EXECUTIVE SUMMARY: REPORT TO THE PRESIDENT FROM THE INTERAGENCY TASK FORCE ON CHILDREN'S HEALTH OUTREACH

As the first step in his public-private children's health outreach campaign, the President directed his own workforce to initiate an historic commitment to enrolling uninsured children in State health insurance programs. In response, eight Federal agencies developed plans in three areas: how to educate their workforce; how this workforce can help educate families about State health insurance programs; and how to coordinate cross-agency and public-private efforts to identify and enroll children in these programs.

Educating Federal Workers, State Workers, and Grantees about Children's Health

Many Federal and State workers, contractors or grantees have direct contact with families with uninsured children. For example, the majority of uninsured children probably have participated in a school lunch program, subsidized child care, or Head Start. Recognizing this fact, the Departments proposed to, among other actions:

- **Send letters from the Cabinet Secretaries to about 350,000 Federal workers,** describing this children's health outreach initiative, how to access it, and strongly encouraging them to help enroll uninsured children.
- **Train the staff of Federal / State information clearinghouses, technical assistance centers, providers and eligibility workers about children's health.** Targets include:

  - National Health Service Corps and Area Health Education Centers that train about 21,000 students and 50,000 providers

  - Education Department's 40 parent assistance programs and 312 community learning centers serving over 50,000 students and community residents

  - Regional and State coordinators for 1,800 State Employment Security Agencies that provide job placement, counseling, and labor market information to job seekers

Educating Families. Many Federal workers and grantees determine eligibility, counsel families and provide services in non-health programs. This gives them an opportunity to

educate families and assist them in enrolling children in Medicaid or CHIP. The agencies have proposed to:

- **Distribute information on options and/or applications to families at:**

    - 700 community health centers

    - 1,400 Head Start grantees, State Child Support and TANF sites

    - 400 IRS Walk-In Centers and 8,600 Voluntary Income Tax Assistance sites

    - 1,300 Social Security Administration field offices

    - 3,000 employers, schools, education organizations, and community and religious groups that comprise the Education Department's Partnership for Family Involvement program

    - 185 Federally operated and Tribally contracted schools, 24 reservation-based community colleges, and over 500 Indian Child Welfare programs

    - 15,000 public housing projects and 81 field offices and information sites

    - 113 Job Corps Centers and 700 One-Stop Career Centers

Coordinating Efforts Across Agencies and with the Private Sector. Efforts to enroll uninsured children will be more effective if coordinated. To facilitate this, agencies could:

- **Link Internet sites,** to provide both Federal workers and families using these sites with links to children's health insurance outreach site (e.g., America's Job Bank site, used by millions)
- **Coordinate outreach campaign with major national associations, advocacy groups, and other private organizations in outreach.** Each Department has a set of outside organizations that could be partners in this outreach initiative. These include:

    - Elderly groups, to assist in enrolling uninsured grandchildren

    - Historically Black Colleges and Universities, to develop strategies for minority children

- Earned Income Tax Credit outreach organizations, that target similar families

- National Education Association, to focus on school-based approaches

Cross-Cutting Issues. Two topics were special focuses of the task force.

- **Vulnerable children**. Many children eligible for Medicaid or CHIP are difficult to reach due to sociocultural and linguistic differences, low literacy levels, geographic isolation, homelessness, or transient living situations that make it difficult for them to enroll in health insurance. A number of activities are proposed to address these unique problems, including:

    - Use of mapping to identify all service delivery sites for reservation-based sites that could be used for children's health outreach to Indian families

    - Media campaign for Hispanic children developed through focus groups to identify barriers to enrollment and Spanish language material

    - Use of "distance learning," such as new telemedicine communication capabilities, to educate rural providers about children's health insurance

- **Coordinating program enrollment.** Integration of health and non-health program enrollment can increase the number of children with insurance. Models identified include:

    - Single application for multiple programs: Most States (e.g., Illinois, Iowa, Maryland, Michigan, Ohio) use joint applications for their social services programs

    - "Adjunctive" eligibility (allowing eligibility for one program to fulfil some or all of the eligibility requirements for another): Children are automatically eligible for Florida's Healthy Start program if eligible for the school lunch program

    - Referral of families to Medicaid and/or CHIP: To efficiently target uninsured children, Tennessee compared lists of Food Stamps and TennCare recipients; families on Food Stamps but

not in TennCare were sent a mail-in application and number for questions

Full Report Available at www.hcfa.gov

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OVERVIEW: REPORT OF THE TASK FORCE ON CHILDREN'S HEALTH INSURANCE OUTREACH

This report outlines a series of multi-agency proposals on children's health insurance outreach. It is in response to a Presidential Executive Memorandum issued on February 18, 1998. The President requested that eight Departments develop options for assisting in the education of families and the enrollment of children in Medicaid and the new Children's Health Insurance Program (CHIP). Given their broad-based contact with families targeted by this initiative, the Departments' proposed activities could make an important contribution to reducing the number of uninsured children in America. All of the named activities could be implemented in the time frames described, should the President approve of the proposals.

BACKGROUND

Executive Memorandum on Children's Health Outreach

On February 18, 1998, the President issued an Executive Memorandum to eight Federal Departments operating programs to assist working families requesting that they develop options to participate in his public-private initiative to enroll uninsured children in Federal-State health insurance programs (see Appendix A). This report outlines a wide range of options developed by the Departments of Treasury, Agriculture, Education, Labor, Housing and Urban Development, Health and Human Services, Interior and the Social Security Administration. At the President's request, the Departments' reports: (1) identify all employees and grantees who work with families; (2) develop an educational strategy to ensure that employees and grantees are educated about the availability of Medicaid and the CHIP; (3) develop an Agency-specific plan as part of the Administration-wide outreach plan; and (4) identify any statutory or legislative barriers which impact identification and enrollment of uninsured children in Federal-State insurance programs. The President also asked the Department of Health and Human Services to be the coordinating Agency for the development of a report on these activities and to ensure that Federal interagency activities are complementary, aggressive, and consistent with the overall initiative to cover uninsured children.

Importance of Children's Health Insurance

This call to Federal Agencies to assist in children's health insurance outreach is one step towards the President's goal of improving the health and development of American children (see Appendix B). As recent studies have confirmed, children without health insurance are more likely to be sick as newborns, less likely to be immunized, and less likely to receive medical treatment for illnesses such as recurrent ear infections and asthma. Without treatment, these diseases can have lifelong consequences (U.S. GAO, 1997; IOM, 1998). Yet, the problem of children lacking insurance is large. The Agency for Health Care Policy and Research (1998) found that 4.7 million uninsured children are eligible but not enrolled in Medicaid. Several million more have income too high for Medicaid but too low to afford private health insurance.

To help these children, the President, with bipartisan support from the Congress, created the **Children's Health Insurance Program (CHIP)**. The Balanced Budget Act of 1997 allocated $24 billion dollars over the next five years to extend health care coverage to uninsured children through State-designed programs. CHIP enables States to insure children from working families with incomes too high to qualify for Medicaid through non-Medicaid State programs, Medicaid expansions, or a combination of both programs. Each State with an approved plan gets its expenditures matched with Federal funds up to a fixed State "allotment".

As of mid-June, nearly 20 State plans have been approved, and almost all other State are developing plans for approval.

CHIP builds on **Medicaid**, a joint Federal-State program, that provides health insurance for most poor children. All States extend Medicaid eligibility to children less than age 6 in families with income below 133 percent of poverty; children between ages 6 and 14 in families with income below 100 percent of poverty; and, by 2002, children between ages 15 and 18 in families with income below 100 percent of poverty. Many States have taken advantage of options that allow them to cover children in families with higher income.

While Medicaid and CHIP have the potential to cover many of the over 11 million uninsured children in America, without an aggressive, broad-based effort to identify and enroll eligible children, they will not succeed. Experience with Medicaid has shown that many families do not know about their children's eligibility. Working parents often assume that they cannot receive premium assistance for their children. Medicaid is considered by many a "welfare" program and the stigma of welfare remains strong in many areas. In some States, the application process can be long and arduous and beyond the ability of many families to complete. Cultural barriers, like difficulties in language comprehension, also pose a barrier for some families.

To encourage full participation in these programs, the President has launched a **children's health insurance outreach initiative**. The 1999 Budget includes proposals to give States the funds and flexibility to find and enroll hard-to-reach children. Specifically, the President supports (1) allowing States to let schools, child care resource and referral centers and others who have contact with children to facilitate Medicaid enrollment and (2) broadening the use of an existing fund so that States may use it for activities to decrease the number of uninsured children. In addition, the President, the First Lady, and Secretary Shalala have repeatedly challenged both the public and private sectors to undertake a wide range of children's health outreach efforts. In February 1998, they launched a series of administrative and private sector actions including distribution of a letter outlining options for outreach funding and application simplification; development of a national toll-free number to connect families with local eligibility offices; commitments by private businesses like supermarket and drug store chains to assist in educating families about Medicaid and CHIP; and a partnership with not-for-profit organizations to develop a mass media campaign to stress the importance of insurance for children. The Administration will continue to work through public and private actions to improve children's health coverage.

What is "Outreach"

Children's health insurance outreach is a dynamic process in which broad networks of concerned Americans work together to identify, educate and enroll uninsured children in Medicaid or CHIP. These networks include people in the public and private sectors and at the Federal, State and local levels. Activities that could increase enrollment in health insurance programs include advertising on billboards, television and radio; sending messages in simple language and in multiple languages; using toll-free hotlines to answer questions and enroll individuals; spreading the word through community health advocates, children's agencies, parents' networks and religious groups; and targeting uninsured children where they spend most of their time: in schools, child care settings and Head Start sites. Outreach also involves Federal and State efforts to streamline the application and enrollment process by shortening forms, accepting mail-in applications, reducing processing time, and placing eligibility workers in convenient locations. Use of a joint application form for different programs can also enhance coordination of resources across programs serving the same children.

Outreach activities are not new. All States -- to greater or lesser degrees -- currently conduct outreach for uninsured children (NGA, 1998). States may receive Federal matching payments for outreach for Medicaid and CHIP. In addition, private organizations like foundations, children's advocacy groups, health care providers, and businesses have also sponsored some projects to educate and enroll children in health insurance. These groups have access to and communicate with families in different, potentially more effective ways.

However, most experts would agree that, to date, many children's health insurance outreach efforts have not been very successful. Thus, in partnership with the President, these public and private groups have been planning, coordinating and implementing a more aggressive outreach strategy. This includes efforts to identify and promote outreach models that work; engage a new, broader, and nationwide set of participants; and employ mass media in the same way that advertisers do. Part of this effort involves identifying how different Federal programs can target, educate and assist families in enrolling their children in Medicaid or CHIP.

Federal Government's Potential Contribution to Outreach

Federal departments can play a critical role in children's health insurance outreach. Many children eligible for Medicaid or CHIP are currently in contact with one or more Federal programs, making these programs appropriate places for reaching out to uninsured children. Most children are enrolled in school, child care, or Head Start. Many participate in school breakfast and lunch programs. Others are enrolled in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC)

and the Federal Food Stamp Program. They attend public health clinics for immunizations and school nurses for injuries. Their parents interact with the IRS, job programs, or housing assistance. Some uninsured children are American Indians and benefit from Bureau of Indian Affairs and/or Indian Health Service programs. In addition to this vast workforce, Federal agencies also have a network of private sector counterparts and partners who can get involved in children's health insurance outreach. Examples of programs that could assist in children's health outreach are listed in Table 1.

Table 1. Federal Programs That Could Contribute to Children's Health Outreach

DEPARTMENT		EXAMPLES OF PROGRAMS SERVING FAMILIES
HEALTH AND HUMAN SERVICES		
	Health Care Financing Administration	Medicaid: Insures about 18 million poor and near-poor children Children's Health Insurance Program (CHIP): Will insure millions of children above Medicaid eligibility through a non-Medicaid, Medicaid, or combination plan.
	Health Resources & Services Administration	Maternal and Child Health Bureau: Runs MCH program, Healthy Start Initiative to reduce infant mortality & Prenatal Hotline linking callers to local health resources Bureau of Primary Health Care: Funds 700 community health centers, Health Care for the Homeless Program, and the National Health Service Corps
	Administration for Children & Families	Head Start / Early Head Start: Provides preschool for low-income 830,00 children Child Care: Assists low-income families in obtaining safe, affordable child care Foster Care/Adoption Assistance: Provides stable environment for children
	Agency for Health Care Policy & Research	Research on children's health: Funds about $13.5 million in research relating to children's health (e.g., emergency health services for children)
	Centers for Disease Control & Prevention	Immunization: Funds vaccinations and a hotline for questions about immunization Childhood Lead Poisoning Prevention: Funds grantees to screen 1.8 m. at-risk kids
	Indian Health Service	Reservation Based Health Services: Funds and/or operates a network of 49 hospitals, 195 outpatient facilities and 297 health clinics

	Substance Abuse & Mental Health Admin.	Comprehensive Community Mental Health for Children Program: Provides grants to States and Tribes to care for children with serious emotional disturbances
AGRICULTURE		National School Lunch Program: Gives low-cost/free meals to 24 million children Food Stamp Program: Assists over 11 million children in obtaining healthy food WIC: Provides supplemental foods, nutrition education and health care referrals to 7.4 million low-income women, infants and children
EDUCATION		Special Education Grants: Funds States' special education for 6 million children 21st Century Community Learning Centers: Safe havens during non-school hours
HOUSING & URBAN DEVELOPMENT		Public/Indian Housing: Provides low-cost housing for 2.9 million households Multi-Family Housing: Reaches 2.6 million low-income households McKinney Act Programs: Assists 250,000 homeless people annually
INTERIOR		Indian Child Welfare Program: Provides Tribes with resources to protect Indian children and prevent the separation of Indian families Office of Indian Education Programs: Provides education services to Indian kids
LABOR		Unemployment Insurance: Provides assistance to 6 million unemployed people Job Corps: 113 centers that provide vocational training to disadvantaged youth
SOCIAL SECURITY ADMINISTRATION		Supplemental Security Income: Provides income floor for 1 m. disabled children Surviving Children: Provides benefits to children of deceased workers
TREASURY		IRS Walk-In Centers: Operates over 400 offices that assist taxpayers, including low-income families, applying for the Earned Income Tax Credit (E.I.T.C.)

Interagency Task Force on Children's Health Insurance Outreach

To respond to the President's Memorandum, an Interagency Task Force on Children's Health Outreach was created. This Task Force included representatives from the White House and the eight Departments included in the Memorandum. The Department of Health and Human Services (DHHS) coordinated this effort. The Task Force met on a weekly basis to learn about existing public health insurance programs, to discuss specific ideas, and to coordinate activities. Each Department was tasked with developing an action-oriented plan to assist in children's health insurance

outreach, focusing on programs that serve low-income children. Because of its unique role as taskforce lead and its traditional involvement in the health care field, DHHS asked seven of its own agencies to develop outreach plans as well. The subsequent chapters of this report contain those plans.

In this review, two particular topics merited special attention. First, outreach strategies may differ for certain vulnerable children. Proposals to address their unique barriers are outlined in Appendix C. Second, coordination of program eligibility and application processes can increase the number of children insured. Models of successful coordination are described in Appendix D.

SUMMARY OF PLANS FOR CHILDREN'S HEALTH INSURANCE OUTREACH

The Departments have proposed an impressive and diverse set of actions to engage in children's health insurance outreach. All together, more than 150 activities are proposed (see Table 2 at the end of the overview). Some are one-time actions, while others are ongoing, ensuring that their effects are not temporary. Activities proposed by the Departments have been divided into three general categories: (1) educating Federal workers, State workers and grantees about children's health insurance outreach; (2) educating families about their children's potential eligibility for health insurance; and (3) coordinating efforts across Departments and with private sector groups.

Educating Federal Workers, State Workers, and Grantees

One of the major strengths of the Federal government is its workforce. There are about 1.2 million Federal government, executive branch, non-defense and postal service employees. A number of these Federal employees directly administer programs that assist low-to middle-income families (e.g., SSA's field office workers, Treasury's Walk-In Center workers, and Indian Health Service workers). Other Departments work primarily through State-based or Tribal programs (e.g., Agriculture's Food and Nutrition Services, DHHS's Maternal and Child Health program, Interior's Indian Child Welfare Program). Virtually every one of the eight Federal Departments work with private grantees, contractors, and technical assistance providers (e.g., Education's Parent Centers, HUD's Public Housing projects, and Labor's Job Corps).

Because this network of Federal, State and other workers has direct contact with low-income and working families, a central activity proposed

by all of the Departments is to educate these workers about the health insurance options for children. The following are proposed strategies for educating Federal workers:

- **Send letters from the Cabinet Secretaries to Federal workers**. About 350,000 Federal employees could receive a letter, e-mail or other form of communication from their Secretary describing this children's health insurance outreach initiative and asking for their help.
- **Target Federal employees through newsletters with updates on outreach activities**. Newsletters for SSA (*OASIS*), Agriculture Food and Nutrition Service (*The Friday Letter*), Education (*EdInfo*), Interior (*Pathways*), Labor *(The Labor Exchange*), and DHHS's Health Care Financing Administration (*HCFA Healthwatch*) reach hundreds of thousands of employees and alumni. These Departments could use these newsletters to publish periodic updates on children's health insurance outreach activities and how employees can refer and enroll children.
- **Educate grantees or potential grantees about Medicaid and CHIP**. Departments have thousands of grantees who could be informed about CHIP and Medicaid. For example, DHHS could send letters to its 221 rural health grantees and HUD could place information on its call for proposals, thus educating 80,000 applicants for grants.
- **Inform clearinghouses, technical assistance centers, providers and eligibility workers about children's health.** Departments could train people who interact with families about children's health insurance eligibility and application process. Examples include:

  - DHHS could add children's health insurance components to training of National Health Service Corps providers; Area Health Education Centers that train about 21,000 students and 50,000 providers; public health grantees (e.g., childhood lead poisoning prevention workers, immunization providers), welfare and child support technical assistant contractors, and Tribal health workers.

  - DHHS (CDC) and HUD could use "distance learning" or satellite telecommunications to educate workers nationwide.

  - Agriculture could educate and inform its Cooperative State Research, Education and Extension

Service, which can disseminate information at the local level.

- Education could train Parent Centers, community centers and other clearinghouse workers that interact with potentially eligible families.

- Interior could train agencies, Tribal contractors, and social services program personnel and produce a 10-minute video about outreach.

- Labor could add outreach to training for regional and State coordinators for State Employment Security Agencies and Welfare-to-Work grantees.

- SSA could include outreach information in its 35,000 teacher's kits.

To support this education initiative, DHHS and the White House will develop a simple, explanatory flyer about CHIP, Medicaid and outreach for Federal workers. Interior will adapt this flyer for use among Native American program workers.

Educating Families

Once Federal workers are educated, many are in positions to: (1) identify eligible children, (2) educate the parents of eligible children about Medicaid or CHIP, and (3) assist in enrolling eligible children. Assistance in enrollment could take several forms. Workers could refer families to the name and number of the State agency responsible for children's health insurance. By September, they could also give the family a single, national toll-free number that will direct families to local eligibility offices. In addition, some private organizations are developing simple cards and posters that could be displayed in sites frequented by eligible families. Applications for CHIP and Medicaid could also be placed at these cites. State agencies could arrange to either allow health insurance eligibility workers to come to different program sites or allow those different program eligibility workers to determine eligibility for Medicaid or CHIP. The following summarizes the actions proposed by the Departments to educate and assist families:

- **Distribute information and/or applications for CHIP and Medicaid through:**

  - DHHS: 700 community health centers (HRSA); grantees who conduct children's health research (AHCPR);

State Child Support, TANF, Head Start sites (ACF); State and local health departments (CDC); School Health Programs (HRSA); and Health Facilities for Indian people (IHS).

- Agriculture: WIC, Food Stamps and School Lunch Programs when possible.

- Education: 3,000 employers, educators, community and religious groups that comprise its Partnership for Family Involvement program.

- HUD: 15,000 public housing projects, 30,000 assisted multi-family housing developments, and 81 field offices and information kiosks.

- Interior: 185 Federally operated and Tribally contracted schools, 24 reservation-based community colleges, and over 500 Indian Child Welfare programs.

- Labor: 113 Job Corps Centers; 700 One-Stop Career Centers; and 15 regional and district offices that distribute 200,000 "Pension and Health Care Benefits" brochures that will include Medicaid and CHIP information.

- SSA: 1,300 field offices.

- Treasury: 400 IRS Walk-In Centers, 8,600 Voluntary Income Tax Assistance sites

- **Refer callers of information hotlines to health insurance 1-800 numbers.** Education, Agriculture, SSA and State Maternal and Child Health programs could add a "referral screen" to their toll-free/departmental numbers to direct families toward health coverage.

Coordinating Efforts

Effective, ongoing communication about Medicaid and CHIP across Departments is essential to this initiative's success. Some of these linkages already exist. For example, SSA and DHHS already coordinate eligibility for certain children, and Agriculture's WIC program workers must refer potentially eligible people to Medicaid. However, in some cases, the relationships across Departments and with the private sector are new. The

following includes examples of activities proposed to facilitate coordination:

- **Link Internet sites:** All of the Departments could link their Internet sites to the appropriate DHHS site on children's health insurance. For example, millions of job seekers access America's Job bank and could learn about health coverage. Some Departments, like Agriculture, could post articles about outreach on their own sites.
- **Engage major national associations, advocacy groups, and other private organizations in outreach.** Each Department's programs have outside organizations that could be partners in this outreach initiative. These include:

  - DHHS: Cosponsor outreach conference with Historically Black Colleges and Universities (HCFA/HRSA); notify 200 agencies on child health e-mail list (AHCPR).

  - Agriculture: Send letter to major associations and advocacy groups on outreach; add outreach information to database on food recovery programs, accessed by more than 30,000 individuals.

  - Education: Work with National Education Association on effort to educate teachers at its July conference; disseminate information through mass e-mails.

  - HUD: Send letter regarding the initiative to public interest groups and ask them to promote children's health outreach.

  - Interior: Encourage national Indian teachers unions and grassroots organizations that serve Indian families to assist in outreach by educating parents about Medicaid and CHIP.

  - Labor: Work with 2,000 small businesses to help them help their employees.

  - SSA: Use new database of 5,000-10,000 community groups to educate about outreach.

  - Treasury: Encourage groups that conduct Earned Income Tax Credit outreach to add children's health insurance information to the material.

- **Develop and distribute model applications for integrating School Lunch and children's health programs**. DHHS, Agriculture and Education could develop and distribute prototype applications to facilitate enrollment in Medicaid or CHIP.

Statutory and Regulatory Barriers

The President's February 18, 1998 Executive Memorandum asked each of the eight Departments to identify any statutory or regulatory barriers that impede the identification and enrollment of uninsured children in Medicaid and CHIP. For the most part, the Departments reported that there is considerable flexibility under current law to coordinate health and non-health program enrollment. Some Departments did note that only some (not all) non-health program eligibility workers can use the new children's "presumptive eligibility" option in Medicaid. The Balanced Budget Act of 1997 gave States the option to let Medicaid providers and eligibility workers for Head Start, WIC and child care subsidies under the Child Care and Development Block Grant grant Apresumptive eligibility@ or temporary Medicaid coverage to children who appear to qualify. Costs associated with this option are subtracted from States' CHIP allotments. Some of the Departments (e.g., Education, HUD, Interior) have eligibility workers who probably work with many families with uninsured children, but cannot now grant presumptive eligibility. The President's 1999 budget specifically addresses this issue. It would give States greater flexibility in the definition of "qualified entities@ to include sites such as schools, child care resource and referral centers, child support enforcement agencies and CHIP eligibility workers. It would also eliminate the subtraction of presumptive eligibility expenditures from State CHIP allotments, removing a disincentive to take this option.

Cross-Cutting Issues

The Interagency Task Force determined that two topics deserve special attention: children in vulnerable populations with unique access problems and coordination of health and non-health program eligibility.

Targeting Vulnerable Groups of Children. Many children eligible for Medicaid or CHIP are difficult to reach because of barriers to understanding and/or responding to outreach geared to the mainstream population. Vulnerable populations often face sociocultural, socioeconomic, and linguistic differences; low literacy levels; geographic isolation; homelessness; or transient living situations that make it difficult for them to enroll in health insurance. As a result, these groups tend to have higher rates of uninsurance.

A number of the activities proposed by the Departments are targeted at reducing these barriers (see Appendix D for a full description). Examples include:

- **Native American and Alaska Native children**: An interagency work group could promote the use of mapping to identify all service delivery sites and reservation-based sites that could be used for children's health outreach and will develop a culturally relevant brochure for Indian families. (See Appendix E)
- **Hispanic children**: DHHS could conduct focus groups to identify barriers to enrollment for different Hispanic groups and then could develop strategies to overcome them.
- **Rural children**: DHHS's Office of Rural Health could notify its grantees about the importance of children's health outreach; Centers for Disease Control's "distance learning" programs could educate rural providers about children's health insurance.

Coordinating Eligibility in Health and Non-Health Programs. While much of the focus of the Federal Interagency Task Force has been on education about children's health insurance, the differing eligibility rules, applications, and enrollment processes for health and non-health programs can create barriers to enrollment. A subgroup of the Task Force looked at the major social programs to identify issues in coordination of program eligibility; and models of Federal and State-level collaboration (see Appendix D).

Three major barriers can prevent coordination of Medicaid, CHIP and non-health programs. The first is the financial and non-financial eligibility rules. Different programs often have -- because of law, regulations, or State choice -- different definitions of family size, type of income counted toward eligibility, income disregards, upper income limits, and allowable resources. A second issue is the documentation required from the applicant. Families are usually required to bring proof of income, resources, birth certificates and other types of documentation -- even when a different agency might have already verified that information for their own program. Third, the application process itself may require multiple visits to different sites that may be geographically inaccessible or whose hours may be restricted.

Some Federal and State programs have overcome these barriers by coordinating these health programs with other non-health programs. Examples include:

- **Using same application for multiple programs** ensures that a child eligible for two or more public programs gets enrolled both is through the use of a single, joint application. For example, many

States (e.g., Delaware, Maryland, South Dakota) use a single application for Medicaid and other programs such as TANF, Food Stamps, and WIC.

- **Employing "adjunctive" eligibility** means that eligibility for one program may be used to fulfil some or all of the eligibility requirements for another. For example, Florida's Healthy Start Program makes children eligible for the free or reduced school lunch program automatically eligible for its State health insurance program.
- **Referring families to Medicaid and/or CHIP** from non-health programs is an efficient way to target uninsured children. For instance, to identify uninsured children eligible for its Medicaid expansion ("TennCare"), Tennessee compared the lists of families with children participating in Food Stamps and TennCare. The families participating in Food Stamps but not in TennCare were sent an information letter, a mail-in application with a pre-addressed, postage-paid envelope, and a toll-free number for questions.
- **Assisting families at other program's eligibility offices** can make the health application process easier. For example, Louisiana contracts with Head Start staff and other community-based organizations to assist families in completing Medicaid applications.

CONCLUSION

Insuring America's children is a national priority. Children who miss school because they are sick or who cannot see well because they lack glasses may not develop to their full potential. Two programs offer millions of uninsured children health coverage: Medicaid and the new Children's Health Insurance Program. Enrolling uninsured children in these programs will take an aggressive, sustained, public-private, Federal, State, and local effort. As demonstrated by the activities described in this report, Federal Departments can make an important contribution toward this outreach effort. We look forward to working with the President on implementation of this initiative.

Table 2. Comprehensive List of Proposals for Children's Health Insurance Outreach

(Note: Numbers correspond to numbering of proposals in reports)

EDUCATING WORKERS		EDUCATING FAMILIES		COORDINATION	
DEPARTMENT OF HEALTH AND HUMAN SERVICES					
HEALTH CARE FINANCING ADMINISTRATION					
1	Establish network of outreach specialists (Fall 1998)	10	Provide technical assistance to improve cultural competency of outreach efforts (Beginning in Summer 1998)	12	Encourage distribution of CHIP toll-free number (Beginning in Fall 1998)
2	Develop Regional Interagency Work Groups (Beginning in September 1998)	11	Outreach to grandparents through Medicare (Beginning in September 1998)	13	Work with minority groups to promote outreach (Ongoing)
3	Create an on-line clearing house for outreach information (Fall 1998)				
4	Distribute flyer on outreach to workers (Summer 1998)				
5	Identify outreach needs of State Medicaid and CHIP officials (October 1998)				
6	Facilitate partnerships between State health and non-health program officials (Beginning in Summer 1998)				
7	Identify and share best practices (Beginning October 1998)				
8	Assist States in reducing barriers to enrollment through a Task Force (Beginning in Summer 1998)				
9	Publish articles on children's health insurance coverage (Ongoing)				
HEALTH RESOURCES AND SERVICES ADMINISTRATION					
1	Convene Regional meetings with other Federal workers, particularly ACF (Ongoing)	8	Disseminate information on Medicaid and CHIP through 700 community-based health centers and 50 State MCH programs. (Fall 1998)	10	Work with border communities' programs on outreach (FY 1999)
2	Train providers on outreach including the National Health Service Corps and Area Health Education Centers	9	Build and coordinate community coalitions with a focus on hard-to-reach populations (Beginning in June 1998)	11	Train outreach workers in Empowerment Zones and Enterprise Communities' health

	health providers. (July 1998)				1998)
3	Distribute best practices in coordination between insurance and Maternal and Child Health programs (Ongoing)			12	Refer Title V and Healthy Start toll-free hotline callers to CHIP / Medicaid information services (Ongoing)
4	Encourage outreach through 26 School Health Programs (Beginning in June 1998)				
5	Broaden technical assistance to grantees and community-based organizations (Beginning in June 1998)				
6	Require Ryan White grantees to educate staff about Medicaid and CHIP (August 1998)				
7	Send letter to 221 rural grantees to encourage them to get involved in State outreach plans (June 1998)				
ADMINISTRATION FOR CHILDREN AND FAMILIES					
1	Brief and distribute outreach information to all ACF office staff and other Federal partners (Ongoing)	5	Encourage State Child Support offices to routinely put information on health insurance in child support orders. (Ongoing)	9	Coordinate efforts with other Federal and State agencies (Ongoing)
2	Distribute outreach information to State and local directors (Beginning in Summer 1998)	6	Encourage distribution of CHIP and Medicaid promotional material and applications in Welfare/TANF offices, Head Start program locations, etc. (Ongoing)		
3	Invite State directors to participate in conferences and forums (Ongoing)	7	Conduct outreach to Tribes, Native Hawaiians and Pacific Islanders (Beginning in January 1998)		
4	Engage ACF grantees and technical assistance contractors in outreach efforts (Ongoing)	8	Encourage States to place outstationed workers in Child Care and Head Start sites (July 1998)		
AGENCY FOR HEALTH CARE POLICY AND RESEARCH					
1	Inform employees through e-mails; desk-to-desk handouts; follow-up reminders (Beginning in Summer 1998)	2	Encourage grantees and contractors to educate families about outreach (Summer 1998)	4	Notify outside individuals and groups about outreach via its child health listserve (200-plus subscribers) (Summer 1998)
			Encourage grantees in co-sponsored research to educate families about outreach (Beginning in Summer 1998)	5	Support evaluations of CHIP and Medicaid outreach through its

		3			programs (Ongoing)
CENTERS FOR DISEASE CONTROL AND PREVENTION					
1	Send letters to grantees to describe how they might assist in outreach (Summer 1998)	4	Assist State and local health departments in helping to insure children (Summer 1998)	7	Link appropriate Internet locations to HCFA's children's Internet site (Summer 1998)
2	Allow States to use database of "pockets of need" to target eligible children (Summer 1998)	5	Add Medicaid/CHIP toll-free number to CDC publications, pamphlets, etc. (Fall 1998)	8	Coordinate with WIC program for children's health outreach (Summer 1998)
3	Use distance-based learning (e.g., satellite sessions) to educate about outreach (Summer 1998)	6	Educate parents and grandparents about outreach through non-children's programs (e.g., cancer screening programs) (Summer 1998)		
INDIAN HEALTH SERVICE					
1	Organize a headquarters leadership team to promote outreach (July 1998)	6	Establish stakeholder advisory committee to provide input on outreach to American Indians and Alaska Natives (September 1998)	10	Enhance interaction within DHHS and across Federal agencies on outreach (Ongoing)
2	Send directives to agency specialty annual meetings (e.g., National Councils of Chief Medical Officers) to include workshops and plenary session on outreach (Summer, 1998)	7	Develop culturally sensitive messages on outreach for American Indians and Alaska Natives (Beginning in October 1998)	11	Identify and develop partnerships with public and private advocacy groups to provide education and assistance to Indian families (Beginning in August 1998)
3	Provide access to training on CHIP and related programs to other Department, State, or private workers who serve American Indians (Fall 1998)	8	Create a survey to monitor access and satisfaction of Indian families with CHIP/ Medicaid; use existing data to target communities (Beginning in October 1998)		
4	Include CHIP as a topic in future meetings scheduled with Indian Tribes (Quarterly)	9	Use "train the trainer" techniques to educate community members who can provide information to the rest of the community (October 1998)		
5	Distribute brochure about CHIP / Medicaid designed for people working with American Indians/Alaska natives (July 1998)				
SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION					
1	Provide briefings for project officer staff about outreach (July 1998)	8	Distribute information on CHIP and Medicaid through State alcohol and drug abuse agencies (Summer 1998)	10	Develop SAMHSA Internet site on children's health (Summer 1998)
2	Create workgroup on outreach for children with special needs; fund educational campaign (Beginning June 1998)	9	Send mailing to Starting Early Starting Smart grantees about outreach (October 1998)	11	Mobilize stakeholders to assist States with outreach (Ongoing)

3	Track outreach and mental health and substance abuse benefits in CHIP (Fall 1998)				
4	Add chapter on outreach to CHIP benefits book (Fall 1998)				
5	Send updates on outreach to substance abuse and mental health directors, grantees and organizations (every 6 months)				
6	Sponsor regional meetings w/ substance abuse /mental health programs on CHIP that include outreach (FY 1999)				
7	Develop and implement media strategy to educate substance abuse providers about CHIP and outreach (September 1998)				
DEPARTMENT OF AGRICULTURE					
1	Send a message from the Secretary to 92,000 employees about outreach (August 1998)	7	Include referral to the Medicaid/ CHIP toll-free line on the USDA information phone number (1999)	12	Link FNS and USDA websites to DHHS's; add information to FNS & USDA sites (Jan. 1999)
2	Put a message on wage and earning statements for employees (January 1999)	8	Display and make available Medicaid/ CHIP information at the USDA Visitors' Center in DC (Fall 1998)	13	Develop and distribute prototype applications for integrating 94,000 school lunch and children's health programs with D-Ed and DHHS (September 1998)
3	Provide information on CHIP and Medicaid outreach to 28 FNS regional and State program directors (September 1998)	9	Send memorandum to 7 WIC regional directors and 88 State agencies about new option to determine Medicaid presumptive eligibility for children (September 1998)	14	FNS will send information to national associations, advocacy groups and other organizations to encourage them to provide information on Medicaid and CHIP (Fall 1998)
4	Issue memorandum to FNS regional / State agency program directors encouraging them to coordinate with State Medicaid and CHIP directors; publish information on outreach in newsletters; display info. on children's health at meetings (September 1998)	10	Send memorandum to 28 FNS regional, State and local program directors encouraging them to give information to families about health options and, if feasible, consolidate program applications with Medicaid/CHIP (September 1998)	15	Encourage Food Stamp nutrition education programs and cooperators to provide information on CHIP/Medicaid (Fall 1998)
5	Update FNS regional program directors on State CHIP plan approvals (Periodically)	11	Provide information on children's health outreach through cooperative research, education and extension service (September 1998)	16	Provide DHHS with a contact list for FNS regional and State conferences for display of outreach material (Ongoing)
6	Send electronic messages to cooperative research, education and extension service program administrators, directors and			17	Include information on outreach in the USDA National Hunger Clearinghouse data base that over 30,000 individuals and groups access (January 1999)

	(September 1998)				
	DEPARTMENT OF EDUCATION				
1	Send memo from the Secretary to all 4,800 employees and a companion newsletter article to 12,400 subscribers (July 1998)	7	Include information on health insurance on the Department's 1-800 number (July 1998)	9	Encourage all stakeholders to engage in outreach through mailings and meetings (Beginning in July 1998)
2	Encourage Asst. Secretaries to develop specific strategies for children's health outreach and educate speech writers about the initiative (Beginning in June 1998)	8	Mobilize Partnership for Family Involvement: (3,000 employers, educators, community and religious groups) to educate families about children's health insurance (Beginning in June 1998)	10	Link appropriate Departmental Internet locations to DHHS's children's Internet site (Beginning in June 1998)
3	Provide periodic updates in news letters and bulletins regional representatives (Beginning in Summer 1998)			11	Disseminate information through both Departmental and outside group Listserves (June through August 1998)
4	Include information on outreach in new employees' packets (Ongoing)			12	Distribute information at major conferences of PTA, NEA, US Conference of Mayors, etc (Beginning in June 1998)
5	Educate relevant clearinghouses, technical assistance centers /providers, parent centers, and grantees (September-October 1998)			13	Develop and distribute models for integrating school lunch and children's health programs with USDA and DHHS (September 1998)
6	Develop outreach plans for major programs (e.g., special education; migrant education) (Beginning in June 1998)			14	Work with Chicago Public School District to develop targeted outreach model (Summer 1998)
	DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT				
1	Send a letter and e-mail to all 9,500 employees on outreach (July 1998)	7	Place CHIP/Medicaid outreach information on HUD's computer "kiosks" at headquarters and 81 field offices (September 1998)	14	Send a letter to all Secretary's Representatives, State Coordinators and Area Coordinators requesting they contact Medicaid/CHIP State offices (July 1998)
2	Provide information about outreach to 80,000 grant applicants (Beginning in July 1998)	8	Send a letter about outreach to HUD grantees providing assistance to homeless families requesting that CHIP/Medicaid information is a part of their outreach and assessment (July 1998)	15	Incorporate information on outreach in "Community Builders'" training (Beginning in June 1998)
3	Send a letter describing outreach initiative to directors of 72 Urban Empowerment Zones/ Enterprise Communities (July 1998)	9	Send a letter asking directors of 3,400 public housing authorities administering 15,000 public housing developments to provide information to residents, applicants & post information (July 1998)	16	Link appropriate HUD Internet to DHHS's Internet site (June 1998)
4	Provide outreach information to colleges and universities participating in Community Outreach Partnership Centers and Historically Black Colleges & Universities Program (July 1998)	10	Send a letter to project owners and managers of HUD assisted and insured Multifamily properties providing		

			(Fall 1998)		
5	Provide information about outreach in technical assistance meetings, conferences, satellite broadcasts, and written material (Beginning in June 1998)	11	Expand the WIC / public housing collaboration (MOU) to include the CHIP/Medicaid outreach initiative (July 1998)		
6	Provide information to 585 State and local jurisdictions administering HOME program funding, encouraging involvement (July 1998)	12	Send information regarding CHIP/ Medicaid to beneficiaries of the Native American Mortgage Loan Program (Beginning in July 1998)		
		13	Add CHIP/Medicaid information for parents and community groups on lead hazards (Beginning in July 1998)		
DEPARTMENT OF THE INTERIOR					
1	Send memo on outreach to BIA area offices, field offices, Tribal social services contractors, Office of Indian Education Program line officers, Bureau-funded schools, Tribal leaders (July 1998)	7	Develop and distribute culturally relevant information (e.g., poster, supplementary packets of information) for families to a wide range of sites (Beginning in Summer 1998)	12	Encourage national unions (NFFE and IEF) to notify their membership of CHIP and outreach (September 1998)
2	Include in newsletter (Pathways and OIEP) feature articles and updates about Medicaid expansion/ CHIP (Ongoing)	8	Encourage intake workers to ask about children's health needs and distribute referral information (August 1998)	13	Provide information about Medicaid/ CHIP to grassroots organizations that serve Indian families (June 1998)
3	Provide technical assistance to agencies, Tribal contractors, social services program staff on Medicaid/ CHIP and how to incorporate it into intake procedures (Ongoing)	9	Prepare press releases about Medicaid / CHIP for Indian newspapers (July 1998)		
4	Provide briefings and programmatic updates via e-mail which area social workers will transmit to agencies and tribes without e-mail (Ongoing)	10	Encourage schools, tribal colleges, departments of education, OIEP line officers to send home notices about Medicaid/ CHIP; focus on it at the monthly parents' meetings; hold information sessions/ distribute info. (Beginning in September 1998)		
5	Disseminate outreach information to Office of Indian Education Program staff (August 1998 to January 1999)	11	Sponsor public service announcements on Indian radio stations on Medicaid/ CHIP (October 1998)		
6	Develop and distribute 10-minute video about outreach for Tribes, schools, agencies (February 1999)				
DEPARTMENT OF LABOR					
1	Send letter to 17,000 employees about outreach (July 1998)	8	Encourage States to outstation eligibility workers at Job Corps Centers (Fall 1998)	14	Create internet links, including a

					Bank used by millions of job seekers (Summer 1998)
2	Provide employees with updates on children's health outreach (Ongoing)	9	Include Medicaid and CHIP information in 200,000 brochures on pension and health benefits and material on HIPAA (Beginning in July 1998)	15	Send mailings to DOL constituencies (Fall 1998)
3	Ask the Federal Executive Board to coordinate all DOL agencies in the Regions to keep Federal employees informed on an ongoing basis (Ongoing)	10	Include Medicaid / CHIP message in information from the Employment Standards Administration (e.g., with Family and Medical Leave info.) (Beginning in September 1998)		
4	Send letters to State Unemployment Insurance offices about Medicaid and CHIP (July-September 1998)	11	Encourage OSHA offices to distribute information on outreach through its offices and Consultation Program that visits about 25,000 businesses (September 1998)		
5	Include outreach in major employment training conference (July 1998)	12	Distribute information to miners through district offices and inspectors (September 1998)		
6	Send notices about outreach to the employment and training community (e.g., 113 Job Corps Centers; 700 One-Stop Careers Centers) (July-September 1998)	13	Distribute information through Office of Small Business Programs that has contact with 2,000 small employers (September 1998)		
7	Educate 1,300 "Honor Roll" members of Woman's Bureau about outreach (July 1998)				
SOCIAL SECURITY ADMINISTRATION					
1	Send a Commissioner's broadcast on outreach to 65,000 employees (June 1998)	5	Display information on children's health insurance in 1,300 SSA field office reception areas (Fall 1998)	7	Create internet link to DHHS's children site, add to the SSA's children's page (Summer)
2	Publish an article in newsletter distributed to 65,000 employees and the Alumni Association about outreach (August 1998)	6	Develop a referral screen for health insurance on the SSA 800 number (Fall 1998)	8	Provide HCFA with a mailing list of children denied SSI or who receive benefits on a different basis. (Fall 1998)
3	Distribute children's health outreach material at SSA booths at about 110 health fairs and at conferences, forums (Ongoing)			9	Collaborate with DHHS to use new database of 5,000 to 10,000 community groups for outreach (Fall 1998)
4	Include outreach information in 35,000 SSA teacher's kits (January 1999)				
TREASURY DEPARTMENT					
1		3		5	

	the Secretary to all 158,000 employees (July 1998)		flyers) at the 400 IRS walk-in centers, provide information to 8,600 Voluntary Income Tax Assistance sites (FY1999)		community groups through the Electronic Fund Transfer (EFT99) initiative (Fall 1998)
2	Help make information available with E.I.T.C. outreach (Ongoing)	4	Invite State outreach workers to the annual E.I.T.C. awareness days at IRS walk-in centers (FY 1999)	6	Link Treasury and IRS Internet site to DHHS children's health site (Fall 1998)

2. REPORT FROM THE SECRETARY OF HEALTH AND HUMAN SERVICES

The Department of Health and Human Services (DHHS) is the Nation's largest health insurer. The Department's mission is to enhance the health and well-being of Americans by providing for effective health and human services. DHHS Secretary, Donna Shalala has made children's health one of her top initiatives and is committed to insuring America's children. Her Department oversees the Medicaid program, which, in 1996, provided comprehensive health insurance coverage to over 18 million low-income children. DHHS also is the Department responsible for the administration of the new State Children's Health Insurance Program (CHIP). This program provides approximately $20 billion over the next five years to extend health insurance at no or low cost to millions of uninsured children with incomes above Medicaid eligibility levels.

DHHS is in a unique position to conduct outreach and to support other Federal Departments in their own outreach efforts. DHHS Agencies and their State partners have had years of experience in enrolling low-income children in these and other social service programs. Thus, DHHS could educate the other Federal Departments about Medicaid and CHIP, share with them our knowledge of effective outreach strategies and provide them with informational and enrollment materials to conduct their own outreach activities.

The DHHS Agencies also could educate their own workers about Medicaid and CHIP who can distribute enrollment information to families in their roles as health and social service officials, providers, community volunteers, and neighbors. DHHS could work with States to reduce the

logistical, administrative, cultural and legal barriers to enrolling in Medicaid and CHIP. Lastly, DHHS could develop partnerships with public and private businesses and associations with national scope and local roots to spread the word about Medicaid and CHIP throughout the country.

The Department asked the following Agencies to develop outreach plans: the Health Care Financing Administration (HCFA), the Health Resources and Services Administration (HRSA), the Administration on Children and Families (ACF), the Agency for Health Care Policy and Research (AHCPR), the Centers for Disease Control an Prevention (CDC), the Indian Health Services (IHS), and the Substance Abuse and Mental Health Services Administration (SAMHSA). As a result of DHHS' unique role in administering many of the key programs that serve low-income children, each of the Agency reports will be presented individually.

The following sections contain reports from each of these Agencies describing the specific outreach activities they could undertake to enroll children in Medicaid and CHIP.

A. HEALTH CARE FINANCING ADMINISTRATION

I. CURRENT PROGRAMS AND OUTREACH ACTIVITIES FOR CHILDREN

HCFA's mission is to ensure quality health care coverage for its beneficiaries. This Agency is the largest purchaser of health care in the United States, currently providing benefits to approximately 72 million beneficiaries through Medicaid and Medicare. It will also oversee State Children's Health Insurance Program (CHIP). Through this new insurance program, we have the opportunity to cover millions more of the Nation's currently uninsured children.

A. Programs that Serve Middle to Low-Income Children

Medicaid ($91 billion Federal, $69 billion State in FY 1996) provides comprehensive health insurance coverage for low-income children, families, seniors, and persons with disabilities. Authorized under Title XIX of the Social Security Act, Medicaid is a joint Federal and State funded program that is administered by the States with oversight from HCFA. Children constitute nearly half of all Medicaid beneficiaries. In 1996, approximately 22 percent of all America's children were covered by Medicaid. An estimated 4.7 million uninsured children could be covered

by Medicaid today but they have not enrolled. *Target population: 18 million low-income children, among others.*

State Children's Health Insurance Program (CHIP) ($4.275 billion budgeted in FY 1998) is authorized under Title XXI of the Social Security Act. CHIP is the largest national expansion of health insurance coverage for low-income children since the enactment of Medicaid in 1965. CHIP provides States with a legislatively specified amount of Federal matching funds to provide comprehensive health coverage to uninsured children with family income above Medicaid eligibility standards. With CHIP funds, States generally are able to increase eligibility for health insurance up to 200 percent of the Federal Poverty Level for children under age 19. *Target population: Low-income children under age 19 with income above Medicaid eligibility levels.*

B. Current Activities in Children's Health Outreach

Through discussions with State and Federal health officials and advocates, HCFA has identified several approaches for successful outreach:

- Bring simplified eligibility information and enrollment processes to where families live and feel comfortable;
- Get the message out in different ways and in different venues because people often must hear a message several times before they act on it;
- Provide hands-on assistance in completing applications; and
- Use linguistically and culturally appropriate messages and messengers so that people understand the information and trust the programs.

These approaches require extensive field operations. By joining with other Federal and State health programs, advocates, primary care providers, faith communities, community-based organizations, schools, and child care and Head Start centers, we can greatly expand the reach and effectiveness of existing field networks. These groups work with uninsured children everyday and share an interest in seeing them covered. HCFA and State Medicaid and CHIP Agencies can provide these partners with materials and training. These partners can provide frontline workers to identify uninsured children and help families fill out and follow-up on applications.

Therefore, HCFA's broad strategy for current and proposed outreach initiatives is to:

- Facilitate partnerships between State agencies that administer Medicaid and CHIP and other Federal and State health programs,

community organizations, advocates and providers to assist in the design and conduct of outreach programs;
- Provide these partners with accurate and up-to-date information on Medicaid and CHIP;
- Identify and share examples of simplified applications, effective outreach strategies, and methods to reduce barriers in the enrollment process; and
- Work with State Medicaid and CHIP Agencies to collect data to measure the effectiveness of our combined outreach efforts.

Below is a description of HCFA's current outreach activities:

Training HCFA Staff on CHIP. HCFA and the Health Resources and Services Administration (HRSA) trained 400 HCFA Central and Regional Office staff to ensure their understanding of CHIP legislation, the State Plan approval process, and strategies for effective outreach. HCFA continues follow-up training for its staff through issue-specific tele-conferences held twice a month. In addition, HCFA Central Office holds monthly conference calls with all Regional Offices to consolidate our perspective on effective outreach strategies.

Training and Technical Assistance to States on Medicaid and CHIP Outreach. Early this year, HCFA and HRSA held regional conferences to assist States in designing their CHIP programs. Conference attendees included State and Federal officials and legislators, advocates, health care providers, and consumers. We explained the new options CHIP provides for States to increase health care coverage for uninsured children. We also discussed effective outreach programs. State and community leaders shared the outreach strategies they currently use to reach low-income individuals. Conferees considered what outreach strategies work best for certain minority populations and for persons in rural and urban settings.

Outstationing Eligibility Workers. HCFA and HRSA also are jointly sponsoring a $1 million demonstration in twelve States to work with Medicaid Agencies on increasing their effective use of outstationed eligibility workers in Federally Qualified Health Centers (FQHCs). Although State Medicaid Agencies have been required to have outstationing arrangements with FQHCs since July 1991, we have learned that they are not in place in some areas and could be more effective in others. This project is designed to identify effective outstationing arrangements and to share this information with States.

Sharing Strategies to Reduce Enrollment Barriers. HCFA is promoting strategies to reduce barriers for enrolling in both Medicaid and CHIP. On January 23, 1998 we wrote to State health officials on this subject. The letter contains 2 pages of promising outreach strategies and examples of

both shortened Medicaid applications and joint applications for Medicaid and CHIP. The letter also encourages States to use mail-in applications. To reduce logistical barriers and stigmatization associated with Medicaid, HCFA recommends that States outstation eligibility workers at community sites such as schools, child care and Head Start centers. The letter highlights new statutory options available to States to grant presumptive eligibility and 12 months of continuous eligibility for children in Medicaid.

II. PROPOSED PLANS FOR CHILDREN'S HEALTH OUTREACH

1. Establish network of outreach specialists. In summer 1998, HCFA could establish a network of outreach specialists who would be responsible for the Medicaid and CHIP outreach initiatives described in this report. The network could consist of staff from HCFA's Central Office and each of its Regional Offices. The team would be led by a Central Office coordinator. The Agency would train these outreach specialists and keep them current with new developments. HCFA envisions an outreach effort that is community-based. The outreach strategies, however, need to be portable. This network would enable the close coordination between Central and Regional Offices necessary to identify and share successful outreach strategies in use around the country and to keep States current on program and policy changes. HCFA could establish speakers' guidelines that Central and Regional Office outreach specialists would follow when educating Federal workers about Medicaid and CHIP. The guidelines would be established by Fall 1998.

A. Educating Workers about Medicaid and CHIP

<u>Federal Workers</u>

To meet the challenge in the President's Executive Memorandum, every participating Federal agency must mount a successful outreach program. As the Federal agency responsible for Medicaid and CHIP, HCFA needs to provide its Federal agency partners with up-to-date and accurate information to conduct their own outreach efforts. Outlined below are the activities HCFA proposes to meet this responsibility:

2. Mirror the Interagency Children's Health Outreach Task Force in the regions. Beginning in September, HCFA Regional Offices could convene quarterly tele-conference meetings of the regional components of the agencies and departments participating in the Task Force. This group would discuss how they can work together to implement the outreach

initiatives each has undertaken as a result of the President's Executive Memorandum.

3. Create an on-line clearinghouse for outreach information. HCFA could create a webpage, linked to its existing child health page, to provide other Federal agencies with the information necessary to continue, enhance, and monitor their own outreach efforts. This on-line clearinghouse could include a summary of the outreach component, eligibility requirements, and delivery system for each approved CHIP State Plan and Medicaid expansion demonstration. It could provide feedback to our partners on the effectiveness of our combined outreach efforts. This information would be updated monthly until all CHIP State Plans are approved and quarterly thereafter. The on-line clearinghouse could be linked to State Medicaid and CHIP Agencies' homepages so that visitors can click on them for more detailed information about a specific State's Medicaid or CHIP program. HCFA could ask the Interagency Children's Health Outreach Task Force to report to us on outreach strategies and materials they have found to be effective. This information, in addition to other documents containing examples of best practices, could be downloaded from the homepage. The on-line clearinghouse for outreach could become operational in Fall 1998.

4. Distribute flyer on Medicaid and CHIP. HCFA could distribute a flyer to its Federal workers developed by the Interagency Children's Health Outreach Task Force as an easy reference on Medicaid and CHIP. The flyer contains an overview of Medicaid and CHIP and describes how people can get involved in outreach. HCFA could begin distributing this flyer in the Summer of 1998.

State Workers

While HCFA oversees Medicaid and CHIP, it is the States who actually administer the programs. As a result, HCFA must work in partnership with States to accomplish the President's outreach goals. HCFA also must continue to facilitate partnerships between State Medicaid and CHIP Agencies and other Federal and State health programs, community organizations, advocates, and providers to help States better design and conduct outreach programs. Below are activities HCFA proposes to accomplish this:

5. Identify outreach needs of State Medicaid and CHIP programs. HCFA could contract to conduct focus groups with State Medicaid and CHIP Officials to identify their outreach needs and ways in which HCFA can assist them in meeting those needs. The contractor could also meet with States, advocates, providers, and community organizations to collect information on exemplary outreach initiatives and to learn how to

effectively partner with these organizations. The contractor would report its findings by September 1998. HCFA could use the findings to develop outreach tools and could disseminate innovative outreach strategies to States as best practices in October, 1998.

6. Facilitate partnerships between Federal and State workers. HCFA, and the Regional Offices in particular, could facilitate partnerships between State Medicaid and CHIP Agencies and other Federal and State health programs, advocates, health care providers, faith communities, community-based organizations, schools, and child care and Head Start centers to help States better design and conduct outreach programs for Medicaid and CHIP. The members of these organizations interact with uninsured children everyday and many have developed their own approaches for reaching and enrolling them. HCFA could assist States in identifying potential partners and could sponsor meetings of these groups to explore how they can work together on outreach. We also could assist States in educating new partners about Medicaid and CHIP so that they can appropriately identify children and help families accurately complete and follow-up on applications. The facilitation of partnerships would be an ongoing activity for HCFA beginning in Summer 1998.

7. Identify and share outreach "best practices." HCFA could work with States and our other partners to define criteria for determining best practices in outreach and could solicit them for examples of such. Regional Office staff also would use these criteria to identify outreach best practices in the course of carrying out daily programmatic and outreach activities. These best practices would be accessible through HCFA's on-line clearinghouse and distributed in hard copy to all States as outreach guidelines. Regional Offices could convene meetings of the States in their region so that they can learn from each other what does and doesn't work for Medicaid and CHIP outreach. These activities would be ongoing for HCFA beginning in October 1998.

8. Assist States in reducing barriers to enrollment. To assist States in reducing barriers to enrollment, HCFA could form a Task Force comprised of State health agencies, advocates and providers to provide guidance on how to simplify applications and the whole enrollment process. HCFA could collect and share examples of how States have attempted to destigmatize Medicaid and to increase cultural competency in the enrollment process. We would work with States to change the incentive for eligibility workers from screening people out to screening them in. The Agency would encourage States to elect presumptive eligibility and 12-month continuous eligibility for Medicaid children and assist them in implementing these options. These activities could begin during Summer 1998.

Others Workers

To further the understanding of Medicaid and CHIP beyond the groups already mentioned, HCFA could:

9. Publish articles on children's health insurance coverage. HCFA could include future articles regarding Medicaid and CHIP in its newsletter, *HCFA HealthWatch*, which is distributed to health providers, State Medicaid and CHIP Directors, advocacy groups, beneficiaries, and special interest groups. Articles could focus on successful outreach strategies used by our Federal and State partners. HCFA could also write an article for the *HealthyMothers/ HealthyBabies* newsletter describing how this organizations' local chapters can help in Medicaid and CHIP outreach efforts. Lastly, HCFA could dedicate an entire issue of *Health Care Financing Review*, the Agency's quarterly publication, to children's health issues. We could solicit articles to be published in Winter 1998.

B. Educating Families and Enrolling Children in Medicaid and CHIP

Ultimately, it is families of uninsured children who need to hear the message about Medicaid and CHIP and must understand how to enroll their children. HCFA understands that for outreach to be successful the message must be customized for specific segments of the population being targeted for outreach. In order to accomplish this HCFA could:

10. Provide technical assistance to improve cultural competency of outreach efforts. HCFA could work to increase the cultural competency of Medicaid and CHIP outreach programs. HCFA could devote $350,000 to conduct consumer focus groups to assist in the design and test the effectiveness of culturally sensitive mass media messages for CHIP. These messages could be made available for use by State Medicaid and CHIP Agencies, State and Local Health Departments, and advocacy groups. This money could also be used to advertise CHIP messages in selected radio and TV markets that provide ethnic programming. HCFA could also conduct focus groups to identify the outreach needs of newly arrived and well-established Hispanic immigrants and share this information with States. These two projects could begin during Summer 1998. In addition, HCFA could encourage State Medicaid Agencies to partner with providers who serve Asian Americans and Pacific Islanders (AAPI). Through these partnerships, States can educate providers about Medicaid and CHIP and providers can educate States about effective methods for reaching out to AAPI immigrants. HCFA could also create regional databases of organizations that serve AAPIs so that we can identify and work with groups that have first-hand knowledge of AAPI communities. This project could begin in Fall 1998.

11. Outreach through grandparents. Today, many children are raised with the involvement of their grandparents. HCFA will look for opportunities to communicate with grandparents through Medicare materials. HCFA could include a message that encourages grandparents to find out about the children's health insurance program on its initial enrollment package for new beneficiaries. We also will explore using National Medicare Hotline agents to refer callers to the CHIP toll-free number if they have questions about coverage for their grandchildren. (Beginning in September 1998)

C. Coordination with Other Programs

To facilitate outreach conducted by other Federal departments and agencies named in the President's Executive Memorandum, HCFA could:

12. Encourage nationwide distribution of CHIP toll-free number. The Administration, National Governors' Association, and private groups are creating a national CHIP slogan and establishing a toll-free number that would link callers to the agency administering CHIP in his/her State. HCFA could partner with national public and private businesses and associations that may be willing to use their own resources to promote this number. This activity could begin as soon as the CHIP toll-free number is operational (Beginning in Fall 1998).

13. Work with minority advocacy groups to promote outreach. HCFA could partner with organizations representing minority groups to explore how they can assist State Medicaid and CHIP Agencies in conducting outreach. For example, the Agency may work with La Raza, the National Congress of Black Churches, Historically Black Colleges and Universities, Tribal Colleges and Universities, and Washington Internships for Native Students. HCFA could provide them with information and materials about Medicaid and CHIP that they could distribute to their members (Ongoing).

B. HEALTH RESOURCES AND SERVICES ADMINISTRATION

I. CURRENT PROGRAMS AND OUTREACH ACTIVITIES FOR CHILDREN

The mission of the Health Resources and Services Administration (HRSA) is to improve the Nation's health by assuring access to quality health care for under served, vulnerable and special-needs populations and promoting appropriate health professions workforce capacity and practice. HRSA has an ambitious portfolio of projects that seek to improve the health and well-being of children. Of HRSA's $3.67 billion budget for FY 98, roughly one third is invested in young people. HRSA's child health programs are

successful because of the partnerships the agency has developed to identify eligible children and assist them in gaining access to quality health care services. HRSA has been actively engaged in outreach for Medicaid and new CHIP programs.

A. Programs that Serve Middle to Low-Income Children

The Maternal and Child Health Bureau ($842.5 million in FY 1998). While it has a special focus on children with special health care needs, low income families, families with diverse racial and ethnic heritages, and families living in rural or isolated areas without access to care, the Maternal and Child Health Bureau (MCHB) provides leadership, partnership, and resources to advance the health of all of the Nation's mothers, infants, children, and adolescents.

The Maternal and Child Health Services Block Grants (Title V) are awarded to 59 States and territories to conduct outreach activities that enhance Medicaid enrollment and improve access to preventive and primary health services for women, infants, children and adolescents. State Title V programs have outreach expertise and play a central role in designing and implementing outreach activities in each State, training providers and outreach workers, and assuring administration and oversight of outreach activities.

The Healthy Start Initiative funds programs to reduce infant mortality in targeted high-risk communities and supports their replication across the Nation. As a supplement to the Healthy Start Program, HRSA recently launched the first-ever Prenatal Care Hotline (800-311-BABY), which links callers to State and local health care resources. The National Emergency Medical Services (EMS) for Children Program funds grants to the States for the development and enhancement of EMS programs for children with critical illnesses and life-threatening injuries. Finally, the Traumatic Brain Injury Demonstration Grant Program provides for studies and programs for traumatic brain injury in children.

The Bureau of Primary Health Care (FY 98 budget - $966 million). The Bureau of Primary Health Care (BPHC) seeks to increase access to comprehensive primary and preventive health care and to improve the health status of under served and vulnerable populations who experience financial, geographic, or cultural barriers to care, through the programs described below.

The Community Health Center Program (CHC) funds over 700 public and nonprofit private entities, under Section 330 of the Public Health Service Act, to provide access to preventive and primary health care services for people in areas where economic, geographic, or cultural barriers limit

access to primary and preventive health care for a substantial portion of the population.

The Health Care for the Homeless Program (HCH) improves access for homeless individuals to primary health care and substance abuse treatment. The 123 HCH grantees develop or participate in local coalitions of health care providers and social service agencies to identify community resources for the provision of shelter, food, clothing, employment training, and job placement for homeless individuals.

The National Health Service Corps (NHSC) increases access to preventive and primary care services for people in health professional shortage areas by assisting in the development, recruitment, and retention of community-responsive, culturally competent, primary care providers. Approximately 350 scholarships are awarded annually.

HIV/AIDS Bureau ($1.15 billion in FY 1998). The HIV/AIDS Bureau administers the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, which seeks to improve the quality and availability of care for people with HIV/AIDS and their families. The Bureau funds a number of programs to benefit low-income, uninsured and underinsured individuals and families affected by HIV/AIDS.

The CARE Act has four titles. Title I provides formula and supplemental grants to Eligible Metropolitan Areas that are disproportionately affected by the HIV epidemic. Title II provides formula grants to States, the District of Columbia, Puerto Rico and eligible territories to provide health care and support services for people living with HIV disease, including home and community-based health care and support services, continuation of health insurance coverage through a Health Insurance Continuation Program, and pharmaceutical treatments through an AIDS Drug Assistance Program. Title III supports outpatient HIV early intervention services for low-income, medically under served people in existing primary care systems. Finally, Title IV programs coordinate HIV services and access to research for children, youth, women, and families in comprehensive, community-based, family-centered systems. In addition, Ryan White supports the training of AIDS providers and reimburses dental services to persons with HIV/AIDS.

The Bureau of Health Professions ($290 million in FY 1998). Through Titles VII and VIII of the Public Health Service Act, the Bureau administers health professions education and training programs that promote a health care workforce with the skills necessary to deliver cost-effective quality care, improve cultural diversity in the health professions, and meet the needs of vulnerable populations. The Bureau supports

training of primary care providers and family medicine and pediatric residencies.

Office of Rural Health Policy ($47.1 million in FY 1998). HRSA's Office of Rural Health Policy works within DHHS and with other Federal agencies, States, national associations, foundations, and private-sector organizations to seek solutions to health care problems in rural communities. The Office administers the Rural Health Outreach Grant program which promotes collaborative arrangements among providers to bring basic health care services to under served populations in rural areas. The Office also funds grant programs to develop vertically integrated systems of care in rural communities and to demonstrate the use of telecommunications technologies in improving access to care.

B. Current Activities in Children's Outreach

Current Activities to Educate Workers about Medicaid and CHIP

Informing grantees and constituencies about outreach for Medicaid and CHIP. HRSA has sent letters to its grantees about CHIP, Medicaid, and outreach issues. These letters stress the need for grantee participation in the collection of data on outreach efforts and children's insurance status. States' Title V directors hold monthly calls to discuss Medicaid and CHIP implementation, including successful outreach strategies. HRSA also informs constituent organizations about important issues around outreach and children's health, including States' primary care associations and organizations, the National Association of Community Health Centers, the Association of State and Territorial Health Officers (ASTHO) (with monthly calls with its management committee), the National Association of City and County Health Officers, the National Association of States Legislatures, the National Governors Association, and the Association of Maternal and Child Health Programs (AMCHP).

Sharing successful outreach models. HRSA has published information on successful, easily replicated models for outreach for uninsured children and special populations in *Reaching Our Children*, *Community Outreach* (Volume IV: The Healthy Start Initiative, already available), and other publications. Successful outreach models are collected and featured on HRSA's newly established child health websites (see http://www.hrsa.dhhs.gov/ childhealth and http://www.bphc.hrsa.dhhs.gov).

Collecting data about effective outreach practices. HRSA will collect information on outreach and child health insurance status from its grantees. The Uniform Data System, a tool used to collect data from community health centers regarding clients and services delivered**,** has

been modified. It now requests information about the number of children served who are insured by State CHIP plans and Medicaid. Title V performance indicators also require States to identify the percentage of children without health insurance, the percentage of children with special health care needs to receive comprehensive services, etc. This information will be valuable to HRSA's staff in examining the success of outreach and enrollment strategies.

Joint multi-state project to expand Medicaid enrollment by outstationing eligibility workers. The Bureau of Primary Health Care has initiated a joint HCFA- HRSA, $1 million demonstration project in 12 States that began in April of l998 to improve utilization of outstationed eligibility workers. The demonstration encourages comprehensive and innovative approaches to Medicaid enrollment in Federally Qualified Health Clinics (FQHCs) and document the impact on improving Medicaid enrollment.

Outreach conference. The Bureau of Primary Health Care held an outreach conference in Washington D.C., June 17-19, 1998, to provide workshops on funding, policy recommendations, and skills building for outreach workers. Policy makers, community health workers, outstationed eligibility workers, health center executives, HMO and private health industry representatives, and key persons from non-profit and community based organizations attended.

Using interdepartmental collaboration to provide information about outreach. HRSA's Midwest Field Cluster convened an outreach conference on April 8 - 9, l998, involving 10 States. This conference was planned with input from Regional Federal staff, including HRSA, HCFA, ACF, HUD, and the EPA. It will serve as a model for similar conferences that might be convened in other regions.

Using toll-free numbers to provide direct patient information. Title V programs sponsor toll-free numbers in every State, that provide information about health care services and providers under Title V and Medicaid for pregnant women and infants. Currently, these lines educate callers about Medicaid and refer callers to Medicaid eligibility workers, and (as CHIP comes on line in each State) CHIP eligibility workers. Last year, more than 1 million callers received assistance.

Educating and enrolling families. HRSA's Bureaus share the goal of educating families and assisting them in enrolling children in Medicaid and CHIP. Grantees funded through the Bureau of Primary Health Care and the Office of Rural Health Policy provide clients with direct application assistance for Medicaid and other programs; the Maternal and Child Health Bureau works with parent advocates to identify and enroll

children with special health care needs in Medicaid; and Ryan White grantees funded through the HIV/AIDS Bureau are required to assess clients for eligibility for Federal, State or private health coverage before providing Ryan White CARE Act funded services.

Working with advocacy groups. HRSA works with advocacy groups to develop and implement outreach strategies. The Maternal and Child Health Bureau has contacts with organizations representing families, including Family Voices, which represents families of children with special health care needs.

Working with other Federal groups that have a child health focus. HRSA's Bureaus meet with major Federal organizations that represent or affect their target populations and encourage collaboration at the national level, including the Maternal and Child Health/Medicaid Technical Assistance Group (TAG), the Maternal and Child Health/Administration for Children and Families Technical Assistance Group (ACF TAG), and the Secretary's Advisory Council on Infant Mortality. These groups all have an interest in outreach for children's health.

Assessing States' outreach strategies as they design and implement CHIP. The Bureau of Primary Health Care has commissioned the Texas Association of Community Health Centers to work with the primary care associations in the five States receiving the largest CHIP allotments to assess CHIP opportunities and to document the impact of the CHIP design/implementation on Federal programs such as community health centers. Effective strategies for ensuring Bureau-supported program participation in CHIP, including their role in providing outreach, will be identified and shared with other States.

Linking health providers. The Maternal and Child Health Bureau's Title V programs are required to coordinate their activities with other programs that serve mothers and children, including Medicaid, EPSDT, WIC, health and developmental disability programs, and family planning programs. For example, in Tennessee the State Title V program provides outreach to all families in TennCare, the Tennessee Medicaid managed care program. In North Carolina, the Baby Love Program is jointly administered by three agencies, the State's Title V agency, the Division of Medical Assistance, and the Office of Rural Health and Resource Development. Healthy Start projects' front line workers and supervisors assure linkages among health provider networks, social service agencies, and non-traditional providers that assist in identifying children who are eligible for child health insurance programs. Healthy Start grantees are expected to coordinate with State and local agencies on resource availability, especially Medicaid and CHIP. Finally, State Offices of Rural Health also are encouraged to work with existing programs and coordinate activities across the range of

State and Federal initiatives that help serve rural populations, including programs that identify eligible children and provide health services for them.

Requiring SSDI to describe its collaboration. State Systems Development Initiatives (SSDI), a $5.9 million grant program to each State and jurisdiction for maternal and child health network building, proposes to require projects to report on how they collaborate for outreach with other maternal and child health projects in that State, including: State primary care and State Medicaid programs, WIC, Social Security Administration, health professions education (including AHEC), special education, early intervention, social services/child welfare, rehabilitation services, corrections; and State mental health, alcohol and substance abuse programs.

Educating Rural Grantees. The Office of Rural Health Policy included an article in the spring, 1998 edition of it's publication *Rural Health News,* highlighting successful outreach efforts for improving access to health care services for low-income families and children.

II. PROPOSED PLANS FOR CHILDREN'S HEALTH OUTREACH

A. Educating Workers about Medicaid and CHIP

Federal Workers

1. Convene regular meetings with other Federal workers at the Regional level. HRSA's Regional Offices, principally through their maternal and child health coordinators, would provide information to other regional Federal staff about CHIP, Medicaid enrollment, and outreach on a regular basis. Several regions already hold regular meetings, and this practice should be expanded to all regions. For example, in Region IX (San Francisco), HRSA, HCFA and ACF are meeting on a biweekly basis to develop CHIP outreach strategies. In Region II (New York), HCFA and HRSA are collaborating to provide information to the Federal workforce around CHIP, with a particular emphasis on outreach, through formal presentations to ACF, the Office of the Inspector General, the Welfare Task Force, and the Office of Civil Rights. (Ongoing)

2. Train health professionals who serve underserved communities about outreach. The Bureau of Primary Health Care will begin a new National Health Service Corps training program around community-based issues and outreach with field and State offices. This will serve as a

vehicle for delivering messages about CHIP, Medicaid, and outreach. The Bureau of Health Professions' 140 Area Health Education Centers (AHECs), which support community-based health professions training, could distribute information about outreach for Medicaid and CHIP by utilizing AHEC center directors to provide information to over 21,000 health professions students and 50,000 health care providers in FY 98. Both projects could be completed, without additional resources, by July l998.

3. Distribute best practices in coordination with Maternal and Child Health and State child health insurance programs. The Maternal and Child Health Bureau has contracted with the Lewin group to examine the relationship between Title V programs and six previously existing State-only child health insurance programs. This study will be completed at the end of May, l998. Information gained from this study could be used to provide technical assistance to State Title V directors that helps them to maximize their Title V resources around outreach and other areas.

State Workers

4. Encourage outreach through School Health Programs. The Bureau of Primary Health Care is developing a campaign for the 26 Bureau-funded Healthy Schools/Healthy Communities School Health Programs, on CHIP and Medicaid eligibility and enrollment. The Bureau could use a multimedia approach to educate school health clients and their parents about Medicaid and CHIP eligibility. Flyers could be distributed, a video on CHIP and Medicaid could be played, and posters could be displayed in clinic waiting rooms. This activity could begin in June of l998.

Other Workers

5. Broaden children's health outreach technical assistance to grantees and community-based organizations. HRSA's Bureaus propose to broaden their efforts to provide technical assistance on child health and outreach to grantees and community-based organizations beginning in June 1998. The Maternal and Child Health Bureau, working with the Association of State Maternal and Child Health Programs, State Maternal and Child Health Directors and Children with Special Health Care Needs Directors, could identify outreach and enrollment problems and solutions as States implement CHIP programs. In particular, technical assistance would focus on identifying and enrolling uninsured and special population children, breaking down barriers, and ensuring that these children have access to care. Information would be provided through State-wide Maternal and Child Health toll-free information lines, articles in organizational newsletters, key information on all websites with linkages

to specific HRSA programs, and presentations at continuing education meetings for grantees.

6. Require Ryan White grantees to educate staff about Medicaid and CHIP. HRSA's HIV/AIDS Bureau would develop a *Policy Directive* requiring grantees to educate appropriate staff about State-specific Medicaid and CHIP eligibility requirements and develop procedures for facilitating client enrollment. Case managers, benefits counselors, social workers, and others who assess eligibility for services or make referrals for services could receive special training. This activity would be completed by August of l998.

7. Encourage rural grantees to ensure that State outreach plans addressed the needs of rural communities. The Office of Rural Health Policy could send a letter to its 221 grantees from its four programs (Outreach, Network, Telemedicine, and State Offices) informing them about CHIP and Medicaid and encouraging them to get involved in their individual State CHIP activities. This activity could be completed by the end of June l998.

B. Educating Families and Enrolling Children in Medicaid and CHIP

8. Disseminate Medicaid and CHIP information through 700 community-based health centers and 50 State MCH programs. The Bureau of Primary Health Care and the Maternal and Child Health Bureau could disseminate State-based Medicaid and CHIP information through its 700 health centers and 50 State MCH programs. CHCs could utilize flyers developed at the Department level to educate their workers, then develop materials for their centers that are multilingual and culturally competent. The Bureau of Primary Health Care could encourage community health centers to print the CHIP hot line number on the immunization cards handed out to parents of newborns and toddlers. Community health centers could begin to distribute the new immunization cards as soon as the State they are located in has an approved CHIP plan. (Fall 1998)

9. Building and coordination community coalitions. HRSA proposes to develop a community mobilization effort that promotes community-based outreach for CHIP and Medicaid. Members of the coalition could include the Urban League, the Parent Teacher Association (PTA), the Kiwanis Club, the National Association for the Advancement of Colored People (NAACP), and other groups that have a community oriented focus. Activities would include mass mailings, participation in community pride days, and local town meetings. In addition, HRSA could work with the American Association of Retired Persons (AARP), the Administration on Aging, and the Retired Senior Volunteer Program to target grandparents

who are care givers of CHIP and Medicaid eligible children. These activities could begin by June of l998.

C. Coordination with Other Programs

10. Working with border communities. The Bureau of Primary Health Care and the Border Health Program are exploring the opportunity for a demonstration project in two border settings that would integrate behavioral health and primary care services for at-risk children ages 0-7 in two border health centers. Outreach to children would be a critical component of the program and the evaluation. This project could begin in FY 1999 and would cost $250,000 per border setting.

11. Training outreach workers in EZ/EC communities. The Bureau of Primary Health Care could target Federally designated Empowerment Zones and Enterprise Communities (EZ/EC) for community empowerment, economic stimulation, job creation around outreach, and the provision of primary health care. Health centers are an ideal environment for training outreach workers because of the center's socially supportive environment. Many residents would be able to find employment and training opportunities within walking distance of their homes. This approach could result in economic development which would anchor outreach services as a vital part of the community health structure. This activity could begin August 1, l998.

12. Referring Title V hotline callers to CHIP information sources. Title V (Maternal and Child Health) and Healthy Start toll-free hotlines could direct callers inquiring about health insurance to CHIP information sources. This activity began in March 1998. When the national CHIP toll-free line is operational, it could also be linked (Fall 1998).

C. ADMINISTRATION FOR CHILDREN AND FAMILIES

I. CURRENT PROGRAMS AND OUTREACH ACTIVITIES FOR CHILDREN

A. Programs That Serve Middle To Low-Income Children

The Administration for Children and Families, together with its partners -- States, localities, and non-profit organizations -- supports strategies and creates opportunities for low-income and disadvantaged families and individuals to lead economically and socially productive lives; for children to develop into healthy adults; and for communities to become more prosperous and supportive of their members. Because of its vast human

services networks with States, local and tribal government organizations, community-based organizations, child care and Head Start Centers, ACF is in a unique position to assist in providing information about outreach and enrollment services to assure that eligible children actually are enrolled in CHIP and Medicaid.

Temporary Assistance for Needy Families (TANF) ($16.5 billion in 1997/98), authorized under Title IV-A of the Social Security Act, amended by P.L. 104-193, promotes work, responsibility and self sufficiency and strengthens families through funding of State-designed and administered programs that provide support to needy children and move their parents into work. *Target population: All families that meet States' new public assistance criteria.*

Child Support/IV-D Program ($12 billion collected in 1997/98), authorized under Title IV-D of the Social Security Act, as amended, locates parents, establishes paternity and support obligations and modifies and enforces those obligations (to assure financial support is available to children) through State agencies that administer the program. *Target population: The 11.5 million families whose child has a parent living elsewhere.*

Head Start/Early Head Start ($4.35 billion in 1997/98), authorized under Section 639 of the Head Start Act, as amended, provides comprehensive child development services to children and families, primarily for preschoolers from low-income families through grants to 1,400 local, public and private non-profit agencies. *Target population: About 830,000 low-income, pre-school children. At least 10 percent of the enrollment opportunities in each program must be made available to children with disabilities.*

Foster Care ($3.5 billion in 1997/98)**, Adoption Assistance** ($701 million in 1997/98)**, Independent Living** ($70 million in 1997/98), Sections 470 and 477 of Title IV-E of the Social Security Act, as amended; Section 205 of the Child Abuse Prevention and Treatment and Adoption Reform Act of 1978, as amended; and Section 104(a)(1) of the Abandoned Infants Assistance Act of 1988, as amended; for children who cannot remain safely in their homes, foster care provides a stable environment that assures a child's safety and well-being while their parents attempt to resolve the problems that led to the out-of-home placement or when the family cannot be reunified, until the child can be placed permanently with an adoptive family. Independent Living programs provide education and employment assistance, training in daily skills, and individual and group counseling to youth reaching adulthood. *Target population: All children that are in foster care and teenagers who were or are in foster care ages 16+.*

Child Care ($3.1 billion in 1997/98), authorized under sections 658A through 658S of the Omnibus Budget Reconciliation Act of 1981, as added by P.L. 101-508, amended by P.L. 102-586, 103-171 and 104-193, assists low-income families and those transitioning off public assistance to obtain child care that is safe, healthy and affordable so that they can work or attend training/education programs. *Target population: All children under the age of 13 and all youth under court supervision, older youth that are mentally and/or physically challenged to the age of 19. (Note: Serving older youth over age 13 is a State option)*

Community Services Block Grant ($415 million in 1997/98), authorized under Section 672 of the Community Services Block Grant Act, as amended, provides an array of social services and programs to assist low-income individuals and alleviate the causes and conditions of poverty through flexible funding at the State and local level. *Target population: Low-income children, individuals and families that meet the poverty income guidelines.*

Refugee Resettlement ($396 million in 1997/98), authorized under Title IV of the Immigration and Nationalization Act and Section 501 of the Refugee Education Assistance Act of 1980 (P.L. 96-411) and Section 414(a) of the Immigration and Nationalization Act under P.L. 104-134 [103-333], assists refugees and entrants who are admitted into the United States to become employed and self-sufficient as quickly as possible by providing grants to States and other grantees for employment-related services, social adjustment, transitional cash and medical assistance, and other services. *Target population: Refugees and Cuban and Haitian entrants who are admitted into the United States.*

Child Welfare ($292 million in 1997/98), authorized under Sections 470 and 477 of Title IV-E of the Social Security Act as amended, funds State programs that provide services focused at assisting at-risk children and their families in achieving the best and most appropriate outcomes for the children: preventive intervention services to strengthen the family unit; services to move children more rapidly from foster care to safe, permanent homes; and reunification services to facilitate the return home of the child if in the child's best interest. *Target population: All children, newborns to 18 years of age that may be at risk for abuse and/or neglect.*

Developmental Disabilities ($114.2 million in 1997/98), authorized under Sections 130, 143, 156 and 163 of the Developmental Disabilities Assistance and Bill of Rights Act of 1990, as amended, funds programs which assist States to assure that individuals with developmental disabilities and their families participate in the design of and have access to culturally competent services, supports, and other assistance and opportunities that promote independence, productivity, and integration and

inclusion into the community. *Target population: All children and adults with developmental disabilities.*

Youth Programs ($58.6 million in 1997/98) [requested reauthorization], supports services provided through local agencies to reduce sexual abuse of runaway, homeless and street youth; provide alternate activities for at-risk youth and further the goal of providing safe passages for the Nation's youth, giving them the tools they need to successfully move from childhood to adulthood by stimulating positive development and preventing high-risk behavior. (A major focus includes looking at what works in all areas of development and disseminating best practices and proven products.) *Target population: Provides shelter, food, clothing, counseling and other supports to 80,000 + young people ages 11 through 18.*

Native Americans ($35 million in 1997/98), authorized under Sections 816(a) and 803A(f)(1) of the Native American Programs Act of 1974, as amended, promotes economic and social self-sufficiency of American Indians, Alaska Natives, Native Hawaiians, and Native Pacific Islanders by supporting programs and encouraging local strategies in economic and social development. *Target population: American Indians, Alaska Natives, Native Hawaiians and Native American Pacific Islanders.*

B. Current Activities in Children's Health Outreach

Collaborate with DHHS partners on interagency implementation and planning committee meetings. ACF staff have begun and will continue to collaborate with other DHHS partners on interagency implementation/planning committees at Regional and Central Office levels. ACF Regional staff have begun and will continue to review State CHIP plans, in cooperation with HCFA, to ensure that ACF constituencies are being included.

Developing of website links to HCFA's CHIP information site.

Sent letters to grantees and colleagues. ACF program offices have written letters to grantees and colleagues to inform them about CHIP implementation and the importance of their involvement in the process, e.g. Community Service Block Grant State Administrators.

Discuss the importance of CHIP at meetings and conferences. ACF is currently and will continue to discuss the importance of involvement in CHIP implementation at grantee meetings and conferences, e.g. State Child Care Administrators meeting in July 1998; Tribal Child Care Conference in May 1998; National Community Action Agency Conferences in April, May and June; Developmental Disabilities

Commissioners Forum (TBS); Family Independence Forum (TBS); national Head Start Meetings in February and April; and numerous Regional Office conferences.

II. PROPOSED PLANS FOR CHILDREN'S HEALTH OUTREACH

Our major program offices, as well as our ten Regional offices, have submitted specific CHIP outreach plans. These plans identify the following major areas for ACF focus: coordination efforts with Federal and State health agencies to ensure that outreach opportunities are included; general information dissemination regarding CHIP/Medicaid; technical assistance and training to ACF staff and partners regarding CHIP/Medicaid and outreach opportunities; and assistance with a national media campaign. ACF could also focus CHIP and Medicaid promotional efforts in those communities that have families considered to be "under served" by State Primary Care Access Plans (as submitted to the Bureau of Primary Health Care based on poverty rates, minority populations, and ratio of physicians to population) and Empowerment Zone/Empowerment Community initiatives. These proposed activities would be part of ongoing outreach and would not require additional funding resources.

A. Educating Workers about Medicaid and CHIP

Federal Workers

1. Brief and distribute outreach information to Regional office staff and other Federal partners. ACF Regional staff have been and could continue to work with HCFA to periodically brief Regional office staff and other Federal partners on CHIP/Medicaid implementation and progress. ACF could also conduct monthly ACF, CHIP and Medicaid outreach and implementation update meetings that involve representatives from all Regional offices and central office staff. Distribute information to all ACF offices (10 Regions and 9 Central Offices) through mailings, weekly Regional/Central Office video conference video calls and E-mail as important Medicaid/CHIP outreach and implementation materials are received/acquired. (Ongoing)

State Workers

2. Distribute outreach information to State and local partners. Using materials and language created by HCFA as guides, ACF could develop and distribute program specific Information Memoranda/Dear Colleague letters to 50 State and U.S. Territories Welfare/ACF Program Directors on

CHIP/Medicaid outreach and implementation, e.g., State/Tribal /Territorial Child Care Administrators, State Child Welfare Directors, Social Services State Directors, State Developmental Disabilities Councils, Protection and Advocacy Agencies and University Affiliated Programs, Runaway and Homeless Youth grantees, Head Start grantees, State Refugee Coordinators. (Initial Introductory letter in Summer 1998, updated thereafter as necessary)

3. Invite State Directors to participate in conferences and forums. ACF program offices could invite and encourage State Welfare/ACF Program Directors to participate in conferences and forums that contain CHIP and Medicaid outreach information or updates, by providing feedback and specific examples of barriers and opportunities in providing outreach to CHIP/Medicaid eligibles. (Ongoing)

Other Workers

4. Actively enroll ACF grantees and technical assistance contractors in outreach effort. In cooperation with HCFA staff, ACF could continue to actively work with ACF grantees and technical assistance contractors by providing them with CHIP and Medicaid information and briefings (i.e., understanding enrollment application procedures, etc.); inviting and encouraging them to participate in conferences and forums that contain CHIP information and updates; including CHIP in grantee and technical assistance contractor meetings, conferences and forums by adding CHIP and Medicaid related topics and speakers to agendas; providing updates on CHIP implementation in news letters and bulletins that target ACF programs, grantees and technical assistance contractors; and requesting that ACF grantees and technical assistance contractors share exemplary outreach strategies, tools and best practices. (Ongoing) *Note: For specific ACF programs included in this activity, refer to listing of programs under the first section.*

B. Educating Families and Enrolling Children in Medicaid and CHIP

5. Encourage State Child Support offices to promote outreach. ACF could encourage State Child Support offices via letter, to routinely petition court and administrative authorities to include CHIP and Medicaid information in new and modified child support orders and provide periodic mailings to families with children that have no health coverage in Child Support cases. (Initial notice in February 1998, updates thereafter as needed)

6. Encourage distribution of CHIP and Medicaid promotional, enrollment, and application materials. ACF could encourage programs,

grantees and contractors to provide Medicaid and CHIP enrollment applications and assistance to customers and client families. Additionally, ACF could, when possible, display and distribute CHIP and Medicaid promotional materials at prominent and visible locations in States where ACF programs/grantees/contractors are located (e.g., Welfare/TANF Offices, Head Start/Early Head Start program locations, Tribal Government Offices). (Ongoing)

7. Provide technical assistance for outreach to Tribes, Native Hawaiians and Pacific Islanders. ACF/Native Americans Programs could supplement a technical assistance contract to include CHIP and Medicaid outreach activities to allow them to outreach to urban Indians, off-reservation groups and Native Hawaiians and Pacific Islanders at no additional cost to the contract. (Ongoing)

8. Send letter to States encouraging outstationing in areas with high Child Care, Early Head Start and Head Start enrollments. These workers would assist families in understanding the importance of CHIP and Medicaid enrollment and provide for the grantees a vehicle for information and assistance. (July 1998)

C. Coordination with Other Programs

9. Coordinate efforts with other Federal and State agencies. ACF could coordinate efforts with HRSA, HCFA and other DHHS agencies as they begin to implement outreach strategies in communities (see activities under II, A-C). ACF could ensure that all community-based organizations/programs (e.g. Community Service Block Grant and Head Start grantees) are collaborating with other DHHS community based programs and agencies to facilitate and simplify outreach efforts and strategies. (Ongoing)

D. AGENCY FOR HEALTH CARE POLICY AND RESEARCH

I. CURRENT PROGRAMS AND OUTREACH ACTIVITIES FOR CHILDREN

The Agency for Health Care Policy and Research (AHCPR) is the lead agency charged with supporting research designed to improve the quality of health care, reduce its cost, and broaden access to essential services. AHCPR's broad programs of research bring practical, science-based information

to medical practitioners and to consumers and other health care purchasers.

A. Programs that Serve Middle to Low-Income Children

In 1997 AHCPR supported approximately $13.5 million in research projects related to children's health. Projects included development and testing of a consumer-focused survey on the quality of children's health care, a study testing alternative approaches to implementing HHS-developed guidelines for asthma care in children, a study testing a computer-based decision-support system to help providers identify newborns at risk of jaundice, and several studies of emergency services for children. AHCPR-supported researchers on these and other AHCPR-supported projects have contact with organizations that serve children (e.g., hospitals, health care providers) or with children and their families directly. AHCPR does not fund service programs per se.

B. Current Activities in Children's Health Outreach

Conduct Children's Health Initiative workshop for States. AHCPR has traditionally held workshops for State and local policy makers on issues in children's health such as quality, reaching children with special health care needs, and access. This year, AHCPR consulted with State policy makers with responsibility for implementing CHIP; this year's workshop will be responsive to their needs related to CHIP and related programs. AHCPR's User Liaison Program will hold a 2-day workshop for State and local policy makers on the Children's Health Insurance Initiative on June 30-July 1, 1998. The purpose of the workshop is to present health services research and best practices from State programs to State and local policy makers, including Medicaid Directors, Maternal and Child Health Directors, and Public Health Officers from States that are in the process of developing policies for implementation of the Child Health Insurance Initiative. The workshop will include sessions presenting research and "best practices" on outreach models.

II. PROPOSED PLANS FOR CHILDREN'S HEALTH OUTREACH

A. Educating Workers about Medicaid and CHIP

Federal Workers

1. Inform Federal employees about outreach. AHCPR would take a 3-step approach to inform its staff of approximately 270 FTEs:

- E-mail to all staff describing CHIP and Medicaid, the problem of uninsured but eligible children, the HHS and Administration-wide outreach initiative, and how staff can use the materials to reach out to targeted eligible children and families in their communities. (June 1998)
- Desk-to-desk handout of HHS/Administration-developed flyer and other HHS/ Administration-developed informational materials on outreach for employees to use in their capacities as health care providers, volunteers in community agencies, and neighbors. (Summer 1998)
- Follow-up with Office and Center Directors (supervisors) to remind employees of the outreach initiative. (Fall 1998)

B. Educating Families and Enrolling Children in Medicaid and CHIP

2. Encourage grantees and contractors to educate families about outreach. Send letter to the principal investigator(s) and team of each "child health" grantee and contractor, enclosing the Department-developed flyer and other Department-approved outreach materials. The letter would ask each grantee team to do one or both of the following:

- Distribute the flyer directly to families with children with whom the grantee team comes in contact;
- Post the flyer in places where families with children can see it (or see that the relevant departments in the grantee institution do so).

Letters could be prepared and sent when departmental flyer is available (planned for summer 1998).

3. Encourage grantees in co-sponsored research projects to educate families about Medicaid and CHIP outreach. AHCPR could continue to co-sponsor research projects with other agencies (e.g., HRSA, NIH). For example, AHCPR is collaborating with HRSA on four research projects on emergency services for children and on a project investigating office systems to improve preventive care for children. NIH is co-funding development of a child health status measure for children ages 5-11, as well as an evidence report on attention deficit hyperactivity disorder. AHCPR could ensure that these grantees are informed about children's health outreach. (Summer 1998 and ongoing)

C. Coordination with Other Programs

4. Notify outside individuals and groups about outreach via its child health listserv (200-plus subscribers). AHCPR could send e-mail that alerts subscribers to the availability of CHIP and Medicaid, the problem of

uninsured but eligible children, and the HHS and Administration-wide outreach initiative. The information provided would be based on the flyer and related materials for Federal workers being prepared by HHS and the Administration. (Summer 1998 and ongoing)

5. Support evaluations of CHIP and Medicaid outreach. AHCPR is involved in developing a departmental and national framework for "learning from CHIP." We are including a focus on evaluating varying approaches to outreach as part of the evaluation framework. In addition, a cross-departmental group is developing a paper synthesizing the rigorous evidence on "what we know or could know" about effective CHIP and Medicaid outreach from completed work in broadly varying areas (e.g., marketing, social marketing of all kinds). (Ongoing)

E. CENTERS FOR DISEASE CONTROL AND PREVENTION

I. CURRENT PROGRAMS AND OUTREACH ACTIVITIES FOR CHILDREN

A. Programs that Serve Middle to Low-Income Children

The Centers for Disease Control and Prevention (CDC) has been active in the fight against disease for more than half a century. The mission of CDC is to promote health and quality of life by preventing and controlling disease, injury, and disability. As such, CDC works through partnerships with State and local health departments, educational institutions, and other private and public organizations to ensure healthy lives in a healthy world.

CDC has a long and unique history in this country and throughout the world of preventing disease, injury, and disability in children. In fact, CDC spends close to half (42 percent) of its total $2.8 billion budget on activities related to children. Current child health activities at CDC include research, surveillance, and interventions with an emphasis on prevention and control in immunization, lead poisoning prevention, birth defects, tobacco control, adolescent and school health, infectious disease, violence and unintentional injuries prevention, nutrition, physical activity, sexually transmitted disease prevention, oral health, prevention of developmental disabilities, and chronic diseases such as asthma.

Considering the immense scope of CDC's child health activities, the agency is limited in the number of programs which offer direct services to children. In the broadest of terms, CDC's children's outreach activities can be placed in five categories: immunization, childhood lead poisoning

prevention, sexually transmitted disease prevention, HIV/AIDS prevention, unintentional injury prevention, and youth work-related/farm-related safety.

Immunization ($407 million for Section 317; $487 million for VFC in FY 1998) is authorized under Section 317 of the Public Health Service Act and Public Law 103-66, the Omnibus Reconciliation Act of 1993, which authorizes the Vaccines for Children Program (VFC). The VFC program provides public-purchased vaccines to both private and public providers for children 0 to 18 years of age who are Medicaid enrolled, have no health insurance, or are American Indian/Alaska native. In addition, children who have health insurance that does not cover immunizations are eligible if they receive vaccines at a Federally Qualified Health Center or a Rural Health Clinic. CDC's National Immunization Program also maintains a hotline to answer questions concerning immunization or vaccines. From March 1997 to March 1998, the hotline handled over 30,000 calls. *Target population: Children in "pockets of need"; i.e., primarily children living in poverty.*

Childhood Lead Poisoning Prevention ($58.7 million in FY 1997) is authorized under Section 317A of the Public Health Service Act. It is estimated that there are 1 million children in the Nation with elevated blood lead levels. Targeting communities with demonstrated high risk for lead poisoning, CDC funds a grant program aimed at screening at-risk children, identifying the source of the exposure, monitoring medical and environmental management of lead-poisoned children, and educating the family members/community about the effects of lead poisoning. Because lead poisoning disproportionately affects racial and ethnic minority children and children of low-income families, these targeted communities tend to be in poverty stricken areas. In 1996 alone, CDC programs in State and local health agencies screened over 1.8 million children. *Target population: Although grantees target large minority and low-income populations, those who receive benefits from the screening program include infants and children from 6 months to 6 years of age and family members who care for lead-poisoned children. 1.8 million children were screened in 1996.*

Sexually Transmitted Disease Prevention ($113.7 million in FY 1998) is authorized under Section 318(a) of the Public Health Service Act. CDC funds State and local health departments (in addition to non-governmental organizations) to conduct STD screening and counseling among all populations. Some grants are directly aimed at at-risk youth. CDC currently funds several cooperative agreements to screen young women for STDs. Rates of chlamydia and gonorrhea are highest among 15-19 year olds and STDs facilitate the sexual transmission of HIV. Clinics and screening projects nation-wide serve each year more than one-half million

women. Well over a quarter of a million of those women are under 20 years of age. *Target population: Although an actual assessment of numbers of youth helped by the many activities of the nation's STD programs is not available, in 1996 there were more than 673,000 STD cases reported to CDC, with over 38 percent of them occurring among youth under 20 years of age.*

HIV/AIDS Prevention ($58.7 million in FY 1997) is authorized under Sections 301, 307, 310, 311, 317, and 1102 of the Public Health Service Act. CDC has a variety of programs aimed at reaching high-risk youth associated with HIV/AIDS. During FY 1997, it funded youth-serving programs at State, local, and community levels, including 94 Community-Based Organizations (CBOs). Of particular interest is the National AIDS Hotline which received 65,333 calls from persons under 18 years of age (the figure is not available for the Spanish speaking lines). *Target population: Youths in high-risk situations.*

Unintentional Injuries ($1,390,000) is authorized under Section 394A of the Public Health Service Act. Bicycle helmet usage and residential fire protection (through the use of smoke detectors) are two unintentional injury programs whose target population is children. Through a grant program, CDC funds States to conduct public education programs on bicycle helmet safety, helmet give-aways, neighborhood canvassing, multilingual educational materials, etc. Residential fire protection through the use of smoke detectors is aimed most specifically at low-income households with children under 5 and adults 65 and older. Grantees make use of outreach workers for door-to-door canvassing or other forms of public assistance programs (WIC, Head Start, etc.) to identify those in need. *Target population for bicycle helmet programs: Children 5 to 12 years of age in given communities with a high percentage of youth-related bicycle injuries and fatalities. Target population for residential fire protection: Low-income households with children under 5 and adults 65 and older who have no smoke detector; several programs target low-income households with children aged 5 and under, living in rural mobile or single duplex homes, and no smoke detector in the home.*

Youth Work-related/Farm-related Safety ($1.3 million in FY 1998) is authorized under Sections 301, 304, 306, 308, 310, and 311 of the Public Health Service Act and Sections 20, 21, and 22 of the Occupational Safety and health Act of 1970. CDC currently funds several community education projects focusing on young workers' safety and the hazards of farm work. Several of these grantees strive to reach unique groups of farming and ranching using culturally sensitive approaches. *Target population: Youth in rural farming and ranching communities.*

B. Current Activities in Children's Health Outreach

Secure hot-link to HCFA CHIP website and establish partnerships. In response to CHIP, CDC has secured the hot-link to the HCFA CHIP website. We have also begun discussions with program staff at CDC to determine how State and local health officials can become involved with the CHIP and Medicaid outreach effort using organizations like the management committee of the Association of State and Territorial Health Officers (ASTHO).

II. PROPOSED PLANS FOR CHILDREN'S HEALTH OUTREACH

A. Educating Workers about Medicaid and CHIP

Federal/State/Other Workers

1. Send mailing to grantees about Children's Health Insurance. Through our grantees, CDC is in a unique position to reach and assist in providing information and enrollment forms to a large number of children. Because most of the workers involved with CDC projects are grantees, CDC feels the best strategy for educating these outreach workers is a tailor-made mailing which could focus on how a grantee in a particular program would become involved in CHIP and how they can assist in outreach. For instance, an outreach worker in the lead screening program who visits a high-risk home to screen children for lead poisoning would also be encouraged to hand out information on CHIP and/or Medicaid, assist in completing the application form, and even mail the form. Another example is an occupational safety and health official who visits migrant communities and farms to educate the workers on farm safety. The first targeted audience would include immunization grantees, lead poisoning grantees, STD/HIV grantees, unintentional injuries grantees, work-related youth grantees -- actual direct services to children programs. Soon thereafter, another mailing would be sent to the other CDC programs that deal with other family members such as the breast and cervical screening program and the diabetes screening program. Those grantees would be encouraged to ask adults that are being seen if their children or grandchildren have insurance. If not, the grantees would follow through in much the same way the grantees for direct children's services do. (Summer 1998)

Several non-governmental agencies are currently partners with CDC, assisting with our school-based education programs throughout the States. Among the organizations are the National Network of Runaway and Youth Services, Advocates for Youth, the National School Health Education Coalition, and Girls Incorporated. These types of groups are in

a unique position to reach a large number of children in a variety of settings. CDC proposes that these types of groups assist in outreach through the use of educational materials, enrollment applications, etc. Again, these groups would be reached through a mass-mailing according to grantees. Mailing could begin on these groups as soon as CDC receives outreach materials to accompany the letter. (Summer 1998)

2. Allow States to use existing database to target eligible children. CDC maintains a database that has the ability to profile "pockets of need" children in certain cities (currently 62 clusters). When queried, this database can profile psychographic characteristics, consumer and media habits that would be of great assistance to outreach workers as they search for eligible children and determine the most effective means of reaching them. CDC could make this information available to the States. (Summer 1998)

3. Use distance-based learning to educate about Medicaid and outreach. CDC uses several different types of distance-based learning for training health professionals around the country. One such mechanism is the Public Health Training Network. CDC uses a satellite that can be up-linked from various parts of the country at once to conduct training sessions, conference, seminars, etc. The possibility exists to put information about CHIP or the 800 number on the screen either before or after the session. CDC is also exploring the possibility of conducting a satellite training session on CHIP and Medicaid during the summer of 1998.

B. Educating Families and Enrolling Children in Medicaid and CHIP

4. Assist State and local health departments in helping to insure children. CDC has several strategies for actually reaching and assisting enrollment children in Medicaid and CHIP. Perhaps most important is the use of the State and local health departments and State and local education agencies. CDC is the only Federal public health agency with grant relationships with all fifty State health agencies and all fifty State education agencies as well as many of the Nation’s largest cities. Although traditional health departments do not see the large numbers of low-income families they once did, the State and local health agencies remain a critical link in the effort to identify and assist in enrolling children into either CHIP or Medicaid. Each of the State agencies have access to a large number of children through several different programs. CDC could encourage each of these agencies to ensure that a child is enrolled in CHIP or Medicaid every time a child is seen for whatever reason. This could be done by providing information, completing applications, and mailing the application possibly as early as summer of 1998.

5. Add the CHIP/Medicaid toll-free number to CDC publications. Another strategy involves using the national 800 number being set up for the CHIP program. CDC has an extensive inventory of publications, pamphlets, educational materials, etc. that routinely make their way into the States. An effective use of the 800 number would be to publish the 800 number on printed material sponsored by CDC. Because the CDC clearinghouse already has many of the materials on hand, CDC is exploring a way to possibly use stickers to put the 800 number on existing materials that are requested by grantees and organizations. (Fall 1998)

6. Educate parents or grandparents through non-children's programs. CDC has several non-children's health programs that by nature lend themselves to reaching children in need. One such example is the breast and cervical screening program. CDC sees this program as a link to mothers and grandmothers who may be interested in learning more about CHIP or who are Medicaid eligible. The diabetes screening program also affords an opportunity to reach fathers, mothers, and other family members. Those program grantees would be encouraged to ask adults that are being seen if their children or grandchildren have insurance. If not, the grantees would follow through in much the same way the grantees for direct children's services do. This activity is scheduled to begin in the Summer 1998.

Two other important CDC programs with direct links to children are the teen pregnancy program and the prenatal smoking cessation program. Both of these programs could provide for immediate evaluation for enrollment in either CHIP or Medicaid. This activity could begin in Summer 1998.

C. Coordination with Other Programs

7. Add Internet links. Approximately 96,209,000 hits have been received on CDC homepage just in the past year. CDC has provided a hot-link directly to the HCFA website for those wishing to learn more about the program. There are several other websites which CDC has identified as potential bridges to the HCFA site. CDC is currently under discussions with these owners to determine the best way to hot-link these various sites. (Summer 1998)

8. Develop coordination of WIC, immunization and children's health insurance programs. A critical component to CDC's effective immunization delivery system is the linkage with the U.S. Department of Agriculture's (USDA) Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). The WIC program is the largest single point of access to health-related services for low-income preschool children. Children who apply for WIC services are screened for

immunization records thereby allowing for the discovery of under- or unimmunized children. CDC could work with the Department of Agriculture, HCFA and HRSA to see if we can expand this linkage for children's health insurance. (Summer 1998)

F. INDIAN HEALTH SERVICE

I. CURRENT PROGRAMS AND OUTREACH ACTIVITIES FOR CHILDREN

A. Programs that Serve Middle to Low-Income Children

The Indian Health Service (IHS) is the principle Federal agency with responsibility for the provision of comprehensive health care services to the approximately 1.5 million American Indians and Alaska Natives (AI/AN) living in the United States. The Indian people are among the most disadvantaged minority in this country not only in terms of social and economic indicators, but also in most aspects of health status. The provision of health services to Federally recognized Indians has grown out of a special relationship between the Federal Government and Indian Tribes. This Government-to-Government relationship is given form and substance by numerous treaties, laws, Supreme Court decisions, and Executive Orders. In meeting its goal to raise the health status of Indian People to the highest possible level, the IHS provides clinical and preventive health care services, Contract Health Services, and ensures that American Indians and Alaska Natives receive needed clinical, preventive, and rehabilitative services.

All of the IHS's resources, approximately $2.4 billion annually, are directed toward the health care needs of American Indians and Alaska Natives. The organizational structure of the IHS is decentralized, with 12 Regional administrative units called Areas. The Areas are subdivided into 150 service units which operate 49 hospitals (12 tribal), 195 health centers (134 tribal), 8 school health centers (4 tribal), 289 health stations (89 tribal) and 152 Alaska Village Clinics.

IHS also funds 34 urban Indian health programs, that provide health care for members of the AI/AN population residing in urban areas. The urban Indian health service delivery system is a major component of the total Indian health care system, specifically authorized by the Indian Health Care Improvement Act.

Title XXI requires States to describe how their plans will include Indian children. This requirement is intended to further enhance the partnerships between the States and tribes, as referenced in the Presidential Executive Order on consultation with tribes. Eligible Indian children are entitled to receive CHIP services even if they already receive their health care services from the IHS.

B. Current Activities in Children's Health Outreach

The Indian Health Service is committed to working with Federal agencies, State agencies, and tribal health programs by assisting the development and implementation of State CHIP plans. IHS is working directly with Indian communities to encourage them to seek greater access to both Medicaid and CHIP. Several ongoing programs within the IHS have assisted the outreach work to Indian communities and their youth:

Distribution of information on CHIP and outreach through its agency infrastructure. Specifically the following activities have occurred:

- The administrative and clinical components of the Office of Public Health, IHS through the Division of Managed Care, and Division of Clinical and Preventive Services have been given the principal task of providing an education program to IHS Tribal and urban Indian health workers on CHIP.
- The IHS Council of Clinical Directors and the IHS Council of Chief Medical Officers have been provided general information on CHIP and have discussed how their advocacy and support can assist in effective outreach efforts. The members have been active in local meetings with tribes and staff to provide a clinical perspective to the discussions.
- Through HCFA-sponsored Regional meetings, IHS has facilitated discussions with tribal workers, government organizations, and community representatives. For example, a meeting with representatives from the Western Governors' Association has resulted in the issuance of a "3 Point" resolution focusing on the health care needs of AI/AN children. This resolution has provided a forum in which information about the importance of Medicaid and CHIP outreach can be shared and discussed.
- The monthly IHS leadership conference call is used as a mechanism to exchange current information and strategies on Medicaid and CHIP Outreach activities.

Consultation with Indian Tribes and Alaska Native Corporations in providing information on CHIP. As a result of the Executive Memorandum issued by President Clinton, the IHS has made the

commitment to include discussions about Medicaid and CHIP in all future meetings. These meetings have resulted in activities such as:

- IHS distributed the names of the HCFA Regional Contacts for American Indian Issues.
- The agencies' public relations office has provided information about Medicaid and CHIP to local and Regional offices that have Tribal newspapers and newsletters.
- Short public service announcements have been made on Indian radio and television programs.

Targeting vulnerable communities. IHS is assisting in the mapping of residences of Indian families. This data will be used to help target areas of high Indian census, where outreach activity for CHIP can be directed.

II. PROPOSED PLANS FOR CHILDREN'S HEALTH OUTREACH

A. Educating Workers about Medicaid and CHIP

Federal and Tribal Workers

In order to educate Federal and Tribal workers about the importance of Medicaid and CHIP outreach, the IHS will:

1. Organize a headquarters leadership team. IHS could organize a headquarters leadership team consisting of staff from the Office of Public Health, Maternal and Child Health, Health Education and the Managed Care Division, to champion the outreach activities within the agency and Indian tribes. The team could be in place by the end of July 1998.

2. Send directives to participants of specialty meetings. In an effort to increase awareness of CHIP and outreach, IHS could send directives to each of the agency speciality annual meetings (National Councils of Chief Medical Officers, Clinical Directors, Nurse Administrators, Service Unit Directors, Eye Care, and Radiologists) to include workshops and plenary sessions on CHIP and outreach. They could be notified at the upcoming quarterly meetings. (Summer 1998)

3. Provide access to CHIP and Medicaid training to IHS workers. IHS could provide workers with access to training on CHIP and the Medicaid program that are sponsored by other Federal agencies and State or Private organizations who serve American Indians and Alaska Natives. This could be an activity that the local level and the tribes would coordinate. (Summer 1998)

4. Include CHIP as a topic in future meetings scheduled with Indian tribes. National meetings are usually held in September with the National Indian Health Board, which is representative of all the Area health boards. Area health board meetings are held quarterly.

5. Distribute American Indian and Alaska Native CHIP brochure. In collaboration with the Bureau of Indian Affairs, IHS will design culturally appropriate CHIP brochure specifically for American Indian and Alaska Natives. This brochure will be distributed in the summer of 1998.

B. Educating Families and Enrolling Children in Medicaid and CHIP

IHS could continue to work in consultation with Indian Tribes and States to provide information to Indian Families. This could include:

6. Establish a key stakeholder advisory committee. IHS could establish a key stakeholder advisory committee consisting of representatives of the Tribal Self-Governance Advisory Committee and Area health boards to provide adequate input on the current strategy and activities directed toward increasing outreach activities to AI/AN. This activity could begin in September, 1998.

7. Develop culturally sensitive messages on outreach. IHS could define key terms related to CHIP so that communication between Indian clients and State enrollment workers can be enhanced and assisted. This could be an outcome from the jointly sponsored training sessions that would begin by the end of October, 1998.

8. Create a survey to monitor access and satisfaction of Indian families with CHIP and Medicaid. Also, IHS could identify potential Indian beneficiaries by using HCFA projections on uninsured children by State and county, while focusing on sites of large Indian census. This activity could begin in October, 1998.

9. Provide CHIP and Medicaid outreach training to American Indian and Alaska Native community leaders. IHS could use the "Train the Trainer" technique to provide education to select community members who can then provide the information to the rest of the community. These sessions could occur by October, 1998.

C. Coordination with Other Programs

10. Improve communication on cross-agency issues within HHS and across Federal agencies. IHS and HCFA have met on a regular basis since the inception of CHIP and could continue these meetings in the

future. The IHS has also initiated interaction with social service workers from the Bureau of Indian Affairs at both the local and Regional levels to increase the interaction between the two agencies. BIA programs have great potential in terms of providing information to Indian families who are eligible for CHIP. IHS could also continue meeting with the major Federal organizations working with children's health issues. One of the major focuses is developing a means of monitoring the impact of the work that is currently underway with CHIP, in terms of both access and service delivery. The IHS works with several service providers which have great access to low-income people including WIC, the Department of Agriculture food distribution program, and Head Start. IHS could encourage better outreach services to the communities served.

11. Identify and develop partnerships. IHS could identify and develop partnerships with public and private advocacy groups working with CHIP to help provide education and assistance to Indian Families. This activity could begin in August, 1998.

G. SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

I. CURRENT PROGRAMS AND OUTREACH ACTIVITIES FOR CHILDREN

The Substance Abuse and Mental Health Services Administration (SAMHSA) and its three Centers, the Center for Mental Health Services (CMHS), Center for Substance Abuse Treatment (CSAT), and Center for Substance Abuse Prevention (CSAP), in partnership with State, local, and community-based organizations, strive to improve the quality and availability of prevention, early intervention, treatment and rehabilitation services for persons with addictive and mental health disorders. In the area of children and adolescents, SAMHSA pursues its mission by assisting States to promote seamless, comprehensive services for children and adolescents at risk for substance abuse or emotional disturbance. Early childhood substance abuse prevention and treatment and mental health programs are more critical than ever given the negative impact of violence on our society. The more we provide effective early interventions, the more likely we are to reduce the long-term costs to society. SAMHSA's FY 1998 budget for children's and youth programs is $224.5 million.

A. Programs that Serve Middle to Low-Income Children

The Comprehensive Community Mental Health for Children Program ($72 million in FY 1998), authorized under Title V of the Public

Health Service Act, provides grants to States, political subdivisions of States, and Native American Tribes to implement systems of care and to provide direct services to children with serious emotional disturbances. This program includes 31 five-year projects that support service systems to provide diagnosis and evaluation, outpatient, emergency, intensive home-based, day treatment, therapeutic foster care and group home, transitional and case management services and respite care. These programs are designed to fill gaps in services, promote collaboration among community agencies, and to ensure case management. They require individual service plans for children and their families and encourage family involvement. *Target population*: *25,000 children up to age 21 with serious emotional disturbance.*

The Youth Substance Abuse Prevention Initiative ($66.7 million in FY 1998), is a Secretarial Initiative designed to reduce substance abuse among youth. One of the activities of the initiative is to form a parenting group in order to initiate a parents' movement around substance abuse prevention. Parents from all socioeconomic backgrounds, especially the working poor, will be involved. *Target population: Youth ages 12-17.*

The High Risk Youth Demonstration Grant Program ($6 million in FY 1998), authorized under Title V, supports the development and implementation of innovative and effective models for the prevention of alcohol and drug use among high-risk youth ages 4-18. *Target population: Approximately 50,000 youths.*

The Starting Early Starting Smart Initiative ($6.6 million in FY 1998), authorized under Title V of the Public Health Service Act, is one of SAMHSA's Knowledge, Development and Application (KD&A) Programs which provide grants to aid in the transfer of knowledge from research to practice. Starting Early Starting Smart is a public/private collaboration with the Casey Family Program and SAMHSA's three Centers, the Health Resources and Services Administration, the Administration for Children and Families, and the National Institutes of Health designed to test the effectiveness of integrating substance abuse and mental health services in primary care or early childhood settings for young children who have multiple risk factors for substance abuse or mental health problems. *Target population: Children with substance use and/or mental illness disorders from various racial/ethnic background, ages 0-7. In general, the KD&A programs will address children, ages 0-21. The number of children served has not been determined.*

The Residential Treatment Services Grants for Pregnant and Postpartum Women and Their Infants ($1 million in FY 1998) and **The Residential Demonstration Treatment Grants for Women and Their Children Program** ($4.6 million in FY 1998)**,** authorized under Title V of

the Public Health Service Act, provide in addition to substance abuse-specific services, other services which address the physical, emotional, psychosocial, and economic needs of the women and children served. These services include but are not limited to: childbirth education, parenting classes, housing assistance, employment referral, and counseling and treatment services. The goals of the program are to provide comprehensive treatment for addicted women; to decrease substance abuse, drug-related crime, homelessness, and child abuse among this population of women; to increase the social, emotional, and educational functioning of addicted women and their children; to provide children's services to improve development and educational functioning and family relationships. *Target population*: *1,433 substance-abusing women and their children have been served by the Residential Treatment Services Grants for Pregnant and Postpartum Women and Their Infants program of whom 716 were children. The number of substance-abusing women and their children served by the Residential Demonstration Treatment Grants for Women and Their Children Program were 1,693 of which 923 were children.*

B. Current Activities in Children's Health Outreach

SAMHSA, in coordination with other Federal and State agencies and national organizations, has provided several workshops, trainings, updates, and written correspondence to inform Federal, State, and other substance abuse and mental health practitioners about the State Children's Health Insurance Program (CHIP) and outreach as described below.

In October 1997, a SAMHSA CHIP Steering Committee and a subcommittee on Outreach were formed to address outreach specific issues relating to CHIP and Medicaid.

In November and December 1997, a training on CHIP which emphasized the importance of outreach was provided in collaboration with the Health Resources Services Administration (HRSA) and the Health Care Financing Administration (HCFA) for SAMHSA's State Block Grant Project Officers, other staff, and Management Team.

During February and March, SAMHSA conducted several meetings for various audiences which provided either a plenary session or workshop on CHIP and included information on the importance of States performing outreach to find children with special needs and enrolling them into Medicaid or CHIP. For example:

- February 1998, "National Workshop for Community Coalitions Grantee Conference."
- March 1998, Children's Health Insurance Constituency Meeting.

- March 1998, the Annual Women's Grantee meeting.
- In April 1998, SAMHSA conducted a CHIP workshop at its Fourth State System Development Conference. A HRSA representative presented on the President's Executive Memorandum on Outreach and encouraged State and Alcohol Drug Abuse Directors to identify and enroll eligible children into Medicaid or CHIP. More than 400 individuals-from Federal, State, and public and private organizations in the substance abuse field attended. Information on CHIP and Medicaid was available at our exhibit table.

In March 1998, the President of the National Prevention Network (supports networking, resource sharing, and information exchange among State alcohol and other drug prevention professionals and individuals) sent a letter to all National Prevention Network and Single State Agency Directors informing them of CHIP and how it provides an opportunity to provide substance abuse prevention services to uninsured children. The letter also encouraged States to participate in outreach and identify uninsured children and enroll eligible children into Medicaid and CHIP, submit a CHIP plan, and become involved in their State's CHIP planning process.

In April 1998, an updated "Dear Colleague" letter was mailed by SAMHSA's Administrator to mental health and substance abuse treatment and substance abuse prevention directors, grantees, and constituency organizations. The letter focused on outreach and encouraged States to enroll eligible children in Medicaid or CHIP.

In May 1998, SAMHSA sponsored its annual grantee meeting for the Comprehensive Mental Health Services for Children Program. A workshop was provided on CHIP and the importance of educating families and enrolling children in Medicaid and CHIP.

SAMHSA's Technical Assistance Centers have been monitoring the implementation of CHIP. One activity has been the development of a linked website that disseminates information regarding CHIP and Medicaid including outreach.

SAMHSA sponsored a national, mental health block grant program meeting in May 1998 which included a workshop on CHIP focusing on encouraging States to promote outreach and discussed how families can assist States in outreach efforts to identify and enroll children with special needs in Medicaid and CHIP.

II. PROPOSED PLANS FOR CHILDREN'S HEALTH OUTREACH

SAMHSA's proposed plan for conducting outreach to uninsured children with substance use disorders and/or serious emotional disturbances include the following:

A. Educating Workers about Medicaid and CHIP

Federal Workers

1. Provide briefings of State Block Grant Project Officers about the Children's Health Initiative. SAMHSA could conduct several briefings to update State Block Grant Project Officers about CHIP and Medicaid focusing on encouraging States to promote outreach. These briefings could tentatively begin in May and conclude in July 1998. HRSA and HCFA would be invited as presenters to participate in the training.

2. Create SAMHSA workgroup and encourage outreach to children with special needs. Currently, SAMHSA is organizing a workgroup to further promote coordinated outreach strategies germane to Federal, State and local substance abuse treatment grantees to increase their awareness of the importance of identifying and enrolling eligible children with special needs into Medicaid or CHIP. A contract will be awarded in FY 1998 to the National Mental Health Association to enhance the educational activities with their State affiliates related to CHIP and to assist States in conducting outreach to find children with special needs.

3. Track CHIP outreach and coverage of substance abuse and mental health. SAMHSA Centers will collaborate to develop a CHIP tracking system to monitor the inclusion of substance abuse and mental health benefits in CHIP plans and State outreach efforts. (Fall 1998)

State Workers

4. Add chapter on outreach to CHIP workbook on behavioral health. SAMHSA is planning for the development of a workbook to assist States with the analysis of CHIP benefits packages from the behavioral health actuarial and fiscal perspective. One chapter could also focus on recommended outreach methods for States to find eligible children and enroll them into Medicaid or CHIP. Expected publication date is Fall 1998. SAMHSA could also revise a recently developed policy paper, "Mental Health Components of a Quality System of Care for Children and Adolescents," to add a section on encouraging States to participate in outreach by identifying and enrolling eligible uninsured children into Medicaid or CHIP.

Others Workers

5. Mail an updated "Dear Colleague" letter every six months to substance abuse and mental health directors, grantees, and constituency organizations on CHIP and Medicaid. SAMHSA could encourage them to identify eligible uninsured children for enrollment into Medicaid or CHIP. The letter could provide detailed instructions on who they are, where they are located, and how to enroll eligible uninsured children in Medicaid or CHIP. SAMHSA could monitor this activity through the SAMHSA CHIP tracking activity proposed in the "State Workers" section.

6. Sponsor Regional meetings on CHIP with State Alcohol and Drug Abuse Treatment Directors, State CHIP Administrators, State Mental Health Commissioners, and State Substance Abuse Prevention Directors. SAMHSA could hold a series of 5 to 6 CHIP Regional meetings throughout the United States during Fiscal year 1999. SAMHSA could collaborate with other Federal and State agencies, and HRSA and HCFA Regional offices in the planning of this meeting. One of the purposes of the Regional meetings is to facilitate partnership development for the State Substance Abuse Directors with their State partners (Mental Health, CHIP Administrator, Substance Abuse Prevention) to leverage State resources committed to conduct outreach activities, and assist State Substance Abuse Agencies to build and strengthen a successful enrollment and outreach strategy for reaching uninsured children among the special substance abuse populations.

Key areas for discussion by the participants at the Regional meetings to assist State Substance Abuse Agencies with outreach efforts include: a "brainstorm" session to simplify effective outreach strategies for reaching uninsured children of substance abusing parents; provide information on CHIP development and updates; conduct presentations on "hot topics" relating to CHIP and Medicaid, and identify technical assistance needs specific to individual States and their Federal Substance Abuse Prevention and Treatment grantees and discretionary grantees to establish successful outreach and enrollment efforts. Planning for the Regional meetings will begin in May 1998 and the meetings are expected to conclude by May 1999.

7. Develop and implement market and media strategy to educate substance abuse treatment providers about CHIP and outreach. SAMHSA could launch a coordinated effort to develop a market strategy for distributing information and a media strategy directed at various sub-populations who are supported using Substance Abuse Prevention and Treatment Block Grant funds. Outreach strategies for distributing CHIP

and Medicaid information to substance abuse treatment providers and constituency as follows are proposed:

- Developing a fact sheet or brochure to disseminate quarterly to the substance abuse stakeholders to include updates on CHIP and "Effective Outreach Models that Work"-- best practices.
- Maintaining updated CHIP information on the Treatment Improvement Exchange Forum and website, which is accessible to substance abuse State directors, constituency organizations, etc.

Some activities would be on-going once they are implemented; for other projects, the expected completion date is September 30, 1998.

B. Educating Families and Enrolling Children in Medicaid and CHIP

8. Distribute information on CHIP and Medicaid through State alcohol and drug abuse agencies. SAMHSA could develop a fact sheet/brochure on CHIP and Medicaid that would be available for State alcohol and drug abuse agencies to provide to their patients and grantees. SAMHSA would work with States to develop the brochure and encourage mailings to their respective grantees. The start date is June 1998 and expected completion is September 1998.

9. Send mailing to Starting Early Starting Smart grantees about outreach. SAMHSA could collaborate with the Casey Family Program to mail a letter to Starting Early Starting Smart grantees about CHIP and Medicaid. The letter would focus on outreach by encouraging grantees to identify and enroll eligible children in Medicaid or CHIP and to assist in promoting outreach among other early intervention and primary care providers of services to young children. The start date would be October 1998.

C. Coordination with Other Programs

10. Create SAMHSA CHIP/Medicaid webpage. SAMHSA could develop a CHIP page on its website to provide updates on CHIP and Medicaid to substance abuse and mental health directors, providers, grantees, and constituency organizations. Information on the importance of outreach will be included. Expected completion date is May 1, 1998.

11. Mobilize stakeholders to assist States with outreach. SAMHSA is currently working with the following organizations regarding CHIP and could continue on an on-going basis to collaborate with these organizations to inform the States about outreach such as developing a

compendium of resources and contacts, and providing technical assistance to States that can assist them with their outreach efforts.

- National Association of State Mental Health Program Directors (NASMHPD)
- National Technical Assistance Center for Children's Mental Health at the Georgetown University, Child Development Center
- Federation of Families for Children's Mental Health
- Children's Division of the National Association of State Mental Health Program Directors (NASMHPD)
- National Prevention Network Directors
- National Association of State Alcohol and Drug Abuse Directors (NASADAD)
- American Psychiatric Association

2. REPORT FROM THE SECRETARY OF AGRICULTURE

I. CURRENT PROGRAMS AND OUTREACH ACTIVITIES FOR CHILDREN

A. Programs that Serve Middle to Low-Income Children

Two Agencies in the Department of Agriculture operate programs that affect families that may also be eligible for the Children's Health Insurance Program (CHIP) or Medicaid: the Food and Nutrition Service (FNS) and the Cooperative State Research, Education and Extension Service (CSREES).

Food and Nutrition Service. The Food and Nutrition Service administers the nutrition assistance programs of the U.S. Department of Agriculture. FNS's goals are to provide needy people with access to a more nutritious diet, to improve the eating habits of the nation's children, and to stabilize farm prices through the distribution of surplus food. FNS works in partnership with the States and local agencies in all its programs. The following is a description of its major programs:

Food Stamp Program (FSP) ($25.1 billion in FY 1998) is authorized under the Food Stamp Act of 1977, 7 U.S.C 2011-2036. The FSP helps put food on the table for about 9 million households and 22 million individuals each day. Of these Food Stamp households, 59.5 percent have children. It provides low-income households with coupons or an electronic benefit card that can be used like cash at most grocery stores to ensure that they have access to a healthy diet. The Federal government pays for the benefits issued through the FSP and shares with the States the cost of

administrative expenses. State agencies operate the FSP through their local offices and use State Merit System employees to determine eligibility. These same State employees may also interview households for TANF and Medicaid. *Target population: Low-income individuals and families. The gross monthly income of most households must be 130 percent or less of the Federal poverty guidelines for the household's size. U.S. citizens and some aliens who are admitted for permanent residency may qualify for FSP benefits. The program serves over 11 million children.*

National School Lunch, School Breakfast, and Special Milk Programs ($5.6 billion appropriated for FY 1998) are authorized by the National School Lunch Act, 42 USC 1751; and Child Nutrition Act of 1966, 42 U.S.C 1771 and 42 USC 1772. The school nutrition programs provide cash and commodity assistance to assist schools in making nutritious, low-cost and free meals or milk available to all school children. To qualify for free and reduced price meals, households must be at or below 130 percent of the Federal poverty guidelines for free meals or milk and between 130 to 185 percent of the Federal poverty guidelines for reduced price meals. Applications, designed at the State and local levels, are distributed annually. Households complete the application at home, usually without any assistance. In lieu of an application, the school can obtain information directly from the local Food Stamp or TANF office about households' participation in those programs. These households are automatically eligible for free meals or milk. *Target population: All children of high school grade or under in participating schools. About 56 percent of the meals are served to children at or below 185 percent of the Federal poverty guideline. The program serves about 24 million children.*

Special Supplemental Nutrition Program for Women, Infants and Children (WIC) ($3.926 billion appropriated for FY 1998) is authorized by the Child Nutrition Act of 1966, 42 U.S.C 1786.

The WIC Program provides, at no cost, supplemental foods, nutrition education, and health care referrals to low income, pregnant, postpartum, and breast-feeding women, and infants and children up to age 5 who are determined by a health professional to be at nutritional risk. Program benefits include breast-feeding promotion and support, substance abuse education, and referrals to local health care and social service programs such as Medicaid, Maternal and Child Health Care, immunizations, and Food Stamps. Legislation requires WIC agencies to provide written information about the Medicaid program and referrals to individuals who appear to be income eligible but currently not participating in the Medicaid Program. To be income eligible for WIC, applicants must have an income at or below 185 percent of the Federal poverty guidelines or be determined automatically income eligible based on eligibility for programs such as Medicaid, Food Stamps, or Temporary Assistance For Needy

Families. *Target population: As of the beginning of FY 1998, the WIC Program served an average monthly participation of about 7.4 million women, infants, and children of which almost 5.7 million were infants and children.*

Child and Adult Care Food Program (CACFP) ($1.4 billion appropriated for FY 1998) is authorized under the National School Lunch Act, 42 U.S.C. 1776. The Child and Adult Care Food Program provides healthy meals and snacks to children and adults in day care facilities through cash reimbursements to sponsoring organizations for meals served. Higher levels of reimbursement are provided for meals to children at or below 185 percent of the Federal poverty level. Sponsoring organizations that are eligible for reimbursement include licensed or approved non-residential, public or private non-profit child care centers, certain for-profit child and adult care centers, licensed day care homes, and Head Start Centers. *Target population: Children 12 years and younger. The program serves about 2.3 million children.*

Emergency Food Assistance Program (TEFAP) ($170 million appropriation in FY 1997, $145 million appropriation in FY 1998) is authorized by the Emergency Food Assistance Act of 1983, 7 U.S.C. 7501-7516. Through TEFAP, foods and administrative support are provided to State agencies to assist the needy. States provide the foods to local food banks, food pantries, or soup kitchens, for distribution to needy households, or provision of meals to the needy. TEFAP foods may be utilized in both household distribution and meal service. *Target population: Low income individuals and families with or without children.*

Commodity Supplemental Food Program (CSFP) ($76 million in FY 1997, $96 million in FY 1998; 20 percent of appropriation and 20 percent of food funds carried over from the previous year is for State and local agencies program administrative costs) is authorized by the Agriculture and Consumer Protection Act of 1973, 7 U.S.C. 612c note. CSFP, which is operative in 18 States and on two Indian reservations, helps to improve the health of low-income infants and children up to age 6, pregnant, post-partum, and breast-feeding women, and elderly persons 60 years of age and older, by providing a package of USDA foods each month, and nutrition education. USDA Assistance is provided to households through State and local administering agencies. *Target population: Women, infants, and children must be income eligible for another Federal, State, or local food, health, or welfare program for low-income individual. The average monthly participation of infants and children in fiscal year (FY) 1997 was 105,833.*

Food Distribution Program on Indian Reservations (FDPIR) ($71.8 million in FY 1997, $75 million in FY 1998, of which $20.8 million is

earmarked for administrative funds for State agencies and Indian tribal organizations) is authorized by the Food Stamp Act of 1977, 7 U.S.C. 2011-2036. FDPIR provides a package of USDA foods each month to low-income households on Indian reservations, and to low-income Native American households living near Indian reservations, as an alternative to the Food Stamp Program. State agencies and Indian tribal organizations administer the program at the local level. *Target population: Income eligibility is based on the Food Stamp Program's net monthly income guidelines plus the standard deduction. Average monthly participation of adults and children in FY 1997 was 124,000 (no separate count for children).*

Homeless Children Nutrition Program (HCNP) ($3.4 million appropriated for FY 1998) is authorized under the National School Lunch Act, 42 U.S.C. 1766b. The Homeless Children Nutrition Program provides food assistance to homeless children under the age of 6 in participating emergency shelters. The program is administered directly by FNS Headquarters. Private nonprofit organizations, State or local government, and other public entities are eligible to participate as sponsoring organizations if they operate congregate food service in shelters serving preschool children. Currently, about 85 private nonprofit organizations and 1 public organization are approved to sponsor programs in approximately 117 emergency shelters. *Target population: About 2,500 homeless children monthly.*

Cooperative State Research, Education, and Extension Service (CSREES). In cooperation with partners and customers, CSREES provides the focus to advance a global system of research, extension and higher education in the food and agricultural sciences and related environmental and human sciences to benefit people, communities, and the Nation. CSREES programs increase and provide access to scientific knowledge; strengthen the capabilities of land-grant and other institutions of research, extension and higher education; increase access to and use of improved communication and network systems; and promote informed decision making by producers, families, communities, and other customers. A major program is listed below:

Expanded Food and Nutrition Education Program (EFNEP) ($58 million appropriation in FY 1997) is authorized by the Agriculture and Food 1981-Nutrition Education Program and the National Agricultural Research, Extension, and Teaching Policy Act of 1977, 7 U.S.C. 3175. EFNEP assists limited resource youth and families with young children in acquiring the knowledge, skills, attitudes, and behavior changes necessary for nutritionally sound diets, personal development, and improvement of the total family diet and nutritional well-being. The program is delivered by the Land-Grant University Cooperative Extension System in

partnership with USDA/CSREES. There are 778 County Extension offices and 56 Land-Grant University Cooperative Extension systems. *Target population: In FY 1994, 426,837 youth and 198,931 families; about 737,000 family members were indirectly reached through the adult participant.*

B. Current Activities in Children's Health Outreach

As a result of the President's directive in February, FNS has:

Sent Memoranda to Department and FNS leadership. Sent memoranda to Secretary Glickman on 3/23/98 and to the FNS Administrator on 2/13/98 notifying them about the CHIP/Medicaid outreach initiative. Sent memorandum to the 7 FNS Regional Administrators on 3/9/98 notifying them about the CHIP/Medicaid outreach initiative. Suggested they include CHIP/Medicaid on meeting agendas and disseminate CHIP/Medicaid information. Copies were also sent to all 28 FNS Regional Program Directors on 3/10/98. Regions have included CHIP/Medicaid on their Regional meeting agendas.

Sent informational CHIP and Medicaid messages to FNS Regional Personnel, State Agencies, and State Representatives. Sent electronic messages, during period from 12/97 to present, (1) notifying FNS Regional Program Directors of State CHIP/Medicaid contacts, HCFA contacts, and the HHS Internet Website; (2) providing CHIP/Medicaid information to Regional Program staff to share with State agencies including legislative information, and information about HHS Regional CHIP conferences; (3) encouraging Regional and State staff to attend Regional HHS' CHIP/Medicaid conferences. Encouraged State agencies to attend meetings concerning CHIP/Medicaid, including meetings to develop State Plans. Many State agencies have attended meetings in the State on CHIP/Medicaid; and (4) requesting assistance in designating CHIP coordinators. Each region has since designated a CHIP coordinator and many regions have shared CHIP information with their State agencies. Distributed copies, 4/98, of the six-month progress report, *Implementation of the Children's Health Insurance Program*, to each FNS Regional program staff CHIP coordinator. Provided updates on CHIP State Plans to Regional Offices. Sent letter to State officials considering CHIP implementation in Western Region to encourage coordination of outreach efforts with FNS programs that serve children. Provided list of State director contacts for FNS programs.

Participated in CHIP and Medicaid Meeting and Conferences. FNS has participated in meetings/conferences with representatives from HHS and other Federal agencies, such as interagency councils and forums and

arranged for HFCA staff to make CHIP/Medicaid presentations at program, national, and Regional meetings. (12/97 to present).

Published an article about the CHIP/Medicaid initiative in the *FNS Friday Letter* in Vol. 21 No.3, 3/98. This FNS newsletter is distributed to 1,600 Federal employees.

Included CHIP/Medicaid talking points in speeches given by the Under Secretary, Food, Nutrition, and Consumer Services, and other FNS officials, during period from 4/98 to present. Examples of conferences include the National Association of Food Distribution Programs on Indian Reservations and the National Association of WIC Directors.

Established communications within FNS to add outreach information on FNS' website with linkage to HHS CHIP website. Sent a memorandum to FNS Internet Website Staff on 3/27/98 to create a "What's New" article on the CHIP/Medicaid initiative and linkage to HHS' CHIP Website.

Co-sponsored Regional conference on CHIP and Medicaid. Co-sponsored, along with other agencies and HHS' Chicago and Kansas City Regional offices, a conference on CHIP/Medicaid outreach (April 1998).

II. PROPOSED PLANS FOR CHILDREN'S HEALTH OUTREACH

A. Educating Workers about Medicaid and CHIP

<u>Federal Workers</u>

1. Send a message from the Secretary, USDA, about CHIP/Medicaid to all employees. This message could be provided to over 92,000 employees. (August 1998)

2. Put a message about CHIP/Medicaid on the Wage and Earnings Statements received by over 92,000 USDA employees. (January 1999)

Federal, State and Other Workers

3. Coordinate with HHS to provide information about Medicaid and CHIP to the 28 FNS Regional Program Directors and State agencies. (September 1998)

4. Issue memoranda by September, 1998 to the 28 FNS Regional Program Directors encouraging participation in outreach, reemphasizing the need for FNS Regional offices and State agencies to:

- Coordinate discussions and presentations about CHIP/Medicaid at various FNS Regional and State meetings/conferences. FNS will provide the list of HHS CHIP contacts.
- Submit articles/updates on CHIP/Medicaid for publication in Regional and State newsletters. Examples include the quarterly Inter Tribal Council of Arizona, Inc. Newsletter, "Healthy Happenings," and the monthly Texas WIC newsletter, "WIC News."
- Contact State CHIP representatives to coordinate outreach efforts to minimize duplication of effort among programs serving children and to participate in CHIP planning and implementation meetings.
- Make available CHIP and Medicaid information at FNS Regional and State meetings/conferences.

5. Apprise FNS Regional Program Directors and State agencies as CHIP State Plans are approved through sending electronic messages as soon as updates are received from HHS. (Ongoing)

6. Send electronic messages to CSREES program administrators, program directors, and community-based educators to inform them of the CHIP/Medicaid outreach initiative. The Cooperative State Research, Education, and Extension Service in partnership with the Land-Grant University System will send these messages. (September 1998)

B. Educating Families and Enrolling Children in Medicaid and CHIP

7. May revise USDA's Information Phone Number to include a message about CHIP/Medicaid with referral to the national 800 number. The Information Phone Number receives approximately 500 calls per day. (Undetermined)

8. Display and make available CHIP and Medicaid information at the USDA Visitors' Information Center in Washington, D.C. On a yearly

basis, an estimated 10,000 people visit the USDA Visitors' Information Center. (Fall 1998)

9. Send a memoranda to the 7 WIC Regional Directors and the 88 WIC State agencies that re-emphasizes that Title XIX sites WIC as a program that may perform presumptive Medicaid eligibility determinations. (September 1998)

10. Issue memoranda by September, 1998 to the 28 FNS Regional Program Directors encouraging them to help educate families by:

- Disseminating information about CHIP and Medicaid to individuals/families who may be potentially eligible for benefits.
- Displaying and/or distributing CHIP/Medicaid promotional materials in places where FNS programs are located.
- Incorporating, when feasible, CHIP/Medicaid eligibility as part of current or future joint application processes.
- Providing guidance for the Child Nutrition FNS Program Directors on allowing parents to waive their rights to confidentiality under the School Nutrition Programs to allow use of children's free and reduced price eligibility status for CHIP/Medicaid purposes.
- Encouraging coordination of co-located programs that serve children with the CHIP/Medicaid outreach effort to minimize duplication of effort.
- Encouraging State agencies to, where feasible, outstation or establish offsite visits of CHIP/Medicaid eligibility workers and/or include a CHIP/Medicaid message on program toll- free hot lines.

11. CSREES could provide information on children's health outreach. The Cooperative State Research, Education, and Extension Service in partnership with the Land-Grant University System could provide information via the system for local clientele and media. In addition, through the partnership we could share the CHIP and Medicaid materials with the System. They could, in turn, share these materials with appropriate local clientele groups and community collaborators working with families in all 50 States, Territories, and the District of Columbia, representing 105 Land-Grant Universities. (September 1998)

C. Coordination with Other Programs

12. Include information about the CHIP/Medicaid outreach initiative on FNS' and USDA's Website with linkage to HHS' CHIP/Medicaid Website. (January 1999)

13. Develop and distribute prototype applications for integrating the 94,000 National School Lunch Program schools and children's health programs. Collaborate with the Departments of Education and Health and Human Services to develop for distribute to the Child Nutrition State agencies and Chief State School Officers, one or more prototype school lunch program applications that can be used to facilitate enrollment in Medicaid or CHIP. (September 1998)

14. FNS could provide Medicaid and CHIP information to major national associations, advocacy groups, and other organizations (Fall 1998) that encourages them to:

- Include information about the CHIP/Medicaid outreach initiative on their Websites.
- Publish CHIP/Medicaid articles in their newsletters.
- Include CHIP/Medicaid presentations/workshops in their conferences and meeting agendas.

15. Encourage Food Stamp nutrition education programs and cooperators to provide information on CHIP/Medicaid. Issue electronic message to Food Stamp Regional Program Directors requesting that the 41 State agencies with approved optional Food Stamp Program Nutrition Education plans notify and request the assistance of their Nutrition Education Cooperators (e.g., Extension Service, Health Services, etc.) in providing CHIP/Medicaid informational materials. (Fall)

16. Provide a list of FNS' Regional and State conferences to HHS for possible conference displays of CHIP/Medicaid information. (Ongoing)

17. Include CHIP/Medicaid information in the USDA National Hunger Clearinghouse database, accessed by State and local entities, non-profit organizations, food banks, and other individuals and groups that help low-income Americans with nutrition, health, and self-sufficiency issues. The Clearinghouse is a repository for the latest and best information on fighting hunger in this country, including food recovery and gleaning; it is accessed by more than 30,000 individuals and groups each year. (January 1999)

3. REPORT FROM THE SECRETARY OF EDUCATION

I. CURRENT PROGRAMS AND OUTREACH ACTIVITIES FOR CHILDREN

A. Programs that Serve Middle to Low-Income Children

The Department of Education's mission is to ensure equal access to education and to promote educational excellence throughout the nation. Children's health plays a critical role in achieving these goals.

The U.S. has over 86,000 public elementary and secondary schools and 26,000 private schools. The Department of Education programs, many of which target low-income and disadvantaged students, reach every State and region in the country as well as the territories of American Samoa, Guam, Northern Marianas, Puerto Rico, and the Virgin Islands. These provide an expansive network for dissemination of information about the children's health initiative. The Department works with school districts, institutions of higher education, State educational agencies, national education organizations, and other private entities in our efforts to improve educational opportunities for all students.

Title I Grants to Local Educational Agencies ($7.375 billion in FY 1998). Title I, authorized under the Elementary and Secondary Education Act (ESEA), provides supplemental education funding to local educational agencies (LEAs) and schools, especially in high poverty areas, to help low-achieving students achieve to high standards. Funds flow to almost all school districts in the country. *Target population: Funding is based on counts of children from low-income families, weighted by State per pupil expenditure. Eligible schools have a percentage of students from low-income families exceeding the district-wide average or at least 35 percent. Currently, services are provided to approximately 10 million children in about 50,000 schools, including two-thirds of the country's elementary schools.*

Special Education Grants to States ($3.8 billion in FY 1998). Special Education Grants to States, authorized under Part B of the Individuals with Disabilities Education Act (IDEA), provides formula grant assistance to States to support special education and related services to children with disabilities ages 3 through 21. Funds are awarded by formula on the basis of the number of children with disabilities. Under IDEA, State educational agencies are required to coordinate with other State agencies that are obligated to pay for services required under the IDEA such as certain health-related services. It is estimated that approximately 60 percent of children served in special education are Medicaid eligible. *Target population: Children with disabilities ages 3 through 21. Approximately 6 million children served in 1997.*

Grants for Infants and Families ($350 million in FY 1998). The Grants for Infants and Families Program, authorized under Part C of IDEA, provides financial assistance to States to implement Statewide

comprehensive interagency systems to make available early intervention services to infants and toddlers with disabilities. Medicaid is a primary source of funding for direct services provided under this program. *Target population: Infants and toddlers with disabilities and developmental delays and their families. Approximately 190,000 infants and toddlers served in 1997. Children at risk of developmental delays may be served at a State's discretion.*

Adult Education: State Grants ($345.3 million in FY 1998). Adult education State grants, authorized under the Adult Education Act, provides formula assistance to States to support programs that assist educationally disadvantaged adults in developing basic skills, including literacy, achieving certification of high school equivalency, and learning English. Many of these adults are the parents or caregivers of potentially eligible children. *Target population: Disadvantaged adults, including limited-English proficient and incarcerated and institutionalized individuals. Approximately 4 million adults served in 1997.*

State agency programs -- Migrant ($305.5 million in FY 1998). The Migrant Education program, funded under Title I, provides assistance to State educational agencies to improve education programs for children of migratory farm workers and fishers. Over two-thirds of migratory children come from households with incomes below the Federal poverty level. Funds may be used for after-school and summer programs, family literacy programs in which adults learn alongside of their children, GED programs, and mentoring programs. *Target population: Children of migratory farm workers and fishers, over 80 percent Hispanic. Approximately 564,000 children were served in 1997.*

Federal TRIO Programs -- Upward Bound and Talent Search ($215 million in FY 1998). The TRIO programs, authorized under the Higher Education Act, fund postsecondary education outreach and student support services designed to encourage youth from disadvantaged backgrounds to enter and complete college. At least two-thirds of the eligible participants must be low-income, first-generation college students. *Target population: Youth from disadvantaged backgrounds, ages 11 to 27. In 1997, Upward Bound served nearly 45,000 students, and Talent Search served nearly 300,000 students.*

Bilingual Education: Instructional Services ($160 million in FY 1998). Bilingual Education Instructional Services, authorized under the ESEA, provides competitive grants to local educational agencies to assist them in providing quality programs for limited-English proficient (LEP) students. *Target population: The program supports about 700 projects, serving 1.3 million LEP students.*

Even Start ($124 million in FY 1998). The Even Start program, authorized under the ESEA, provides services to improve the educational opportunities of children and parents by providing early childhood education, adult education, and parenting education in integrated family literacy programs. The Department makes formula grants to States, and the States make competitive grants to about 700 partnerships of local educational agencies and other organizations. *Target population: Low-income families, including parents eligible for services under the Adult Education Act and their children birth through age 7. In 1997, approximately 34,000 families, including 36,000 adults and 48,000 children, were served.*

Indian Education -- Grants to Local Educational Agencies ($59.75 million in FY 1998). Indian Education Grants, authorized under ESEA, provide formula awards to local educational agencies and schools supported and operated by the Bureau of Indian Affairs (BIA) to improve elementary and secondary programs that serve Indian children to increase school readiness and integrate educational and other services. *Target population: Indian students from preschool to secondary school. The program serves about 1,073 LEAs and 146 BIA schools.*

21st Century Community Learning Centers ($40 million in FY 1998). The 21st Century Community Learning Centers program, authorized under the ESEA, provides grants to rural and inner city schools to provide extended learning and a safe haven for youth during non-school hours. Centers may serve the needs of all members of the community. The legislation specifically includes health services as an authorized activity. *Target population: Lower-income youth and other community members. In 1998, this program will serve about 312 schools and an estimated 50,000 students or other community members. In 1999, this number could expand to 4,000 schools and 500,000 students.*

Goals 2000: Parental assistance ($25 million in FY 1998). The Parental assistance program, authorized under Title IV of Goals 2000, currently supports 40 parent information and resource centers, run by nonprofit organizations that collaborate with institutions of higher education and social service agencies to increase parents' knowledge of child-rearing, strengthen partnerships between parents and professionals to meet their children's educational and developmental needs. *Target population: Low-income, minority, and limited-English proficient parents.*

Parent Information Centers ($18.5 million in FY 1998). The Parent Information Centers program, authorized under IDEA, currently funds 70 centers that provide training and information to meet the needs of parents of children with disabilities in that area. The program also anticipates supporting 10 Community Resource Centers, operated by local parent

organizations, that help provide underserved parents the training and information they need. *Target population: Parents of children with disabilities, particularly underserved parents.*

B. Current Activities in Children's Health Outreach

Formed a working group to develop outreach strategies for Children's Health Initiative. Since the President's directive in February, the Department of Education has formed a working group, led by Libby Doggett and Carol Cichowski and including members from most of the principal offices of the Department. This group has met weekly to develop outreach strategies for the children's health initiative. Members of this working group have also been active participants of the Interagency Task Force and the Communications and Minority Outreach subcommittees.

II. PROPOSED PLANS FOR CHILDREN'S HEALTH OUTREACH

The Department of Education provides funding and guidance through formula grants to States and districts to support their own programs, and we provide funding for technical assistance, research, and information clearinghouses to assist educators and parents in every area of education. For this reason, the Department is best able to reach the goals of the CHIP initiative by providing information and materials to State and local educational agencies, technical assistance providers, and information clearinghouses. It would then be up to the State and local administrators to determine effective ways of reaching potentially eligible students. Strategies involving teachers would be more appropriately handled by the NEA and other teacher organizations, but we could coordinate our efforts with them to the greatest extent possible.

We also have numerous grantees that target special populations, including low-income, limited-English proficient, migrant, and special education students. By providing materials and guidance to these grantees, we hope that they will embrace the importance of this initiative and infuse that mission into their daily work.

A. Educating Workers about Medicaid and CHIP

Federal Workers

1. Send a memo from the Secretary of Education to all of the Department's 4,800 employees explaining the importance of enrolling all

children in Medicaid and CHIP and stressing the link between children's health and learning.

Publish the same message and a supplementary article in *Inside Ed*, the Department of Education's newsletter that goes to all employees. The Department also sends out two publications via E-mail, *Ed Info* and *Ed Initiatives*, that could include information on Department outreach efforts. More than 12,400 direct subscribers receive *EDInfo* and *ED Initiatives*, in addition to approximately two to three times that many who receive it from cross-postings on other listservs. In addition, *ED Initiatives* is sent to all Department employees. (July 1998)

2. Ask each Assistant Secretary to educate all staff, with special emphasis on Department speech writers, about CHIP and Medicaid and discuss specific strategies to get the word out to the Department of Education's customers, including schools and families. This could include infusing the importance of children's health for learning into the ongoing work of the Department of Education and into speeches given by Department leaders. (June 1998)

3. Provide a briefing and periodic updates to all of the Secretary's Regional Representatives about CHIP and Medicaid by utilizing the Office of Intergovernmental and Interagency Affairs weekly conference calls with its Regional Offices. Solicit their ideas of further outreach activities and local events, and get their feedback about how the outreach strategies are working. Provide periodic updates to all staff on CHIP implementation in Department of Education news letters and bulletins. (Beginning in June, 1998)

4. Include information on children's health insurance in all orientation packets for new employees. (Ongoing)

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Grantees

5. Inform all relevant Department of Education clearinghouses, technical assistance centers/providers, parent centers , and other Department grantees of the Federal effort to enroll all eligible children in CHIP and Medicaid. Encourage them to use materials that are already developed or to develop other appropriate materials about Medicaid and CHIP and to distribute these through their networks and post them on their websites. These may include: National Information Center for Children and Youth with Disabilities (NICHCY), the Parent Training and information Centers and Regional Resource and Federal Centers supported under the IDEA, State Literacy Resource Centers, and the Adult Education and Literacy Clearinghouse. This could be done most efficiently through the Department's central mailhouse. Develop cover letter appropriate to these grantees. (September to October 1998)

6. Work with program offices to determine effective program-specific outreach strategies for major formula grant programs, focusing on Title I, Special Education, Migrant Education, Indian Education, Adult Education, and Even Start. (June to July and ongoing) This could include outreach to grantees at the Department's Regional Improving America's Schools Act conferences (October to December, 1998).

B. Educating Families and Enrolling Children in Medicaid and CHIP

7. Include information about the children's health insurance initiative on the Department's 800 number, 1-800-USA-LEARN. (July 1998)

8. Mobilize the Department of Education's Partnership for Family Involvement in Education, a group of over 3,000 organizations (with four sectors -- employers, education, community and religious) working to increase family involvement in education. Membership in the Partnership is voluntary and the level of participation is determined by each member. In 1998, the Department provided $1.3 million for administrative and publication expenses to support the Partnership. No additional funds would be needed for these activities, depending on 1999 funding.

Include materials in monthly Partnership mailings explaining the importance of enrolling all children in Medicaid and CHIP and stressing the link between children's health and learning.

Submit an article for publication in *Community Update*, the Partnership newsletter which reaches over 200,000 parents, educators, and organizations involved in school improvement efforts. Published monthly, the newsletter features "best practices" and model programs from around

the nation and focuses on how communities can learn from each other to improve their schools. (June-July)

Send a follow-up mailing to Partnership for Family Involvement organizations, with examples of specific actions groups are taking to support the effort to enroll all eligible children. (October-January)

Collaborate with Partnership for Family Involvement organizations to conduct targeted events in local communities. (Ongoing)

C. Coordination with Other Programs

9. Identify all major education stakeholders in outreach efforts to their members. Determine which organizations we can most effectively reach, and which are already being reached by other agencies. Conduct targeted meetings and collaborate on outreach strategies with identified education stakeholders. (Beginning in June 1998) These may include:

- Specific groups who either reach out to special populations (advocacy groups such as ASPIRA, Literacy Volunteers of America, the Advisory Group on Higher Education for Native Americans, the National Black Children's Development Institute, the Child Care Action Campaign and the NAACP) or
- Groups that have resources to bring to the effort (such as the Council of Chief State School Officers, Council of Great City Schools, National Association of State Directors of Special Education, National Association of Elementary School Principals, the National Association of Secondary School Principals, and foundations).

10. Provide information on the Department's website and establish a hotlink to HHS's CHIP website. Include appropriate information including the Secretary's e-mail message and activities being undertaken by principal offices as they relate to programs and CHIP/Medicaid. Update the website regularly with information on CHIP-related activities. (Beginning in June 1998)

11. Use the Office of Public Affairs Listserve of public affairs directors of key stakeholder organizations to engage their publications and write articles about CHIP and Medicaid, the important links between a child's health and education, and successful outreach strategies. Place applicable information on other relevant Listserves including the NEC*TAS Interagency Coordinating Council Listserve, the FICC Listserve, the Teacher Listserv, the Communities Can Listserv, and the National Institute for Literacy Listserve, with instructions to widely distribute the information. (June to August 1998)

12. Obtain Department endorsement for HHS-produced materials, or produce Department materials about Medicaid and CHIP. Distribute these materials in the Department's exhibit booth at major national conferences such as PTA, NEA, AFT, US Conference of Mayors, National Association of Counties, Congressional Black Caucus Annual Meeting, Urban League, and NAACP, as well as the Department's Improving America's Schools Act conferences. (Beginning in July, 1998)

13. Develop and distribute prototype applications for integrating the 94,000 National School Lunch Programs and children's health programs. Collaborate with the Departments of Agriculture and Health and Human Services to develop for distribute to the Child Nutrition State agencies and Chief State School Officers, one or more prototype school lunch program applications that can be used to facilitate enrollment in Medicaid or CHIP. (September 1998)

14. Work with the Chicago Public School District to: (1) launch a pilot outreach project to use mapping techniques to identify areas where significant numbers of children who appear to lack health coverage either through Medicaid or CHIP live; (2) assist innovative outreach efforts implemented by the Chicago school district (in conjunction with their State agencies) and determine feasibility for replication potential for all public school districts; (3) identify and recommend waivers for the Chicago public schools that are needed to allow innovative outreach enrollment efforts to be implemented; and (4) establish a communication forum between the Department of Education, HHS, USDA, Chicago, and other school districts to determine the extent to which promising outreach efforts implemented in Chicago can be replicated in other school districts. (July to November, 1998)

4. REPORT FROM THE SECRETARY OF HOUSING AND URBAN DEVELOPMENT

I. CURRENT PROGRAMS AND OUTREACH ACTIVITIES FOR CHILDREN

A. Programs That Serve Middle To Low-Income Children

The Department of Housing and Urban Development (HUD) was created in 1965 with the mission of empowering people and communities. HUD administers more than 100 programs aimed at providing affordable housing, home ownership opportunities, and creating community economic development. Through these programs HUD provides services

to millions of families across the nation, many of whom have children eligible for CHIP or Medicaid.

HUD's CHIP/Medicaid outreach efforts could be implemented through several program areas. Three of these, the Office of Public and Indian Housing, the Office of Housing/Federal Housing Administration, and the Office of Community Planning and Development, are major program areas that also administer smaller programs and initiatives, described below.

Office of Public and Indian Housing (PIH). Programs administered by PIH include:

Public and Indian Housing: HUD's 3,400 public and Tribally Designated housing authorities administer approximately 15,000 public housing developments providing approximately 1.2 million units of housing for low-income individuals and families. The Office also administers a number of supportive service programs designed to assist residents with job training, transportation, child care, resident opportunities, and other supportive services. *Target population for all PIH programs: Low-income residents of public and Indian housing.*

Section 8 Rental Certificates and Rental Vouchers Programs and Contract Renewals: ($8.2 billion in FY 1998) provides funding to local public housing agencies so that they may provide approximately 1.4 million rental certificates or rental vouchers to subsidize rental costs for qualified very low-income households.

Hope VI ($441 million in FY 1998) provides funds for local agencies to revitalize distressed public housing communities

Public Housing Drug Elimination Program ($288 million in FY 1998) provides funds to reduce or eliminate drug-related crime in public and Indian housing neighborhoods. This program also supports the Public Housing Youth Sports Program, which provides funds to establish positive, drug-free, cultural, and educational activities for youth residing in Public Housing.

Early Childhood Development Program (ECD) ($21 million in FY 1994) provides funds to locate or expand child-care facilities in or near public housing developments and in Empowerment Zones and Enterprise Communities.

Economic Development And Supportive Services Program (EDSS) and Tenant Opportunities Program ($2.5 million in FY 1998) provides funds to public housing agencies, Indian tribes and their Tribally Designated Housing Entities and residents to create and operate programs that increase resident self-sufficiency and support independent living for elderly and disabled residents (including those who are primary care givers of children).

Office of Housing/Federal Housing Administration (FHA). Programs administered by the Office of Housing/FHA include:

Assisted Multi-Family Housing Program provides direct subsidies or mortgage insurance through this program to help provide affordable housing for more than 2.6 million low-income families in approximately 30,000 multi-family, assisted-housing developments nationwide. For FY 1998, the Office of Housing could also provide up to $15 million for outreach and training grants to organizations to help provide information to residents of assisted multifamily housing developments. *Target population: Low-income residents of HUD-assisted multi-family housing developments.*

Housing Counseling Program ($20 million in FY 1998) provides funding to more than 1,200 housing counseling agencies that qualify to apply for HUD funding. Counseling agencies help home buyers, homeowners and renters learn more about the home buying process and responsible home ownership and tenancy. *Target population: Open to all, but mainly targets lower-income people and first-time buyers.*

Neighborhood Network Program (No specifically targeted Federal funding) encourages property owners and residents of assisted multi-family housing developments to develop computer learning centers that provide residents for job training and employment opportunities. Approximately 400 Neighborhood Network Centers are currently in operation nationwide. Access to the Internet and a Neighborhood Networks Website are also provided.

Office of Community Planning and Development (CPD). Programs administered by CPD include:

The HOME Program ($1.5 billion in FY 1998) allocates funds to 585 State and local jurisdictions for affordable housing. Since 1992, more than 315,000 low-income renters and home owners have received housing assistance through this program. *Target population: Families with incomes at 80 percent of median income or less, with most assistance going to families at 60 percent of median income or less.*

HUD's McKinney Act Programs ($823 million in FY 1998) provide grants to provide emergency shelter, supportive housing and services that will enable homeless people to live as independently as possible. *Target population: Homeless individuals and families.*

Housing Opportunities For Persons With Aids (HOPWA) ($204 million in FY 1998) provides housing assistance and supportive services for low-income people with HIV/AIDS and their families. *Target population: HOPWA primarily benefits low-income persons living with AIDS and their families, especially those who are homeless or at great risk of becoming homeless.*

Historically Black Colleges And Universities (HBCU) ($6.5 million in FY 1998) awards grants to HBCUs to address community development in their localities. *Target population: The HBCU program primarily benefits low- and moderated income residents of the community in which the HBCU is located.*

Empowerment Zones And Enterprise Communities Initiative (EZ/EC) targets tax incentives, performance grants, and loans to designated low-income areas, called Empowerment Zones or Enterprise Communities, to create jobs, expand business opportunities, and support sustainable community development (including health and other human services and environmental remediation). *Target population: Residents and businesses in areas of inner cities designated as Empowerment Zones or Enterprise Communities.*

Office of Lead-Based Paint Hazard Control ($50 million in FY 1998) administers program providing funding to State and local governments to evaluate and reduce lead-based paint hazards in private housing rented or owned by low-income families, reducing the exposure of young children to lead-based paint hazards in their homes. *Target population: Low-income families, especially those with children, residing in the housing assisted under this program.*

Community Outreach Partnerships Center Program (COPC) ($7 million, FY 1998) helps colleges and universities apply their human, intellectual, and institutional resources to economic development, local housing, neighborhood revitalization, health care, job training, crime prevention, education, planning, and community organizing. *Target population: Determined by colleges and universities, no HUD restrictions on target population.*

B. Current Activities in Children's Health Outreach

Since President Clinton signed the Children's Health Insurance Outreach Memorandum in February 1998, the Department of Housing and Urban Development has implemented the following outreach and coordination strategies:

Provided demonstrations of the Department's award-winning Communities 2020 computer mapping technology to other agencies and organizations involved in the CHIP/Medicaid Initiative. The technology, which has been widely acclaimed as a planning and coordinating tool, has been made available, at a nominal cost, for use by local, State, and other Federal agencies, private and/or not-for profit organizations, and interested individuals.

Developed a Website on HUD's award-winning homepage for presenting basic information about CHIP/Medicaid, with linkages to Websites with more detailed information. HUD's Homepage receives more than 30,000 hits per month.

II. PROPOSED PLANS FOR CHILDREN'S HEALTH OUTREACH

A. Educating Workers About Medicaid and CHIP

Federal Workers

1. Issue a departmental-wide electronic communication from the Secretary. This communication could be transmitted via the *HUD Focus Message,* which reaches almost all of the Department's 9,500 employees, and send a letter from the Secretary to reinforce the message and ensure that those employees without regular access to a computer are aware of the CHIP/Medicaid initiative. (July 1998)

Other Workers

2. Provide information about the Children's Health Insurance Initiative to applicants for funding through the Department's competitive programs for assisting families with children. More than 80,000 organizations request information for funding through HUD's 40 competitive programs. Information could be provided to applicants in appropriate Technical Assistance meetings, workshops, conferences and satellite broadcasts, in application packages, appropriate program fact sheets, booklets, and Question and Answer (Q&A) documents. Technical Assistance workshops and conferences reach thousands of providers of housing and services each year. (Beginning in July 1998)

3. Send a letter from the Secretary to all implementation directors of the 72 Urban Empowerment Zones/Enterprise Communities, the local governing structures, local government officials and representatives of the residents/stakeholders of the EZ/EC communities informing them of the Initiative, and encouraging these individuals and groups to support or implement efforts to enroll uninsured but eligible children into the Medicaid or CHIP. (July 1998)

4. Provide outreach information to colleges and universities participating in Community Outreach Partnership Centers and Historically Black Colleges and Universities programs, encouraging involvement in local, State, or Regional outreach efforts. (July 1998)

5. Provide information in appropriate technical assistance meetings, conferences, satellite broadcasts, and written materials, encouraging participants to assist local, State, and Regional outreach efforts. (Beginning July 1998)

6. Provide information to 585 State and local jurisdictions administering HOME program funding, encouraging involvement in State and local outreach efforts. (July 1998)

B. Educating Families and Enrolling Children in Medicaid and CHIP

7. Place CHIP/Medicaid information on HUD's kiosks at headquarters and in the Department's 81 field offices across the country. The user-friendly kiosks harness state-of-the-art computer technology to provide the general public with useful information about housing and services and are expected to serve thousands persons each year. (September 1998)

8. Send a letter to HUD grantees providing assistance to homeless families from the Deputy Assistant Secretary for Economic Development, who is responsible for administering HUD's homelessness assistance programs, requesting that grantees make CHIP/Medicaid information available as part of their outreach, intake/assessment process and that they also establish connections to local Medicaid/CHIP providers so as to link eligible families to the appropriate source for children's health insurance. (July 1998)

9. Send a letter from the Assistant Secretary for Public and Indian Housing to the Executive Directors of the nation's 3,400 Public Housing Authorities, requesting that the Housing Authorities encourage the Executive Directors of the 15,000 public housing developments administered by these Authorities to: make space available, when possible, for eligibility workers to provide information and enroll children who are

eligible for Medicaid/CHIP, and/or provide information to families with children applying for or renewing Section 8 certificates and vouchers, and to individuals and organizations administering grants for social services. The letter could also urge Housing Authorities to post notices and provide information regarding CHIP/Medicaid in areas of public housing where families congregate or interact, particularly at child care facilities, and encourage resident organizations in the housing developments to provide information and help ensure enrollment of eligible children. (July 1998)

10. Send a letter from the Assistant Secretary for Housing/FHA Commissioner to project owners and managers of HUD assisted and insured Multifamily properties, providing them with information regarding the Initiative, and requesting that they assist in disseminating the information to residents with children. (Fall 1998)

11. Expand the Department's Memorandum of Understanding (MOU) with the U.S. Department of Agriculture to include the CHIP/Medicaid initiative. Currently the MOU provides for pilot projects in public housing developments in eight cities to help ensure that eligible families are enrolled in the Women, Infants, and Children (WIC) food and nutrition program. The two Departments have committed to work cooperatively to locate space and establish locations for nutrition and education programs, provide special consideration for grants to public housing developments that incorporate program operation at their sites, refer residents to appropriate programs, and disseminate information. Information regarding the CHIP/Medicaid Initiative may be made available as well. (July 1998)

12. Send information regarding CHIP/Medicaid from HUD's Office of Native American Programs to families who have purchased homes under the Department's Section 184 Indian Home Loan Guarantee Program as the children in these families are likely to be eligible for CHIP. Families applying for Section 184 loans could be provided with CHIP/Medicaid information. Approximately 350 families have purchased homes under the Section 184 loan program, and approximately 500 families apply each year. (Beginning in July 1998)

13. Send CHIP/Medicaid information from HUD's Office of Lead Paint Hazard Reduction to parent and community groups educating families about lead hazards. HUD will fund new partnerships with parent and community groups, including United Parents Against Lead, to educate families about the dangers of lead paint. CHIP/Medicaid information could be included in informational mailouts. By the year 2000, these groups will educate more than 10,000 families. (Beginning in July, 1998)

C. Coordination with Other Programs

14. Send a letter from the Secretary to all Secretary's Representatives, State Coordinators, and Area Coordinators, requesting that they work with other agencies in coordinating and implementing the Initiative. State Coordinators will be especially urged to contact and work with the director of the State's Medicaid/Chip program to help ensure coordination of interagency efforts to implement the Initiative statewide. (July 1998)

15. Incorporate information on CHIP/Medicaid in HUD's Community Builders' training and encourage Community Builders to work with other agencies in coordinating and implementing the Initiative in the localities they serve. Community Builders are HUD's new front-line customer service representatives in the community and can link communities and individuals to other Federal resources as well as HUD resources. (Beginning in July, 1998)

16. Include a CHIP/Medicaid website on those Neighborhood Networks Center computers that are connected to the internet. (July 1998)

5. REPORT FROM THE SECRETARY OF THE INTERIOR

I. CURRENT PROGRAMS AND OUTREACH ACTIVITIES FOR CHILDREN

A. Programs that Serve Middle to Low-Income Children

Created in 1849, the U.S. Department of the Interior is responsible for protecting and providing access to the Nation's natural and cultural heritage and to honor its trust responsibility to Indian Tribes. Of the eight Interior bureaus, only the Bureau of Indian Affairs deals directly with families and children.

The Bureau of Indian Affairs (BIA) provides services to 554 Federally recognized Indian Tribes either directly or through contracts, grants, and compacts with tribes. The BIA, Office of Tribal Services, provides social services to families, children, the elderly and persons with disabilities. The BIA, Office of Indian Education Programs, has the responsibility of providing educational programs for more than 50,000 elementary and secondary school students, and helping fund 24 Tribally Controlled Community Colleges.

The Office of Tribal Services (OTS) is the primary BIA office that provides social services to targeted Indian children and families at middle

to low-income. OTS provides services through four fundamental programs:

Welfare Assistance Program ($86,520,000 in FY 1997) is authorized under the Snyder Act of 1921 and offers three types of programs that provide essential services: General Assistance, Child Welfare Assistance, and Emergency Disaster and Burial Assistance. These programs provide for the basic needs (shelter, food, clothing, and utilities) of low-income Indian families. Approximately 85 percent of the welfare assistance program is contracted by Indian Tribes or tribal organizations. *Target population: Low-income Indian individuals or families who are members of a Federally recognized Indian Tribe and are residing on an Indian reservation or in a designated near-reservation area. Recipients must: (1) meet income and liquid asset criteria and (2) have applied for and been denied from all other forms of Federal, State, and local assistance. In FY 1996, the average monthly general assistance caseload nation-wide was 34,000 persons. The child welfare assistance caseload averaged 3,400 persons per month.*

Indian Child Welfare Program (ICWA) ($14,092,000 in FY 1997) is authorized by the Indian Child Welfare Act of 1978. Under the ICWA program, the BIA functions as a grantor to every Federally recognized Indian Tribe; it is a 100 percent tribally contracted program. The ICWA program provides Tribes with resources to protect Indian children, prevent the separation of Indian families, and to exercise tribal authority over Indian children in need of out-of-home placement. *Target population: Although ICWA programs are reservation-based, they serve all Indian children, both on and off reservation, in need of out-of-home placements. Children must be an enrolled, or enrollable, member of a Federally recognized Indian Tribe. Approximately 12,000 Indian children and families were served by more than 500 Tribal ICWA programs in FY 1996.*

Housing Improvement Program (HIP) ($15,760,000 in FY 1997) is authorized under the Snyder Act of 1921. HIP has three assistance categories: (1) safety and sanitation repairs to houses that remain substandard pending replacement, (2) repairs which will bring housing up to standard condition, and (3) new housing. The goal of HIP is to eliminate substandard housing and homelessness on reservations, and it is about 85 percent tribally contracted. *Target population: HIP is available to needy Indian families who do not qualify for other Federal/State/Tribal/local housing programs. Applicants must be (1) a member of a Federally recognized Tribe, (2) residing on a reservation, (3) meet income guidelines and liquid asset criteria, and (4) own a home or have land appropriate for a house. Applicants who meet eligibility criteria*

are served in order of priority (applying a "neediest of the needy" standard) until funds are exhausted.

Child Protection Program ($0 in FY 1997) is authorized under Title IV of Public Law 101-630, the Indian Child Protection and Family Violence Prevention Act of 1990. A tribally operated program, it is intended to protect Indian children from abuse and neglect. Currently BIA Law Enforcement provides training in background investigations for tribal personnel and processes FBI fingerprint and name checks for the Tribes. The Act authorizes Indian Child Resource and Family Services Centers and base funding for tribally-operated programs to protect Indian children and reduce the incidence of family violence on Indian reservations. When funds are available ($5.0 million is included in the FY 1999 President's Budget), BIA will act as a grantor to all Bureau and tribal programs. *Target population: Indian children who are at risk for abuse and neglect. In 1997, there were about 26,000 referrals to more than 500 Bureau and tribal programs for child abuse and neglect investigations.*

Office of Indian Education Programs (OIEP) is the second major BIA office that provides services to middle to low-income Indian families. It provides educational services to children and families through 8 primary programs:

Indian Student Equalization Program ($293,703,000 in FY 1997) is authorized under the Snyder Act (1921). The Indian Student Equalization Program (ISEP) funds school operations and teachers' salaries at Bureau-funded primary and secondary schools. ISEP also provides funding for the Bilingual, Gifted and Talented, and Intensive Residential Guidance programs. *Target population: In School Year (SY) 1997-98, 185 Federally operated and tribally contracted schools will serve an estimated 50,820 students enrolled/enrollable members of Federally recognized Indian Tribes.*

Title I Program ($45,458,316 in FY 1997) is authorized by the Improving America's Schools Act (1994). The Title I program provides set-aside funding to directly assist Federally operated and tribally contracted schools in promoting academic achievement and challenging standards. *Target population: All enrolled/enrollable Indian students attending Bureau-funded schools are served by the Title I program.*

Title II Program (Eisenhower Math & Science Professional Development Program) ($1,545,125 in FY 1997) is authorized under the Improving America's Schools Act (1994). The Title II program provides set-aside funding for teacher and administrator professional development in Federally operated and tribally contracted schools. *Target population: The*

Title II program, benefits all enrolled/enrollable Indian students attending Bureau-funded schools.

Title IV Program (Drug Free Schools and Communities Act of 1994) ($5,309,780 in

FY 1997) is authorized by the Improving America's School Act of 1994. The Title IV program provides the Office of Indian Education Programs with set-aside funding to assist Federally operated and tribally contracted schools in developing violence prevention programs and strengthening programs that involve parents and prevent substance abuse. *Target population: All enrolled/enrollable Indian students attending Bureau-funded schools are served by the Title IV program.*

Title IX Program (Indian Education Formula Grant Program) ($2,198,876 in FY 1997) is authorized by the Improving America's Schools Act of 1994. These funds, set-aside for the Office of Indian Education Programs, are provided directly to Federally operated and tribally contracted schools, provide the resources for meeting the special academic and culturally-relevant education needs of Indian students. *Target population: The Title IX program provides funding for all enrolled/enrollable Indian students attending Bureau-funded schools.*

Family and Early Childhood Education Program (FACE) ($5,471,000 in FY 1997) is authorized by the Snyder Act (1921). The FACE program encourages family literacy. It provides infant and early childhood education accompanied by adult education in both home and school-based settings. *Target population: The FACE program targets reservation-based Indian families. Twenty-two program sites, located within Bureau-funded schools, serve about 1,810 children (ages 0-5) and 1,830 adults from a total of 1,500 families.*

Special Education Program ($22,727,012 in FY 1997) is authorized under the Individuals with Disabilities Education Act (1991). The Special Education program provides funds to supplement services to children with disabilities. *Target population: Enrolled/enrollable Indian children with disabilities, ages 5-21, attending Bureau-funded schools are eligible for the Special Education program. About 9,355 students receive services through the Special Education program.*

Tribally Controlled Community Colleges (TCCC) ($29,911,000 in FY 1997) are authorized by the Tribally Controlled Community College Assistance Act (1978). The funding provided to TCCCs allows for the operation of Tribal community colleges and furthers higher education in a supportive environment close to Indian reservations. *Target population: Twenty-four reservation-based community colleges are funded by the*

TCCC program. Funding to TCCCs is based on their Indian Student Count, or number of enrolled/ enrollable Indian students. In FY 1996, a total of 1,225 students graduated from the 24 TCCCs.

B. Current Activities in Children's Health Outreach

Since the President signed the Children's Health Insurance Outreach Memorandum in February, the Bureau of Indian Affairs has enacted the following outreach strategies:

Address Medicaid and CHIP expansion in Assistant Secretary- Indian Affairs Speeches. The Assistant Secretary - Indian Affairs speaks to Indian Tribes, tribal organizations, Federal and Tribal employees, and with university students. At each speaking engagement, the Assistant Secretary-Indian Affairs introduces the Medicaid expansion and new CHIP program. He discusses its applicability to and potential impact on Indian communities. These were key talking points in April, as the Assistant Secretary visited Tribes and Bureau-funded schools in recognition of Child Abuse Prevention month. As other speaking engagements arise, children's health insurance will continue to be a focus. This on-going educational strategy will continue into Spring 1999.

Incorporate Medicaid and CHIP information into Area/agency/tribal contractor program training. The BIA is coordinating with the Health Care Financing Administration (HCFA) to explore options to train social service and education staff regarding the Medicaid expansion and the new CHIP program. An inventory of existing BIA programmatic training has been compiled, and concrete plans for CHIP training sessions within existing program trainings are being made. Potential Regional HCFA trainers are being identified to provide training to BIA and Tribal employees. Medicaid/CHIP training for BIA and tribal education and social services staff will begin during Summer 1998 and continue as necessary.

Disseminate Medicaid and CHIP information at the Tribal Self-Governance conference; at the 16th Annual "Protecting our Children" conference; at the National Congress of American Indians Welfare Reform Forums; at national Indian Education organizations' conferences; at OIEP's 12 Area spring consultation sessions. Because many of these conferences/events will be conducted prior to the development of the HCFA Medicaid/CHIP flyers, the information presently disseminated is word-of-mouth. BIA speakers on panels and giving keynote addresses at these conferences all discuss the Children's Health Initiative and direct audiences to HCFA and their website for further information. Tribes and tribal organizations are encouraged to work with their States in the development of the State plan and to

negotiate with States in the outstationing of eligibility workers and the expenditure of outreach funds to benefit Indian communities. As other conferences and presentation opportunities arise throughout the Summer and Fall of 1998, BIA staff will continue to highlight the Medicaid/CHIP programs.

Link appropriate Internet locations to the Department of Health and Human Service's Children's Health Internet website. By May 15, 1998, all of the appropriate BIA/HHS Internet links could be operative.

Coordinate with all other Federal agencies providing services to reservation-based Indian families to identify common outreach strategies and disseminate Medicaid and CHIP information to all Indian families with minimal duplication of effort. Through the American Indian subgroup of the interagency Federal Task Force on the implementation of Medicaid/CHIP, many Federal agencies delivering services on Indian reservations will provide service delivery sites to the BIA Central Office to assist in the coordination of information dissemination. A national map and several Regional maps identifying all reservation-based Federal/tribally contracted service delivery sites were be produced (see Appendix E).

II. PROPOSED PLANS FOR CHILDREN'S HEALTH OUTREACH

A. Educating Workers about Medicaid and CHIP

Federal and Tribal Workers

1. Send a memo regarding the expansion of Medicaid and the new CHIP program to BIA Area Offices, agencies, field offices, tribal social service contractors, Office of Indian Education Program line officers, and Bureau-funded schools and to all Tribal Leaders. The Assistant Secretary-Indian Affairs could send a memo to all Federal and Tribal social service and education workers. A separate letter specifically addressed to Tribal Leaders could also be sent out under the Assistant Secretary's signature. These mailings, accompanied by the HCFA flyer developed for Federal and Tribal workers, would give a program overview, discuss the benefits of the Medicaid/CHIP programs for Indian Country, and encourage Tribes and Federal and Tribal workers to take advantage of these resources by enrolling eligible Indian children. These mailings could be sent out 30 days after the receipt of the flyers describing children's health insurance outreach (July 1998).

2. Include articles and periodic updates regarding Medicaid/CHIP in quarterly BIA Office of Tribal Services, Office of Indian Education, and Assistant Secretary's newsletters. Articles introducing the Children's Health Initiative and its related insurance programs were featured in the May editions of the Office of Tribal Services and Office of Indian Education newsletters. Follow-up articles could appear in July and September issues. The Assistant Secretary of Indian Affairs could feature a Medicaid and CHIP article in the premier issue of his newsletter, in June, with quarterly updates to follow.

3. Provide technical assistance to BIA agencies, tribal contractors, and social service program personnel in disseminating accurate Medicaid and CHIP information; in developing culturally relevant materials; and in incorporating Medicaid and CHIP information into intake procedures for BIA social service programs. With tribal input, BIA Central Office staff has taken the lead in developing a culturally appropriate Medicaid and CHIP brochure for Indian families. Immediately upon distribution of the culturally relevant Medicaid and CHIP brochure, BIA Central and Area office staff could assist agencies, Tribes, and tribal organizations in developing and disseminating any other Medicaid and CHIP materials that may be needed. As BIA and tribally contracted social service programs begin to incorporate Medicaid and CHIP information into their intake procedures, BIA Central and Area Office staff could assist program directors, administrators, and staff in the provision of relevant materials and in the development of dissemination procedures. Much of the necessary coordination and exchange of information is already taking place at the local level. In situations where States have not provided assistance to Tribes, BIA Central Office could assist Tribes in gathering the relevant State Medicaid and CHIP information and incorporating Medicaid and CHIP information into intake procedures for BIA and tribal social service programs. BIA Central and Area Office staff could provide on-going Medicaid and CHIP technical assistance to Indian Tribes and tribal organizations.

4. Provide Medicaid and CHIP briefings and programmatic updates via e-mail. On May 1, 1998, BIA Central Office provided its first Medicaid/CHIP briefing. BIA Area social workers could transmit these messages to agencies and Tribes that do not have Internet access. After the initial introductory message, monthly updates could include status of State plans, Tribal access to Medicaid and CHIP programs, State and Tribal coordination on issues surrounding children's health care, and innovative outreach efforts targeting at Indian communities.

5. Disseminate Medicaid and CHIP information to Office of Indian Education Programs (OIEP) staff. Between August 1998 and January 1999, the OIEP could provide Medicaid and CHIP brochures and give

appropriate presentations to all Federal and Tribal education staff. This information could be provided through a variety of media, including distributing materials and giving presentations at: quarterly school principal and OIEP line officer meetings, health education workshops, teacher and staff orientation sessions, and through Tribally Controlled Community Colleges.

6. Develop and distribute 10-minute video about Medicaid and CHIP outreach for Tribes, schools, agencies. By February 1999, OIEP could develop and distribute a 10-minute video that gives a Medicaid and CHIP program overview, discusses the benefits of the Medicaid and CHIP programs for Indian Country, and encourages Federal and Tribal employees to assist potentially eligible Indian families to apply for children's health insurance programs.

B. Educating Families and Enrolling Children in Medicaid and CHIP

7. Develop and distribute culturally relevant information for families to a wide range of sites. BIA Central Office could develop posters, brochures, and supplementary information packets to social service delivery sites, tribal community centers, tribal offices, Bureau-funded schools, Indian Education offices, Tribally Controlled Community Colleges, and tribal Departments of Education. Thirty days after receipt of the Medicaid and CHIP Indian family brochures, BIA Central Office could forward the brochures to all social service and education related service delivery sites. Posters and supplementary packets of information could be forwarded as they become available. All of these media would be available to Federal and Tribal employees to assist Indian families in learning about and accessing children's health insurance.

8. Encourage agency and tribal social service intake workers to ask applicants about children's health needs and distribute appropriate referral information. Indian families will benefit greatly from social service intake workers sharing Medicaid and CHIP information with potentially eligible families and referring them to State Medicaid eligibility workers for enrollment. BIA Central Office could send letters to agency and tribal social service staff and use Medicaid and CHIP program training to impress upon workers the necessity of asking parents about their children's health care needs by August 1998.

9. Prepare press releases about Medicaid and CHIP for Indian newspapers. By July, 1998, the BIA Office of Public Affairs could develop Medicaid and CHIP press releases for Indian newspapers throughout the country for publication. Quarterly updates on the status of State Medicaid and CHIP plans, State and Tribal coordination on

children's health issues, and outreach efforts targeting Indian communities could also be forwarded for publication.

10. Encourage Bureau-funded schools, Tribally Controlled Community Colleges, and tribal Departments of Education to send Medicaid and CHIP notices home with students, to focus on the Children's Health Initiative on one of the monthly parents' nights, and to hold informational sessions to distribute Medicaid and CHIP information. During the 1998-99 school year, the BIA could encourage Tribes and Bureau-funded schools to focus on the Children's Health Initiative and to use every available medium to disseminate Medicaid/CHIP information to Indian families. OIEP could send the Medicaid and CHIP brochures designed for Indian families to all Tribes and Bureau-funded schools; suggestions for how Tribes and schools can use these brochures and hold forums for discussion to improve children's access to health care will accompany the brochures.

11. Sponsor Medicaid and CHIP public service announcements on Indian radio stations. By October 1, 1998, the BIA Central Office could submit public service announcements to be broadcast on Indian radio stations throughout the country.

C. Coordination with Other Programs

12. Encourage national unions (National Federation of Federal Employees and Indian Education Federation) to notify their membership of Medicaid/CHIP and the outreach initiative. By September 30, 1998, the Office of Indian Education Programs could have sent Medicaid/CHIP notification memos to its national unions and forwarded sample letters and brochures for the unions to mail out to their membership.

13. Provide Medicaid and CHIP information to grassroots and advocacy organizations that serve Indian families. Upon thirty days of receipt of the Medicaid/CHIP Indian family brochures, the BIA Central Office could forward brochures and a program overview letter with referral contacts attached to Indian grassroots and advocacy organizations throughout the country.

6. REPORT FROM THE SECRETARY OF LABOR

I. CURRENT PROGRAMS AND OUTREACH ACTIVITIES FOR CHILDREN

The U.S. Department of Labor's (DOL) mission is to help American workers, job-seekers and employers. Its responsibilities include: protecting the wages, health, safety, and employment and pension rights of working people; promoting equal employment opportunity; administering job training, unemployment insurance and workers' compensation programs; strengthening free and collective bargaining, and collecting, analyzing, and publishing labor and economic statistics. DOL's programs and services affect children indirectly through their parents who work.

A. Programs that Serve Middle to Low-Income Children

Employment and Training Administration ($11.5 billion in FY 1997) assists American workers in obtaining information, job-search services, income maintenance, and education and training necessary to find and keep good jobs, and assists businesses in securing skilled workers and the training they need. Its major programs include:

Unemployment Insurance (UI) ($6.2 billion collected in FY 1997) provides unemployed workers with temporary income support to facilitate their return to employment. It is funded by State and Federal employer taxes and is administered by States through 1,800 local offices with 38,000 employees. *Target population: Unemployed workers filing jobless claims. The number varies, but currently about 2.2 million insured unemployed receive benefits each week, and 7.6 million people received some benefits in FY 1997.*

Job Corps ($1.2 billion in FY 1997) is a national residential program that provides disadvantaged youth vocational, academic and social skills training, counseling, and health-related advice through 113 centers. *Target population: 68,000 disadvantaged youth between ages of 16 and 24.*

Welfare-to-Work grants for Temporary Assistance to Needy Families (TANF) ($2.2 billion for two years) provides formula grants to States and competitive grants to local communities for transitional assistance to move the hardest-to-serve welfare recipients into unsubsidized jobs. *Target population: Hardest-to-serve recipients of TANF.*

Summer Works (JTPA Title II-B) ($871 million in FY 1997) provides summer jobs, training and educational services through States and localities during the summer months. *Target population: 530,000 economically disadvantaged 14 to 21 year-olds.*

School-to-Work (STW) ($200 million, plus $200 million from Education Department in FY 1997) gives Urban/Rural Opportunities Grants to local initiatives in high poverty areas to increase opportunities for youth for further education and training and to prepare them for first jobs in high-skill, high-wage careers. *Target population: Youth in about 90 high-poverty rural and urban areas*

Economically Disadvantaged Adults (JTPA Title II-A) ($1 billion in FY 1998) provides employment, training and job-placement services to adults with few skills and little work experience. Funding is coordinated with other Federal, State, and local programs. *Target population: 351,000 economically disadvantaged adults.*

National Programs (JTPA) ($670 million in FY 1998) provide grants to local public agencies and nonprofits to deliver employment and training services to specific target groups. *Target populations: Economically disadvantaged Indians and Native Americans; migrant and seasonal farm workers; low-income people aged 55 and older, and people with disabilities*.

State Employment Security Agency (SESA) Liaisons (U.S. Employment Service) ($760 million in FY 1998) include more than 1,800 local offices that provide job placement, counseling, skills assessment, job-search assistance, labor market information to job-seekers, and referrals to employers. It also administers the Welfare-to-Work and Work Opportunity Tax Credits. *Target population: Job-seekers and employers.*

Bureau of Apprenticeship and Training (BAT) oversees the National Apprenticeship System with the National Association of State and Territorial Apprenticeship Directors to assist industry in developing, expanding and improving apprenticeship and training programs.

One-Stop Career Centers ($163 million in FY 1997) include more than 700 locations that provide job-seekers with information on employment, education and training services, and link employers with qualified job applicants. Partners include programs for economically disadvantaged and dislocated workers, older workers and veterans, and the Employment Service and UI. *Target population: Job-seekers and employers*.

Out-of-School-Youth and other Demonstration Program ($30 million; $250 million advance appropriation for FY 1999 pending) operates in six sites, with more planned, to increase the employment rate of poor out-of-school youth from less than 50 percent to 80 percent. ETA also funds other demonstrations whose beneficiaries could be eligible for CHIP or Medicaid.

Pension And Welfare Benefits Administration (PWBA) ($82 million in FY 1998) enforces and administers the Employee Retirement Income Security Act (ERISA) and the Health Insurance Portability and Accountability Act (HIPAA), and provides educational and technical assistance under the Consolidated Omnibus Budget and Reconciliation Act (COBRA). The agency also develops policies and laws to simplify compliance and encourage the growth and preservation of employment-based benefits, and helps workers get information on benefit rights. *Target population: 200 million pension, health and other employee benefit plan participants and beneficiaries; more than 3 million plan sponsors, and the employee benefit community.*

Employment Standards Administration (ESA) ($334 million in FY 1998) enforces and administers laws governing legally mandated wages and working conditions, including child labor, minimum wage, overtime, family and medical leave, equal employment opportunity in businesses with Federal contracts, and workers' compensation for certain employees. ESA includes the Wage and Hour Division, the Office of Federal Contract Compliance, the Office of Workers' Compensation Programs, and the Office of Labor Management Standards. *Target population: All American workers***.**

Occupational Safety And Health Administration (OSHA) ($337 million in FY 1997), through over 200 offices nationwide, establishes protective standards, enforces those standards, and reaches out to employers and employees through technical assistance and consultation programs to save lives, prevent injuries and protect the health of America's workers. *Target population: Approximately 100 million American workers***.**

Mine Safety And Health Administration (MSHA) ($203 million in FY 1998) administers the Federal Mine Safety and Health Act of 1977 and enforces compliance with safety and health standards to eliminate accidents, minimize health hazards, and promote improved mine safety. *Target population: The nation's 370,000 miners.*

Veterans Employment and Training Service (VETS) ($184 million in FY 1998) furthers employment and training opportunities for veterans. Its Homeless Veterans' Reintegration Project just awarded grants to 22 State and local organizations to serve about 4,000 veterans. *Target population: America's 14 million working-age veterans***.**

Women's Bureau ($8 million in FY 1998) promotes working women's interests and workplace rights. Its "Working Women Count Honor Roll" includes 1,300 businesses, nonprofits, and State and local governments

that pledge to initiate policies to improve workplaces. *Target population: Working women and their employers.*

Office of Small Business Programs ($500,000 in FY 1997) promotes opportunities for small businesses in the Department's contract and grant activities.

B. Current Activities in Children's Health Outreach

Because the Labor Department has not historically provided information about public health insurance programs for children, it has only just begun outreach activities in this area.

Outreach at VETS Grantee Conference. At a May 12-13 VETS conference in Washington on homeless reintegration grants, information on CHIP and Medicaid was disseminated to attendees, who were asked to share it with the populations they serve. At a June conference after veterans' training grants are awarded, grantees received CHIP materials and be asked to share them with those they serve.

II. PROPOSED PLANS FOR CHILDREN'S HEALTH OUTREACH

The Department of Labor could focus its outreach activities on its 17,000 employees, as well as its extensive network of partners and stakeholders who actively help to implement DOL programs serving working Americans and their families. These include State and local governments, grantees, labor and business organizations, community colleges and other education providers, and community-based organizations.

A. Educating Workers About CHIP and Medicaid

Federal Workers

1. Distribute letters to all employees about children's health outreach. The Secretary of Labor and the Assistant Secretaries could distribute a letter which describe CHIP and Medicaid outreach activities to all 17,000 employees in the national and Regional offices in July 1998.

2. Provide employees with updated information about children's health outreach. Agencies could hold "Brief & Brunch" presentations on the importance of CHIP and Medicaid outreach for interested employees. Information about CHIP and the importance of outreach would be made available in the Department's employee newsletter, "The Labor Exchange" which is distributed to 18,000 people on a quarterly basis. It could also be included at the bottom of employees' Earnings and Leave statements, with

contact points for additional information when that information becomes available (Fall 1998).

3. Establish coordinated information campaign. The Department could ask the Federal Executive Board to coordinate all DOL agencies in the Regions to keep Federal employees informed on an ongoing basis.

State Workers

4. Send letters to State Unemployment Insurance offices. UI could send a General Administrative Letter (GAL) to all UI and Employment Service offices, asking State Employment Security Agencies (SESA's) to include CHIP and Medicaid information in UI check mailings to claimants in July. Simultaneously, they could also be encouraged to disseminate promotional materials at local offices when those materials become available in September.

5. Include outreach in conference of State Employment Security Agency Liaisons (**U.S. Employment Service**). In the Summer of 1998, a national training conference is being planned for the designated coordinators for each State and Federal region and representatives of participating agencies (e.g., Job Corps, vocational rehabilitation agencies, Food Stamp offices). A knowledgeable presenter could explain CHIP and Medicaid.

Other Workers

6. Send notices to employment and training community. ETA could conduct outreach about CHIP and Medicaid through notices, bulletins, or other documents used to transmit information to the employment and training system. Specifically, ETA could target:

- **113 Job Corps Centers**: Distribute a "Job Corps Notice" about CHIP and Medicaid to all national office senior staff; Regional directors; Job Corps Center operators; training and support contractors; outreach, admissions and placement contractors; and other service providers in July of this year. Centers will be encouraged both to educate workers and to distribute information to families once those materials are made available in September.
- **700 One-Stop Career Centers**: Send information on CHIP and Medicaid to One-Stop State contacts through a Training Information Notice in July. Regional One-Stop contacts, which have been informed about this initiative, could be encouraged to discuss it when they meet with State contacts. Flyers could be distributed at a National One-Stop conference on July 28-30.

- **106 Bureau of Apprenticeship and Training Field Offices:** Distribute a "BAT Notice" providing information on CHIP and Medicaid to the 184 Federal staff and State partners in all field and Regional offices in July. It could also ask partners -- the National Association of State and Territorial Apprenticeship Directors, in the National Apprenticeship System -- to disseminate information to the apprenticeship community, including employers. CHIP and Medicaid flyers could be distributed at all national apprenticeship functions. All field staff could be encouraged to distribute flyers to existing and potential apprenticeship sponsors by September. Because BAT recognizes child care specialists as apprenticeable, it could conduct special outreach to inform them about CHIP and Medicaid
- **Welfare-to-Work Grantees**. Distribute CHIP information to Welfare-to-Work competitive grantees (the first round of awardees will be announced in May) and Welfare-to-Work stakeholders, including community-based organizations and religious institutions. Informational letters may be distributed to grantees as early as July with more specific materials such as brochures to follow in September.
- **Summer Works program.** Distribute formal notices and bulletins about CHIP and Medicaid to State partners and stakeholders who administer the Summer Works in July. These State liaisons could be encourage to share this information with all 640 private industry councils.
- **School-to-Work (STW) grantees and partners.** Distribute CHIP and Medicaid literature, posters, etc. to grant coordinators at periodic grantee meetings; share information with State STW Directors through mailings and at quarterly grantee meetings; share information with members of the STW Advisory Committee and Communications Task Force via fax, tele-conferences, and periodic meetings; and prepare a fact sheet to distribute to the STW community through the STW Learning and Information Center (via the STW Website, in STW information packages and at conferences where the STW Learning Center is an exhibitor). This mass dissemination will begin in September, with specific dates to follow as meetings, conferences, etc. are scheduled.
- **Economically Disadvantaged Adult Program, National Job Training Programs, and Demonstration Projects.** Distribute formal notices and bulletins about CHIP and Medicaid to State and local partners in July.

7. Educate "Honor Roll" members of the Women's Bureau about outreach. The Women's Bureau's could send a letter to 1,300 Honor Roll members to ask them to share CHIP and Medicaid materials with their employees. The Women's Bureau could also do a mailing targeted to

advocacy organizations for low-wage workers, urging them to share CHIP information with their constituents. Both of these activities can take place in July.

B. Educating Families About CHIP and Medicaid

8. Encourage States to outstation eligibility workers at Job Corps Centers. The national office could send a letter encouraging Job Corps Centers to serve as a CHIP outstation agency for State CHIP workers, particularly in remote areas where some centers are. (Summer 1998)

9. Include CHIP and Medicaid Information in Pension and Health Care Benefits Booklet. In late spring, the Pension Welfare and Benefits Administration (PWBA) will release and distribute 200,000 copies of "Pension and Health Care Benefits ... Questions and Answers for Dislocated Workers," a 32-page booklet outlining health and pension benefits coverage for dislocated workers and their families. It could include a general reference to low-cost or no-cost insurance coverage at the State level for children whose family income is temporarily reduced. In addition, PWBA's Health Care Portability Team, which conducts educational efforts about the Health Insurance Portability and Accountability Act, could include information about children's health in their presentations, and is drafting a fact sheet to be inserted in the booklet for distribution by team members. Brochures also could be distributed through 15 Regional and district PWBA offices, at seminars and meetings concerning health insurance, and through a targeted outreach campaign to State and local officials administering the Worker Adjustment and Retraining Notification Act (WARN) and Economic Dislocation and Worker Adjustment Act (EDWAA).

10. Distribute information to people contacting the Employment Standards Administration. The Wage and Hour Division could include information on CHIP and Medicaid in its mailings on the Family and Medical Leave Act (FMLA) beginning in September. The Office of Federal Contract Compliance Programs (OFCCP) could distribute information on CHIP and Medicaid to its Regional and district offices, which, in turn, could provide copies to the public when they come to the offices for OFCCP business.

11. Encourage OSHA offices to distribute information on children's health. OSHA could make available information about CHIP at its 10 Regional offices, 67 area offices, 6 district offices, and through its 25 State plan offices, which are the agency's partners, as well as at its public meetings and seminars, beginning in September. In addition, OSHA could encourage its Consultation Program, visits about 25,000 businesses per year, to distribute information about CHIP. It also could provide booklets

to the small business centers and new start-up businesses with which it works.

12. Distribute information to miners through district offices and inspectors. The Mine Safety and Health Administration (MSHA) could reach uninsured children in the mining community by distributing CHIP and Medicaid flyers to district offices in selected regions of the country; encouraging inspectors to disseminate information to miners; and establishing a hot link on the MSHA Website. Website links can be operational in July, while distribution of materials can begin to take place in September.

13. Distribute information through small employers. The Office of Small Business Programs could encourage 2,000 small businesses to distribute CHIP and Medicaid information to their employees in July for initial advisement, and later in September for distribution of flyers and other promotional materials.

C. Coordination with Other Programs

14. Create Internet and Intranet "Hot Buttons." Information on CHIP and Medicaid could be available via a "hot button," developed by the Office of the Assistant Secretary for Policy, that will link all of the Department's Websites to CHIP PSA's and the HHS CHIP Website. It could also be linked with internal DOL Websites. This information could reach Federal, State and other workers in intermediary organizations that connect with DOL Websites, as well as the general public. A hot button could be placed on the Website for America's Job Bank, ETA's successful online database of 750,000 job listings, used by millions of job-seekers. Though the Departmental Website already has CHIP and Medicaid PSA's, work could continue to link other sites and modify those that already exist (Summer 1998).

15. Send mailings to DOL constituencies. Office of Congressional and Intergovernmental Affairs could include CHIP information as part of weekly mailings to trade associations, labor organizations, and Congressional Committee offices.

7. REPORT FROM THE COMMISSIONER OF SOCIAL SECURITY

I. CURRENT PROGRAMS AND OUTREACH ACTIVITIES FOR CHILDREN

The Social Security Administration (SSA) and other benefit programs have the same basic objectives: to keep individuals and families from destitution; to help them attain economic and personal independence; to keep families together; to give children the opportunity to grow up healthy and with some financial security. SSA has a network of 1,300 field offices which serve the local community.

The outreach activities in this report outline SSA's efforts to work with other Federal agencies to respond to President Clinton's challenge to make every effort to enroll uninsured children in Medicaid or CHIP.

A. Programs that Serve Middle to Low-Income Families

Supplemental Security Income (SSI; $5.2 billion in FY 1997) is a Federal program, administered by SSA, which provides a floor of income to individuals and families who are aged, blind or disabled. Children are eligible if they are disabled and their income and resources are below specified amounts. *Target population: Individuals who have limited income and resources. Currently there are just under one million children receiving SSI.*

Surviving Children (Approximately $6.6 billion in FY 1997). Title II of the Act provides for a variety of benefits, including payments to surviving children of deceased workers and is intended to protect against the loss of income due to the death of the worker. *Target population: All children of workers covered under Title II who meet certain criteria (1,895,030 as of December 1997). Children must be under age 18 (or over 18 and disabled or a full-time student age 18-19); not married and have been dependent on the deceased worker.*

Children of Disabled Workers (Approximately $4.1 billion in FY 1997). Title II protects children against the loss of income due to the disability of the worker/parent. Benefits are paid to children of disabled workers based on the worker's earnings record and other eligibility criteria. Applications for children (auxiliary beneficiaries) are taken automatically at the time the workers' applications for benefits are filed. *Target population: Dependent, unmarried children who are under 18 (or older and disabled or a full-time student age 18-19); not married and have been dependent on the deceased worker (1,442,540 as of December 1997).*

Children of Retired Workers (Approximately $1 billion in FY 1997). Title II protect children against the loss of income due to the retirement of a worker/parent. *Target population: All children of insured workers who retire that are under age 18 (or disabled and over 18 or a full-time student age 18-19), not married and were dependent upon the worker. (441,210 as of December 1997).*

B. Current Activities in Children's Health Outreach

SSA staff is participating in interagency implementation planning committees.

SSA has been soliciting comments from field office staff on CHIP products.

SSA sends notices to children who are redetermined under the Welfare Reform Bill to inform them of their continuing Medicaid eligibility under the Balanced Budget Act.

SSA workers are informed about Medicaid eligibility and know the general rules for Medicaid in their respective States.

II. PROPOSED PLANS FOR CHILDREN'S HEALTH OUTREACH

A. Educating Workers about Medicaid and CHIP

1. Send a Commissioner's broadcast about the children's health insurance initiative to all SSA and Disability Determination Service (DDS) employees. The Commissioner's broadcast is an urgent, timely message which the Commissioner wants to get out to all employees as soon as possible. It is usually limited to one page and is received by more than 65,000 SSA and DDS employees. (June 1998)

2. Publish an article in the summer issue of the OASIS magazine about CHIP and Medicaid outreach. The OASIS magazine is a quarterly Social Security publication that goes to more than 65,000 employees and members of the SSA Alumni Association. This issue of the OASIS could be distributed in mid-to-late August 1998.

3. Distribute information on children's health outreach at conferences. SSA's Office of Communications staff and the regional public affairs specialist participate in approximately 110 conferences, health fairs and other community activities annually. These conferences are sponsored by virtually every type of advocacy group/organization — business, children's, disability, ethnic, women's, religious, etc. Central office and regional office personnel perform a number of functions at conferences in addition to staffing exhibits to answer participants' questions and pass out printed information on Social Security-related

issues and concerns. They also conduct workshops and seminars, arrange for the Commissioner and other agency officials to speak at plenary sessions and serve on panels with private sector and other Government agency officials. Since these activities are ongoing, information about the Children's Health Insurance Program could be incorporated in talking points or exhibit materials (when appropriate) as soon as the materials are finalized. (Fall 1998)

4. Include children's health insurance publications in our Teachers' Kits when they are reprinted in early 1999. The SSA Teachers' Kit is a self-instructional set of materials for teachers to use in high school classrooms. It includes five lesson plans, a teacher's guide, a 24-minute video, fact sheets, and other handouts. The material are designed to provide a basic understanding of Social Security programs young people can use now and in the future. It is anticipated that 35,000 Teachers Kits will have been distributed during the period beginning September 1996 and ending December 1998. SSA plans to print another 20,000 Teachers' Kits in early 1999.

B. Educating Families and Enrolling Children in Medicaid and CHIP

5. Display children's health insurance pamphlets and posters in SSA's 1,300 field office reception areas and distribute them at various publicity functions. SSA could provide HFCA a summary sheet, disk, and labels containing the field office addresses. The summary sheet could list the various classes (sizes) of field offices and the suggested numbers of flyers and posters that should be sent to each. This number of flyers and pamphlets includes a supply of these items to be stored in SSA's Public Information Distribution Center (PIDC) so local offices can reorder whenever necessary. (Fall 1998)

6. Annotate field office referral screen with the national toll-free number for CHIP/Medicaid. The 800-number system contain's pop-up screens of information on the most prevalent SSA issues/concerns. This system currently has a Medicaid screen and CHIP could be added to that screen. The staff could be informed about the CHIP outreach program via either e-mail or a Teleservice Center Guide. (Fall 1998)

C. Coordination with Other Programs

7. Link SSA's website to DHHS children health website. SSA currently has a children's webpage in addition to its main home page. Links could be established on SSA's children's page and on the main webpage to HCFA's website. This would not require an interagency agreement and

would be updated whenever HCFA made changes in the CHIP website. (Summer 1998)

8. Provide HCFA a mailing list for an outreach letter about Medicaid and CHIP. HCFA or States could send an outreach letter to children denied SSI or who are receiving benefits on the basis of the death, disability, or retirement of the worker/parent. This kind of mailing list would be via a tape that SSA can produce in approximately four months. (Fall 1998)

9. Send a message on children's health outreach to community organizations. The Office of Communications will have a national community organization database in the summer of 1998. This database will contain 5,000 to 10,000 community organizations and it will be possible to identify those that serve families, children, and others who are interested in health issues. (Fall 1998)

8. REPORT FROM THE SECRETARY OF TREASURY

I. CURRENT PROGRAMS AND OUTREACH ACTIVITIES FOR CHILDREN

A. Programs that Serve Middle to Low-Income Children

As the Federal Government's financial agent, the Treasury Department not only interacts face-to-face with many families every year — including many families with children that are middle to low-income — but also works with a number of groups and organizations that serve this population. While these contacts occur primarily through the Internal Revenue Service (IRS) and its efforts to assist taxpayers, some will also arise as part of the Department's efforts to expand the use of electronic transfers of Federal benefit payments.

Earned Income Tax Credit (E.I.T.C.) Compliance Initiative ($138 million appropriation in FY 1998) is authorized under section 5702 of the Balanced Budget Act of 1997, P.L. 105-33. The E.I.T.C. is a refundable tax credit for working families with low and moderate income. It encourages families to move from welfare to work by making work pay, and helps ensure that parents who work full-time do not have to raise children in poverty and that families with modest means do not suffer from eroding incomes. Among other things, this appropriation supports expanded customer service, including increased community-based tax preparation sites and a coordinated marketing and educational effort to assist low-income taxpayers in determining their eligibility for the

E.I.T.C.. *Target population: Over 15 million low-income working families — generally those with one child and income below about $26,000 or those with more than one child and income below about $29,000 — are expected to claim the E.I.T.C. on their 1997 tax returns.*

IRS Walk-in Office Operations ($50 million appropriation in FY 1998) are funded through the Treasury Department Appropriations Act, P.L. 105-61. This appropriation helps the IRS operate a network of over 400 walk-in offices around the country, where taxpayers can go for answers to questions and to help resolve problems about Federal income taxes. While assistance is available at these offices year round, starting this year certain days during the tax season are focussed on helping taxpayers who are eligible for the E.I.T.C. fill out their returns and calculate their credit (with identifiable E.I.T.C.-related costs allocated to the E.I.T.C. Compliance Initiative). *Target population: Taxpayers with questions or who are seeking to resolve problems related to Federal taxes, including those seeking assistance in determining their eligibility for the E.I.T.C..*

Electronic Funds Transfer Initiative (EFT99) ($1.9 million appropriation in FY 1998) is authorized under the Debt Collection Improvement Act of 1996, P.L. 104-134. Under this appropriation, the Department's Financial Management Service (FMS) is actively pursuing measures to enhance the use of electronic fund transfers, which cost less and provide a more secure and reliable means of making payments to Federal beneficiaries. In the summer of 1998, FMS will begin an intensive year-long effort to encourage more beneficiaries to receive their payments electronically. As part of this process, FMS has developed an extensive list of community-based organizations around the country — most of which have constituents living in low-income communities — that will be contacted. *Target population: Those who receive Federal benefits by check — many of whom are low-income — who are to be reached through community-based organizations which serve them.*

B. Current Activities in Children's Health Outreach

Because the Treasury Department has historically not played a role in disseminating information about health insurance options for children, it currently has no outreach activities in this area.

II. PROPOSED PLANS FOR CHILDREN'S HEALTH OUTREACH

A. Educating Workers about Medicaid and CHIP

Federal Workers

1. Send memorandum from the Secretary to all Treasury employees. Considering both the high priority attached to this initiative and the extent to which they work with low-income families, the Department would propose to educate its workers about Medicaid and CHIP by sending a memorandum from the Secretary to every Treasury employee — about 158,000 in all. Incorporating language to be developed by HHS for use by other agencies, this memo would summarize the President's outreach initiative and the steps the Department plans to take as a result. It would also indicate that further guidance will be forthcoming for employees that would be affected by these proposed steps, and would refer both to the weblinks (see below) and to the Medicaid/CHIP toll-free information number that will be established as sources of more detailed and updated information about these programs. Implementation could take place soon after this report is approved by the President. Once the steps proposed in this report are implemented, options for updating employees about progress that has been made and for soliciting ideas about further possible steps would be explored.

Other Workers

2. Help make information on Medicaid and CHIP available in conjunction with certain E.I.T.C. outreach efforts and events. The IRS is engaged in a wide range of activities as part of its marketing and educational campaign to assist low-income taxpayers in determining their eligibility for the E.I.T.C.. Though in some cases it would not appear possible to incorporate Medicaid and CHIP materials into these efforts without unduly complicating the process of disseminating information about the E.I.T.C. itself — information that is also very important for lower-income working families — in other cases the two outreach efforts could dovetail nicely. For example, E.I.T.C. outreach workers will be participating in 12 conventions held by relevant organizations (e.g., NAACP, La Raza, hotel/motel workers, tax practitioners) this fiscal year. The Department would propose to begin discussions with HHS at the earliest opportunity about the best way to provide information on Medicaid and CHIP though these contacts. The IRS also interacts regularly with the Center on Budget and Policy Priorities — which has sent its own E.I.T.C. mailing to over 25,000 groups and organizations in its database — and the American Association of Retired Persons (AARP), which has been active both in Medicaid outreach and taxpayer assistance; both groups could be encouraged through these channels to add or expand communications about Medicaid and CHIP and to contact HHS for outreach materials.

B. Educating Families and Enrolling Children in Medicaid and CHIP

3. Post basic materials on Medicaid and CHIP at IRS walk-in centers and provide them to Voluntary Income Tax Assistance (VITA) sites. The Department would place in each of the 400 IRS walk-in centers a copy of outreach posters which highlight the availability of these health insurance programs for children, and urge potentially eligible families to call the toll-free Medicaid/ CHIP information number so that they can find out more about whether they are actually eligible and about how to apply. Pamphlets provided by HHS — or another item that families could take with them describing the programs and highlighting the toll-free number — could also be posted. In addition, there are about 8,600 VITA sites around the country where non-profit groups provide help to tax filers, most often those who are lower-income; here too the HHS posters and possibly other referral information could be provided with high impact. The Department would propose to begin discussions with HHS at the earliest opportunity about how best to reach these VITA sites (e.g., by providing HHS with a mailing list and collaborating on the text of a transmittal letter) and on the quantity and type of materials required. Contingent on the provision of these materials by HHS early in the next fiscal year — and on the successful implementation of the toll-free number to which they would refer — these steps could begin in FY 1999 and be updated as appropriate in subsequent years.

4. Invite State outreach workers to certain walk-in centers on E.I.T.C.-focussed days. Given the overlap between the E.I.T.C. and Medicaid/CHIP target populations, the days at certain walk-in centers that will be focussed on E.I.T.C. assistance provide a substantial opportunity to reach this audience. To take maximum advantage of this opportunity while absolutely minimizing the burden on the IRS workers at these centers during times of peak demand, the Department would propose having a Medicaid/CHIP outreach worker at appropriate walk-in center on those days. Because these centers are generally small and have very limited space available, and due to taxpayer privacy concerns, an extensive presence would not be feasible. Where space permits, this worker could be available in the waiting area to provide information materials and possibly mail-in application forms that are requested, and to answer the questions of walk-in center patrons. The Department would propose discussions with HHS to resolve any logistical and implementation issues surrounding this proposal. Based on these discussions, the Department would propose to have this invitation be coordinated through HHS, with Treasury providing a list of the centers and days involved to be passed on to the relevant State agencies. If practical, a notice could be posted at the designated walk-in centers in advance, announcing the dates that an outreach worker will be available on-site. Implementation of the steps

outlined here could begin once the dates and locations of these E.I.T.C.-focussed days have been established for FY 1999.

C. Coordination with Other Programs

5. Help provide information about Medicaid and CHIP to the community-based organizations being contacted through the EFT99 initiative. Since the organizations being contacted through this initiative over the next year are likely to interact with many families that are eligible for Medicaid and CHIP, the list of them that has been developed — which includes a large number of local offices located in the communities of interest — constitutes a valuable database for outreach purposes. The Department would propose sharing this list with HHS at the earliest opportunity and coordinating about the most effective means of distributing materials such as posters and pamphlets to these organizations, once these materials are available.

6. Add Medicaid/CHIP link to Treasury's websites. The Department could add a link to the CHIP/Medicaid webpage at HHS to its external website for the general public; to its internal website for Departmental employees; and to the E.I.T.C. home page maintained by the IRS. Implementation may depend on further development of this HHS webpage. (Fall 1998)

APPENDIX A:

EXECUTIVE MEMORANDUM, FEBRUARY 18, 1998

MEMORANDUM
FOR THE
SECRETARY OF
TREASURY

THE SECRETARY
OF AGRICULTURE

THE SECRETARY
OF THE INTERIOR

THE SECRETARY
OF LABOR

THE SECRETARY
OF HEALTH AND
HUMAN SERVICES

THE SECRETARY
OF HOUSING AND
URBAN
DEVELOPMENT

THE SECRETARY
OF EDUCATION

THE
COMMISSIONER
OF SOCIAL
SECURITY

SUBJECT:
Children's
Health Insurance
Outreach

Over 10 million of our Nation's children are currently uninsured and, as a consequence, often cannot afford much-needed health care services such as doctor visits, prescription drugs or, hospital care. Last year, with bipartisan support, we took a major step toward solving this problem. The Balanced Budget Act that I signed into law enacted the largest single expansion of children's health insurance in 30 years. The new Children's Health Insurance Program (CHIP) provides $24 billion over 5 years for coverage of millions of uninsured children in working families. It builds on the Medicaid program, which currently covers nearly 20 million poor children across the country.

We now face the serious task of enrolling uninsured children in both Medicaid and State-administered children's health programs. We know that well over 3 million uninsured children are eligible but not enrolled in Medicaid. This is largely due to a lack of knowledge about Medicaid eligibility and the difficulty of the enrollment process. These same

problems could limit the potential of CHIP to successfully enroll millions of uninsured children.

To ensure that both Medicaid and CHIP fulfil their potential, I am calling for a nationwide children's health outreach initiative involving both the private and public sectors. As illustrated by my announcement today, foundations, corporations, health care providers, consumer advocates and others in the private sector are already responding to our challenge to make every effort to enroll uninsured children in Medicaid or CHIP. In the public sector, my FY 1999 budget proposal includes policies to give States the flexibility and funding they need to conduct innovative outreach activities. The Health Care Financing Administration (HCFA) and Health Resources and Services Administration (HRSA) should continue their focused efforts to promote outreach through administrative actions.

There is clearly more that the Federal Government can do to help the States and the private sector achieve our mutual goal of targeting and providing coverage to uninsured children. Many children who lack health insurance are the same children who benefit from the programs your agency now administers. Eligibility for Medicaid and CHIP is often similar to that for programs like WIC, Food Stamps, Head Start, tax programs, job training, welfare to work, Social Security , public housing, and homeless initiatives. Thus, a coordinated Federal interagency effort is critical to the success of the Administration and the States to provide health care coverage for children.

Therefore, to increase enrollment of uninsured children in Medicaid and CHIP, I hereby direct you to take the following actions consistent with the mission of your agency.

First, I direct you to identify all of the employees and grantees of your agency's programs who work with low-income, uninsured children who may be eligible for Medicaid or CHIP.

Second, I direct you to develop and implement an educational strategy aimed at ensuring that your agency's employees and grantees are fully informed about the availability of Medicaid and CHIP to our Nation's children.

Third, I direct you to develop an agency-specific plan as part of our Administration-wide, intensive children's health outreach plan. Your agency's plan should include distributing information and educating families about their options; coordinating toll-free numbers and other sources of information on public programs; simplifying, coordinating, and, where possible, unifying the application process for related public

programs; and working with State and local agencies on broadening the locations where families can apply for Medicaid and/or CHIP.

Fourth, I direct you to identify any statutory or regulatory impediments in your programs to conducting children's health insurance coverage outreach.

Finally, I direct the Department of Health and Human Services to serve as the coordinating agency to assist in the development and integration of agency plans and to report back to me on each agency's plan in 90 days with recommendations and a suggested implementation timetable. In so doing, I direct the Department to ensure that Federal interagency activities are complementary, aggressive, and consistent with the overall initiative to cover uninsured children.

APPENDIX B:

PRESIDENT CLINTON'S INITIATIVE FOR CHILDREN'S HEALTH

Enacted Single Largest Investment in Children's Health Care since 1965. The Balanced Budget that President Clinton signed into law on August 5, 1997 included $24 billion for the Children's Health Insurance Program (CHIP) -- the single largest investment in health care for children since the passage of Medicaid in 1965. CHIP will provide health care coverage to millions of currently uninsured children -- including prescription drugs, vision, hearing, and mental health services.

Passed Meaningful Health Insurance Reform. The President signed the Health Insurance Portability and Accountability Act which limits exclusions for pre-existing conditions, makes coverage portable and helps individuals who lose jobs maintain coverage. This law helps millions of children keep their health care coverage when their parents lose or change jobs.

Raised Immunization Rates to All Time High. 90 percent or more of America's toddlers in 1996 received the most critical doses of each of the routinely recommended vaccines -- a record high that surpasses the goal set by the President in 1993.

Protected Children in Child Care Settings by Ensuring Proper Immunization. In July 1997, President Clinton proposed new child care regulations to ensure that children in child care receive the immunizations they need on time. The proposed rule would require that all children in Federally subsidized child care be immunized according to State public

health agency standards. This will particularly help children in child care arrangements that are legal but exempt from State licensing.

Ensured that Prescription Drugs Have Been Adequately Tested for Children. President Clinton announced an important Food and Drug Administration regulation requiring manufacturers to do studies on pediatric populations for new prescription drugs -- and those currently on the market -- to ensure that prescription drugs have been adequately tested for the unique needs of children.

Established Protections for Mothers and Their Newborns. The President spearheaded legislation requiring insurance companies to cover at least 48 hour hospital stays following most normal deliveries and 96 hours after a Caesarean section. This legislation ensures that mothers and babies do not leave the hospital before they and their doctors decide they are ready.

Increased Research Funding at the National Institutes of Health. The President increased funding at the National Institutes of Health (NIH) by over $900 million, for a total of $13.6 billion for NIH in FY 1998. Between 1993 and 1998, NIH funding increased by $2.4 billion, or 35 percent, benefitting critical research areas such as cancer, the Human Genome Project, and children's health.

Improved Children's Health and Safety with Healthy Child Care America. In an effort to improve the health and safety of child care programs and to provide child health education to child care providers and parents, the Clinton Administration launched the Healthy Child Care America initiative. This effort has established partnerships between child care providers and health care services in 46 States, helping to ensure safe and healthy environments for children.

APPENDIX C:

TARGETING VULNERABLE GROUPS OF CHILDREN

Some children eligible for Medicaid or CHIP are difficult to reach due to barriers to understanding or responding to outreach activities geared to a mainstream population. Special populations and minorities often face sociocultural and linguistic differences, low literacy levels, geographic isolation, homelessness, or transient living situations that make it difficult for them to enroll in health insurance. As a result, these groups tend to have higher rates of uninsured children. While general outreach strategies for CHIP and Medicaid enrollment may result in increased enrollment

among these groups, a number of outreach activities have been proposed by Departments targeted specifically at reducing the unique barriers faced by minorities and special populations.

Native American/Alaska Native Children

American Indians are among the most disadvantaged minority in this country, particularly with respect to health. Approximately 38.3 percent of Native American children live in families below the Federal poverty level. Native American families may be hesitant to apply for or receive State health care or supportive services because of cultural differences. Although many Native Americans are eligible to receive a comprehensive range of health care services through the Indian Health Service (IHS), these services are often limited by budget constraints. In addition, State workers are often unfamiliar with tribal lifestyles, family values, and communication styles. The coordination of reservation based IHS services with the Medicaid and CHIP programs will be crucial in providing Native American children with access to health care services. Activities proposed to increase the enrolment of Native American/Alaska Native children include:

Mapping Service Delivery Sites. Under the direction of the Department of the Interior, Federal agencies providing any reservation-based social, supportive, and health care programs or services will map all of their service delivery sites in order to efficiently coordinate outreach efforts to potentially eligible Native American children.

Brochure Development. Because of the experience that many Native American families have had in dealing with IHS and with State programs, the Department of the Interior will develop a brochure explaining the Medicaid and CHIP programs, how they differ from IHS services, and how Native American families can work with the State to enroll their children.

Targeted Mailings. The Department of Housing and Urban Development (HUD) could send information on CHIP and Medicaid to families who have purchased homes under the Department's Section 184 Indian Home Loan Guarantee Program as the children in these families are likely to be eligible for health insurance programs.

Hispanic Children

Hispanic children have the highest rate of uninsured children of all major racial and ethnic minority groups: 29 percent were uninsured in 1996 (U.S. Census Bureau, 1998). Seventy-three percent of Hispanic children live in families with incomes below 200 percent of the Federal poverty

level and are potentially eligible for Medicaid or CHIP. Barriers to enrollment in health insurance programs for this population include lack of Spanish language outreach information and applications in some areas, the welfare stigma of health programs, and a fear that applying for a public program could cause problems with immigration officials for family members. The following activities have been proposed in an attempt to alleviate existing barriers to enrollment in health insurance programs for this population:

Development of Bilingual Educational Materials. The Health Care Financing Administration (HCFA) could partner with Educational Video in Spanish, Inc. to develop public service announcements about the availability of Medicaid and CHIP. These advertisements could be aired on Spanish language television nationwide.

Partner with Minority Advocacy Groups. HCFA could partner with La Raza and other organizations representing Hispanic populations to explore how they can assist State Medicaid and CHIP agencies in conducting outreach.

Focus Groups. HCFA could conduct focus groups to identify outreach needs of newly arrived and well-established Hispanic immigrants and will share this information with States. The focus groups will identify perceived application barriers to enrollment, specific cultural barriers, and identify to what extent States target outreach activities to address the Hispanic population.

African American Children

Almost 19 percent of black children live in very poor neighborhoods, where over 40 percent of the residents are below the Federal poverty level. Sixty-eight percent of black children live in families with incomes below 200 percent of the Federal poverty level and are potentially eligible for Medicaid or CHIP. Barriers to enrollment in health insurance programs for this population include a lack of culturally appropriate information about available programs and inaccessibility of sites for applications in some urban areas. The following activities have been proposed in an attempt to alleviate existing barriers to enrollment in health insurance programs for this population:

Outreach Conference. The Health Resources and Services Administration and the Health Care Financing Administration are sponsoring a Children's Health Insurance Program Outreach Conference for Historically Black Colleges and Universities (HBCUs) on August 13-14, 1998. The purpose of this conference is to provide HBCUs with information on the Federal framework for CHIP and State options for its implementation and

administration, and to examine outreach strategies that HBCUs can employ to assist in enrolling children in Medicaid and CHIP.

Partnership with Minority Advocacy Groups. HCFA could develop partnerships with the National Congress of Black Churches, Historically Black Colleges and Universities, and other organizations representing African Americans to explore how they can assist State Medicaid and CHIP agencies in conducting outreach.

Training on Cultural Sensitivity and Cultural Competence. HCFA could develop educational outreach modules for training its Central and Regional Office outreach specialists on cultural sensitivity and cultural competence to minority populations, particularly African American children. This training will assist staff in providing technical assistance to States in developing culturally sensitive information specific to minority populations.

Asian American/Pacific Islander Children

Approximately 16.7 percent of Asian American children are part of families with incomes below the Federal poverty level. Barriers to enrollment in health insurance programs for this population include language barriers and the welfare stigma associated with public assistance programs. To address existing barriers to enrollment in health insurance programs for this population, ACF proposes the following activity:

Provide Technical Assistance for Outreach. DHHS' Administration for Children and Families (ACF) could, as part of a broader effort, supplement a technical assistance contract to include CHIP and Medicaid outreach activities to allow the to outreach to Pacific Islanders.

Homeless and Transient Children

Research has demonstrated a strong relationship between residential stability and the well-being of children. Young children are the most mobile of any child age group. In 1994, 22 percent of children under the age of five had changed residencies in the previous year. Estimates of homeless children range widely, based on seasonal and other variations. These children are at high risk for lacking insurance because of their transient life situations. The following activities have been proposed in an attempt to alleviate existing barriers to enrollment in health insurance programs for this population:

Education of Health Care Providers to the Homeless. HUD has proposed to educate homeless providers about CHIP and Medicaid by having HUD Field Office staff speak about the programs in technical assistance

meetings, satellite broadcasts, and conferences held to distribute HUD program information.

Revision of Existing Educational Materials. Information on CHIP and Medicaid could also be added to existing HUD homeless program fact sheets, booklets, and question and answer documents, as well as the homeless assistance Notice of Funding Availability materials.

Encourage Collaboration. Providers of services to the homeless could also be encouraged to establish relationships with local CHIP providers and make information on CHIP and Medicaid a standard part of their outreach, intake, and assessment processes.

Migrant/Border Children

These children are difficult to find and track because of migrant families' transient lifestyles. Migrants often face communication barriers due to poor literacy and linguistic difficulties. Further, some immigrant migrants are apprehensive about enrolling their families in public assistance of any kind. The Department of Health and Human Services has a number of health programs targeted specifically for migrant and border populations. In addition, HRSA proposes the following activity to help alleviate existing barriers to enrollment in health insurance programs for this population:

Expanding Site Visit Protocol. HRSA has proposed to expand the outreach worker site visits that presently take place through the Migrant Health Program and the Border Health Program to include dissemination of CHIP and Medicaid information.

Children With Special Health Care Needs

An estimated 16.9 percent of low income uninsured children had a special health care need in 1994. The primary reason for absence of coverage for this population is the high cost of health insurance. Without health insurance, low income children with disabilities experience substantial difficulties in accessing the health care services they need; these children are eight times more likely than insured children to be without a usual source of care. The following activity has been proposed to address barriers to enrollment in health insurance programs for this population:

Targeting Children With Special Health Care Needs for Enrollment. HRSA's Maternal and Child Health Bureau, through partnership with advocacy organizations such as Family Voices, could expand its efforts to identify and enroll children with special health care needs in Medicaid to include States' new CHIP programs. DHHS' Substance Abuse and Mental

Health Services Administration will also set up a workgroup to identify these children's unique access barriers and launch an effort to reducing them.

Rural and Isolated Children

Children in rural or isolated places often face communication and geographic barriers when attempting to enroll in health care insurance programs. The following activities have been proposed in an attempt to alleviate existing barriers to enrollment in health insurance programs for this population:

Encourage State Outreach Plans to Consider Rural Communities. HRSA could send letters to its 221 grantees from the Office of Rural Health Policy informing them about Medicaid and CHIP and encouraging them to get involved in their State's CHIP activities.

Using Distance Based Learning. CDC uses several different types of distance based learning for training health professionals around the country. CDC will put information about CHIP and Medicaid enrollment on the television screens either before or after the educational sessions. CDC is also exploring the possibility of conducting a satellite training session on CHIP and Medicaid during the summer of 1998. These forms of communication can educate rural health providers who, in turn, see must sick, uninsured children in their area.

APPENDIX D:

COORDINATING ELIGIBILITY IN HEALTH AND NON-HEALTH PROGRAMS

As outlined in the Presidential memorandum, Federal agencies can help enroll children in health insurance programs in a number of ways. One of these ways is through coordination of program eligibility rules, applications, and enrollment processes. Because of their unique goals and histories, public assistance programs often have different rules for income and/or resource limits; how income is defined; who is considered a member of the family; what type of documents are required for enrollment; and how applications are processed. These differences can result in children being enrolled in programs like Head Start or the National School Lunch program but not being enrolled in Medicaid or CHIP even when eligible.

Three major barriers can prevent coordination of Medicaid, CHIP and non-health programs. The first is the financial and non-financial eligibility rules. Different programs often have -- because of law, regulations, or State choice -- different definitions of family size, type of income counted toward eligibility, income disregards, upper income limits, and allowable resources. A second issue is the documentation required from the applicant. Families are usually required to bring proof of income, resources, birth certificates and other types of documentation -- even when a different agency might have already verified that information for their own program. Third, the application process itself may require multiple visits to different sites that may be geographically inaccessible or whose hours may be restricted.

The goal of simplifying and integrating eligibility for multiple Federal programs is both important and long-standing. In 1991, at the request of Congress, a DHHS and USDA produced a joint application for seven Federal programs -- WIC, Title V, Head Start, Migrant and Community Health Centers, Health Care for the Homeless and Medicaid. In 1994, the Department of Health and Human Services and the Department of Agriculture developed a report to Congress outlining the differences in program rules under Food Stamps, AFDC and Medicaid.

Most recently, DHHS sent a letter to States encouraging them to coordinate CHIP with Medicaid as they plan for their new programs (January 23,1998). It made specific suggestions on how to simplify Medicaid and integrate Medicaid and CHIP, including: using a simple, mail-in application; using a joint Medicaid-CHIP application; using joint processing of the Medicaid and CHIP applications; and taking advantage of new Medicaid options like presumptive eligibility and 12-month continuous eligibility for children. It also reiterated that there are few verification requirements under Federal Medicaid law. While it is important to maintain program integrity, excessive requirements for documentation can deter families from completing the application process. HCFA will continue to work with States on ways to simplify the Medicaid program.

A simple, coordinated Medicaid-CHIP application process is not only important to integrating those two programs, but is essential to linking health and non-health programs, many of which target similar families. For example, Food Stamps (income below 130 percent of poverty), free or reduced-price lunch under the National School Lunch Program (income below 185 percent of poverty), Head Start (most participants are below 100 percent of poverty) and subsidized child care all cover children who are probably also eligible for Medicaid or the new Children’s Health Insurance Program (CHIP). The simpler the health application process, the easier it is for formal or informal linkages across these programs.

This appendix describes both examples and suggestions of how States may improve enrollment in Medicaid and CHIP through coordination with other programs.

Same application for multiple programs. One of the best ways to ensure that a child eligible for two or more public programs gets enrolled in them is through the use of a single, joint application. By using a single application, the family fills out the application, provides necessary documentation and completes other necessary steps only once, improving the likelihood that the child is efficiently enrolled. This also can reduce State administrative costs associated with processing the same family multiple times.

- **Same application for WIC and Medicaid**. Vermont has a joint application for the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and its Medicaid program called "Dr. Dynasaur." The family fills out the application and checks boxes corresponding to the benefits that they would like to receive. If the WIC office receives the application, it photocopies it and sends it to Medicaid.
- **Same application for welfare, Food Stamps and Medicaid**. Most States (e.g., Illinois, Maryland, Michigan, Ohio) use joint applications for the various social services programs that are administered by the same agency. Similarly, Iowa uses a common application for Medicaid, Maternal and Child Health Services, WIC and Presumptive Medicaid Eligibility for Pregnant Women. When a joint application is filed at a different program site, Medicaid accepts this application date as the date Medicaid services can start.
- **Common Form for Referrals**. In South Dakota, health and social services programs use separate intake forms, but use a common page for referral to other programs that gives information about how to contact programs listed, including Child and Adult Care Food Program, Child Care assistance, Children's Special Health Services, Community/Migrant Homeless Health Centers, Family Planning, Head Start, Healthy Start, Medicaid/CHIP and WIC.

In an example like South Dakota, where many programs' applications are combined, there is often a need for follow-up questions on the application. However, it does not have to be a several-step process. In Vermont, once the application is completed, little additional information is needed from the family. States with a joint Food Stamps, welfare and Medicaid application frequently use the same agency to determine eligibility for these programs. This usually means that the joint application is sufficient, although some States have attached supplemental application pages for Medicaid. It is important to note that, in some instances, using a joint

application may not achieve the goal of improving enrollment of children in health insurance. If the additional questions required by other programs are long and difficult, it could make families' less likely to complete the application.

"Adjunctive" eligibility. An alternative to using a joint application for several programs is allowing eligibility for one program to be used to fulfil some or all of the eligibility requirements for another. For example, a family that shows its eligibility card for one program can be deemed fully or income eligible for another without going through an extensive application process. This "adjunctive" eligibility can shorten the Medicaid and/or CHIP application and speed up eligibility determinations.

- **SSI eligibility automatically means Medicaid eligibility for most children**. Children who are disabled and whose income and resources are below specified amounts are eligible for Supplemental Security Income. In most States, SSI children are not required to make a separate application to Medicaid, but are automatically eligible.
- **Medicaid eligibility automatically means WIC income eligibility**. By law, all women, infants and children enrolled in Medicaid are income eligible for WIC. WIC applicants must meet other eligibility requirements (e.g., must be determined at nutritional risk). Although not required, it can work in the opposite direction in States where Medicaid income eligibility is higher than that of WIC.
- **School Lunch Program eligibility for CHIP**. Florida's Healthy Kids program makes children eligible for the free or reduced-price meals under the National School Lunch Program automatically eligible for its State health insurance program. School districts in Colorado are also helping determine a child's eligibility for its State health program.

States with non-Medicaid CHIP expansions can use adjunctive eligibility, since there are few CHIP eligibility rules. Given Medicaid's flexibility on both State definition of income for children (e.g., 1902(r)(2)) and documentation requirements, States could also design an expansion where a child's enrollment in a program like Head Start, subsidized child care, or free school lunch programs either reduces the length of the application or substitutes for the usual documentation requirements.

Referral of families to Medicaid and/or CHIP. A third way that States may increase enrollment in health programs via other programs is to use a referral system. For example, the names of families screened or enrolled in one program could be sent to the Medicaid and/or CHIP agency for follow-up.

- **Food Stamp / Medicaid applicants match**. To identify uninsured children eligible for its Medicaid expansion ("TennCare"), Tennessee compared the lists of families with children participating in Food Stamps and TennCare. The families participating in Food Stamps but not in TennCare were sent an information letter, a mail-in application with a pre-addressed, postage-paid envelope, and a toll-free number for questions.
- **Check-box on School Lunch Program application**. Washington State includes a check-box on its School Lunch Program application for families interested in information on health insurance. This box plus a signature releases the name and address of the family to the State's Healthy Kids program. Like in Tennessee, families then receive an information letter and a mail-in application with a pre-addressed, postage-paid envelope.

In Tennessee, because the same State agency administers Food Stamps and Medicaid, the State may use the information from Food Stamps for Medicaid eligibility purposes. The information provided by families in the National School Lunch Program application may be shared with a number of Federal, State and local agencies. Federal law, however, specifically prohibits sharing the school lunch applicant information with Medicaid or CHIP agencies, without first receiving written permission from a student's parent or guardian. Washington State's approach is successfully structured within the statutory parameters, although not all families might check the box and not all Washington schools submit the names of interested families in a timely manner.

Assisting families at other program's eligibility offices. Finally, even if there is not a formal link in either the application itself or its processing, States have often outstationed eligibility workers at other program sites and/or trained other workers in the health application process so they can help families.

- **Outstationing eligibility workers in other program sites.** California is both expanding the number of sites where Medicaid eligibility workers will be outstationed and paying an "enrollment fee" to private contractors who successfully assist families in enrolling their children in the new Healthy Families program.
- **Using the new "presumptive eligibility" option**: Some States (e.g., Indiana, Connecticut, Massachusetts) have filed State plan amendments to allow workers to give children "temporary" or "presumptive Medicaid eligibility." Under Medicaid, States now have the option of allowing health care providers and eligibility workers for Head Start, WIC and the Child Care Development Block Grant to grant presumptive eligibility for children.

- **Training Head Start eligibility workers to screen and assist in health insurance enrollment.** Because children must have a health assessment and immunizations before enrolling in Head Start, people assisting in Head Start applications are in a good position to identify and help uninsured children. In Philadelphia, the school district's Head Start health coordinator refers families with uninsured children to a local advocacy organization that assists them in completing Pennsylvania's mail-in application over the phone. Louisiana contracts with Head Start staff and other community-based organizations (with Federal Medicaid administrative match) to assist families in completing Medicaid applications.

These examples are not exhaustive. Other Federal programs and States are successfully using these as approaches to integrate children's health and other programs. While a considerable amount of coordination can occur under current law, Federal agencies, States and advocates have identified some statutory barriers to coordination of programs (e.g., complexity of the Medicaid transition benefit; confidentiality rules that prevent programs from sharing names of potentially eligible families without parental permission). The Administration is committed to continuing to identify and remove such barriers, and DHHS has proposed a work group to accomplish this.

NOTE: This section was developed in with input from the Eligibility Technical Assistance Group of the American Public Welfare Association and the Center on Budget and Policy Priorities. Although their opinions or recommendations are not represented here, their assistance is appreciated.

APPENDIX E:

TARGETING NATIVE AMERICAN / ALASKA NATIVE CHILDREN USING MAPS

INTRODUCTION

Children's health insurance outreach presents a number of challenges in reservation-based and urban American Indian and Alaska Native communities. Through a comprehensive, coordinated Federal effort that supports localized integration of Medicaid/CHIP information dissemination, these barriers to children's health outreach may be overcome.

To coordinate children's health outreach efforts to potentially eligible American Indian/Alaska Native children, Federal agencies providing any reservation-based social, supportive, and health care programs and services have mapped their service delivery sites. Federal and tribally-contracted reservation-based programs under the Department of Agriculture, the Department of the Interior, the Department of Health and Human Services (including the Indian Health Service), and the Department of Housing and Urban Development were mapped on national and regional maps.

MAPS

The maps of Federal and tribally contracted service delivery sites allow for coordination of children's health outreach implementation strategies on reservations. Federal agencies can collaborate about the development of appropriate outreach materials and strategies, but avoid duplication of effort in the information dissemination stage. Maps provide a visual depiction of data. Displaying color-coded symbols make data easier for users to identify. These maps will benefit all Federal and tribal service providers, as they allows users to integrate implementation strategies and divide responsibilities and activities. The overall benefit of the use of maps for the purposes of children's health outreach include being able to quickly identify outstationed Medicaid/CHIP eligibility offices.

This Appendix includes two sample Regional maps. The legend notes the symbols and color-coding of assorted reservation-based federal agency programs and service delivery sites. The Aberdeen Area office encompasses the three states of South Dakota, North Dakota, and Nebraska. The 15 Indian tribes in the Aberdeen Area boast a total of 10 outstationed eligibility determination sites. The Portland Area office serves the states of Washington, Oregon, Idaho, and a portion of western Montana. The Indian tribes in the Portland Area, are highly concentrated in the northwest corner of Washington state. This area is enlarged on a separate Puget Sound detail map to allow the user a better view of the 18 tribes located in the vicinity. A great variety of social, support, and health services are available to reservation-based Indian communities in the Portland Area.

These maps, and any others that are developed, may be accessed on the internet at:

http://gdsc.bia.gov/hs.htm.

REFERENCES

Agency for Health Care Policy and Research (AHCPR). (1998). *Children's Health 1996*. Rockville, MD: Agency for Health Care Policy and Research, MEPS Chartbook No. 1.

Cohen-Ross, D. (Forthcoming, summer 1998). *Start Healthy, Stay Healthy Outreach Campaign Kit.* (Includes a comprehensive handbook on outreach strategies). Washington, DC: Center on Budget and Policy Priorities.

Institute of Medicine (IOM). (1998). *America's Children: Health Insurance and Access to Care*. Washington, DC: National Academy of Sciences.

Lave JR, Keane CR, Chyongchiou JL, Ricci EM, Arnersbach G, LaVallee CP. (1998). Impact of a Children's Health Insurance Program on Newly Enrolled Children. *JAMA* 279: 1820-25.

National Governors' Association (NGA). (1998). *Nation's Governors are Proud Partners in Effort to Expand Health Insurance to America's Children.* Washington, DC: National Governors' Association.

National Governors' Association (NGA). (1998). *How States Can Increase Enrollment in the State Children's Health Insurance Program.* Washington, DC: National Governors' Association.

Newacheck PW, Stoddard JJ, Hughes DC, Pearl M. (1998). Health Insurance and Access to Primary Care for Children. *New England Journal of Medicine* 338(8): 513-518.

Shuptrine SC, Grant VC, McKenzie GG. (1998). *Southern Regional Initiative to Improve Access to Benefits for Low Income Families with Children.* Columbia, South Carolina: Southern Institute on Children and Families.

U.S. General Accounting Office (U.S. GAO). (1998). *Medicaid: Demographics of Nonenrolled Children Suggest State Outreach Strategies*. Washington, DC: U.S. General Accounting Office (GAO/ HEHS-98-93).

U.S. General Accounting Office (U.S. GAO). (1997). *Health Insurance: Coverage Leads to Increased Health Access for Children*. Washington, DC: U.S. General Accounting Office (GAO/ HEHS-98-14).

U.S. Census Bureau. (1998). *Who Goes Without Health Insurance? Health Insurance Coverage: 1996*. Washington, DC: U.S. Department of Commerce, Economic and Statistics Administration.