Improving SCHIP Access for Hispanic Children

Report and Recommendations from the Field

National Alliance for Hispanic Health
Washington, D.C.

Mission: To improve the health and well-being of Hispanics.

The National Alliance for Hispanic Health (the Alliance) is the Nation's oldest and largest network of Hispanic health and human services providers. Alliance members deliver quality services to over 12 million persons annually.

As the nation's action forum for Hispanic health and well-being, the programs of the Alliance:

- Inform and mobilize consumers;
- Support providers in the delivery of quality care;
- Promote appropriate use of technology;
- Improve the science base for accurate decision making; and,
- Promote philanthropy.

The Alliance provides key leadership and advocacy to ensure accountability in these priority areas resulting in improved health for all throughout the Americas. The constituents of the Alliance are its members, Hispanic consumers, and the greater society that benefits from the health and well-being of all its people.

Published by the National Alliance for Hispanic Health. Supported by Grant Number 6H48MC00009-04 from the Health Resources and Services Administration (HRSA) Maternal and Child Health Bureau (MCHB). The opinions expressed herein are solely those of the author and contributors and do not necessarily reflect the policy or position of the funding source, Board of Directors of the National Alliance for Hispanic Health, or the members of the National Alliance for Hispanic Health.

Printed in the United States of America

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Table of Contents

Table of Contents

Figures

Tables

Executive Summary

In 1997, Congress enacted the State Children's Health Insurance Program (SCHIP) designed to make free or low-cost health insurance available to uninsured children not eligible for Medicaid. Hispanic children are nearly three times as likely to be uninsured as white non-Hispanic children and almost twice as likely to be uninsured as black non-Hispanic children. According to the U.S. Census Bureau's report on Health Insurance Coverage, in 2001, one in four (24.1%) Hispanic children were uninsured. This disproportionate lack of health insurance remains an important factor in the quality of life for Hispanic children.

Moving Forward: SCHIP for Hispanic Children, a program of the National Alliance for Hispanic Health, was created in 1998 to increase the enrollment of eligible Hispanic children in the SCHIP program. With funding from the Health Resources and Services Administration (HRSA) Maternal and Child Health Bureau (MCHB), this program established a National Advisory Committee and implemented a community initiative in eight cities with large Hispanic populations (Albuquerque, NM; Chicago, IL; Dallas, TX; Los Angeles, CA; Miami, FL; New York, NY; Phoenix, AZ; and, San Diego, CA). This effort was designed to improve health care services for Hispanic children in SCHIP programs; build a framework for community action; link Hispanic community leaders, federal agencies, and other key players at the state and local levels; and, provide recommendations to improve service and enrollment of eligible Hispanic children in SCHIP.

Eight Hispanic community-based organizations (CBOs) were selected as lead agencies to carryout the program in each of the selected cities. The CBOs implementing the initiative in each city had a unique perspective as circumstances varied from one site to another. The sites also had much in common: barriers to enrollment and retention for Hispanic children; the need to develop successful interventions in their communities; and, the goal of identifying recommendations for improving participation of Hispanics in SCHIP.

The National Advisory Committee (NAC) was created with the purpose of identifying the common and most significant barriers and best practices at the local level. The NAC was also charged with providing recommendations to HRSA and other government and private organizations interested in improving Hispanic children's access to health care. The NAC was composed of the executive directors from the eight Hispanic CBOs serving as lead agencies in this initiative and state or city government officials representing the SCHIP program from the same localities. The NAC met annually in Washington, D.C. The following are the challenges, best practices, and recommendations made by the NAC to improve Hispanic access to SCHIP and sustain enrollment gains.

Barriers to Implementation

Overall, the barriers identified in the project sites during the four-year initiative were:

- Inappropriate marketing and outreach in diverse racial and ethnic communities;
- Complex enrollment and renewal policies and procedures in Hispanic communities;
- Confusing policies to plan, implement, and sustain SCHIP in the states and local communities; and,
- Deficits within the states' budget that constrained efforts to sustain enrollment and services in SCHIP.

These barriers created significant challenges to Hispanic enrollment including:

- Lack of knowledge about the program and eligibility requirements for SCHIP;
- Lack of a basic understanding of the enrollment process;
- Lack of knowledge on how to navigate the health care system;
- Concerns regarding "public charge"[1]; and,
- Concerns about confidentiality.

Best Practices for SCHIP Implementation

The CBOs and the states addressed their local challenges to increase Hispanic access to SCHIP in unique ways. The most significant practices and policies implemented by the CBOs and the states to improve Hispanic participation in SCHIP were:

Community-Based Organizations

- Conducting one-on-one information, application assistance, and education on how to navigate the health care system;
- Utilizing mobile enrollment units to reduce transportation barriers and to reach rural and migrant communities;
- Establishing local coalitions and partnerships among community agencies to ensure culturally proficient and linguistically appropriate outreach and education in Hispanic communities;
- Distributing informational materials in English and Spanish;
- Providing one-on-one and written information on the "public charge" issue; and,
- Partnering with public and private agencies as well as other programs reaching Hispanic families in the community to better utilize community resources.

[1] "Public charge" is a term used in immigration law to describe persons who cannot support themselves and who depend on government benefits that provide cash, such as Temporary Assistance for Needy Families (TANF), General Assistance (GA), and Supplemental Security Income (SSI) for their income. Legal residents who become a "public charge" are ineligible to become U.S. citizens. Public benefits such as SCHIP and Medicaid are not considered as public charge for those participating in these programs (Department of Justice, Immigration and Naturalization Services, Washington, D.C.)

States

- Establishing partnerships between states, counties, cities, and CBOs to plan and implement appropriate community outreach and education;
- Development of streamlined and bilingual program applications;
- Development and dissemination of Spanish–language informational materials;
- Use of Spanish-speaking media to increase the awareness of the program;
- Elimination of face-to-face interviews;
- Eliminating the use of asset test to determine eligibility; and,
- Collecting data by race and ethnicity.

Recommendations

In general, the recommendations provided by the NAC were based on their local experiences and were geared to improve access to SCHIP and sustain enrollment gains:

Marketing and Outreach

- Link public information campaigns to CBOs that serve the targeted community;
- Develop public information campaigns that will include use of the most effective media outlets in Hispanic communities;
- Develop marketing and outreach plans that will distinguish among awareness of the program, education about it, and strategies with which to navigate the system;
- Redefine the goal of outreach to be to get families into a medical home; and,
- Take into consideration the literacy level of the community when planning media and outreach campaigns.

Enrollment and Retention

- Simplify enrollment and renewal policies and process;
- Eliminate lengthy and confusing forms;
- Promote the use of bilingual applications and renewal forms;
- Increase links among agencies that provide services for children and families; and,
- Establish presumptive eligibility and passive renewal to ensure timely enrollment and continuity of services.

Policy

- Eliminate five-year ban on SCHIP enrollment for new immigrants;
- Adhere to the Executive Order 13166 and DHHS Policy Guidance on services to limited English proficient (LEP) persons;
- Make available clear information about "public charge";
- Refrain from asking questions about immigration issues;
- Develop policies to ensure the continuity of services for migrant families across states;
- Develop programs to promote the medical-home concept; and,
- Collect data by race and ethnicity on enrollment and retention in SCHIP.

Funding

- Stabilize funding to ensure the continuity of services for all children and families in SCHIP;
- Fund CBOs to conduct comprehensive outreach for Hispanics and for the development of local initiatives;
- Provide economic incentives for clinics located in underserved neighborhoods to increase the number of providers accepting the program's insurance; and,
- Modify and redirect resources to educate families on how to become better health care consumers.

Conclusion

There has been a significant increase in SCHIP enrollment during the past four years, and many challenges are now being addressed at the community and state levels. Still, formidable obstacles remain— some, which were obvious from the beginning and others that have emerged along the way. In 2002, 2.2 million Hispanic children remain uninsured even though they are living in families with incomes under 150% of poverty, a level of poverty under which all states provide SCHIP qualification.

Introduction

Hispanic children and youth are more likely to lack health insurance than children in any other racial or ethnic group. According to the U.S. Census Bureau's report on Health Insurance Coverage in 2001, five years after the implementation of the SCHIP program, the proportion of Hispanic children uninsured has dropped from 28.9% to 24.1%. Despite this improvement, one in four Hispanic children (24.1%) continue to be uninsured compared with 13.9% of black non-Hispanic children, 11.7% of Asian and Pacific Islander children, and 7.4% of white non-Hispanic children who lacked health insurance in 2001.[2] The over-representation of Hispanic children among the uninsured impedes their access to the very health care services that are critical for healthy development and well-being.

To address the lack of health insurance for children, in 1997 Congress enacted the State Children's Health Insurance Program (SCHIP). This state-run program, funded with federal and state dollars was designed to make free or low-cost health insurance available to approximately 40% of an estimated 10 million uninsured children under the age of 19. Authorized by a new Title XXI of the Social Security Act, SCHIP gave states the option of creating a separate program for SCHIP, expanding Medicaid, or combining Medicaid and SCHIP. To date, all states, the District of Columbia, and five of the U.S. Territories have implemented Title XXI initiatives. One-third of the states have implemented SCHIP by expanding their respective Medicaid programs. The remaining states have chosen to create separate SCHIP programs, either as stand-alone initiatives or in combination with Medicaid expansions.[3]

To attend to the challenges regarding the disproportionate lack of health insurance among Hispanic children and youth, the National Alliance for Hispanic Health developed a program in eight communities with large Hispanic populations. With funding from the Health Resources and Services Administration (HRSA) Maternal and Child Health Bureau (MCHB), the National Alliance for Hispanic Health established *Moving Forward: SCHIP for Hispanic Children*. The program was designed to increase SCHIP enrollment and to improve health care services for Hispanic children in SCHIP programs. *Moving Forward* built the framework for community action; fostered collaboration among federal agencies, Hispanic community leaders, and other key players at the state and local levels; and provided recommendations on innovative, practical, and effective approaches to improve service and enrollment of eligible Hispanics in SCHIP. The following Hispanic community-based organizations served as the lead agencies in the implementation of *Moving Forward* in each of the eight selected communities:

- Chicago Hispanic Health Coalition, Chicago, Illinois;
- Concilio Latino de Salud, Phoenix, Arizona;
- Dallas Concilio of Hispanic Service Organizations, Dallas, Texas;

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[2] U.S. Census Bureau, *Health Insurance Coverage Status and Type of Coverage by Selected Characteristics for Children Under 18: 2001.* Current Population Survey, March 2002.

[3] Judith Wooldridge et al., *Interim Evaluation Report: Congressionally Mandated Evaluation of the State Children's Health Insurance Program.* Mathematica Policy Research, Inc., The Urban Institute, and the Health Systems Research, Inc. HHS-100-01-0002; MPR Reference No.: 8782-110, February 26, 2003.

Introduction

- Family Health Centers of San Diego, San Diego, California;
- Little Havana Activities and Nutrition Centers of Dade County, Miami, Florida;
- Multicultural Area Health Education Center (MAHEC), Los Angeles, California;
- Puerto Rican Family Institute, Inc., New York, New York; and,
- Youth Development Incorporated (YDI), Albuquerque, New Mexico.

This report outlines both the lessons learned from *Moving Forward* and key recommendations for others seeking to address the urgent health care needs of uninsured Hispanic children and families. As such, the report will be of particular interest for health and social service professionals, policymakers, members of CBOs, and advocates.

The first part of this report consists of an overview of the health insurance status of Hispanic children in the United States and background information about the State Children's Health Insurance Program (SCHIP), including a budget update. The second part of this report includes a brief description of the eight *Moving Forward* sites as well as the health insurance status of Hispanic children in the states where the sites are located, barriers that have dissuaded Hispanic families from enrolling their children in SCHIP programs, and best practices implemented at the state and local levels to address specific challenges facing Hispanics. A compilation of the most significant challenges and best practices carried out in the eight sites is presented in the final section to better represent the condition of Hispanics in the United States. The report concludes with a set of recommendations made by the *Moving Forward* National Advisory Committee to accomplish the mission of improving enrollment and health care for Hispanic families enrolled or eligible to participate in SCHIP programs.

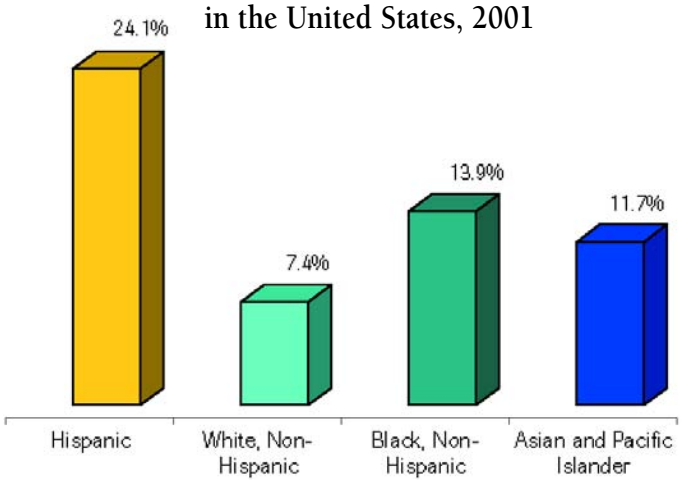
It is important to note that data collected to illustrate the status of the Hispanic uninsured and the SCHIP coverage for the 7 states in which the project was implemented was collected from different sources, which in turn have different methodologies to gather data. Regardless, the data presented in this document is the most updated available for each state. For the most part, cities, with the exception of San Diego and Los Angeles, have not yet made available SCHIP enrollment data by race and ethnicity.

Over the past four years, the *Moving Forward* initiative has both identified the serious failures in providing health insurance for Hispanic children and helped to uncover new strategies for promoting greater coverage and care. We trust the information in this report will serve as a road map for policymakers and practitioners seeking to improve access to health insurance and quality health care for the nation's underserved Hispanic children and families.

Health Insurance Status of Hispanic Children in the United States

An estimated 14.6 % of the United States population or 41.2 million people were without health coverage during the entire year in 2001.[4] This lack of health insurance disproportionately affects Hispanic families in the U.S. In 2001, 33.2% of Hispanics were uninsured, compared to 10.0% of white non-Hispanics and 19.0% of black non-Hispanics under the age of 65.[5] Furthermore, compared to other racial and ethnic groups, Hispanics have the largest percentage of uninsured children in the U.S. One in four (24.1%) Hispanic children are uninsured, compared to 7.4% of white non-Hispanic children, 13.9% of black non-Hispanic children, and 11.7% of Asian/Pacific Islander children[6] [See Figure 1]. In addition to decreasing access to quality care, this disproportionate representation of Hispanic families and children among the uninsured, often creates other health challenges for Hispanics.

Figure 1:
Percent of Children Uninsured by Race and Ethnicity in the United States, 2001



Source: U.S. Census Bureau, *Health Insurance Coverage Status and Type of Coverage by Selected Characteristics for Children Under 18: 2001.* Current Population Survey, March 2002.

The consequences from the lack of health insurance are unfortunately too real for many Hispanics. Uninsured children are nearly four times as likely to have an unmet health care need than insured children (22 percent vs. 6 percent).[7] Uninsured children are also 70% more likely than insured children not to receive medical care for

[4] Robert J Mills, *Health Insurance Coverage: 2001.* The United States Census Bureau, Current Population Reports P6-220. September 2002.

[5] U.S. Census Bureau, *Health Insurance Coverage: 2001*, People without Health Insurance Coverage for the Entire Year by Race and Ethnicity (3-year Average): 1999-2001. http://www.census.gov/hhes/hlthins/hlthin01/hi01t3.html

[6] U.S. Census Bureau, *Health Insurance Coverage Status and Type of Coverage by Selected Characteristics for Children Under 18: 2001.* Current Population Survey, March 2002.

[7] Paul Newacheck et al., *Health Insurance and Access to Primary Health Care for Children.* New England Journal of Medicine 338, No. 3, pp. 513-19.

common conditions like ear infections and 30% less likely to receive medical attention when they are injured.[8] In addition to the health consequences, lack of health insurance can have a substantial financial impact on the household. In 2002, about 44% of the uninsured families had a serious problem paying medical bills.[9] While some uninsured Hispanics do not qualify to be enrolled in Medicaid or SCHIP, others are eligible to participate in either of these programs; however, systemic, economic, and cultural barriers, among others, prevent them from accessing health insurance and quality care.

The barriers that dissuade Hispanic families from enrolling their children in Medicaid also affect the State Children's Health Insurance Program in all fifty states, the District of Columbia, and the U.S. territories. According to the U.S. Government Accounting Office (GAO), Hispanic children are more likely than other racial and ethnic groups to remain uninsured despite their eligibility for Medicaid benefits.[10] Some of the reasons cited by the GAO and Hispanic leaders[11] for the failure to enroll eligible children include: 1) families' lack of awareness about services and eligibility; 2) cultural and linguistic barriers; 3) fear of government programs and confusion about "public charge;"[12] 4) complex policies and procedures for enrollment and maintenance of SCHIP health coverage; and 5) not wanting public insurance coverage or feeling insurance coverage is not needed.[13] Despite progress in increasing SCHIP enrollment during the past three years, many barriers remain, and new challenges have emerged that continue to impede the process.

Furthermore, citizenship status of the child and the child's parents are major determinants of whether the child is insured. A study conducted by the Center on Budget and Policy Priorities shows that nearly half (46%) of non-citizen children are uninsured.[14] [See Table 1, Page 9].

A report from the Urban Institute also found there may be concerns that a child's participation in Medicaid or SCHIP might threaten the immigration status of non-citizen parents. Conflicting federal statements in regard to the "public charge" issue has been one of the most significant barriers for eligible immigrant families enrollment in SCHIP. Moreover, for children whose parents view welfare negatively, the issue may involve general family reluctance to participate in government programs.

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[8] The Kaiser Commission on Medicaid and the Uninsured, *Key Facts: The Uninsured and Their Access to Health Care*. Henry J. Kaiser Family Foundation, January 2003.

[9] Ibid.

[10] The United State General Accounting Office, *Medicaid: Demographics of Nonenrolled Children Suggest State Outreach Strategies*. Report to the Honorable John McCain, U.S. Senate; GAO/HEHS-98-93. March 1998.

[11] The National Alliance for Hispanic Health, *National Advisory Committee 2000, 2001, and 2002 Meeting Reports. Moving Forward: CHIP for Hispanic Children*. Unpublished reports.

[12] "Public charge" is a term used in immigration law to describe persons who cannot support themselves and who depend on government benefits that provide cash, such as Temporary Assistance for Needy Families (TANF), General Assistance (GA), and Supplemental Security Income (SSI) for their income. Legal residents who become a "public charge" are ineligible to become U.S. citizens. On the other hand, public benefits such as SCHIP and Medicaid are not considered as public charge for those participating in these programs.

[13] Lisa Dubay, Ian Hill, and Genevieve Kenney, *Five Things Everyone Should Know About SCHIP*. The Urban Institute and the New Federalism: Issues and Options for States. Series A, No. A-55; October 2002. .

[14] Leighton Ku and Shannon Blaney, *Health Coverage for Legal Immigrant Children: New Census Data Highlight Importance of Restoring Medicaid and SCHIP Coverage*. Center on Budget and Policy Priorities, October 10, 2000, pp. 8.

Table 1:
Percent of Children Who are Uninsured by Citizenship Status, Ages 0-17, U.S., 2000

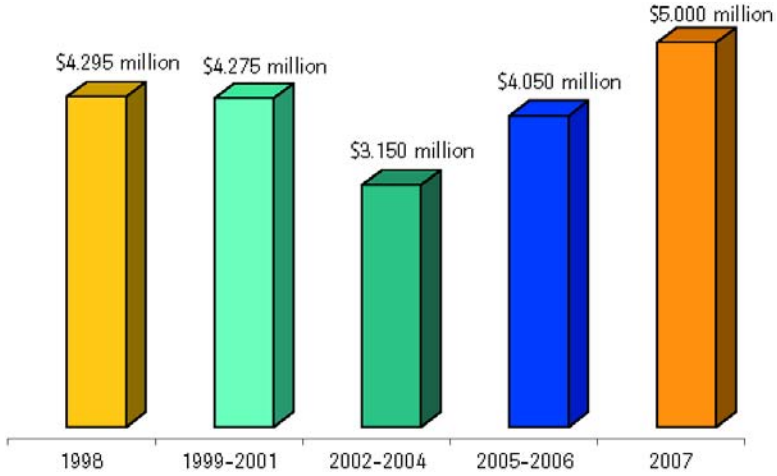
Citizenship Status	Percent of Uninsured
Non U.S. Citizen Children	46%
U.S. Citizen Children with Non-Citizen Parents	31%
U.S. Citizen Children with U.S. Born Parents	20%

Source: Leighton Ku and Shannon Blaney, *Health Coverage for Legal Immigrant Children: New Census Data Highlight Importance of Restoring Medicaid and SCHIP Coverage.* Center on Budget and Policy Priorities, October 10, 2000, pp. 8.

State Children's Health Insurance Program (SCHIP) and Medicaid Overview

The Balanced Budget Act of 1997 established the State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act. The enactment of SCHIP gave states $39.7 billion over 10 years to provide health coverage for low-income, uninsured children that do not qualify for Medicaid. The total annual appropriations are $4.295 billion for fiscal year (FY) 1998; $4.275 billion for each fiscal year from 1999 through 2001, $3.15 billion per year from FY 2002 through FY 2004; $4.05 billion per year from FY 2005 through FY 2006; and $5.0 billion in FY 2007.[15] [See Figure 2]

Figure 2:
State Children's Health Insurance Program Appropriations



Source: Frank Ullman, Brian Bruen, and John Holahan, *The State Children's Health Insurance Program: A Look at the Numbers.* Assessing the New Federalism; The Urban Institute, March 1998, Pp. 3.

[15] Frank Ullman, Brian Bruen, and John Holahan, *The State Children's Health Insurance Program: A Look at the Numbers.* Assessing the New Federalism; The Urban Institute, March 1998, Pp. 3.

After the implementation of the program there was a steady decline in the rates of children who were uninsured (from 13.9% in 1997 to 10.8% in 2001). The total number of enrolled children increased from 2.2 million in 2000 to 4.5 million in 2001. This decline was probably due to both enrollment of eligible children in SCHIP and greater Medicaid participation among previously eligible children, as a result of increased outreach and eligibility simplification.[16] However, the program's achievements are being affected by the lower amount of funding allocated for the 2002-2004 fiscal years in comparison with previous years (the so called "SCHIP funding dip"); the pending reversion of unspent federal money to the U.S. Treasury; and the states' budget crises exacerbated by the slowdown of the economy.

Eligibility levels for public programs or integration across programs are often limited by federal regulations. A strategy being implemented to provide health coverage to previously non-eligible populations is the approval of "waivers" from some of these federal regulations. States can submit applications to the U.S. Department of Health and Human Services with a plan for how they would like to change their SCHIP or Medicaid program and request a "Section 1115 waiver" for certain federal requirements. For instance, some states have received waivers to expand eligibility under SCHIP and Medicaid for childless adults and for parents of SCHIP eligible children.[17]

Other expansions and enrollment reforms being conducted through waivers include enrollment simplification, decreased cost sharing, allowing self-declaration of income, eliminating face-to-face interviews, implementing a passive enrollment renewal process, eliminating the assets test, 12-month continuous eligibility, allowing presumptive eligibility,[18] joint application for SCHIP and Medicaid, and eliminating or shortening waiting periods of uninsurance. Table 2 (page 11) shows some of the most significant simplification and expansion approaches carried out by the states to increase SCHIP access to children and families.

These expansion reforms, however, are being affected by growing budget deficits in many states. States affected by budget deficits are adopting strategies that influence enrollment and access to health care. Freezing enrollment and/or limiting the time period in which the SCHIP participant can enroll; increasing family premium requirements; reducing or eliminating benefits; and undoing eligibility and enrollment simplifications that make it easy for families to enroll and retain SCHIP coverage, are some of the practices being implemented at the state level to balance their health care spending. Projections made by the Office of Management and Budget (OMB) for fiscal year 2003 estimated that SCHIP enrollment will decline by 900,000 between 2003 and 2006 due to these access limitations.

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[16] Lisa Dubay, Genevieve Kenney, and Jennifer Haley, *Children's Participation in Medicaid and SCHIP: Early in the SCHIP Era*. The Urban Institute and the New Federalism National Survey of America's Families; Series B, No. B-40, March 2002.

[17] FamiliesUSA, *Disparities in Eligibility for Public Health Insurance: Children and Adults in 2001*. February 2002.

[18] Presumptive eligibility is granting a short-term eligibility before an actual determination is made so the child can receive immediate health services.

Table 2:
State Children's Health Insurance Enrollment Simplifications and Expansions

- Thirty-nine states and the District of Columbia make health coverage available to children in families of four with incomes of up to $36,800 a year.
- Forty-six states and D.C. do not require face-to-face interviews to determine eligibility for their Medicaid and separate SCHIP programs.
- Forty-three states and D.C. do not use asset tests to determine eligibility for their Medicaid and separate SCHIP programs.
- Seventeen states guarantee a full 12 months of coverage for children enrolled in their Medicaid and separate SCHIP programs, regardless of changes in family circumstances.
- Nine states have adopted a presumptive eligibility option (providing immediate coverage as soon as an application is submitted) for children in Medicaid, and six states use the option in both their Medicaid and separate SCHIP programs.
- Eighteen states do not require children to be uninsured for a length of time before they can enroll in the state's SCHIP-funded programs.
- Thirteen states do not require families to provide verification of income when applying for the state's Medicaid and separate SCHIP programs, relying instead on existing state databases to gather that information.
- Forty-one states and D.C. allow children's coverage for the state's Medicaid and separate SCHIP programs to be renewed annually.
- Forty-seven states and D.C. do not require face-to-face interviews for the renewal of children enrolled in the state's Medicaid and separate SCHIP programs.
- Forty-four states and D.C. have a Spanish version of the SCHIP application form.

Source: The Kaiser Commission on Medicaid and the Uninsured. *Enrolling Children and Families in Health Coverage: The Promise of Doing More.* June 2002.

Budget Update

On August 15, 2003 the "SCHIP Fix" bill (H.R. 2854) amending Title XXI of the Social Security Act became Public Law No: 108-74. This law preserves $2.7 billion in unspent federal State Children's Health Insurance Program (SCHIP) funds that would have otherwise reverted to the Treasury Department. Now these funds will be available for states to maintain and/or expand health care coverage to eligible children and families.

Under this law, states with remaining fiscal year (FY) 2000 and 2001 SCHIP funds will keep 50% of these funds. FY 2000 funds will be available until the end of FY 2004; while FY 2001 funds will be available until the end of FY 2005. The other 50% of unspent FY 2000 and 2001 funds will be reallocated to states that have already spent their allotments for those years. Reallocated FY 2000 funds will be available until the end of FY 2004, and FY 2001 funds will be available until the end of FY 2005.[19] States will also get back any remaining unspent FY 1998 and 1999 funds that they lost at the end of FY 2002. These funds will be available until the FY 2004.

Additionally, states that had expanded Medicaid eligibility to at least 184% of the federal poverty level (FPL) prior to the enactment of SCHIP will get an additional option. They will be able to use up to 20% of their original SCHIP allotment for reimbursement of services provided to children with incomes above 150% of the FPL. This reimbursement will be at the higher SCHIP rate. The following 10 states can benefit from this provision if they have available funds: Connecticut, Maryland, Minnesota, New Hampshire, New Mexico, Rhode Island, Tennessee, Vermont, Washington, and Wisconsin.

Overall, states have made a notable effort to increase SCHIP access to uninsured children and their families. Equally significant has been the work carried out by Hispanic community-based organizations to ensure the enrollment of Hispanic eligible children in SCHIP. Each of the communities participating in the *Moving Forward* project brings a unique perspective and although circumstances vary from one site to another, the barriers to enrollment and retention for Hispanic children, the successful interventions and strategies implemented in their communities, and recommendations for improving participation of Hispanics in SCHIP have much in common. The following section illustrates the health insurance status of Hispanic children in the eight communities around the nation that implemented the *Moving Forward: SCHIP for Hispanic Children* initiative. This section also includes a summary of each participating CBO perspective regarding barriers to SCHIP enrollment for Hispanics and a compilation of the best practices carried out by both the leading CBOs and the states in order to address the disproportionate lack of health insurance among Hispanic children.

[19] In March 2003, the Centers for Medicare and Medicaid (CMS) reallocated a portion of the FY 2000 funds to the 14 states that had spent their FY 2000 allotment. These states will now have until FY 2004 to spend these funds. These states may also receive some additional FY 2000 funds that are still to be reallocated.

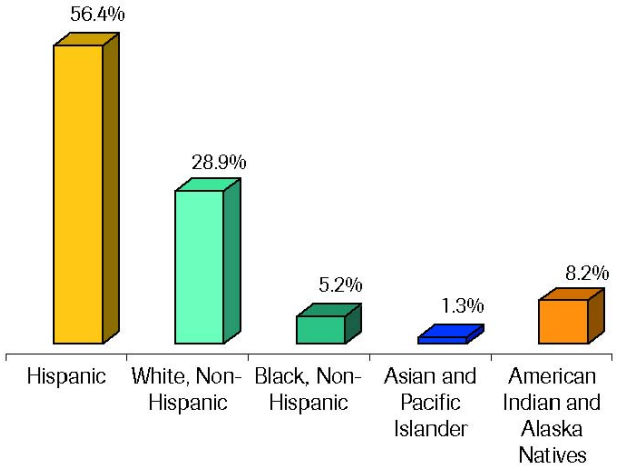
Phoenix, Arizona

Since 1989, Concilio Latino de Salud has served the Hispanic communities in Phoenix by promoting health education and disease prevention. Concilio actively pursues the goals of "Healthy People 2010" by providing cross-cultural and bilingual assistance, advocacy, public policy analysis, workshops, education, service programs, resources, applied research, client referrals, and media links.

Uninsured Children

Arizona State has the third highest rate (18.3%) of uninsured children nationwide.[20] About one in five children lacks health insurance and 16% of the state's population is uninsured.[21] In Arizona, Hispanic children (56.4%) are twice as likely as white non-Hispanic children (28.9%) to be uninsured. [See Figure 3]

Figure 3:
Uninsured Children 18 Years of Age and Under in Arizona, 2000-2001



Source: Data from the Urban Institute and the Kaiser Commission on Medicaid and the Uninsured. "State Health Facts Online." Estimates based on pooled data from the March 2001 and March 2002 Current Population Surveys (CPS). August 2002. http://www.statehealthfacts.kff.org

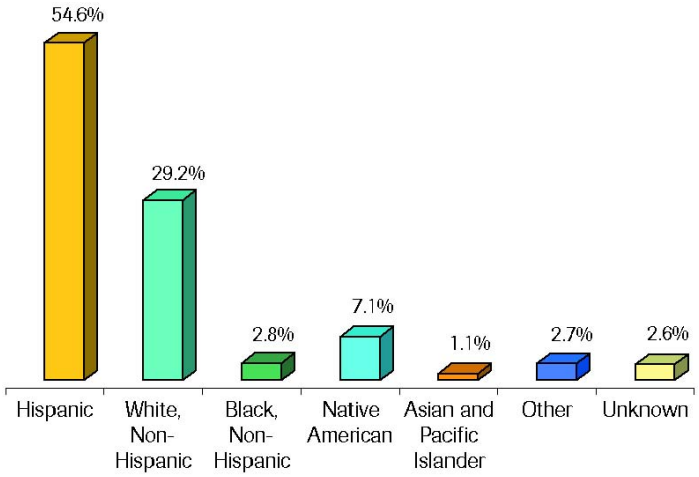
[20] Children's Defense Fund, *Uninsured Children Under Age 19 in the States, 2001*. March 2002 Current Population Survey. Revised on April 2003. http://www.childrensdefense.org.

[21] The United States Census Bureau, *Count of Persons Under 19 by State*. March 2000-2002 Current Population Surveys (CPS); Census 2000, Summary: File 1, Children's Defense Fund, *Uninsured Children Under Age 19 in the States, 2001*. Calculations by the Children's Defense Fund, December 2002. http://www.childrensdefense.org

KidsCare in Arizona

KidsCare, the Arizona's Children's Health Insurance Program, provides medical coverage for children who have had no health insurance for the last three months, do not qualify for Medicaid, and cannot afford to buy private health insurance. Approximately 55% of KidsCare enrollees are Hispanic children, compared to 29% of white non-Hispanic, 3% of black non-Hispanic, and 7% of Native American children.[22] [See Figure 4]

Figure 4:
Children Enrolled in the KidsCare Program in Arizona, October 2002



Source: Data from the Governor's Annual KidsCare Report prepared by the Arizona Health Care, Cost, Containment System, October 1, 2001-October 1, 2002. Submitted on January 1, 2003.

Barriers to Enrollment and Access to Care

Some of the barriers to Hispanic enrollment and quality care in Arizona are related to low hourly wages, premium cost, lack of understanding of the need for health care, lack of linguistically appropriate services and outreach, fear of "public charge," immigration status, and lack of knowledge about KidsCare. For the large number of mixed families (some family members are documented and some are undocumented) the battle with the health care system to obtain access to services and to maintain enrollment is a significant barrier. Structure and logistical barriers to access care have made many families in Arizona go to Mexico for health care services rather than to deal with the system in Arizona.

[22] DMS Stats/KidsCare/Full Stats.xls. (KC-8). Arizona Health Care Cost Containment System (AHCCCS), KidsCare; May 1, 2003.

Community-Based Best Practices

Providing one-on-one information on KidsCare to families and establishing community partnerships have been Concilio's effective strategies to address the challenges related to information and education in Phoenix. Concilio has also worked with policy makers and other public and private organizations in the promotion of health policies and programs that benefit underserved groups, particularly Hispanics.

State Spotlights

The state's implementation of the Application for Health Insurance (universal application) to determine eligibility for all household members in any program that is applicable to them increased the effectiveness of the application process for all programs. Other strategies adopted in Arizona to increase the number of enrollees in the KidsCare Program include: the development of a one-page bilingual application form; the reduction of the mandatory waiting period without health coverage from 6 to 3 months; expansion of health coverage for parents of eligible children; the establishment of partnerships with small businesses, interfaith groups, community-based organizations, and government agencies for the promotion of the program; the development of a self-screening flier to assist families determining their eligibility for KidsCare; and the implementation of a fully automated web-based electronic form called Health-e-Arizona.

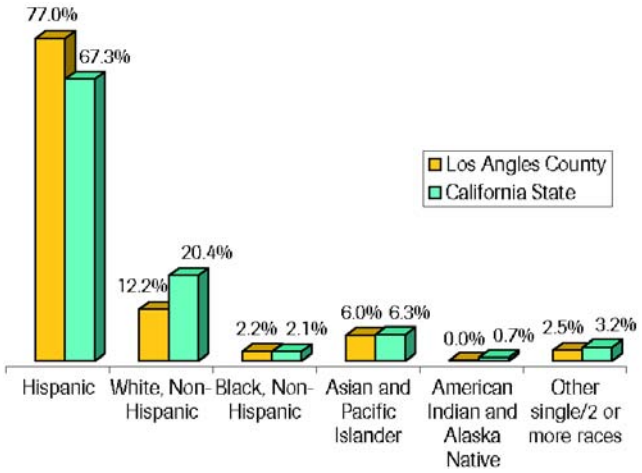
Los Angeles, California

Established in 1985, The Multicultural Area Health Education Center (MAHEC) provides leadership to influence advocacy and the necessary services to promote improved health and wellness of the Latino population in Los Angeles. MAHEC, recognized as a model for other AHEC's, has now evolved into a multi-faceted agency, and for some time it remained the only Area Health Education Agency nationwide to focus on Latino health issues. In keeping with its original mandate, MAHEC continues to expand community-based, individual, and family-oriented health programs and services.

Uninsured Children

California ranks as number eight among the ten states with the highest rate of uninsured children in the United States.[23] It is estimated that there are 2.2 million uninsured persons in Los Angeles County; and more than 1 million are Latinos. About 12.3% of children in Los Angeles are uninsured.[24] [See Figure 5]

Figure 5:
Children Ages 0-18 Without Health Insurance
in Los Angeles County and the State of California, 2001



Source: Data from the 2001 California Health Interview Survey (CHIS). Online access at: http://www.chis.ucla.edu; July 2003.

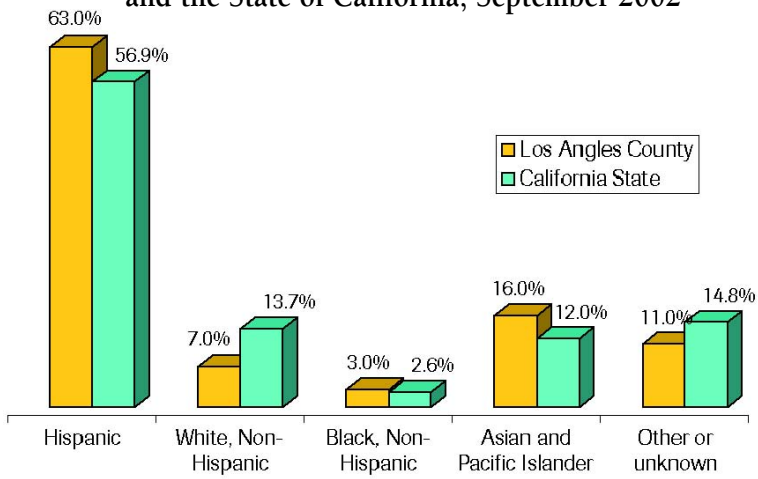
[23] U.S. Census Bureau, March Current Population Surveys 2000-2002; Census 2000, *Count of Persons Under 19 by State*. Summary: File 1, Children's Defense Fund. Calculations by the Children's Defense Fund, December 2002.

[24] The 100 Percent Campaign: Health Insurance for Every Child, *County Level Data, Children 0-17*. Fact sheet, March 2003. http://www.100percentcampaign.org

Healthy Families in California

Until September 2002, Healthy Families, the California's Children's Health Insurance Program, had 590,218 children enrolled; and over 30% of these children were enrolled in Los Angeles County. About 63% of Healthy Families enrollees in Los Angeles are Hispanics. [See Figure 6]

Figure 6:
Healthy Families Enrollment by Race and Ethnicity in Los Angeles County and the State of California, September 2002



Source: Managed Risk Medical Insurance Board, Healthy Families Monthly Reports, http://www.mrmib.ca.gov, September 2002.

Barriers to Enrollment and Health Care Access

The main challenge in Los Angeles was the high disenrollment from Healthy Families among Hispanics. This was due to the lack of knowledge about the renewal process or not being able to afford co-payments. Due to the state's budget crisis, access to care for Hispanic families was drastically reduced with the closing of 11 medical centers, 4 school-based clinics, a major hospital, and the elimination of the Public-Private Partnership funded by the Los Angeles Health Department. This crisis also increased the amount of people receiving health care across the border. Changes in the state administration, coupled with changes in the Health Department, and the elimination of services available has created more confusion and mistrust in the community. The total cut of all funds for CBOs to conduct outreach activities is contributing to the existing gap in information, education on how to access health services, and in filling out the applications for the program. Currently there are no outreach activities or media campaigns funded by the state to promote the program.

Community-Based Best Practices

MAHEC's practice of providing application assistance, one-on-one information in health fairs, schools, and in community centers as well as collaboration with other CBOs and community agencies proved to be effective to increase Hispanic enrollment in Healthy Families.

State Spotlights

State best practices to increase enrollment of Hispanics in Healthy Families are the simplification of the application form in English and Spanish, as well as the efficient telephone services available in several languages, including Spanish. In addition, the Departments of Health and Education developed guidance for counties and school districts to implement Express Lane Eligibility (ELE).[25] Currently Los Angeles, San Diego, Fresno, and Alum Rock (in Santa Clara) school districts are planning to implement ELE in several of their schools in the 2003 school year.

[25] Express Lane Eligibility (ELE) facilitates a child's enrollment in health insurance by connecting two state health insurance programs, Medi-Cal and Healthy Families, with other public program such as Food Stamps, Supplemental Nutrition Programs for Women, Infants, and Children (WIC), and the School Lunch Program.

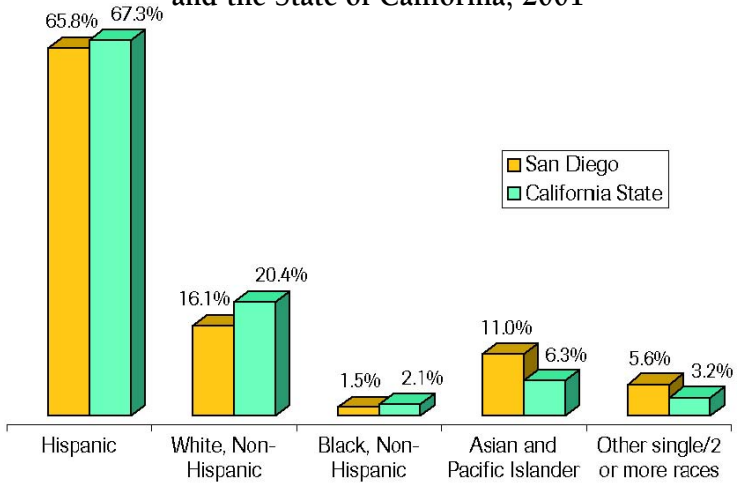
San Diego, California

For over 30 years, the Family Health Centers of San Diego (FHCSD) has functioned as a federally funded non-profit Center providing primary care services and a comprehensive array of health services to low-income, inner-city, and medically underserved populations. With eight primary care centers throughout the city, two mobile medical units, and a family-counseling center, FHCSD is regarded as a community institution. During 2001, the center provided care for approximately 75,168 unduplicated patients where 61% of the patients identified themselves as Hispanic. Eighty two percent of the FHCSD patients were at 100% or below the federal poverty level, and 61% of all its patients were uninsured.

Uninsured Children

In 2001, about 1.3 million California children lacked health insurance for the entire year or experienced gaps in coverage over a 12-month period, resulting in one out of seven California children (14.3%) being uninsured.[26] Furthermore, Latino children are three times as likely as white children to lack health insurance.[27] Poor and low-income children are significantly more likely to lack health insurance (24.8% and 21.8% uninsured, respectively) than more affluent children (4.4% uninsured).[28]

Figure 7:
Children Ages 0-18 Without Health Insurance in San Diego and the State of California, 2001



Source: Data from the 2001 California Health Interview Survey (CHIS). Online access at:http://www.chis.ucla.edu; July 2003

[26] E.R. Brown et al., *The State of Health Insurance in California: Findings from the 2001 California Health Interview Survey* (Los Angeles, CA; UCLA Center for Health Policy Research 2002), p. 10. http://www.healthpolicy.ucla.edu. The 100 Percent Campaign: Health Insurance For Every California Child, *California's Uninsured Children.* Fact sheet, March 2003. http://www.100percentcampaign.org.

[27] Children Now, *The 2002 California Report Card, Children's Critical Early Years.* October 23, 2002.

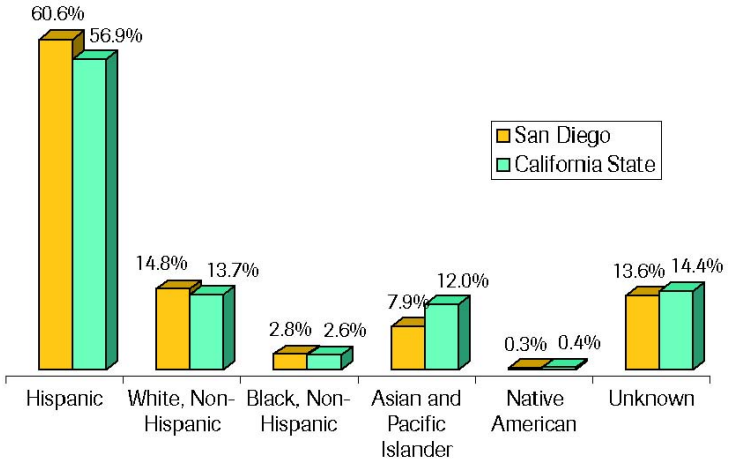
[28] Ibid., p. 15

Healthy Families in California

The Healthy Families Program in California is a state and federally-funded health coverage program for children with family incomes above the level eligible for no-cost Medi-Cal and below 250% of the Federal Income Guidelines.

Based on the 2000 U.S. Census Bureau, San Diego has about three quarters of a million children aged 0-18 years, and approximately 42% are Hispanic.[29] By July of 2002, San Diego County had 219,501 children enrolled in one of the low or no cost health care coverage programs (Healthy Families, Medi-Cal, California Kids, and Kaiser Care for Kids).[30] [See Figure 8]

Figure 8:
Healthy Families Enrollment by Race and Ethnicity
in San Diego and the State of California, September 2002



Source: Managed Risk Medical Insurance Board, Healthy Families Monthly Reports, http://www.mrmib.ca.gov, September 2002.

[29] San Diego Association of Governments (SANDAG), *Census 2000, Population Ages 0-18, San Diego County.* September 2002. http://www.sandag.cog.ca.us.

[30] Managed Risk Medical Insurance Board, *Healthy Families Monthly Reports, Current Enrollment by County.* September 2002. http://www.mrmib.ca.gov.

Barriers to Enrollment and Access to Care

The main barriers to accessing health care in San Diego are unclear government guidelines about the access that the Immigration and Naturalization Services (INS) has to family records once a family member applies for a program, community mistrust of the government, and fear of the "public charge." Other challenges include the stigma associated with welfare and Medi-Cal by Hispanic families, the mindset of looking for health insurance only when being sick, and the significant disenrollment of Medi-Cal and Healthy Families. In fact, as of September 2002 65.4% Hispanics[31] enrolled in Healthy Families lost their health care coverage within the previous 12 months, mainly because of lack of knowledge about the renewal process, not being able to afford co-payments, or due to wrongful contact information from applicants. In addition, the state budget crisis has reduced the funding for health insurance programs, outreach, and other improvements to the program such as "express lane" and expansion to families.

Community-Based Best Practices

The FHCSD found that collaboration, networking, and community involvement were effective strategies to better outreach and educate Hispanic families on health care and insurance issues. FHCSD has worked in close partnership with the state and county health departments, the school system, a broad base of CBOs and business, and community coalitions. For example, FHCSD led the 100% Campaign, a city-wide outreach and information campaign including more than 200 organizations in San Diego, to decrease the number of uninsured children in San Diego.

State Spotlights

State led effective strategies include the simplification of the application form from 20 to 4 pages, accelerated enrollment, one form for both Medi-Cal and Healthy Families, and income affidavit if no documentation is available. Additionally, San Diego is one of the counties implementing the Express Lane Eligibility for Medi-Cal and Healthy Families.

[31] Managed Risk Medical Insurance Board, *Healthy Families Monthly Reports, Current Enrollment by County.* September 2002. http://www.mrmib.ca.gov.

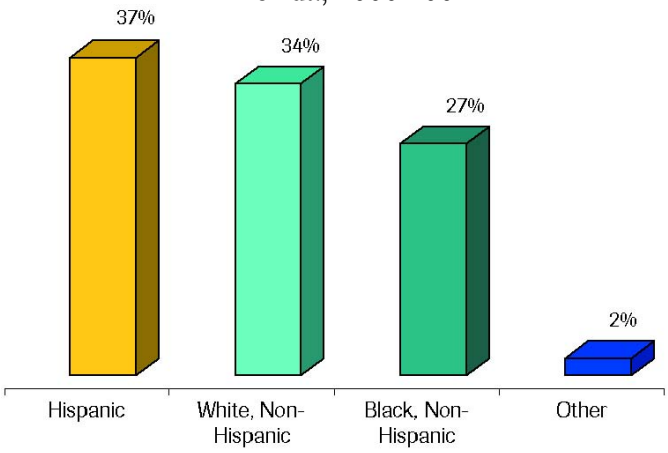
Miami, Florida

Founded in 1973, Little Havana Activities and Nutrition Centers of Dade County (LHANC) is one of the largest agencies providing health, nutrition, and social services programs for disadvantaged Hispanics in the nation. Currently, LHANC serves more than 63,980 people throughout South Florida with 21 multi-service community centers. Each center offers a myriad of preventive and support services to the elderly, children, and their families ranging from nutritional and health services to home and community-based care services.

Uninsured Children

Based on the U.S. Census Bureau of 2000, Florida has a little over 3.9 million children, from which 14.9% are currently uninsured.[32] About 66.7% of uninsured children in Florida are potentially eligible for the KidCare Program.[33] Hispanic children (37%) are more likely to be uninsured than white non-Hispanic children (34%) and black non-Hispanic children (27%). [See Figure 9]

Figure 9:
Uninsured Children Under Age 19 by Race and Ethnicity in Florida, 2000-2001



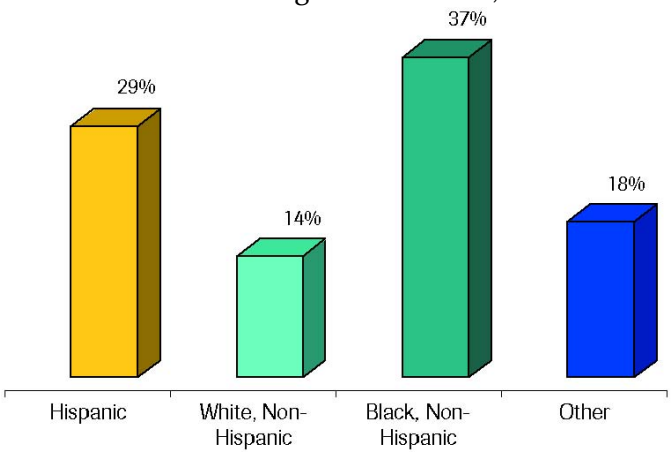
Source: Data from the Urban Institute and the Kaiser Commission on Medicaid and the Uninsured. "State Health Facts Online." Estimates based on pooled data from the March 2001 and March 2002 Current Population Surveys (CPS).

[32] Elizabeth Shenkman and Christine Bono, *The Florida KidCare Program Evaluation Year 4 Report.* The Institute for Child Health Policy, January 2003.
[33] Ibid., p. 4.

KidCare in Florida

The KidCare Program in Florida is financed with a combination of federal and state funds and participant family contributions. Federal funding for the program comes from two sources: Medicaid and SCHIP. The KidCare Program consists of the following components: MediKids, Healthy Kids, Children's Medical Services (CMS) Network, Behavior Health Network, and Medicaid. As of June 30, 2002, there were 1.3 million children enrolled in the KidCare program of which 29% were Hispanic. [See Figure 10]

Figure 10:
Children Under Age 19 Enrolled in Medicaid and the KidCare Program in Florida, 2000-2001



Source: Data from the Urban Institute and the Kaiser Commission on Medicaid and the Uninsured. "State Health Facts Online." Estimates based on pooled data from the March 2001 and March 2002 Current Population Surveys (CPS).

Barriers to Enrollment

Dade County has a large immigrant population, many of them poor and undocumented. One of the main barriers to accessing health care is the existence of policies that prevent immigrants from qualifying for KidCare. Although the Public Health Trust provides some funding to cover immigrant children, the current law does not allow legal non-refugee immigrants to qualify for KidCare, unless they have been in the country for five years. Additionally, families do not want to apply for KidCare due to fear of "public charge." Other challenges in Dade County include the lack of funding for appropriate marketing and outreach for Hispanic communities and the reluctance of providers to accept patients that have KidCare.

Community-Based Best Practices

Some effective strategies implemented by LHANC to address the challenges in this community include the distribution of informational materials in English and Spanish, providing one-on-one information in health fairs and schools, assisting families with the application process, and work with the business community to promote the program. Good coordination among all the organizations doing Florida KidCare outreach has been an effective strategy to also prevent waste of resources by overlapping services.

State Spotlights

The state of Florida has adopted a one-year enrollment in all KidCare program components, developed application forms and other informational materials about the program in several foreign languages including Spanish, implemented passive re-enrollment, and established partnerships with government agencies such as the Department of Education to disseminate information on the program to members of the community. The state has also increased the income guidelines up to 200% of the Federal Poverty Level (FPL) and has expanded services for families with Limited English Proficiency (LEP).

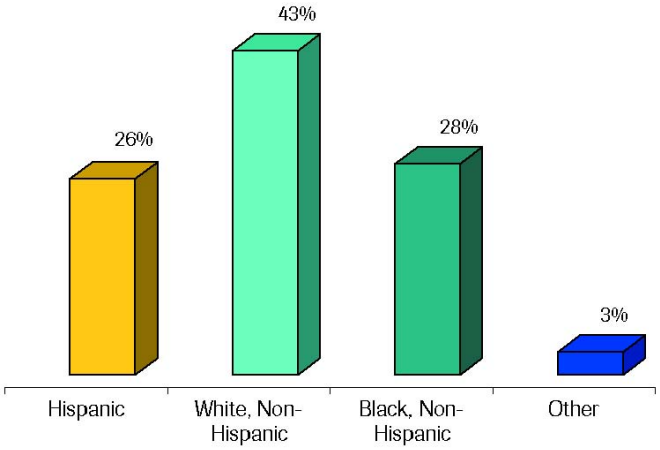
Chicago, Illinois

The Chicago Hispanic Health Coalition (CHHC) was created in June 1991 as a multidisciplinary membership organization to address health promotion and disease prevention among the city's Hispanic communities. The Coalition, currently with more than 800 member agencies, works to identify and address the perceptions of residents regarding their health needs, the availability of services, and the obstacles they face in seeking and obtaining health care. CHHC conducts programs concerning mental health, smoking cessation, substance abuse, violence prevention, child health, and diabetes prevention and management.

Uninsured Children

Based on a 2002 Illinois Kids Count report, during the year 2000 there were 441,000 children without health insurance in the state of Illinois. Unlike other states, in Illinois Hispanic children are less likely to be uninsured than white non-Hispanic children and black non-Hispanic children. About 26% of uninsured children in Illinois are Hispanic, 43% are white non-Hispanic, and 28% are black non-Hispanic. [See Figure 11]

Figure 11:
Uninsured Children Under Age 19 by Race and Ethnicity in Illinois, 2000-2001

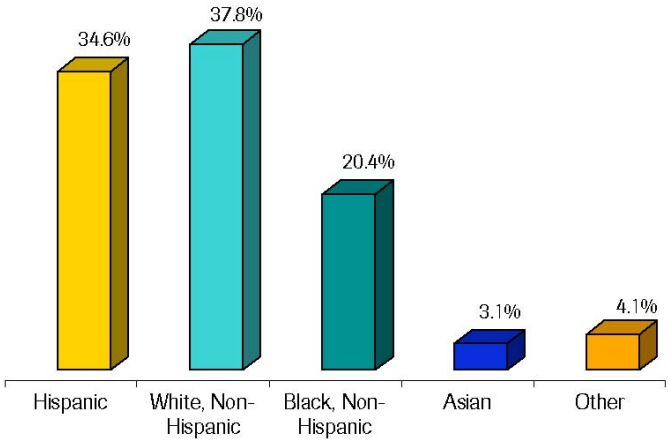


Source: Falling Through the Gap: Uninsured Children in Illinois' "Race/Ethnicity Enrolled in KidCare vs. Uninsured Children, October 1, 2002". Illinois Kids Count 2003 Report. Illinois Kids Count, 2003.

KidCare in Illinois

In Illinois, the KidCare program is a combination of Medicaid and SCHIP programs. By October 2002, there were 188,189 children enrolled in KidCare in the state of Illinois.[34] In Illinois, about 35% of KidCare enrolled children are Hispanics, 38% are white non-Hispanic children, and 20% are black non-Hispanic children.[35] It is estimated that 30%-35% (60 to 70 thousand) of eligible children in Chicago are enrolled in KidCare from which approximately 34% are Hispanics.[36] [See Figure 12]

Figure 12:
Children Enrolled in Medicaid and KidCare
by Race and Ethnicity in Illinois, 2002



Source: Falling Through the Gap: Uninsured Children in Illinois' "Race/Ethnicity Enrolled in KidCare vs. Uninsured Children, October 1, 2002." Illinois Kids Count 2003 Report. Illinois Kids Count, 2003.

[34] Annie E. Casey Foundation and Voices for Illinois Children, *Kids Count 2003 Data Book Online*. Children of Illinois, July 2003. http://www.kidscount.org and http://www.voices4kids.org.

[35] Ibid.

[36] Voices for Illinois Children, State Enrollment Update; October 2002, Falling Through the Gap: Uninsured Children in Illinois.

Barriers to Enrollment and Access to Care

Significant barriers to Hispanic enrollment in KidCare and access to quality care identified by the CHHC are the community fear of "public charge;" lack of knowledge on how to navigate the health care system; the bureaucracy of the application process; and the low approval rates for program participation (for example, of 2,300 applications submitted by the Coalition, only 1,300 obtained approval).

Community-Based Best Practices

Among the successful practices to address these barriers in Chicago were door-to-door visits to provide information and application assistance to Hispanic families; and, the promotion of the program through health fairs, after school programs, church events, and other citywide activities sponsored by the mayor or other elected officials. The CHHC also developed and distributed a fact sheet to educate Hispanic families on the "public charge" issue and to reduce the immigrants' fear to apply for KidCare and Medicaid.

State Spotlights

The state of Illinois expanded the eligibility for KidCare from 6 months to a year and posted a downloadable application form in English and Spanish in their KidCare website. Additionally, Illinois received the Health Insurance Flexibility and Accountability (HIFA) Section 1115 waiver from the Department of Health and Human Services to provide health coverage to parents and caregivers of KidCare enrolled children.

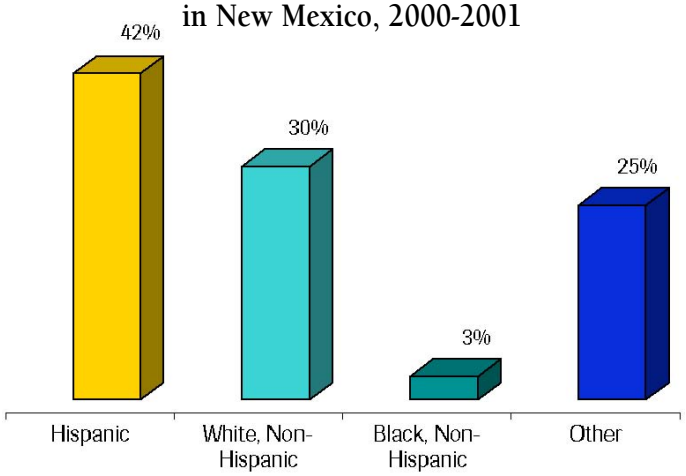
Albuquerque, New Mexico

Youth Development, Inc. (YDI) is a private nonprofit, community-based youth and family service organization established in 1971, whose primary mission is empowering today's youth for tomorrow's challenges. YDI is governed by an elected board of directors, which includes youth representation. YDI's dedication to serving at-risk youth is rooted in a firm commitment to the concept of "offering youth a hand up, not a hand-out," and to the concept of helping communities and families to find their own, unique, innovative solutions to their particular problems.

Uninsured Children

Based on a Children's Defense Fund study, New Mexico has the second highest rate of uninsured children in the United States.[37] About 21% of the 508,574 children in New Mexico still do not have health insurance.[38] Hispanic children (42%) are more likely to be uninsured that white non-Hispanic (30%) and black non-Hispanic (3%) children. [See Figure 13] More than three-fourths (77%) of all uninsured children in the state are eligible for Medicaid/New Mexikids but are not yet enrolled.[39]

Figure 13:
Uninsured Children Under Age 19 by Race and Ethnicity in New Mexico, 2000-2001



Source: Data from the Urban Institute and the Kaiser Commission on Medicaid and the Uninsured. "State Health Facts Online." Estimates based on pooled data from the March 2001 and March 2002 Current Population Surveys (CPS).

[37] Children's Defense Fund, *Advocate Resources: Uninsured Children Under Age 19 in the States, 2001.* Data from the March 2002 Current Population Survey, revised on April 2003. http://www.childrensdefensefund.org

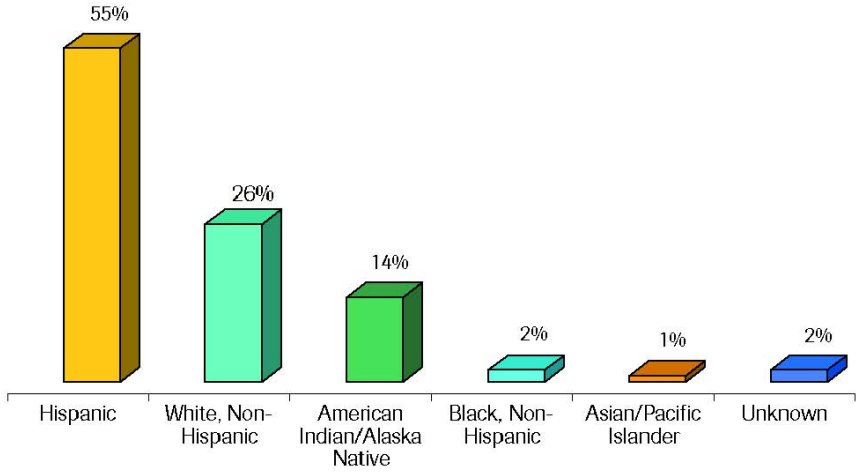
[38] Annie E. Casey Foundation, *Kids Count 2003 Data Book Online: New Mexico Profile*; Data from 2000, July 2003. http://www.kidscount.org.

[39] American Academy of Pediatrics, *2000 Improving Access to Children's Health Insurance in New Mexico*, Helping Us Grow; American Academy of Pediatrics, 2000

Medicaid/New Mexikids

New Mexico expanded Medicaid coverage to children through age 19 up to 235% of the federal poverty level (FPL) with Title XXI funds. The State Children's Health Insurance Program and the Medicaid program are now called New Mexikids. By December 2002, New Mexico had 11,246 children enrolled in New Mexikids.[40] About 42% were Hispanic children, 30% white non-Hispanic, and 3% black non-Hispanic. [See Figure 14]

Figure 14:
Medicaid and New Mexikids Enrolled Children
by Race and Ethnicity, New Mexico, September 2002



Source: Health Care Financing Administration (HCFA 2082 Report), September 2002.

[40] SCHIP Children Under 21 Enrolled in Medicaid, Including Retroactive and Late Reported Eligibility – Thru 04/30/03. April 5, 2003.

Barriers to Enrollment

New Mexico is facing a state budget deficit that has halted the overall implementation of SCHIP in the state. Most recently, the State legislature passed a bill to authorize the use of 70% of the tobacco settlement funds to support SCHIP and Medicaid. In addition to the budget shortages, there is limited access to enrollment offices throughout the state. Specifically, public transportation is not available to access the offices and the enrollment offices have a limited (inflexible) operation schedule that has not been adapted to meet people's needs.

Community-Based Best Practices

YDI has operated 10 enrollment sites in several of their Head Start facilities to aid Hispanic families. In addition, the agency provides application and language assistance.

State Spotlights

To address some of these challenges, the state has provided a mobile enrollment unit that visits low-income areas, including regions where there is a large concentration of farm workers. Additionally, New Mexikids eliminated the face-to-face interview and the asset test to enroll in the program, and established presumptive eligibility for those applying for health coverage. The program also expanded the insurance coverage period from 6 to 12 months and simplified the application form in English and Spanish. In 2002, New Mexico received the approval of a Health Insurance Flexibility and Accountability (HIFA) waiver to provide health coverage to parents of SCHIP and Medicaid enrolled children and to increase the federal income limit for children in SCHIP up to 235%.

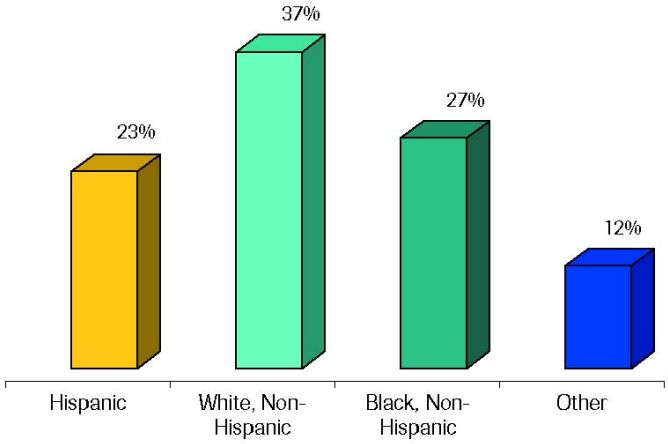
New York City, New York

The Puerto Rican Family Institute, Inc. (PRFI), founded in 1960, is a nonprofit, multi-program family-oriented health and human service agency whose primary mission is to prevent family disintegration and enhance the self-sufficiency of the Latino community. The PRFI offers a comprehensive array of social and health care services, which include mental health treatment, crisis intervention, placement prevention, residential care, and education. The PRFI programs serve a large immigrant population and operate in New York City and in Puerto Rico.

Uninsured Children

According to the Children's Defense Fund there are over half a million children without health insurance in New York; 75% of these children are eligible for free or low-cost children's health insurance but are not enrolled.[41] At least half of the total uninsured children in the state of New York live in New York City.[42] [See Figure 15]

Figure 15:
Uninsured Children by Race and Ethnicity
in New York State, 2000-2001



Source: Data from the Urban Institute and the Kaiser Commission on Medicaid and the Uninsured. "State Health Facts Online." Estimates based on pooled data from the March 2001 and March 2002 Current Population Surveys (CPS).

[41] Data from the Children's Defense Fund in New York, Current Population Survey March 2001 and March 2002.

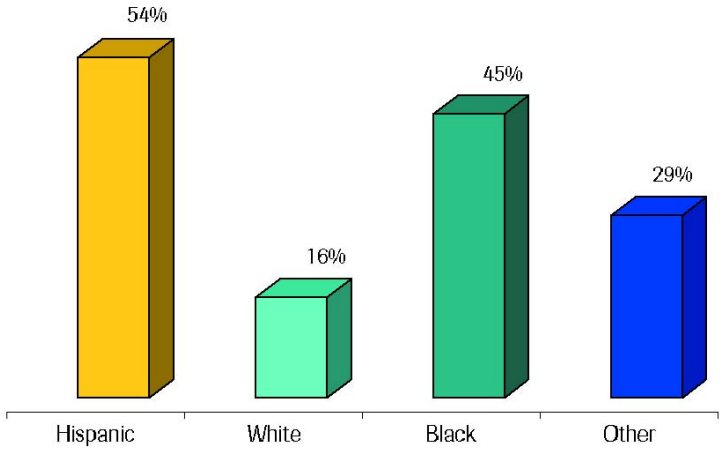
[42] Children's Defense Fund-NY, *Health Insurance for New York's Children and Teens*. Press Release, 1999.

Child Health Plus in New York

New York State has a health insurance plan for children called Child Health Plus. Depending on the family's income, a child may be eligible to join either Child Health Plus A (formerly Children's Medicaid) or Child Health Plus B (SCHIP).

Hispanic children represent about 54% of enrollees in the Child Health Plus program, compared to 16% white children and 45% black children. [See Figure 16]

Figure 16:
Enrolled Children in Child Health Plus in New York State, 2000-2001



Source: Data from the Urban Institute and the Kaiser Commission on Medicaid and the Uninsured. "State Health Facts Online." Estimates based on pooled data from the March 2001 and March 2002 Current Population Surveys (CPS). Race categories White and Black include Hispanics; hence totals are not equal to 100%.

Barriers to Enrollment

New York is currently facing the following major issues affecting the Child Health Plus program. First, there is an increasing unemployment and a lack of health insurance linked to the economic slowdown as a result of the September 11, 2001 terrorist attack. Access to care was affected by the lack of public transportation to downtown, and the loss of 120,000 jobs. Also, government background investigations have increased community fears of the possibility of being affected by receiving public benefits such as health insurance, making some populations less likely to apply for SCHIP. There is a lack of clarity related to confidentiality and the access Immigration and Naturalization Service (INS) and other government agencies have to the information provided by applicants. Other barriers are the lack of knowledge about how to navigate the health care system (families do not know what documents they need, where to apply, or the difference between "providers network" or "out of network providers"), the lack of linguistically proficient services, and the negative way Hispanics are treated when they receive these services. Lastly, a complicated renewal process (even though it has been simplified); frequent failure to receive the insurance card by mail; and, a lack of understanding of what is needed to continue the services are all barriers still faced by Hispanics in New York.

Community-Based Best Practices

The PRFI has addressed many of these barriers by partnering with other family health care programs within the institute. In addition, PRFI has promoted Hispanic enrollment in the Child Health Plus and the Medicaid programs in collaboration with other non-governmental organizations (NGOs), the New York City Health Department, and other advocacy organizations in the state of New York. Activities conducted by the institute are focused on improving state and city policies and to educate the Hispanic community on health care issues.

State Spotlights

Some of the enrollment simplifications carried out in the state of New York are the development of a joint bilingual application form for Medicaid and the Child Health Plus Program, the elimination of the assets test, and the adoption of presumptive eligibility. The state also provides continuous eligibility coverage for a 12-month period for children enrolled in Medicaid or Child Health Plus.

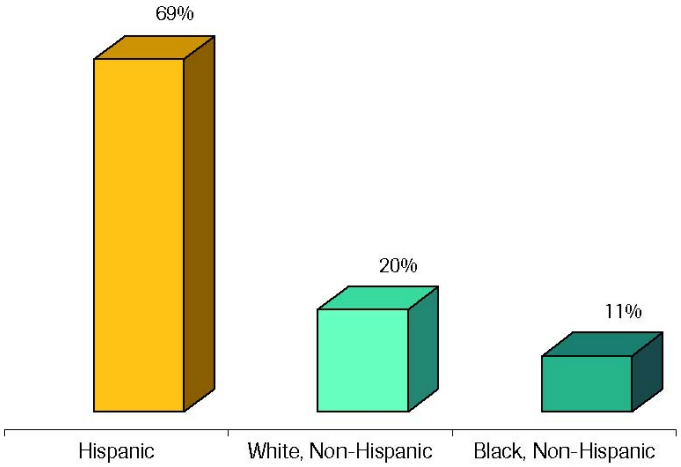
Dallas, Texas

The Dallas Concilio of Hispanic Health Service Organizations (Dallas Concilio) is a nonprofit organization serving the Greater Dallas Community since 1981. Agency staff and volunteers are recognized throughout the community as experts on Hispanic social and health issues, with a special focus on assisting service providers to understand relevant aspects of the Hispanic culture. The Dallas Concilio serves as an umbrella organization for groups–known as the Network of Affiliates–addressing the various needs of the Hispanic community. Dallas Concilio provides assistance to the Network of Affiliates by initiating programs, which are then administered by agencies specialized in that particular area.

Uninsured Children

In 2001, Texas had about 5 million people without health insurance, of which 27 % were children.[43] Hispanic children are disproportionately uninsured compared to children of other racial and ethnic groups in Texas. Sixty-nine percent of uninsured children are Hispanic, compared to 20% of uninsured white non-Hispanic children, and 11% of uninsured black non-Hispanic children. [See Figure 17]

Figure 17:
Children 18 Years of Age and Under
Without Health Insurance in Texas, 2001



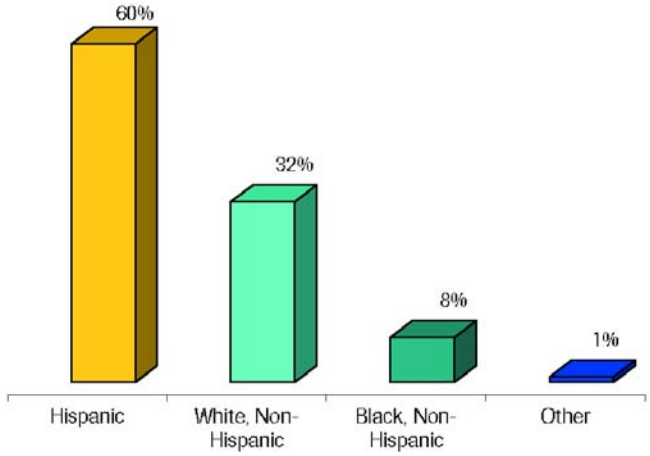
Source: U.S. Census Bureau, Current Population Survey (CPS) for Texas; March 2002.

[43] Elizabeth Shenkman, *Children's Health Insurance Program in Texas: The New Enrollee Survey Report 2003.* Institute for Child Health Policy; March 2003, p. 10. http://www.hhsc.state.tx.us/chip/reports/03_2003EnrolleeSurvey.html

SCHIP in Texas

The Texas' Children's Health Insurance Program is available for low-income families that do not qualify for Medicaid health care, yet cannot afford to buy private health insurance. As of December 2002, approximately half a million children were participating in the Texas' CHIP program. Hispanics represent 60% of enrolled children in CHIP, compared to 32% white non-Hispanic children and 11% black non-Hispanic children.[43] [See Figure 18]

Figure 18:
Texas' Children's Health Insurance Program (CHIP) Enrollment by Race and Ethnicity, December 2002



Source: Shenkman, E., PhD. *Children's Health Insurance Program in Texas: The New Enrollee Survey Report 2003.* Institute for Child Health Policy; March 2003. Pp. 10. http://www.hhsc.state.tx.us/chip/reports/03_2003EnrolleeSurvey.html

Barriers to Enrollment

Some of the main barriers to SCHIP enrollment and health care access are the lack of knowledge about the kind of programs that are available, fear to use services that will affect their immigration status ("public charge"), families' inability to navigate the health care system; lack of culturally and linguistically proficient health professionals, and inconvenient health care service hours.

Community-Based Best Practices

It was determined by Dallas Concilio that the best strategy to address the information, education and enrollment barriers in the Hispanic community was to provide information and services on a one-on-one basis. In fact, using this approach, Dallas Concilio assisted in the enrollment of 425 children during 2001. Other successful strategies include working collaboratively with schools, WIC offices, and other non-profit agencies in the community to provide information for Hispanic families.

State Spotlights

Some of the best practices implemented in Texas include the simplification of the mail-in application form from 16 to 3 pages; the elimination of the face-to-face interview; and the implementation of a telephone-based renewal form. The state also allowed self-declaration of assets, streamlined documentation requirements, and offered 12 months of continuous eligibility for children enrolling in CHIP. In addition, the state of Texas conducted a mass media campaign in Spanish to promote the program in Hispanic communities.

The challenges, best practices, and recommendations included in this report have been drawn primarily on the experience of the eight sites in implementing *Moving Forward* in the seven states during the project period. The following information can serve as a road map for policymakers and practitioners seeking to improve access to health insurance and quality health care for the nation's underserved Hispanic children and families.

Barriers to Hispanic Enrollment and Retention in SCHIP

Since the enactment of SCHIP in 1997, there has been a significant increase in the number of children with health insurance coverage. Many challenges have been addressed at the community and state levels to ensure enrollment. Still, formidable obstacles remain. Overall, the barriers identified in the project sites during the four-year initiative are associated with inappropriate marketing and outreach in racial/ethnic diverse communities; complex enrollment and renewal policies and procedures in Hispanic communities; confusing policies to plan, implement, and sustain SCHIP in the states and local communities; and, deficits within the state budgets that constrained efforts to sustain enrollment and services in SCHIP. In particular, those barriers are:

1. ***Inappropriate marketing and outreach in racial/ethnic diverse communities.***
   States implementing their SCHIP program faced the challenge of reaching all low-income and uninsured populations regardless of their race, ethnicity, and language. Lack of awareness and knowledge about SCHIP continues to be a significant barrier to access SCHIP and to obtain quality care services in Hispanic communities due to:
   - Failure of state media campaigns to target Hispanic families in a culturally proficient and linguistically appropriate manner;
   - Failure of outreach activities to provide one-on-one assistance to Hispanic families;
   - Insufficient campaign efforts to differentiate among activities that will increase awareness, provide application assistance, and teach families how to navigate the health care system;
   - Insufficient CBO involvement at the design and planning stages of the campaign to ensure effective outreach to diverse communities; and,
   - Limited knowledge of the Hispanic community.

2. ***Complex enrollment and renewal policies and procedures.***

The SCHIP enrollment process is complex and burdensome. While some states have developed simpler and shorter applications, others continue to use lengthy and confusing application forms. Despite the efforts of states to enroll and retain children in SCHIP, Hispanics continue to be uninsured at a disproportionate rate in most states. States' policies and procedures that prevent Hispanic children from accessing SCHIP and quality care are:

- Confusing information about SCHIP and Medicaid eligibility;
- Complex enrollment policies and procedures, including lengthy application forms, long waiting periods before approval, and long bare period before accepting an application; and
- English-only application and renewal forms.

3. ***Confusing policies to plan, implement, and sustain SCHIP in the states and local communities.***

The implementation of SCHIP as a separate program, or in combination with Medicaid as well as other eligibility expansions approved along the way, have improved access to care for a great number of families. On the other hand, some policies to address the lack of insurance in diverse communities have been limited, and compliance with policies to ensure access to limited English proficient persons has been uneven at best, adversely affecting Hispanic families. In particular, barriers to SCHIP participation, as they relate to policy are:

- Uneven compliance with Executive Order 13166 to fully implement the Department of Health and Human Service's "Policy Guidance on the Title VI Prohibition Against National Origin Discrimination As It Affects Persons with Limited English Proficiency";
- Limited policies to ensure access to quality care to mobile population, such as migrant and seasonal farm workers, and lack of consistent policies regarding presumptive eligibility for these groups;
- Limited databases on demographic characteristics such as race and ethnicity;
- Insufficient coordination of health and human services and programs to provide comprehensive care for Hispanic families facing multiple needs such as housing, education, and food; and,
- Lack of solutions to cover either the self employed, small employers, or younger workers.

4. ***Deficits within the state budgets that constrained efforts to sustain enrollment and services in SCHIP.***

   The reduced federal funding allocation for years 2002 through 2004 and budget crisis at the state level, combined with increases in enrollment and the cost of providing health care services, is forcing most states to take action to reduce SCHIP spending. Furthermore, expansions and enrollment reforms to facilitate access to SCHIP are being threatened by state budget cuts, increasing the risk to Hispanic families of losing access to services. In particular, the following budget issues will affect Hispanic enrollment and access to care:

   - Insufficient or no funding for CBOs to support planning and implementation of SCHIP in Hispanic communities;
   - Insufficient funding to provide comprehensive services to underserved families; and,
   - Insufficient funding to sustain the increased number of enrolled children in the program and to cover the cost of health care.

These barriers resulted in the following significant challenges affecting Hispanic SCHIP enrollment and access to quality care in the eight participating communities:

- Lack of knowledge about the program and of eligibility requirements for SCHIP;
- Lack of a basic understanding of the enrollment process;
- Lack of knowledge within the Hispanic community on how to navigate the health care system;
- Concerns regarding "public charge", i.e., reluctance to participate in federal or state programs due to the possibility of being considered "public charge" and consequently not eligible for citizenship; and,
- Concerns about confidentiality and lack of trust in government programs.

Best Practices to Improve Hispanic Participation in SCHIP

There have been many accomplishments since the creation of SCHIP thanks to the efforts of the CBOs and the states to improve Hispanic access to quality health care. Although not carried out by all the CBOs or adopted in all states, the most significant practices and policies implemented to improve Hispanic children's participation in SCHIP were:

Community-Based Organizations

- Conducting one-on-one information, application assistance, and education on how to navigate the health care system was one of the most effective outreach strategies to ensure enrollment and retention of Hispanic children in SCHIP programs. The most successful ways to reach the community were door-to-door, health fairs, church and cultural events, schools, and citywide activities sponsored by city/county officials;
- Utilizing mobile enrollment units to reduce transportation barriers and reach rural and migrant communities;
- Establishing local coalitions and partnerships among community agencies to ensure culturally proficient and linguistically appropriate outreach, information, and education in Hispanic communities;
- Distributing informational materials in English and Spanish to increase awareness about the program;
- Providing one-on-one and written information in Spanish on the "public charge" issue to reduce the reluctance of legal immigrants to enroll in SCHIP; and,
- Partnering with health care programs already reaching Hispanic families and other public and private agencies in the community that provide social services to the community such as WIC and Health Start to better utilize community resources and give families an opportunity to receive comprehensive services.

States

- Establishing collaborative relationships between states, counties, cities, and CBOs helped in the planning and implementation of appropriate outreach and education strategies in diverse communities;
- Developing streamlined and bilingual program applications;
- Developing and disseminating Spanish language materials and information;
- Utilizing Spanish-speaking media to increase the awareness of the program was effective in Hispanic communities, particularly when coupled with one-on-one outreach practices;
- Eliminating face-to-face interviews to determine eligibility and for the renewal of children enrolled in SCHIP;
- Eliminating the use of asset tests to determine eligibility for SCHIP; and,
- Collecting data by race and ethnicity at the state level to ensure appropriate program planning and implementation.

Recommendations for Program Implementation

The National Advisory Committee provided the following recommendations to sustain enrollment gains and improve Hispanic access to SCHIP and quality care:

Marketing and Outreach

- Link public information campaigns to CBOs that serve the targeted community;
- Develop public information campaigns that will include use of the most effective media outlets in Hispanic communities, such as radio and local English and Spanish local newspapers;
- Develop a comprehensive marketing and outreach plan that will distinguish among awareness of the program, education about it, and strategies with which to navigate the system;
- Redefine the goal of outreach to be to get families into a "medical home." The outreach would provide a case management for the different issues challenging Hispanic families and follow-up on cases and families to ensure retention and sustained health insurance coverage; and,
- Take into consideration the literacy level of the community when planning outreach activities and media campaigns.

Enrollment and Retention

- Simplify enrollment and renewal policies and process to increase the number of eligible children enrolled and to sustain enrollment gains;
- Eliminate lengthy and confusing forms;
- Promote the use of bilingual application and renewal forms;
- Increase and continue linkages among agencies that provide services for children and families, such as WIC and school lunch programs to enroll eligible children in SCHIP; and,
- Establish presumptive eligibility for SCHIP and passive renewal to ensure timely enrollment and continuity of health care services.

Policy

- Eliminate the five-year ban on SCHIP enrollment for new immigrants;
- Adhere to Executive Order 13166 and DHHS Policy Guidance on services to limited English proficiency (LEP) persons to ensure that Spanish-monolingual families have access to linguistically appropriate information and health care services;
- Make available clear information about "public charge". Although most Hispanic children are U.S. born, their parents or relatives may not be U.S. citizens. These parents may be concerned that a child's participation in SCHIP might threaten their immigration status or that of a non-citizen relative. This concern creates reluctance to participate in SCHIP or other government programs. Participating in SCHIP is a benefit that is not considered for "public charge" purposes. States should make provisions for health and human service providers to convey this information and address the "public charge" and other confusing immigration issues in a non-threatening and easy to understand way for SCHIP participants. That is, make provisions to provide information in the Spanish language, and use layman's terms to clarify prevailing misunderstandings in the community;
- Refrain from asking questions about immigration issues. Hispanic families have a great concern regarding the confidentiality of information they give to government officials. To gain their trust and as a matter of policy, states should refrain from asking for documentation (i.e. a social security card number) on the application forms. Gaining the Hispanic community's trust is essential to ensure children's enrollment in SCHIP;
- Develop policies to establish collaboration between states to ensure continuity of services for migrant families and consistent policies on presumptive eligibility for these groups;
- Develop programs to promote the "medical home" concept; and,
- Collect data by race and ethnicity, including Hispanics at the state and city/county levels on enrollment and retention in SCHIP.

Funding

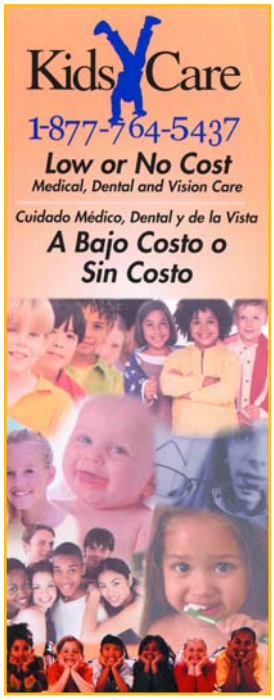
- Stabilize funding to ensure continuity of services for all children and families in SCHIP;
- Fund CBOs to conduct comprehensive outreach for Hispanics and for the development of local initiatives. CBOs are best positioned to provide information, education, application assistance, and other one-on-one necessary services to sustain gains and increase Hispanic enrollment and retention in SCHIP;
- Provide economic incentives for clinics located in underserved neighborhoods, and increase the number of providers accepting the program's insurance; and,
- Modify and redirect the resources that are going into HMOs and other government entities in order to educate consumers on how to become more active participants in the consumption of health care.

Conclusion

This four-year initiative showed that Hispanic families encounter barriers associated with the system policies and procedures as well as challenges specific to immigrant communities. The project also demonstrated the capacity of local communities to identify their problems and to develop strategies to find their own solutions. But communities alone cannot overcome all obstacles. Insuring Hispanic underserved communities also requires the concerted efforts of policy makers and practitioners. This information is a road map to improve the access to health insurance and quality health care for the nation's underserved Hispanic children and families.

Over the past four years, the *Moving Forward* initiative has both identified the challenges Hispanic families face to obtain health insurance and access to quality care for their children and helped to uncover new strategies for promoting greater coverage and care. Although there were significant gains in SCHIP enrollment, Hispanic children remain underrepresented on a large scale. Today, 2.2 million Hispanic children living in families up to 150% of poverty level remain uninsured. Despite their immediate eligibility for SCHIP, these Hispanic children receive no health care services.

National Advisory Committee



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