

USING COMMUNITY GROUPS AND STUDENT VOLUNTEERS  
TO ENROLL UNINSURED CHILDREN IN MEDICAID AND  
CHILD HEALTH PLUS

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## EXECUTIVE SUMMARY

Congress passed the State Child Health Insurance Program (CHIP) in 1997. This historic legislation provides federal funding for states to expand children's access to health insurance, and represents the largest investment in publicly funded children's health insurance since the creation of Medicaid more than 30 years ago. Under CHIP, New York will receive \$257 million per year in new federal funding. In 1998, New York State passed legislation that uses its share of CHIP funds to build on the state's two existing health insurance programs for children—Medicaid and Child Health Plus (CHP).<sup>1</sup> Specifically, New York has used the federal money to expand subsidized coverage for the children of working families, to add new benefits, and to make Medicaid and CHP more affordable. One of the most significant components of the new legislation mandates the creation of a single, community-based system of enrollment for Medicaid and CHP.

An estimated 75 percent of the 710,000 uninsured children in the state are currently eligible for, but not enrolled in, subsidized coverage under Medicaid or CHP.<sup>2</sup> Previous research gives insight into the reasons that these children remain uninsured. Some families, particularly working families, are simply unaware that their children are eligible for subsidized coverage.<sup>3</sup> Some families do understand their eligibility, but find the complex, bureaucratic enrollment system frustrating and impenetrable. This is particularly true for the Medicaid program, which requires a visit to the Medicaid office for a face-to-face interview. In addition, some immigrant families face language and cultural barriers, along with a general distrust of government programs. Much of the success of the children's health insurance program hinges on the ability to establish systems that overcome families' barriers to enrollment.

The new community-based enrollment system will streamline this application process, allowing families to apply for Medicaid and CHP at a single location close to home with the help of culturally and linguistically compatible staff. This new system represents a remarkable departure from past enrollment strategies because it shifts a crucial component of the application process—the family visit—away from the Medicaid office and into the community, thus allowing greater accessibility to families. However, it is crucial that community group members master the enrollment process—a process whose complexity gives cause for concern. The successful completion of the Medicaid and CHP applications

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<sup>1</sup> The new federal funding under CHIP will supplement New York's state annual allocation of more than \$200 million for Child Health Plus, as well as current spending on children's Medicaid.

<sup>2</sup> U.S. Bureau of the Census, March 1994–March 1997.

<sup>3</sup> Peter Feld, Courtney Matlock and David Sandman, *Insuring the Children of New York City's Low-Income Families: Focus Group Findings on Barriers to Enrollment in Medicaid and Child Health Plus*, The Commonwealth Fund, December 1998.

requires a sophisticated understanding of both programs' guidelines. Moreover, Medicaid and CHP eligibility and documentation requirements vary significantly, thus necessitating a mastery of two sets of rules.

In December 1998, the Children's Defense Fund–New York (CDF–NY) began to pilot-test a model for this new enrollment system that sought to accommodate the need for widespread opportunities for enrollment with the need for quality.<sup>4</sup> The Student Health OUTreach Project (SHOUT) placed 25 student volunteers from Columbia University in seven community organizations in Northern Manhattan for six months.<sup>5</sup> SHOUT students educated families about the availability of Medicaid and CHP for their uninsured children, assisted families with the application forms and documentation requirements, and conducted any necessary follow-up with families. CDF–NY served as the quality-control unit, reviewing all applications prior to their submission to Medicaid or CHP.

By the project's close in May 1999, SHOUT had successfully enrolled nearly 200 children and adults in Medicaid or Child Health Plus. More than 81 percent of the applications that the community organizations and student volunteers submitted to the quality-control unit were complete. Of the applications that CDF–NY approved for submission to Medicaid or CHP, more than 97 percent were accepted. SHOUT's high enrollment success and application approval rates reveal that with proper training and oversight, it is possible to use student volunteers effectively in the enrollment process. These findings also demonstrate that a quality-control unit is extremely effective in ensuring the integrity of completed applications before their final submission to Medicaid or CHP. Quality control can also designate areas for retraining if errors appear repeatedly.

These are important lessons to bear in mind as New York makes the transition to community-based enrollment, and we move ahead in our campaign to enroll all of the state's eligible children. Reaching into our community organizations, daycare centers, and churches will not benefit our children if low-quality applications mean that they stay uninsured. This study shows that we can find an optimal balance between maximizing our reach and minimizing our mistakes.

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<sup>4</sup> The first students were placed in Northern Manhattan under the SHOUT project in October 1998. However, full enrollment activities did not begin until December 1998, when the project was authorized to conduct face-to-face interviews for Medicaid and to pilot the joint application for Child Health Plus and Medicaid. Four applications for Child Health Plus were initiated in November 1998, prior to the project's official start date, and those applications are included in the numbers presented for this study.

<sup>5</sup> The following community-based organizations were SHOUT partners: Alianza Dominicana, Northern Manhattan Improvement Corporation, Northern Manhattan Coalition for Immigrant Rights, Harlem Congregations for Community Improvement, West Harlem Head Start, Graham Windham Beacon School, and Sydenham Health Clinic.



## I. BACKGROUND

Congress passed the State Child Health Insurance Program (CHIP) in 1997. This historic legislation provides federal funding for states to expand children's access to health insurance, and represents the largest investment in publicly funded children's health insurance since the creation of Medicaid more than 30 years ago. Under CHIP, New York will receive \$257 million per year in new federal funding. In 1998, New York State passed legislation that uses its share of CHIP funds to build on the state's two existing health insurance programs for children—Medicaid and Child Health Plus (CHP).<sup>6</sup> Specifically, New York has used the federal money to expand subsidized coverage for the children of working families, to add new benefits, and to make Medicaid and CHP more affordable. One of the most significant components of the new legislation mandates the creation of a single, community-based system of enrollment for Medicaid and CHP.

The state's next challenge is the enrollment of all eligible children into the newly expanded programs. There are more than 710,000 uninsured children in New York, and 420,000 of them live in New York City. Nearly 75 percent of these uninsured children statewide are currently eligible for, but are not enrolled in, subsidized coverage under Medicaid or CHP. Much of the success of the children's health insurance program expansion will depend on reaching and enrolling those who are eligible.

There are multiple reasons for the current underutilization of Medicaid and CHP. Working families often assume that their children are not eligible simply because the parents work. Other parents are unaware that the programs exist. Many of the parents who do know about the programs are nevertheless unable to maneuver through a complex, bureaucratic enrollment system. Families who apply for Medicaid are required to have a face-to-face interview at a local Medicaid office, where they may encounter long lines, confusing forms, and unfriendly staff. Also, these offices are not convenient for working families because they are open only during traditional hours. CHP, with its mail-in application process, is more accessible. However, many families don't understand CHP's managed care structure, and they may enroll without a thorough understanding of the benefits and constraints of managed care.

Recognizing these barriers, New York has dedicated \$10 million per year of its CHIP allotment to a new system called "facilitated enrollment." This funding will enable community organizations such as social service providers, childcare centers, places of worship, healthcare providers, and others, to reach out to their communities, identify

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<sup>6</sup> The new federal funding under CHIP will supplement New York's state annual allocation of more than \$200 million for Child Health Plus, as well as current spending on children's Medicaid.

families with uninsured children, and enroll them in Medicaid or CHP. Facilitated enrollment streamlines the application process by allowing families to use a single application form for both programs. They will now be able to complete this form with the help of culturally and linguistically compatible staff at locations close to their homes. In addition to assisting with the application and documentation requirements, representatives of community organizations will track families through the process and conduct follow-up to ensure their successful enrollment.

The new system represents a remarkable departure from past enrollment strategies. It makes the process much more accessible to families because it shifts a crucial component of the application process—the family visit—away from the Medicaid office and into the community. However, it is crucial that the community group members master the enrollment process—a process whose complexity gives cause for concern. Successful completion of the Medicaid or CHP application requires a sophisticated understanding of the programs' guidelines. In addition, the respective eligibility and documentation requirements vary significantly, which necessitates the mastery of two sets of rules. Those who administer this new system must find an optimal balance between the need for widespread opportunities for enrollment and the need for quality in a complex system.

#### The Community-Based Enrollment Project

Following passage of the new legislation, the Children's Defense Fund–New York (CDF–NY) designed a project to test a facilitated model of enrollment in Medicaid and CHP that is designed to achieve this goal. With the generous support of The Commonwealth Fund, CDF–NY launched its Student Health OUTreach Project (SHOUT) in partnership with three community organizations in Washington Heights and 25 student volunteers from Columbia University in the fall of 1998. In January 1999, the project was expanded to Harlem and four additional organizations were added. SHOUT placed the student volunteers in community settings—including multiservice social service organizations, a beacon school, a Head Start program, and a health clinic—to educate families about Medicaid and CHP and to enroll their eligible children. The student volunteers worked under the general supervision of a CDF–NY staff person who had undergone training to become a Medicaid Supervisor accredited by the Department of Social Services, which administers New York's Medicaid program. The CDF–NY Medicaid Supervisor trained the volunteers as Medicaid Screeners, enabling them to conduct the required face-to-face interview for Medicaid-eligible children. This allowed families to bypass the Medicaid office and complete the entire Medicaid application process at the office of the community organization. The supervisor and students also were trained in the CHP application process.

The CDF–NY Supervisor reviewed all completed applications for accuracy and completeness. Approved Medicaid applications were submitted to a pre-arranged contact at the Department of Social Services/Medicaid program, and completed CHP applications were forwarded to contact people at the appropriate managed care plans. Incomplete applications were returned to the volunteers for follow-up with the families. The CDF–NY Supervisor also transmitted all necessary paperwork and communication to the appropriate place and conducted any necessary advocacy.

Seven community-based organizations participated as SHOUT partners: Alianza Dominicana, Northern Manhattan Improvement Corporation, Northern Manhattan Coalition for Immigrant Rights, Harlem Congregations for Community Improvement, West Harlem Head Start, Graham Windham Beacon School, and Sydenham Health Clinic. At a minimum, community partners provided space for student volunteers to meet with families and conduct outreach. Some partners went far beyond this minimum, promoting SHOUT within their programs, and even devoting staff to support the effort. Alianza Dominicana, a founding member of the SHOUT partnership, housed three enrollment sites for the SHOUT project. Alianza Dominicana also lent the support of its existing benefits screening and referral project to SHOUT, serving as a home base for enrollment referrals in the community.

### Project Components

The SHOUT project focused its activities on two areas: outreach to families with uninsured children, and enrollment.

#### *Outreach*

The project needed to relay two important messages to the community: 1) many children are eligible for free or low-cost health insurance under Medicaid or CHP regardless of immigration status; and 2) families can apply for Medicaid or CHP at the offices of the project's community organizations. Volunteers reached families in community settings such as daycare centers, churches, laundromats, and busy commercial districts. These messages were transmitted in several ways, including the distribution of flyers and brochures, and person-to-person encounters in community settings.

Initially, project staffers developed a bilingual flyer for general distribution. The flyer listed all 10 of the SHOUT sites and the times when volunteers would be available to assist families. It also listed referral numbers for Alianza Dominicana, a community-based partner in SHOUT with a full-time enrollment center, and CDF–NY for those in need of further information. Individualized versions of the flyer for each enrollment site gave site-

specific phone numbers and hours of availability for SHOUT services. New and different flyers were developed as the project continued and as the project staff learned more about effective outreach messages. Students helped develop a brochure that included questions and answers for parents about children's health insurance and advertised the SHOUT locations.

Working in conjunction with an energetic and committed group of high-school student volunteers from Prep for Prep, an educational program for gifted minority youth, the project distributed more than 90,000 SHOUT flyers throughout Washington Heights and Central Harlem. The volunteers experimented with different venues for reaching families, including busy commercial districts, laundromats, check-cashing sites, bodegas, and public housing facilities. The Prep for Prep students were proactive in these efforts, engaging families in conversation and informing them of the availability of health insurance for their children. Consequently, many families came to the enrollment sites with the flyers in hand.

In addition, each SHOUT site received hundreds of flyers to reproduce and distribute to families served by their agencies, and CDF-NY mailed packets of the flyers to nonparticipating community organizations, churches, daycare centers, schools, and health care and social service providers. The student volunteers took full advantage of any downtime at the sites by distributing flyers on the street, targeting busy commercial strips and schoolyards where parents awaited their children's dismissal after class.

Student volunteers also attended community forums, community coalition meetings, ESL classes, and CBO staff meetings to create awareness about the project and encourage organizations to refer families to SHOUT sites. The volunteers attended at least one such event per week, reaching more than 300 community residents with information about SHOUT during the test's six-month duration.

### *Enrollment*

Project designers and staffers took care to link outreach tightly to the enrollment process. This is critical to ensuring that once eligible families learn about the availability of health insurance, their opportunities for enrollment are not limited. Further, student volunteers received extensive training in the process itself.

All SHOUT student volunteers participated in the training sessions, which were designed to equip them to function as knowledgeable, effective, and culturally sensitive enrollment workers. The training covered the eligibility requirements for Medicaid and CHP, the programs' structures and application processes, and included sensitivity training on

appropriate screening procedures for immigrant and low-income populations. Throughout the course of SHOUT, CDF–NY trained 100 student volunteers and community organization staff members.

Once stationed at an enrollment site, the student volunteers continued to receive hands-on training and supervision from CDF–NY staff until teams of two to three students each were able to complete the enrollment process without assistance. The amount of supervision needed varied according to the amount of time students committed to the project and the volume of applications at a particular site. Students' skill as enrollment workers proved to be directly reflective of the amount of field experience they had gained. CDF–NY conducted targeted retraining of volunteers and community organizations when repeated errors occurred in the application process.

CDF–NY also produced a comprehensive Medicaid and CHP guidebook as a resource for volunteers who needed answers to the technical details of both programs. It developed a single-page eligibility screening form to determine children's eligibility for Medicaid/CHP, as well as assorted outreach materials for distribution to families. Both the New York State Department of Health and the New York City Human Resources Administration/ Medical Assistance Program (the program that administers New York City's Medicaid program) were consulted for approval on the materials.

CDF–NY served as the quality-control unit, reviewing each application to ensure program eligibility, completeness of information on the application, and inclusion of adequate documentation, before forwarding it to Medicaid or CHP. The quality-control unit could also designate areas for retraining when problems in the process arose.

SHOUT also benefited from partnership with Alianza Dominicana, which devoted staff full time to helping families apply for health insurance. Prior to SHOUT, Alianza Dominicana staff provided application assistance and referral for Medicaid and Child Health Plus, but could not engage directly in enrollment. Under the SHOUT partnership, Alianza Dominicana used their own staff, supplemented by student volunteers, to offer their clients direct enrollment, instead of referral. At the same time, Alianza Dominicana staff provided SHOUT a full-time, community-based presence for enrollment activities. This model proved the most successful of our community enrollment sites, generating approximately half of all the SHOUT project's enrollment.

SHOUT's facilitated enrollment model sought to maximize the enrollment of children in the programs and to minimize the complexity of the process for families. The critical components of the project are:

- Community-based enrollment: SHOUT brought the enrollment process into community settings, offering families the opportunity to complete enrollment in a trusted environment during daytime and nontraditional evening and weekend hours.
- Personalized assistance and counseling: The project supplied each enrollment site with trained volunteers who met with families on an individual basis, informed them about Medicaid and CHP, screened the children for eligibility, and enrolled the family in the appropriate program. Families could call or return to the enrollment site with questions or concerns at any time throughout the application process.
- Authorization to conduct Medicaid interviews: SHOUT received authorization to conduct Medicaid face-to-face interviews in December 1998. This allowed the project to serve as the intermediary between families and the Medicaid program, and enabled families to bring all of their required documents and complete the application process at the enrollment site, rather than at the Medicaid office. The project forwarded the entire application and copies of the required documents to the Human Resources Administration.
- Use of the single Medicaid/CHP application: The New York State Department of Health gave SHOUT the opportunity to pilot the new single Medicaid/CHP application form in December 1998. This single application reduces documentation requirements for older children and eliminates the need to file separate applications with different CHP plans.
- Documentation assistance: Perhaps the greatest barrier to enrollment is the extensive list of documentation requirements for each applicant. SHOUT volunteers assisted families with this critical aspect of the process by walking them through the list and ensuring the availability of all necessary documents. If a mandatory document was unavailable, volunteers helped families devise alternate means of meeting each requirement.
- Follow-up with families: SHOUT volunteers followed up with phone calls or reminder letters to families who had incomplete applications, offering further assistance in completing their applications. This was a crucial to ensure that busy families saw the process through to completion.

## II. QUANTITATIVE EVALUATION—THE PROJECT’S RESULTS

The first section of Table 1 lists the number of children and adults who applied for Medicaid or CHP at the SHOUT enrollment sites from October 1998 to May 1999. These people completed and signed the application form, but did not necessarily return to the site with the required documentation. The second section of the table lists the number of children and adults who were enrolled into the Medicaid or CHP program. For Medicaid, this means that Medicaid approved the applications and informed the families and CDF–NY of its decision. CHP, on the other hand, notified the families—but not CDF–NY—of their children’s acceptance into the program. Even so, a designated representative from each CHP plan contacted CDF–NY about any problematic applications that required more information. Therefore, unless problems were noted by the plans, Table 1 assumes that the completed applications were accepted. Out of a total of 209 children and adults who initiated the application process for Medicaid or CHP, 175 completed the process and were enrolled.

Table 1. Applying\* and Enrolled Children and Adults

	Medicaid	Child Health Plus	Combined Total
Total Applicants	120	89	209
Adult Applicants	29	N/A	29
Child Applicants	91	89	180
Total Enrolled	97	78	175
Adults Enrolled	24	N/A	24
Children Enrolled	73	78	151

\* *Applying* means that an application was completed and signed, but the applicant did not necessarily return to the site with the required documentation.

Table 2 contrasts the number of applications that were for children only with the number that included adults. Although SHOUT focused on enrolling children, the students included parents on the application if they appeared eligible for Medicaid (CHP coverage is limited to children age 19 and younger). Applications that included adults required use of the eight-page Medicaid application and more extensive documentation. Determining eligibility was also more complex. As a result, only a specially trained subset of SHOUT staff and volunteers were able to assist with applications that included adults. Project planners anticipated a greater total of child-only Medicaid applications, since Medicaid’s family income guidelines for children are much higher than for single adults. In fact, more than 86 percent of total SHOUT applications were for children age 19 and younger. However, 40 percent (n=36) of children applying for Medicaid applied together with adults. Of the remaining nonapplying parents, the majority were also uninsured and asked about their potential eligibility for health insurance, but were simply ineligible.

Table 2. Types of Applications Submitted to Medicaid Supervisor

	Medicaid/PCAP	Child Health Plus	Combined Total
Total Applications	60	61	121
Child-Only Applications	36	61	97
Adult and Child Applications	24	N/A	24

Table 3 shows the number of child applicants in each Medicaid age category. Each of these categories has unique income levels, which decrease as the child grows older. Interestingly, despite Medicaid’s more generous income guidelines for younger children, the majority of children applying for Medicaid through SHOUT were older children in the lowest income category. Similarly, the majority of children enrolled in CHP were age 6 and older.

Table 3. Ages of Applying Children

	Medicaid	Child Health Plus	Combined Total
Less than 1 year	4	1	5
1–5 years	23	16	39
6–19 years	63	73	136
Total Applying Children	90	90	180

### Application Results

The student volunteers and partner organizations submitted 121 applications to the CDF–NY Medicaid Supervisor. More than 81 percent of these applications (n=99) were approved by the CDF–NY Medicaid Supervisor during initial review. Nineteen percent (n=22) were found to be incomplete and were returned to the enrollment sites for follow-up.

There were seven incomplete Medicaid applications. Of those, six were family applications with more extensive documentation requirements than child-only applications. Two applications needed the Absent Parent Form, two required proof of income, two needed proof of rent, and one needed to clarify the disparity between rent paid and income received. Interestingly, in five of these cases, the needed documentation consisted of documents that are not necessary for the child-only applications, such as the Absent Parent Form and proof of rent. The single child-only application that was incomplete was missing the Social Security cards. CDF–NY conducted one targeted retraining of volunteers at an enrollment site where applications with repeated errors were submitted.

There were 15 incomplete CHP applications. Of these, 13 were forwarded to the appropriate CHP plan under the presumptive eligibility process. Of these 13 presumptively eligible applications, 11 needed to submit last year's tax returns or further proof of income, one needed all documentation, and one needed additional proof of income. The two applications that the Medicaid Supervisor was unable to send presumptively did not indicate family income and could not be forwarded to the CHP plan.

Of the 104 complete applications that the CDF–NY Supervisor submitted to HRA/Medicaid and the CHP plans, over 97 percent (n=101) were approved. HRA/Medicaid rejected two applications and one was rejected by a CHP plan after submission. One Medicaid application was rejected because HRA/Medicaid discovered unreported income, making the family ineligible. The family that filed the second application was already covered by Medicaid. These rejections do not indicate an error on the part of the SHOUT project staff. The sole CHP application rejection was because the family applied for a CHP plan that did not serve their borough. This does indicate an error on the part of the CDF–NY Supervisor.

Efforts were made to ensure that applications were acted on in a timely way. On average, approximately two weeks passed between the recorded date of a signature on the application and submission to either HRA/Medicaid or the managed care plan.<sup>7</sup> This varied somewhat depending on the type of application used and coverage sought. Approximately three weeks passed between application signature and agency submission for long Medicaid applications (those that included adults), approximately two weeks for child-only Medicaid applications, and approximately one-and-a-half weeks for Child Health Plus applications.

Overall, HRA/Medicaid responded to applications in a timely way. The average time from submission of an application to HRA/Medicaid until issuance of a decision was approximately two weeks. This was the same for both long and short Medicaid applications. Data is not available on the length of time for Child Health Plus plans' responses.

### Additional Results

The HRA/Medicaid program contacted the CDF–NY Supervisor at three separate times to ask for documentation not mandated by the program. This included requests for

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<sup>7</sup> There was some variance in the project regarding when signatures were obtained on applications. Sometimes signatures were obtained at the first contact with applying families, prior to any gathering of supporting documentation for the application. In other cases, signatures were obtained as a last step prior to forwarding the application to the CDF–NY Supervisor. The times here reflect this blended process.

submission of the Absent Parent Form with a Growing Up Healthy application, submission of the Drug and Alcohol Screening Form for nonsingle adults, and separate proof-of-address documentation for adolescent applicants. None of these documents was actually required to complete the application. The CDF–NY supervisor worked with HRA/Medicaid to ensure that the Medicaid staff were retrained on these specifics.

## Lessons

CDF–NY has continually evaluated the project through feedback received from the student volunteers, the community organizations, and the families. The following is a summary of some of the lessons learned:

### *Facilitated Enrollment Model*

The offices of community organizations are ideal places for enrollment. Organizations like multiservice agencies, daycare centers, schools offering after-school programs, adult learning classes, and health clinics provide an array of services to the community, and within such contexts, enrollment in Medicaid and CHP is seen as beneficial to the family. In immigrant communities in particular, the trusted environment of a community organization that understands the language and culture of the client is instrumental to the success of an outreach and enrollment campaign.

The success of enrollment at a particular site depends on the nature of the site and the population served. Enrollment was most successful at sites with a large yet fairly stable population of parents, such as daycare centers and multiservice agencies. Families and enrollment workers see each other on a regular basis in such sites, and the necessary follow-up on documentation occurs most effectively. On the other hand, families visiting the health clinic or attending adult learning classes can be too preoccupied with other responsibilities to apply for health insurance at that time. However, such settings are effective for outreach.

Furthermore, the project revealed that the mere presence of enrollment workers in an organization is insufficient to ensure the trust of families and the community. Staff from the host organizations needed to serve as intermediaries, continually discussing the issue of health insurance with families and referring them directly to the enrollment workers. In the most successful enrollment sites, the host organization claimed ownership of SHOUT— they advanced the project as an additional service for families, they called their families to inform them of the availability of the service, and they incorporated questions about health insurance into their intake process. It appears that such an investment by the host organization is a necessary component of a successful enrollment campaign.

### *The Volunteer–Supervisor Model of Enrollment*

An important role exists for part-time volunteers in an outreach and enrollment campaign. A minimal time commitment requirement will ensure large networks of volunteers capable of reaching all sectors of a community. These large groups of volunteers allow for experimentation in different venues with various models of outreach and enrollment. Part-time volunteers also approach families and the application process with an idealism and enthusiasm sometimes lacking in more-seasoned staff.

The quality of the applications submitted by the student volunteers can be high. Despite the complexity of the Medicaid and CHP enrollment processes, volunteers are able to master these systems. However, it is important to keep in mind that the level of expertise in the process is a direct reflection of the amount of field experience gained. Students who committed more time to SHOUT or who were stationed at higher-volume application sites were more familiar with the enrollment process and more likely to submit acceptable applications.

The importance of the supervisor who serves as a quality-control check cannot be underestimated. The supervisor's higher level of expertise in the enrollment process ensures quality control in the checking of each application before it is forwarded to Medicaid or CHP. The supervisor also serves as an important source of information for the volunteers, providing needed assistance with more complex cases. Moreover, since it is unrealistic for all volunteers to have contacts within Medicaid and CHP, the supervisor is a necessary intermediary between the volunteers and the two systems.

It is also beneficial to complement a network of part-time volunteers with more permanent staff from the community organization. For example, it was Alianza Dominicana, which was able to dedicate full-time staff to work with families when the student volunteers were unavailable, that had the highest enrollment numbers of the project. Another site, Northern Manhattan Improvement Corporation, allocated to the project its graduate-level social work field placement worker, who was on-site three days per week. Part-time volunteers can easily inform families about the two programs, screen families for eligibility, and initiate the application process, but families sometimes require fairly intensive follow-up to ensure completion of the application. The limited availability of part-time volunteers delays the application process in such instances. Linking volunteers with full-time, accessible staff for such items as follow-up prevented unnecessary delays in the application process.

### *Lack of Information*

Establishing the infrastructure and public awareness that would ensure that families in the community knew about SHOUT's outreach and enrollment services was a great

challenge. A vast array of outreach activities is necessary to compliment an enrollment project. Perhaps most importantly, all outreach efforts need to link families to clear opportunities for enrollment. In the past year, the state has invested increased resources to raise public awareness about the Child Health Plus program. However, the project was not directly linked to this outreach or enrollment campaign. As the state embarks on a large-scale outreach and enrollment campaign in the coming months, it is crucial that these efforts are tied directly to community-based enrollment.

#### *Documentation*

The documentation requirements associated with the Medicaid program and sometimes with CHP are often a barrier to enrollment. Families are confused by what is required of them or find that they are unable to provide what is required. SHOUT was able to eliminate some of the confusion and difficulty with documentation by reviewing with each family which pieces of documentation it had at home. SHOUT also followed up with families by phone and mail to ensure that the documentation requirements were completed. As a result, only a few families who initiated an application with SHOUT did not return with their documentation requirements.

#### *The Single Medicaid/Child Health Plus Application*

Although CHP was created to provide coverage for uninsured children ineligible for Medicaid, eligibility screening and enrollment for the two programs traditionally have not been linked. Traditionally, Medicaid and CHP have had separate applications. A family with one Medicaid-eligible child and one CHP-eligible child needed to copy the same information onto two applications, make multiple copies of the necessary pieces of documentation, and direct both applications through the appropriate programs. In addition, each CHP plan has a separate application and families need to obtain the appropriate application prior to enrolling.

With the New York State Department of Health's permission, SHOUT piloted the initial draft of the joint Medicaid/Child Health Plus application. Use of the single application greatly simplifies the entire enrollment process. Families can apply for all their children on a single form, facilitated enrollers need training in only one form, and in the event of an incorrect eligibility screening, the family's application can easily be referred to the correct program with only minor corrections to the joint application.

Some challenges with the joint application do remain. Because of the structural differences between the two programs, certain questions are only necessary for one program or the other. This may create confusion for families. In these cases, enrollment workers fill an important role by making the application form understandable.

### III. CONCLUSION

New opportunities are on the horizon for uninsured children throughout New York State. The unprecedented expansion in children's health insurance programs make affordable and comprehensive benefits for children available to nearly all the families of our state. Perhaps even more important, for the first time, the state is committing substantial resources and energy to making Medicaid and Child Health Plus more accessible to these families. These efforts put an emphasis on serving families and reaching all eligible children. But even these extraordinary efforts cannot succeed alone. New York is a large and diverse state. If every eligible child is to obtain the health care that he or she needs and deserves, a commitment from every available resource—from volunteers to full-time staff, from businesses to universities—will be necessary. By providing a model that can incorporate the commitment of all of these groups without sacrificing quality, the project has shown how limited resources can be extended beyond our immediate reach to ensure that in New York, we leave no child behind.

## RELATED PUBLICATIONS

#372 *The Role of WIC Centers and Small Businesses in Enrolling Uninsured Children in Medicaid and Child Health Plus* (March 2000). Inez Sieben, Terry J. Rosenberg, and Yoly Bazile, Medical and Health Research Association of New York City, Inc.

#369 *Five Boroughs, Common Problems: The Uninsured in New York City* (February 2000). David R. Sandman and Elisabeth Simantov.

#349 *Health Care in New York City: Understanding and Shaping Change* (September 1999). David R. Sandman.

#340 *A New Opportunity to Provide Health Care Coverage for New York's Low-Income Families* (July 1999). Jocelyn Guyer and Cindy Mann, Center on Budget and Policy Priorities.

#305 *Insuring the Children of New York City's Low-Income Families: Focus Group Findings on Barriers to Enrollment in Medicaid and Child Health Plus* (December 1998). Peter Feld, Courtney Matlock, and David R. Sandman.

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