to a Managed Care Environment**



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# EXECUTIVE SUMMARY

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## PURPOSE

To examine the experience of Federally funded health centers in implementing the State Children's Health Insurance Program (SCHIP) and in delivering health care to children covered by SCHIP.

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## BACKGROUND

Federally funded health centers have been major safety-net providers for low income families since the 1960s. These centers have struggled in the 1990s to continue their mission as States move toward Medicaid managed care. Beyond adapting to their changing health care environment, SCHIP have underscored a need for assertive outreach by health centers to enroll uninsured children, many of whom are already their patients. Although there are two types of SCHIP programs, Medicaid expansion programs and separate child health programs, this report, we will use SCHIP inclusively without differentiating program types. To study health centers and their role under SCHIP, we conducted a national survey of a representative sample of 405 health centers from all 50 States, including the District of Columbia and Puerto Rico. A few States were not yet able to address all aspects of a fully operating SCHIP program, but could still respond regarding their experiences in the changing health care environment.

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## FINDINGS

As trusted health care providers within needy communities, these centers can serve as one of the most appropriate agents for enrolling children in the SCHIP. For health centers, emergence of the SCHIP provides a significant additional funding source as they continue to make health care available to uninsured children. Thus, the mutual needs of both States and health centers can be well-served through their stronger collaboration. However, the health centers must also be prepared for changes in reimbursement methods.

### Outreach and Enrollment

Eighty-three percent of health centers conduct their own SCHIP outreach, which primarily entails screening current clients for SCHIP eligibility. Forty-two percent have also relied on outside resource assistance, such as funds and/or manpower, to aid their outreach efforts.

State SCHIP enrollment training for health center staff is four times more likely to increase reported health center enrollment success.

Sixty-one percent of health centers do not have “outstationed eligibility workers”, even though only 7 percent are designated as “low use” sites, i.e. having few Medicaid eligible clients.

Health centers that have outstationed eligibility workers or are authorized to use presumptive eligibility are substantially more likely to receive State enrollment training which, in turn, increases reported enrollment success.

Two-thirds of health centers cited welfare stigma, fear that applying for SCHIP will jeopardize immigration status, and complicated application forms as barriers to enrollment. Lengthy processing times for eligibility determinations reduce the likelihood of having children actually enroll in SCHIP.

## **Adapting to a Changing Health Care Environment**

Sixty-three percent of health centers contracted with a managed care organization that covers children, although half of these centers obtained their contracts recently. Those centers involved in managed care are beginning to accept financial risk for patient care and move away from traditional cost-based reimbursement. However, “enabling services” such as transportation, translation and outreach, critical for access to care, are not always reimbursed under managed care.

Only 32 percent of centers indicated that their States required Medicaid managed care organizations to include them in provider networks. Health centers are more likely to form their own managed care organizations, in part, when the States do not require inclusion of health centers in Medicaid managed care provider networks.

Relatively few health centers (21%) were making changes to specifically adapt to the phase-out of Medicaid cost-based reimbursement. However, health centers were altering their business infrastructures in response to changes in the general health care environment.

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## **RECOMMENDATIONS**

The Health Care Financing Administration (HCFA) should:

Promote enrollment of children in SCHIP through the health centers by encouraging States to provide enrollment training for health center staff and to increase the number of health centers with outstationed eligibility workers and designated as presumptive eligibility sites, where applicable.

Encourage States to promote inclusion of health centers, that are ready for managed care, in the Medicaid and/or SCHIP managed care provider networks, and to expand reimbursement to include enabling services.

The Health Resources and Services Administration (HRSA) should continue to help health centers prepare for the phase-out of Medicaid cost-based reimbursement.

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## **AGENCY COMMENTS**

The HCFA and HRSA generally concur with our recommendations. The HCFA states that it is already addressing many of our recommendations, particularly with regard to eligibility and outreach issues.

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# INTRODUCTION

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## PURPOSE

To examine the experience of Federally funded health centers in implementing the State Children's Health Insurance Program (SCHIP) and in delivering health care to children covered by SCHIP.

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## BACKGROUND

### State Children's Health Insurance Program

Title XXI of the Social Security Act, under The Balanced Budget Act of 1997, created SCHIP. Authorized for ten years, and funded at \$20.3 billion from 1998-2002,<sup>1</sup> the program targets children in low-income families (generally under 200% of the Federal poverty level) with the intent of providing States with an opportunity to design health care delivery systems that are similar in scope and structure to coverage that is available through private insurance. Nearly two million children were enrolled in SCHIP during Federal Fiscal Year 1999.<sup>2</sup> The Health Care Financing Administration (HCFA) is responsible for administering SCHIP, with joint oversight by the Health Resources and Services Administration (HRSA).

The authorizing legislation provides States flexibility in designing their SCHIP programs by allowing them to adopt one of three models. According to HCFA at the time of this study,<sup>3</sup> 27 States, including Puerto Rico and the District of Columbia, opted to expand their Medicaid programs, 13 States selected a combination of Medicaid expansion and a separate SCHIP program, while 16 States elected only to create a separate SCHIP program.<sup>4</sup> Most States that created a separate SCHIP program also established an independent agency to administer the program.

Program benefits vary by model chosen. If Medicaid expansions are used, the same benefits and administrative rules used by the existing Medicaid program apply. States which previously expanded Medicaid for children, or created a separate SCHIP program, are allowed to expand eligibility beyond 200 percent of the Federal poverty level to 50 percentage points higher than their existing eligibility limits.<sup>5</sup> Some States that created a separate SCHIP program had established additional benefits above Federally legislated SCHIP minimum standards.

### Federally Funded Health Centers

Generally located in communities with low to moderate family incomes, Federally funded health centers have been major safety-net providers for low income children since the 1960s.

Centers are funded by Section 330 of the Public Health Service Act, which is administered by HRSA, with some receiving State and local funds as well. In addition to primary health care services, these clinics also provide enabling services such as translation, health education, and transportation which are important to serving the SCHIP population. Since services for children are a large program component for many of these centers, they hold considerable promise in helping realize the goals of the SCHIP legislation. Our prior OIG study of health centers showed that, due to the level of trust and service they have established in their communities, they possess great aptitude for outreach and enrollment.<sup>6</sup>

Besides SCHIP implementation, Federally funded health centers have experienced other substantial changes in the health care system, particularly due to State movement towards Medicaid managed care in the 1990s. Recognizing the need to adapt to this environment, some centers have assertively joined or created managed care organizations or undertaken special developmental efforts like infrastructure enhancements.<sup>7</sup> Our prior case study report indicated that HRSA also makes technical assistance and training opportunities available to aid centers in adapting to managed care.<sup>8</sup> The transition from Medicaid cost-based reimbursement<sup>9</sup> continues to challenge centers as they seek to better manage costs and devise appropriate reimbursement formulae within their health plan contracts.<sup>10</sup>

## Other Recent SCHIP Studies

Another OIG report, *The Children's Health Insurance Program, State's Application and Enrollment Processes: An Early Report From the Front Lines* (OEI-05-98-00310), found that application length and complexity were barriers to enrollment in Medicaid and the SCHIP. Additional work in the field by the United States General Accounting Office (GAO) focused on outreach mechanisms and enrollment between Medicaid and SCHIP and a comparison of optional benefits. The GAO report stated that outreach activities for Medicaid and SCHIP were similar; however, more documentation was required for Medicaid than for SCHIP eligibility determinations in half of the ten States they sampled.<sup>11</sup>

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## METHODOLOGY

In 1999, we published *CHIP's Impact on Changing Service Delivery of Federal Health Centers: Six Case Studies*, OEI-06-98-00320 which employed a case study approach to focus on the experiences of individual centers in implementing SCHIP. Based on issues developed from this case study report, we designed a structured survey to obtain representative, national information on centers' experiences and issues regarding separate child health programs and Medicaid expansions. The results of this national survey are reported here. For the rest of this report, we will use SCHIP inclusively for the separate child health program and Medicaid expansions without differentiating model types unless otherwise noted<sup>12</sup>.

## Study Focus

The survey focused on health centers' involvement in SCHIP planning, outreach activities and enrollment, and health centers' adjustments to the changing health care environment, particularly for provision of children's health care services. The term outreach by health centers as used in this report means encouraging clients to establish SCHIP eligibility rather than encouraging a choice of a particular provider. Health centers' executive directors were the primary survey respondents. Having conducted in-person interviews with them for our case study report, we learned that they are highly knowledgeable about various aspects of their health centers and SCHIP's impact on them. Since our study focused on the health centers' perspectives, we did not attempt to validate center responses, including statements about the SCHIP activities of their States and/or State Primary Care Associations (PCA).

## Sample

Using the HRSA 1998 Uniform Data System (UDS) database, we selected a simple random sample of 462 centers from the total of 615 Federally funded health centers receiving Section 330 grant funding. These grantees include Community Health Centers, Homeless Centers and Migrant Health Centers. In this report, for brevity, we use the term "health centers" to represent each of these Section 330 grantees.

The HRSA 1998 UDS provided general information regarding the centers in our sample. Our study sample included a diverse population of health centers. Forty percent of the patients served by health centers in our sample were between the ages of 0-19, totaling over two million children. These centers also serve a high proportion of racial/ethnic minority populations, including Native Americans (2%), Asians/Pacific Islanders (3%), African Americans (22%) and Hispanics (28%).

## Data Collection

The survey data were collected primarily via the Internet and also by mail. On December 10, 1999, we initially mailed structured survey forms to 94 health centers lacking Internet access. During the first week of January 2000, the remaining 368 health centers in our sample received an e-mail message containing a link to an electronic survey at an Internet site.<sup>13</sup> Data collection was completed by February 19, 2000.

A total of 405 (88%) of the sampled health centers returned completed surveys, and included responses from health centers in all 50 States, the District of Columbia and Puerto Rico. Throughout this report, the term "States" is also applied to the District of Columbia and/or Puerto Rico. At the time of our survey, a few States (Hawaii, Washington, Wyoming and Puerto Rico) had approved SCHIP plans, but were not yet enrolling children. As a result, some of these centers were not able to address all aspects of a fully operating program, but could still respond regarding their experience in the changing health care environment.

## Statistical Analysis

This sample design and our strong response rate yield national results that are statistically significant at a 95 percent degree of confidence with a 5 percent margin of error, unless otherwise noted in the Appendix. Descriptive data are expressed as proportions (%), and statistical differences between categorical variables were assessed using a Chi-square test. For this analysis, we also used *logistic multivariate regression models* to further explain/predict key variables. Of particular interest is understanding what factors contribute to health centers' success in enrolling eligible children in SCHIP. The actual number of children enrolled in SCHIP by each health center was not available. Therefore, the regression model employed a dichotomous dependent variable that simply indicates whether or not the center reported SCHIP enrollment. After controlling for other factors, these explanatory variables for enrollment outcomes were: date of SCHIP plan approval, State SCHIP model, outreach activities, enrollment training for health centers, use of presumptive eligibility, use of outstationed eligibility workers, and application processing times.<sup>14</sup>

The tables in the Appendix present relevant statistics for key survey questions, including standard errors and confidence intervals based on t-statistics. For calculating standard errors, we used finite population correction factors since our sample represents two-thirds of the true population. Consequently, findings presented in this report are based upon strong statistical inference about population characteristics. The Appendix also includes values of the Chi-square test and parameter estimates of the regression results. All tests were performed at a significance level of  $\alpha=0.05$ .

## Non-Respondent Analysis

To detect non-respondent bias, we tested data for significant differences between respondents (405 centers) and non-respondents (57 centers) by the following characteristics: State, SCHIP model type and number of children a health center serves. We did not find significant differences between these two groups.

We conducted our study in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

# FINDINGS

## OUTREACH ACTIVITIES

**Most health centers (83%) conduct their own SCHIP outreach, which primarily entails screening current clients; 42 percent have relied on outside resource assistance.**

The most frequent outreach methods are screening and identifying eligible children from existing clients (76%), posting SCHIP information fliers and/or posters in their health centers (73%), and providing SCHIP information through their health providers (64%). It appears that center outreach was mainly limited to existing clients since most centers utilized in-house activities rather than reaching out to new SCHIP eligible populations. Although one health center in our case study report was aggressively canvassing its local community for eligible applicants, we didn't find this type of outreach activity common among the centers in our national survey.

Outside resources received for outreach were funds and/or manpower. The top sources of outside resources were grants (42%) and contracts (19%) for SCHIP. Some centers (38%) reported that they also received outside resources from various State or local organizations. Eleven percent of the centers indicated that the Robert Wood Johnson Foundation provided outreach resources.

## ENROLLMENT

Understanding factors contributing to health centers' enrollment of eligible children in SCHIP is of particular interest. By February, 2000, when we concluded data collection, *73 percent of responding health centers reported they had already enrolled children in SCHIP*. The logistic regression analysis explains what events or activities most influenced these early enrollments (See Appendix A).

**State outreach activities enhance health centers' SCHIP enrollment.**

Centers which reported State outreach (74%), were 2.5 times more likely to have enrolled children than those centers who said their States had not conducted outreach. (25%)<sup>15</sup> Among this 25 percent of centers, 13 percent indicated that State outreach activities were in the planning stage. The fact that not all centers were aware of State outreach activities is not necessarily an indicator of actual State activity, but may suggest the degree to which State activity is perceptible or the effectiveness of methods used in reaching community level providers. Also, a few States had not fully implemented SCHIP, which may have affected their outreach activities.

Of those centers which reported State outreach, the most frequent State outreach methods cited by health centers were public service announcements (60%), information distribution through schools (46%) and newspaper advertisements (42%).

**State SCHIP enrollment training is four times more likely to increase health center enrollment, and centers that have outstationed eligibility workers or are a presumptive eligibility site are more likely to receive such State training.**

Health centers are almost four times more likely to enroll children if they are receiving SCHIP enrollment training from their States.<sup>16</sup> Enrollment training provides health center staff with a better understanding of the SCHIP enrollment process and the ability to assist clients in completing enrollment forms. A related factor underpinning enrollment success is that centers with outstationed eligibility workers or a presumptive eligibility site designation are more likely to receive this State training. Health centers with outstationed eligibility workers are 2.4 times more likely to be trained, and health centers designated as presumptive eligibility sites are 1.7 times more likely.<sup>17</sup>

States have the option of employing presumptive eligibility, which extends immediate Medicaid or SCHIP coverage to children until a formal eligibility determination is made. Determinations are made by designated presumptive eligibility sites, which can include health centers, hospitals or other providers. Health centers designated as presumptive eligibility sites reported enrolling children in SCHIP more often than those centers that were not.<sup>18</sup> Fifty-seven percent of centers indicated that presumptive eligibility was applicable in their States. Of those centers, 44 percent reported that they were a presumptive eligibility site for SCHIP.

**Sixty-one percent of health centers do not have outstationed eligibility workers, even though only 7 percent are designated as “low use” sites.**

Among the 61 percent of the health centers that did not have outstationed eligibility workers, only 7 percent were reported to be “low use” sites. According to HCFA Medicaid regulations governing low-income eligibility groups, “the State agency must have staff available at each outstation location during the regular office hours of the State Medicaid agency to accept applications and to assist applicants with the application process.”<sup>19</sup> The proposed rule on implementing regulations for SCHIP specifies that States that implemented Medicaid expansions must follow the existing Medicaid rules on application assistance.<sup>20</sup> As one of the designated outstation locations, health centers are exempted when they are “low use” sites, i.e., “outstation locations that are infrequently used by the low-income eligibility groups.” However, States have the discretion to determine what constitutes a “low use” site without regard to a minimum standard.<sup>21</sup>

Thirty-nine percent of the health centers had outstationed eligibility workers with most receiving some State funding. Of the health centers with outstationed eligibility workers, 45 percent indicated that the State provided full funding for the position and another 30 percent

indicated that the positions were partially funded by the State. Twenty-five percent of centers provided their own funding for outstationed eligibility workers. Bearing in mind that patient load varies widely, the number of outstationed eligibility workers in terms of full time equivalents (FTEs) ranged from 0.1 FTE to 13 FTEs per center, with 68 percent reporting up to 1.0 FTE in their center.

### **Two-thirds of health centers reported enrollment barriers, citing welfare stigma, immigration status, and complicated application forms as key concerns.**

Sixty-four percent of the health centers perceived that their clients were experiencing enrollment barriers, indicating these are national issues. The top three barriers cited were: client's negative perceptions of government welfare programs (68%), concerns that application may affect immigrant status (59%) and complicated application forms (41%). Our earlier case study report of selected States, confirmed that some applicant families fear that applying for SCHIP benefits would jeopardize their immigration status, under public charge provisions, or alert the Immigration and Naturalization Service (INS) if they were here illegally. Likewise, another OIG study found that language complexity and application length were deterrents to potential applicants.<sup>22</sup>

### **Short processing times for eligibility determinations increase the likelihood of having children actually enroll in SCHIP.**

Centers, for which enrollment decisions were made within one month, were twice as likely to have enrolled children in SCHIP.<sup>23</sup> Of health centers that had experience with the SCHIP enrollment process, 43 percent said that eligibility was determined in less than one month. However, more centers (50%) indicated that it took more than one month; 37 percent reported that it took one to two months and another 13 percent indicated it took more than two months. Eight percent of centers did not know the time frame for enrollment decisions.

### **State SCHIP models influence health center SCHIP enrollment outcomes, but use of enrollment brokers has little effect.**

The SCHIP model chosen by a State seems to affect enrollment outcomes.<sup>24</sup> Health centers under a combined model or a separate SCHIP program are about three times more likely to enroll children than centers operating under a Medicaid expansion model.<sup>25</sup> A GAO report<sup>26</sup>, which compared Medicaid and SCHIP application processes, noted that Medicaid applications required more documentation than SCHIP applications. This added burden for those who can only apply under a Medicaid expansion plan might be a barrier to enrollment as well.

Twenty-four percent of the health centers indicated that their States were using enrollment brokers, State contractors who administer the enrollment process. The use of enrollment brokers showed no significant relationship with centers' reported success in enrolling children.<sup>27</sup>

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## **ADAPTING TO A CHANGING HEALTH CARE ENVIRONMENT**

Although the introduction of the SCHIP program provides a potentially valuable funding source for health centers, they must also be prepared for other changes in reimbursement methods. The recent challenges to health centers in the health care environment are the general movement of Medicaid programs to managed care and the phase-out of Medicaid cost-based reimbursement to health centers.

### **Sixty-three percent of health centers had managed care contracts that cover children, although half of these centers obtained their contracts recently.**

Health centers either had no managed care experience, or extensive but sometimes recent experience. Health centers have faced critical changes in their health care delivery systems, most notably conversion of State Medicaid programs from fee-for-service to managed care. Those centers with managed care contracts appeared adept at gaining inclusion, with 82 percent of them having garnered contracts with more than one managed care organization (MCO). Yet, the managed care experience for many centers has been relatively recent with over half (53%) first entering into a contract between 1996 and 1999.

### **The health centers are more likely to form their own managed care organizations, in part, when the States do not require inclusion of health centers in Medicaid managed care provider networks.**

Our findings revealed that health centers were significantly more likely to have a managed care contract if their State requires Medicaid MCOs to include safety-net providers, such as health centers, in their provider networks.<sup>28</sup> However, only 32 percent of the Federally funded health centers indicated that their States had such requirements. Nine percent of the centers reported that their States offered incentives for MCOs to include them in their provider networks, while some States employed both strategies. When such State requirements do not exist, health centers are more likely to form their own MCOs.<sup>29</sup>

If center-owned managed care organizations were available, centers tended to be involved in them. Thirty-four percent said that a health center-owned MCO operated in their State. Of these centers, 63 percent indicated that a center-owned MCO was currently operating in the area they served, and 90 percent of those centers were involved. The nature of center involvement with these MCOs varied, but most reported their center was contracted to provide services (96%), had a financial investment (68%) and/or was represented on the board of directors (69%).

### **Health centers involved in managed care are beginning to accept financial risk for patient care.**

Although these centers receive various types of reimbursement under their managed care contracts, almost half were assuming some financial risk through primary care capitation reimbursement. While the reimbursement methods reported are not mutually exclusive, the

most common ones centers reported under their largest SCHIP and/or Medicaid managed care contract included: cost-based (55%), primary care capitation (48%), full capitation (17%), and risk withholding (12%). Thus, beyond the cost-based reimbursement<sup>30</sup> all centers experienced previously under Medicaid, some centers are gaining operating experience under other reimbursement structures common to the growing managed care environment. However, 37 percent of centers are still outside of managed care altogether and have yet to adjust to these other reimbursement methods.

### **Enabling services, critical to health center patients for accessing care, are not always reimbursed under managed care.**

Not considered routine medical services in the private sector, “enabling services” such as transportation, translation, outreach, case management, health education, and other social services to assist patients, are often essential for the populations served by these centers to access health care.<sup>31</sup> In addition to primary and preventive health services, most Federally-funded health centers provide some level of enabling services. However, only 19 percent of the health centers under a managed care contract receive direct reimbursement for enabling services. Among those centers, reimbursement for these services were most frequently reported for: case management (49%), transportation (41%), health education (33%) and outreach (31%). Centers that receive cost-based reimbursement have enabling services built into their cost report and are thereby paid for them.

Just 18 percent of centers were receiving reimbursement from their contracted MCO for translation services, although 34 percent indicated that one or more languages, other than English, were predominantly spoken in the community they serve. Thirty-five percent of health centers reported that SCHIP applications were not available in a language other than English, or they were not aware of the availability of bilingual applications. As indicated earlier, health centers serve a high proportion of ethnic minority populations for whom English is a second language. HCFA’s proposed SCHIP implementation regulations<sup>32</sup> suggest that “a State may overcome language barriers by establishing a methodology for determining the prevalent language or languages in a geographic area and making information available in the languages that prevail throughout the State or in limited geographic areas where appropriate.”<sup>33</sup>

### **Relatively few health centers (21%) were making changes to specifically adapt to the phase-out of Medicaid cost-based reimbursement.**

Under the Balanced Budget Act of 1997, Medicaid cost-based reimbursement to health centers is being phased out, although the Balanced Budget Refinement Act of 1999<sup>34</sup> extended the phase-out period by two years until 2005. Some States, at their option, may continue to pay 100% of Medicaid reasonable costs although most are expected to phase-out of Medicaid cost-based reimbursement. Consequently, many health centers are anticipating a reduction in revenues under the Medicaid expansion component of SCHIP. Medicaid is, and has been, the largest funding source for these centers, followed by HRSA’s Section 330 grants.<sup>35</sup> Current funding levels indicate that SCHIP will provide a significant portion of health center revenues.

Only 21 percent of health centers reported making changes to adapt to the phase-out of cost based reimbursement. Within that group, one strategy employed by 61 percent of those centers, has been to seek out foundation grants/contracts and more State and local subsidies to supplement their revenues. Other options, pursued to a lesser degree, were to reduce administrative staff (47%) and/or reduce clinical staff (39%). Few centers chose to increase administrative staff (4%) or eliminate children's programs/services (5%). However, many centers have presently been able to put off adjusting to new reimbursements, with 52 percent having received an extension to continue under cost-based reimbursement for an additional period of time.

### **Health centers are altering their business infrastructures in response to changes in the health care environment.**

Whether a direct response to SCHIP, managed care, or changing reimbursement methods, health centers indicated some changing dynamics in their operations. Sixty-two percent of centers made changes to their administrative procedures. Of those centers, 90 percent were upgrading their management information system (MIS) and 49 percent were increasing front desk staff for public/private insurance verifications. For some, the introduction of the SCHIP program created a center need to add a marketing budget (41%). Among the 36 percent of centers that increased clinical staff, the most common additions were: more nursing staff (54%), medical assistants (47%) and family physicians (41%). These changes were intended to increase productivity of physician time.<sup>36</sup>

### **Health centers played a role in SCHIP planning, and are positive about their continued role in serving children.**

Federally funded health centers have been major safety-net providers for low income children since the 1960s. In regard to SCHIP particularly, the health centers have contributed to planning for its implementation and are optimistic about their part in its future.

Health centers were primarily involved in SCHIP planning through their States' Primary Care Associations (PCA), although some were also active individually as well. Seventy-one percent of centers reported involvement in the planning process in some capacity. Of these, 77 percent felt that their involvement had a positive impact on the outcome of their States' SCHIP plans. The centers that did not participate in the planning process reported that their States did not request their input, or that they were unaware of opportunities to participate.<sup>37</sup>

Despite challenges, most health centers appear optimistic about the future, with 80 percent expecting to serve more children and 12 percent expecting to serve the same number of children. Only eight centers (2%) thought that they would serve fewer children in the future, while 24 centers (6 %) indicated that they did not know if they will serve more or less. Losing children to other managed care providers and reduction in Medicaid eligibles, due to welfare reform, were the main reasons why some centers believed they would serve fewer children in the future.

# RECOMMENDATIONS

As trusted, established health care providers within needy communities, Federally funded health centers are one of the most appropriate agents to help fulfill the goals of the SCHIP program. In return, SCHIP enables these centers to benefit from additional funding as they continue to make health care available to the uninsured. While HCFA and HRSA have assisted States and health centers with SCHIP implementation, more work lies ahead for both agencies, States and health centers to ensure health centers' future viability.

We believe that close coordination among HCFA, HRSA, and State Medicaid and SCHIP agencies that work with under-served populations can be highly effective in providing health care to needy children through Medicaid and SCHIP. To continue improving and supporting health centers' performance in those areas indicated by our findings, we recommend the following:

## **HCFA should encourage State actions and policies that promote successful enrollment of children in SCHIP through the health centers. HCFA should:**

**Encourage States to provide SCHIP enrollment training to all health centers.** Health centers that received enrollment training from their States were more likely to enroll children in SCHIP than those centers that received none. State enrollment training was the most significant factor that influenced successful enrollment for health centers.

**Promote State adherence to regulations which require the States that implemented Medicaid expansions to appropriately allocate outstationed eligibility workers to health centers.** Our findings indicate that outstationed eligibility workers play a key role in health center enrollment of children in SCHIP. While only a few centers indicated that they were a "low-use" site, more than half of them did not have outstationed eligibility workers in their facilities.

**Encourage States to designate more health centers as presumptive eligibility sites, where applicable.** Under the Balanced Budget Act of 1997, States may establish presumptive eligibility for the Medicaid program. States with separate or combined SCHIP models have considerable flexibility in incorporating presumptive eligibility in their SCHIP program. We found that being a presumptive eligibility site increases the likelihood that a health center will receive enrollment training and, subsequently, enroll children in SCHIP.

**Support continued State outreach activities and enhanced outreach at local community levels where health centers are.** States' outreach activities such as public service announcements, information distribution through schools and newspaper advertisements stimulate health centers' SCHIP enrollment. However, one-fourth of the centers indicated that either their States were in the outreach planning stage or they were not yet aware of any outreach activities conducted by the State. States should continue with their current SCHIP outreach efforts while monitoring to see that the outreach activities are conducted in communities where health centers are present.

**Promote quicker SCHIP eligibility determinations.** We found that centers whose States made enrollment decisions within one month, were twice as likely to have enrolled children in SCHIP.

**Encourage States to promote inclusion of health centers, that are ready for managed care, in Medicaid and/or SCHIP managed care provider networks.** Thirty-seven percent of health centers indicated that they did not have managed care contracts that cover children. However, health centers are more likely to have managed care contracts if the State requires the MCOs to include safety-net providers, such as health centers.

**Recommend that States promote MCO reimbursement for enabling services.** “Enabling services” such as transportation, translation and other social services are often critical for the patients served by these centers to access health care. However, only 19 percent of respondent health centers were receiving direct reimbursement for enabling services from their managed care contracts.

**HRSA should continue to support health center adjustments to the changing health care environment. HRSA should:**

**Continue preparing health centers for the phase-out of Medicaid cost-based reimbursement.** Only 21 percent of health centers reported making changes to adapt to the phase-out of Medicaid cost based reimbursement. Of those, most (61%) sought out additional subsidies rather than making operational changes. Moreover, more than half of the centers under managed care contracts were still reimbursed using traditional cost-based methods. Health centers should be encouraged to aggressively utilize managed care training, managed care contract review and on-site technical assistance from HRSA’s Bureau of Primary Health Care’s Office of Program and Policy Development to help prepare for the conversion from cost-based reimbursement.

**Promote the formation of health center managed care networks to assure effective health center participation in Medicaid and/or SCHIP managed care programs.** If States do not require MCOs to include health centers and/or one is not available in a center’s service area, then HRSA should provide assistance to aid health centers that are ready for managed care in forming center-owned MCOs in communities that will support them. In cases where a center-owned MCO was currently operating in their service area (63%), most centers (90%) were participants.

**HRSA, in coordination with HCFA, should consider further examination of the impact of SCHIP outreach activities.**

To better understand the effectiveness of outreach activities, future review or evaluations which are consolidated with existing Department initiatives are needed.

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## Agency Comments

For this report, both HCFA and HRSA provided written comments, the full texts of which are included in Appendix D. Both agencies generally concur with our recommendations, and both offered technical comments which are reflected in our revisions. As HCFA points out, many of the recommendations are already being addressed by them, particularly with regard to eligibility and outreach issues.

**Outstationed Eligibility Workers** – HCFA and HRSA suggested revisions to our recommendation to HCFA regarding outstationed eligibility worker requirements. HCFA suggested reframing the recommendation to focus on States ensuring outstationed eligibility workers are located in the most appropriate settings and on States expanding the use of outstationing as an enrollment technique. HRSA suggested the need for informing States of their obligation for outstationing workers and providing reimbursement for them, as they believe our data indicate that most States are not adhering to the requirement.

Since the sole focus of our study was to examine the experiences of health centers in a SCHIP environment from their perspective, we do not believe our data warrant the changes regarding State roles and responsibilities suggested by HCFA and HRSA. Conceptually, we agree that schools and community centers are probably valuable points of entry for children into SCHIP, but we cannot claim that in this report. We believe that we have clearly indicated that health centers, except low-use sites, are required to have outstationed eligibility workers placed by States.

**MCO Reimbursement For Enabling Services** – HCFA thought it would be helpful for us to define “enabling services” so that they can determine which ones are already mandatory Medicaid services and which are optional. A full list of enabling services is referenced in the report.

HCFA’s assuring that States provide reimbursement to MCOs for mandatory enabling services is a good plan in our view. However, whether the particular enabling service is mandatory or not, we urge HCFA to promote State support of MCO reimbursement for all these services. We found that enabling services are often critical for the patients served by these health centers. Only 19 percent of health centers indicated that they were receiving direct reimbursement for enabling services from their managed care contracts.

## ENDNOTES

1. Sara Rosenbaum, Kay Johnson, Colleen Sonosky, Anne Markus and Chris DeGraw, "The Children's Hour: The State Children's Health Insurance Program," *Health Affairs*, January/February 1998, pp. 75-89.
2. The State Children's Health Insurance Program Annual Enrollment Report, October 1, 1998-September 30, 1999
3. The HCFA SCHIP website, *State Children's Health Insurance Program (SCHIP) Status Report*. (updated as of October 27, 1999).
4. The HCFA SCHIP website, *Status of State Plan* (as of June 21, 2000) states that Illinois, Indiana, North Dakota, New York and Texas, have changed to a Combined program. Thus, there are 23 Medicaid expansion States, 18 Combined program States and 15 Separate SCHIP program States.
5. Neal Halfon, Moira Inkelas, Helen DuPlessis and Paul W. Newacheck, "Challenges in Securing Access to Care for Children," *Health Affairs*, March/April 1999, pp. 48-63.
6. *CHIP's Impact on Changing Service Delivery of Federal Health Centers: Six Case Studies*, October 1999, OEI-06-98-00320.
7. *Ibid.* OEI-06-98-00320
8. HRSA created the Center for Managed Care in 1996 to assist centers in adapting to changes in the health care system.
9. Cost-based reimbursement is the full reimbursement of allowable expenses from an annual cost report.
10. *Ibid.* OEI-06-98-00320.
11. *Medicaid and SCHIP: Comparisons of Outreach, Enrollment Practices, and Benefits*, GAO, GAO/HEHS-00-86, April 2000.
12. During our data collection stage, States had chosen a variety of SCHIP models, and were at different levels of implementation. Because of this, we asked health centers to comment on the parts of the SCHIP program model and/or implementation with which they were familiar. In this report, we used "SCHIP" as the term to cover all the different model types and implemented programs described by the health centers.
13. The Internet survey was created using the Raosoft Ezsurvey software.
14. See Appendix A for complete logit regression models.

15. See Appendix A for the regression results. The remaining 1 percent of the centers indicated that they did not know whether or not their States were conducting outreach.
16. See Appendix A for the regression results.
17. See Appendix A for auxiliary logit regression model.
18. See Appendix B for the Chi-Square test results.
19. Code of Federal Regulations, Title 42, Volume 3, **42CFR435.904** *passim* (revised as of October 1, 1999).
20. Federal Register, Vol. 64, No. 215, **42CFR457.110** (November 8, 1999). Page 60892 of the preamble for the proposed rule on implementing regulations for SCHIP specifies under “Enrollment simplification” that “States that implement Medicaid expansions must follow all Medicaid rules relating to application assistance and eligibility determination.” States selecting a separate child health program are encouraged to consider outstationing eligibility at sites that are frequented by families with children.
21. Code of Federal Regulations, Title 42, Volume 3, **42CFR435.904** *passim* (revised as of October 1, 1999).
22. *The Children’s Health Insurance Program: States’ Application and Enrollment Processes: An Early Report From the Front Lines*, May 1999, OEI-05-98-00310.
23. See Appendix A for the regression results.
24. See Appendix A for the regression results.
25. See Appendix A for the regression results.
26. *Ibid.* GAO, April 2000.
27. Chi-Square test for this relationship was not significant.
28. See Appendix B for the Chi-Square test results.
29. See Appendix B for the Chi-Square test results.
30. Capitation payment is a fixed monthly payment of a specified set of services for each enrollee.
31. Helen Halpin Schaffler, Jessica Wolin, “Community Health Clinics under Managed Competition: Navigating Uncharted Waters,” *Journal of Health Politics, Policy and Law*, Vol. 21, No. 3, Fall 1996, pp. 461-488.
32. Federal Register, Vol. 64, No. 215, **42CFR457.110** (November 8, 1999).
33. *Ibid.* **42CFR457.110**.

34. Balanced Budget Refinement Act of 1999, (P.L. 106-113), section 603.
35. *Health Care Access: Programs for Underserved Populations Could Be Improved*, GAO, GAO/T-HEHS-00-81, March 2000.
36. Anecdotal evidence from the qualitative case study report, OEI-06-98-00320.
37. It is unclear whether centers believed that their influence affected the SCHIP models chosen by States or SCHIP implementation after the State model had been selected.

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United States General Accounting Office, *Medicaid and SCHIP: Comparisons of Outreach, Enrollment Practices, and Benefits*, GAO/HEHS-00-86, April 2000.

## Discussion of Regression Model

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### Empirical Model and Data

We used the logit model to explain which factors had significant impact on SCHIP enrollment outcomes in health centers. This model allows us to estimate the probability of a health center enrolling children in SCHIP ( $p$ ), or center not enrolling children ( $1-p$ ), based on the linear combination of independent variables. That is,  $\ln(p/1-p) = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \dots + \beta_k X_k + \mu$ . More explicitly, our model of health center's SCHIP enrollment can be written:

Model 1: Base Model

$$\begin{aligned} \text{Enroll} = & b_0 + b_1 \text{Combi} + b_2 \text{Separate} \\ & + b_3 \text{ST\_Out} + b_4 \text{HC\_Out} + b_5 \text{ST\_HC\_Out} \\ & + b_6 \text{Out\_worker} + b_7 \text{Presump} + b_8 \text{Train} \\ & + b_{10} \text{ST\_Out} + b_{11} \text{HC\_Out} + b_{12} \text{ST\_HC\_Out} \\ & + b_{13} \text{Month} + b_{14} \text{App\_Time} \\ & + b_{15} \text{Q2\_Kid} + b_{16} \text{Q2\_Kid} + b_{17} \text{Q2\_Kid} + \epsilon \end{aligned}$$

Model 1a : Auxiliary Model

$$\text{Train} = b_0 + b_1 \text{Out\_worker} + b_2 \text{Presump} + \epsilon$$

Variable descriptions are included in Table A-2 below.

### Results

Empirical findings of the Base Model indicate that receiving SCHIP enrollment training from the State had the strongest impact on a health center's SCHIP enrollment outcome. However, variables that indicate health centers with outstationed eligibility workers and centers designated as presumptive eligibility sites were not significantly related to the probability of enrolling children (See Table A-2). This finding was contrary to our prior expectation based on results from our qualitative studies, and Chi-Square statistics indicating that there was a significant association ( $p < 0.001$ ) between those two variables and the dependent variable. As a result, we examined the relationship between SCHIP training and outstationed worker and presumptive eligibility site variables. We found that there was an indirect effect of these variables on enrollment. As indicated earlier, we employed an auxiliary regression model. The results showed that although outstationed worker and presumptive eligibility site did not have direct impact on health center's SCHIP enrollment, the effects of these variables were working through enrollment training. Table A-1 presents the auxiliary regression results.

Table A-1: Auxiliary Regression Estimates				
Dependent Variable: TRAIN (N = 371, Concordant = 47.5%)				
Independent Variables	Parameter Estimate	Standard Error	Pr > Chi-Square	Odds Ratio
OUT_WORKER	0.8880	0.2251	0.0001	2.430
PRESUMP	0.5089	0.2525	0.0439	1.663

State's SCHIP model type also had a significant effect on a health center's SCHIP enrollment outcome. Health centers under a combined model or a separate SCHIP program are about three times more likely to enroll children than centers under the Medicaid expansions model. State outreach activities were also significant and health centers that reported State outreach were 2.5 times more likely to have enrolled children than those centers which reported their States had not conducted outreach. In addition, eligibility determination time and approval date of State's SCHIP plan also had a significant effect on health centers' enrollment. Table A-2 presents the base model regression results with the variable descriptions.

<b>Table A-2: BASE Regression Model</b> <b>Dependent Variable: ENROLL</b> <b>(n = 371, c = 82.7%)</b>		
<b>Independent Variables</b>	<b>odds ratio</b>	<b>Descriptions</b> (All variables are binary, except MONTH is a continuous variable.)
MEDI_EXP	reference	State SCHIP model is Medicaid Expansion
COMBI	3.141*	State SCHIP model is Combined program
SEPARATE	2.947*	State SCHIP model is Separate program
ST_OUT	2.500*	health center reporting their State's SCHIP Outreach Activities
HC_OUT	0.996	health center reporting their own center SCHIP outreach Activities
ST_HC_OUT	0.167	Interaction variable between ST_OUT * HC_OUT
OUT_WORKER	1.430	health center has outstationed eligibility workers at their site
PRESUMP	1.882	health center is designated as presumptive eligibility site for SCHIP enrollment
TRAIN	3.922*	health center received SCHIP enrollment training from their State
MONTH	1.113*	number of month each State had their SCHIP plan approved. (subtracting State's approval date from January, 2000)
SHORT_APP_TIME	2.143*	eligibility determination took less than one month
Q1_KID^	reference	number of kids(< 1622) served in health center falls in 0-25% distribution
Q2_KID^	1.472	number of kids(1623-3567) served in health center falls in 26-50%distribution
Q3_KID^	1.133	number of kids(3568-7049) served in health center falls in 51-75% distribution
Q4_KID^	0.925	number of kids(> 7049) served in health center falls in 76-100% distribution
MCO	1.418	health center has a managed care contract
* significant at 0.05. ^Using 1998 HRSA UDS data, number of children (ages 0-19) served by sampled health centers.		

**Chi-square Test Results**

Frequency Column percent		Center a presumptive eligibility site for SCHIP			
<b>Actually enrolled children under SCHIP</b>		Yes	No	Not applicable	TOTAL
Yes	86 85.15	87 66.92	109 76.22	282 75.4	
No	15 14.85	43 33.08	34 23.78	92 24.60	
Total	101 27.01	130 34.76	143 38.24	374 100	
<u>Statistic</u> <b>Chi Square</b>	<u>a</u> 0.01	<u>DF</u> 2	<u>Critical <i>chi-sq</i> Value</u> 9.21	<u>Computed <i>chi-sq</i> Value</u> 10.264	<u>Probability</u> 0.006
Frequency Column percent		State requiring managed care contractors to mandate health centers in their provider network			
<b>Health centers that have managed care contracts that include children</b>		Yes	No	Don't Know	TOTAL
Yes	97 71.85	74 69.81	79 52.67	250 63.94	
No	38 28.15	32 30.19	71 47.33	141 36.06	
TOTAL	135 34.53	106 27.11	150 38.36	391 100	
<u>Statistic</u> <b>Chi Square</b>	<u>a</u> 0.01	<u>DF</u> 2	<u>Critical <i>chi-sq</i> Value</u> 9.21	<u>Computed <i>chi-sq</i> Value</u> 13.518	<u>Probability</u> 0.001
Frequency Column percent		State requiring managed care contractors to mandate health centers in their provider network			
<b>Health center-owned managed care organizations in the State</b>		Yes	No	Don't Know	TOTAL
Yes	51 37.78	46 42.20	42 27.81	139 35.19	
No	65 48.15	60 55.05	59 39.07	184 46.58	
Don't Know	19 14.07	3 2.75	50 33.11	72 18.23	
TOTAL	135 34.18	109 27.59	151 38.23	395 100	
<u>Statistic</u> <b>Chi Square</b>	<u>a</u> 0.01	<u>DF</u> 4	<u>Critical <i>chi-sq</i> Value</u> 13.28	<u>Computed <i>chi-sq</i> Value</u> 41.642	<u>Probability</u> 0.001

**Point Estimates and Confidence Intervals from Key Survey Questions**

All Health Centers -- Point Estimates and Confidence Intervals for Key Survey Questions			
Proportion of All Health Centers	Point Estimate (in percent)	Standard Error (in percent)	95% Confidence Interval
<b>Are States conducting outreach activities</b> (n=405) ▶ yes ▶ no ▶ no, but funds allocated ▶ no, but developing ▶ don't know	74 12 8 5 1	1.3 0.9 0.8 0.6 0.3	71.5 - 76.5 10.1 - 13.9 6.5 - 9.5 3.8 - 6.2 0.4 - 1.6
<b>Centers reporting they <u>do</u> conduct outreach activities</b> (n=405)	83	1.1	80.9 - 85.1
<b>Center received outside resources for outreach (funds/manpower)</b> (n=405)	42	1.4	38.9 - 44.5
<b>Actually enrolled children under SCHIP</b> (n=405) ▶ yes ▶ no	73 27	1.3 1.3	70.3 - 75.4 24.6 - 29.7
<b>State provided training on CHIP enrollment to center's staff</b> (n=405) ▶ yes ▶ no ▶ don't know	55 41 4	1.4 1.4 0.6	52.5 - 58.1 37.9 - 43.5 2.8 - 5.1
<b>Centers having outstationed eligibility workers</b> (n=405)	39	1.4	36.2 - 41.8
<b>Of centers having outstationed eligibility workers, State funds the position</b> (n=159) ▶ Fully ▶ Partially ▶ Not at all	45 30 25	3.4 3.1 3.0	38.3 - 51.7 23.9 - 36.1 19.1 - 30.9
<b>Of centers <i>not</i> having outstationed eligibility workers, State designated as "low use"</b> (n=246) ▶ yes ▶ no ▶ don't know	7 82 11	1.3 1.9 1.5	4.5 - 9.5 78.3 - 85.7 8 - 14

**All Health Centers -- Point Estimates and Confidence Intervals  
for Key Survey Questions**

<b>Proportion of All Health Centers</b>	<b>Point Estimate (in percent)</b>	<b>Standard Error (in percent)</b>	<b>95% Confidence Interval</b>
<b>How long to know eligibility from a completed application</b> (n=295)			
▶ Few days	7	1.1	4.7 - 8.9
▶ One to two weeks	12	1.4	9.2 - 14.5
▶ Less than one month	24	1.8	20.2 - 27.2
▶ One to two months	37	2.0	32.6 - 40.6
▶ More than two months	13	1.4	10.4 - 16.0
▶ Don't know	8	1.1	5.6 - 10.0
<b>Center a presumptive eligibility site for SCHIP</b> (n=405)			
▶ IS a presumptive eligibility site	25	1.3	23.0 - 27.9
▶ is NOT presumptive eligibility site	32	1.4	29.4 - 34.8
▶ Not applicable in our State	36	1.4	32.8 - 38.3
▶ Don't know	7	0.7	5.5 - 8.4
<b>Experiencing enrollment barriers</b> (n=405)			
▶ ARE experiencing	64	1.4	61.2 - 66.7
<b>Have managed care contract that covers children</b> (n=405)			
▶ no	37	1.4	34.0 - 39.5
▶ yes	63	1.4	60.5 - 66.0
<b>Type or reimbursement currently receiving under largest SCHIP and/or Medicaid managed care contract</b> (n=256)			
▶ Cost-based	55	2.4	50.8 - 60.1
▶ Full capitation	17	1.8	13.7 - 20.7
▶ Primary care capitation	48	2.4	43.0 - 52.3
▶ Primary care case management	10	1.4	7.3 - 13.0
▶ Risk withholding	12	1.6	9.1 - 15.2
<b>Center receiving direct reimbursement for enabling services through MCO</b> (n=256)			
▶ yes	19	1.9	15.5 - 22.8
▶ no	81	1.9	77.2 - 84.5
<b>State requires MCO to include health centers in provider networks</b> (n=405)			
▶ yes, Medicaid/Medicaid expansion only	18	1.1	16.1 - 20.5
▶ yes, separate SCHIP program only	1	0.3	0.4 - 1.6
▶ yes, for both programs	13	1.0	10.9 - 14.7
▶ no	27	1.3	24.6 - 29.7
▶ don't know	41	1.4	37.9 - 43.5

**All Health Centers -- Point Estimates and Confidence Intervals  
for Key Survey Questions**

Proportion of All Health Centers	Point Estimate (in percent)	Standard Error (in percent)	95% Confidence Interval
<b>Is there a health center-owned MCO in State</b> (n=405)	34	1.4	31.6 - 37.0
▶ yes	46	1.4	42.8 - 48.5
▶ no	20	1.2	18.0 - 22.5
▶ don't know			
<b>Does center-owned MCO operate in your service area</b> (n=139)			
▶ yes	63	3.6	55.5 - 69.7
▶ no	37	3.6	30.3 - 44.5
<b>Which best describes action taken by center to adapt to phase-out of cost-based reimbursement</b> (n=365)			
▶ Center not affected due to freestanding program	16	1.2	13.8 - 18.6
▶ Center received an extension to continue cost-based reimbursement	52	1.7	48.2 - 54.8
▶ Center has made changes	32	1.6	29.3 - 35.4
<b>Has center made changes in ADMINISTRATIVE PROCEDURES</b> (n=405)			
▶ yes	62	1.4	59.2 - 64.7
▶ no	38	1.4	35.3 - 40.8
<b>Has center made changes in CLINICAL STAFFING</b> (n=405)			
▶ Not made any changes	48	1.5	44.8 - 50.5
▶ Decreased clinical staff	16	1.1	14.0 - 18.1
▶ Increased clinical staff	36	1.4	33.6 - 39.0
<b>Health centers expect to serve more, fewer, or same number of children three years from now</b> (n=405)			
▶ More	80	1.2	78.0 - 82.5
▶ Fewer	2	0.4	1.4 - 3.1
▶ Same	12	0.9	9.8 - 13.4
▶ Don't know	6	0.7	4.8 - 7.5

Note: Some estimates are based on a sample size of less than 405. Not all centers in our sample were able to respond to all the questions in the survey because some questions were not applicable to the centers and/or their States.

## **Agency Comments**

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In this appendix, we present comments from the Health Care Financing Administration and the Health Resources and Services Administration.

Office of the Administrator  
Washington, D.C. 20201

OCT 24 2000

**DATE:****TO:** June Gibbs Brown  
Inspector General**FROM:** Michael M. Hash   
Acting Administrator**SUBJECT:** Office of the Inspector General (OIG) Draft Report: "Federally Funded Health Centers and Low-Income Children's Health Care: Improving SCHIP Enrollment and Adapting to a Managed Care Environment," (OEI-06-98-00321)

Thank you for your letter to Nancy-Ann Min DeParle concerning the above-mentioned report.

As of June 2000, there are approximately 2.5 million children enrolled in the State Children's Health Insurance Program (SCHIP). The Census Bureau recently released data showing a decline of 1.7 million people in the ranks of the uninsured between 1998 and 1999, two-thirds of whom were children. These new numbers confirm that the Clinton Administration and the Department of Health and Human Services have made major strides in increasing enrollment in SCHIP and Medicaid. President Clinton recently announced the release of \$700,000 in grants to enhance State efforts to identify and enroll uninsured children, keep them enrolled, and to make sure they have the best care possible. We are very pleased to report these enrollment numbers and will continue our partnership with the States to reach working families whose children need consistent, reliable health care.

Many of the OIG's recommendations are already being addressed by HCFA, particularly with regard to eligibility and outreach issues. For example, OIG recommends that HCFA: a) encourage States to provide enrollment training; b) increase the number of health centers with outstationed eligibility workers; and c) promote wider use of presumptive eligibility. HCFA has released a series of "Dear State Health Official" letters describing examples of and innovative options for successful outreach and enrollment and Federal funding available for these activities such as presumptive eligibility. HCFA continues to work closely with the States, localities, advocacy groups, and our other partners to encourage them to cooperate in improving and increasing enrollment into Medicaid and SCHIP. Prior to releasing this report in final, OIG contacted HCFA and HRSA to get more detailed information on current activities. OIG also makes the recommendation that States promote MCO reimbursement for "enabling" services. We think it would be helpful for the report to highlight what is meant by "enabling" services. There then needs to be further delineation as to which of these "enabling" services are mandatory Medicaid services. Certain services that may be

considered "enabling" such as translation services are required of all Medicaid providers, however, we believe that most other enabling services would only be optional services for States under Medicaid.

It is often difficult to separate "assertive outreach" by health centers or health plans from marketing. It might be useful to point out that the term outreach as used in this report means encouraging clients to establish Medicaid eligibility rather than encouraging a choice of a particular provider.

Our specific comments are as follows:

OIG Recommendation

HCFA should encourage State actions and policies that promote successful enrollment of children in SCHIP through the health centers.

HCFA Response

In general we concur with this recommendation. Please see below for specific discussion of each sub-recommendation.

- Encourage States to provide SCHIP enrollment training to all health centers.

We believe that this report needs to more fully discuss what is meant by enrollment training. Specifics should be given as to what type of training is envisioned and the specific type of training each worker within the center should be receiving. However, in principle we agree that enrollment training should be provided to these health centers in order to further the efforts States are already making to simplify enrollment processes. Such training is necessary to ensure that parents understand the enrollment process and are able to understand and can fill out enrollment forms. Information is one key to success.

- Promote State adherence to regulations which require the States that implemented Medicaid expansions to appropriately allocate outstationed eligibility workers to health centers.

We suggest re-framing this recommendation to focus on working with States to ensure that outstationed eligibility workers are being located in the most appropriate settings (e.g., health centers, schools, community centers) and to encourage States to expand the use of outstationing as an enrollment technique. We believe that establishing outstationed eligibility workers in areas convenient to families is another key step to achieving successful enrollment. For example, in rural areas it may be necessary to provide door-to-door outreach and establish outstations so families can sign up near their homes.

- Encourage States to designate more health centers as presumptive eligibility sites, where applicable.

We agree that States should be encouraged to designate health centers as presumptive eligibility sites. Federally funded health centers can do presumptive eligibility (PE) determinations for Medicaid or Medicaid expansions under Title XXI. Currently there is no explicit presumptive eligibility authority in Title XXI, however, States can do PE-like eligibility determinations within the current eligibility guidelines in SCHIP.

- Support continued State outreach activities and enhanced outreach at local community levels where health centers are.

We agree with this recommendation, however there needs to be more recognition of current State outreach and enrollment simplification activities, including targeted outreach through health centers.

- Promote quicker Medicaid/SCHIP eligibility determinations.

We agree with this recommendation and are already making efforts in this area. We believe that one way to promote quicker eligibility determinations is to simplify eligibility applications. States may want to explore the use of electronic applications to improve the speed and ease of application submittal. Some States are cutting once lengthy applications down to a few pages, are accepting applications by mail and are -eliminating unnecessary verification requirements. We are also encouraging States, through 1115 demonstration proposals, to incorporate innovative outreach strategies to find and enroll eligible children.

- Encourage States to promote inclusion of health centers, that are ready for managed care, in Medicaid/SCHIP managed care provider networks.

We agree with the recommendation. For this population it is imperative that managed care networks include safety-net providers, such as health centers, as they are the backbone of a health care delivery system for low-income children.

- Recommend that States promote MCO reimbursement for enabling services

We agree that States should be promoting MCO reimbursement for enabling services. However, as stated above we think it would be helpful for the report to highlight what is meant by "enabling" services. It can then be determined which of these enabling services are already mandatory Medicaid services and which are optional. We can then accurately delineate which services (e.g., translation) States should already be providing reimbursement to MCOs and which services we should encourage states to employ.

OIG Recommendation

HRSA should continue to support health center adjustments to the changing health care environment.

HCFA Response

We concur with this recommendation.

OIG Recommendation

HRSA, in coordination with HCFA, should consider further examination of the impact of SCHIP/Medicaid expansions outreach activities.

HCFA Response

Several efforts are currently underway to look at the effectiveness of outreach, including the States' evaluations and annual reports; the overall evaluation of SCHIP that is underway by Mathematica Policy Research; as well as the ongoing HCFA/HRSA monitoring efforts. We have heard concerns from several States noting the many site visits and evaluations that are being done simultaneously and seemingly with the same purpose. We would recommend giving the States' programs additional time to further develop and expand their programs before HCFA increases its monitoring and evaluation of the effectiveness of outreach efforts. We also recommend that any future review or evaluations be consolidated with existing Department initiatives.

Attachment

## TECHNICAL COMMENTS

- In general, the references to SCHIP/Medicaid expansions throughout the report are misleading and not consistent with the terminology in the forthcoming final SCHIP regulation. As a rule, references to SCHIP programs are references to any program that receives enhanced Federal matching funds up to the amount of the available SCHIP allotment. There are two types of SCHIP programs - Medicaid expansion programs and separate child health programs - that may be referred to. Although the Medicaid rules apply in States that implement Medicaid expansion SCHIP programs, the funding is structured differently.
- On page 1, the reference to the intent to provide the same "quality" of health care as private insurance may be misleading. We recommend characterizing the intent of SCHIP as providing States with an opportunity to design health care delivery systems that are similar in scope and structure to coverage that is available through private insurance.
- On page 6, it would be useful to provide some examples of "enrollment training. What activities does enrollment training encompass?"
- In the second paragraph on page 6, we are concerned about the references to States using "presumptive eligibility." Our analysis of the States' SCHIP evaluations (submitted to HCFA in March/April 2000) has concluded that States are using the term presumptive eligibility in very different ways and in varying degrees. In fact, most States are not using presumptive eligibility for children in either Medicaid or SCHIP. This point is consistent with the third recommendation to expand the availability of presumptive eligibility providers.
- On page 9 of the draft report, there is a discussion of the "phase out" of "Medicaid cost-based reimbursement" and the same phrase is used throughout the draft report. HCFA has taken the position that the phase-out was of the mandatory levels of cost-based reimbursement; States, at their option, may continue to pay 100% of Medicaid reasonable costs. In other words, the statute no longer says that States MUST pay 100% of reasonable costs, but a State MAY still do so.



Rockville, Maryland 20857

OCT 20 2000

**MEMORANDUM**

TO: Inspector General

FROM: Deputy Administrator

SUBJECT: OIG Draft Report: "Federally Funded Health Centers and Low Income Children's Health Care: Improving SCHIP Enrollment and Adapting to a Managed Care Environment," OEI-06-98-00321

We have reviewed the subject draft report. Attached are HRSA's comments.

Staff questions may be referred to Jeanelle Kallevang on (301) 443-6507.

Thomas G. Morford

Attachment,

**Health Resources and Services Administration's Comments on the Office of the Inspector General Draft Report "Federally Funded Health Centers and Low Income Children's Health Care: improving SCHIP Enrollment and, Adapting to a Managed Care Environment (code OEI-06-98-00321)**

**General Comments**

The Health Resources and Services Administration (HRSA) appreciates the opportunity to provide our comments on the Office of Inspector General (OIG) draft report, "Federally Funded Health Centers and Low Income Children's Health Care: Improving SCHIP Enrollment and Adapting to a Managed Care Environment" (Code OEI-06-98-00321).

**Technical Comments**

On Page 2, under the bold heading, "Methodology", second sentence beginning "The first phase in a two part study, that inspection employed a case study approach.....", doesn't make sense and needs to be rephrased.

On Page 3, the first paragraph titled "Sample", second sentence beginning "These grantees include Primary health Centers, .....", we suggest an alternate clarification: "These grantees include Community Health Centers,....."

On Page 6, in the next to last paragraph discussing "sixty-one percent of health centers.....", this section should include a statement to the effect that all FQHC's except low-use sites, are required by Federal regulations to have out stationed eligibility workers and that the cost of these workers are born by Medicaid. This requirement needs to be clearly indicated on this page. In addition, we recommend an addition of the finding that most states are not adhering to this requirement.

On Page I 1, under the bold heading "HCFA should.....", we suggest that an added paragraph is placed that would include verbiage regarding the requirement for placement and payment for out stationed eligibility workers. For example, the paragraph could start out: Inform states about their obligation to place out stationed eligibility workers in FQHCs and to provide Medicaid reimbursement for these workers.

On Page 12, under the bold heading "HRSA should continue....., while we agree with it conceptually, the second recommendation is of concern because of the financial risk of such an organization and that the success of such an entity is beyond the role of the Federal funding agency but rather lies with the support of both the state and local community and agencies. It is critical to look closely at the particular marketplace before determining what to do in the community. At this point we are supporting the development of health center owned plans only through the Loan Guarantee Program.