

GAO

Report to the Ranking Minority Member,
Committee on Commerce, House of
Representatives

April 2000

MEDICAID AND SCHIP

Comparisons of Outreach, Enrollment Practices, and Benefits



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Abbreviations

EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
FPL	federal poverty level
HCFA	Health Care Financing Administration
SCHIP	State Children's Health Insurance Program
SSN	Social Security number



United States General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-285033

April 14, 2000

The Honorable John D. Dingell
Ranking Minority Member
Committee on Commerce
House of Representatives

Dear Mr. Dingell:

Two federal-state partnerships, Medicaid and the State Children's Health Insurance Program (SCHIP), offer states the opportunity to provide health insurance coverage to low-income children. Medicaid, established in 1965 to provide health care coverage to certain categories of low-income adults and children, reported enrollment of 22.3 million children as of September 1998. SCHIP, established in 1997 to expand health care coverage to uninsured low-income children not eligible for Medicaid, reported enrollment of nearly 2 million children as of September 1999. In designing SCHIP, states had the option of expanding their Medicaid programs, constructing a stand-alone program that operates separately from Medicaid, or developing some combination of both approaches. More than half of the states have chosen SCHIP approaches that are, to varying degrees, separate from their Medicaid programs.

Concerned that program differences may create inadvertent disparities between SCHIP and Medicaid, you asked us to review enrollment practices and benefits available in a sample of states. In this context, we analyzed the differences between both programs with regard to outreach, application and eligibility determination, screening and enrollment, and benefits. For this study, we analyzed responses to questions on these issues given by Medicaid and SCHIP officials in 10 states with SCHIP programs that were essentially separate from their Medicaid programs; we also obtained documentation, such as applications, on their Medicaid and SCHIP programs.¹ We also interviewed officials from the Health Care Financing Administration (HCFA), which has oversight responsibilities for both

¹The 10 states we reviewed are Alabama, Arkansas, California, Colorado, Florida, Kansas, North Carolina, New York, Pennsylvania, and Utah. Within its Medicaid program, Arkansas has two distinct components: ConnectCare and ARKids First. The state is hoping to use ARKids First as a SCHIP stand-alone component. Arkansas has about 900 children enrolled in its SCHIP Medicaid expansion as of fiscal year 1999.

SCHIP and Medicaid. We performed our work in March and April 2000 in accordance with generally accepted government auditing standards.

Results in Brief

Across our sample of 10 states, Medicaid and SCHIP programs are similar in terms of their outreach mechanisms, but have differences in the way they enroll children and the scope of the benefits they offer. Certain information that is federally required for Medicaid eligibility determination is not required for SCHIP.² However, half of the states we surveyed required more documentation for Medicaid than for SCHIP, and states often required more documentation for Medicaid than was federally required. States do have the flexibility under federal law to streamline requirements for Medicaid and SCHIP. Additionally, while all of the states in our sample reported policies and procedures to ensure that eligible children were appropriately enrolled in Medicaid rather than SCHIP, the ease with which Medicaid-eligible children were enrolled varied. In some cases, persons applying for Medicaid for their children were required to fill out additional forms or appear in person in order to determine eligibility and obtain coverage. Finally, our review of five optional benefits (dental, hearing, mental health, prescription drugs, and vision) shows that while states' SCHIP programs offer many of the same benefits as Medicaid, SCHIP imposes more limits on these benefits.

²For example, Medicaid requires that applicants provide the Social Security number (SSN) of children who are applying for benefits, while SCHIP does not.

Background

Authorized under title XIX of the Social Security Act, Medicaid is a joint federal-state entitlement program that annually finances health care coverage for more than 40 million low-income individuals, over half of whom are children. Medicaid coverage for children is comprehensive, offering a wide range of medical services and mandating coverage based upon family income in relation to the federal poverty level (FPL). Federal law requires states to cover children up to age 6 from families with incomes up to 133 percent FPL, and children ages 6–15 up to 100 percent of FPL.³ Medicaid benefits are particularly important for children because of Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. EPSDT, which is mandatory for categorically needy children,⁴ provides comprehensive, periodic evaluations of health and developmental history, as well as vision, hearing, and dental screening services to most Medicaid-eligible children.⁵ Under EPSDT, states are required to cover any service or item that is medically necessary to correct or ameliorate a condition detected through an EPSDT screening, regardless of whether the service is otherwise covered under a state Medicaid program.

³Children ages 15–18 are generally covered if their family incomes are below the state's cash assistance standard for families in effect on July 16, 1996.

⁴See 42 U.S.C. sec. 1396a(a)(10)(A).

⁵The EPSDT benefit is optional for the medically needy population, an optional category of eligibility for individuals who generally have too much income to qualify for Medicaid, but have "spent down" their income by incurring medical and/or remedial care expenses. See 42 U.S.C. sec. 1396a(a)(10)(C). If a state chooses to provide one EPSDT service, it must provide all EPSDT services to all medically needy individuals under age 21.

SCHIP, created under title XXI of the Social Security Act, authorized nearly \$40 billion in federal matching funds over fiscal years 1998 to 2008 for states to offer coverage to children in families with incomes up to 200 percent of the FPL who do not qualify for Medicaid.⁶ In designing their SCHIP programs, most states chose to establish separate, stand-alone components, often concurrent with a Medicaid expansion.⁷ As of September 30, 1999, the majority of the almost 2 million SCHIP enrollees—nearly 1.3 million—were in states' stand-alone programs, while about 700,000 were in Medicaid expansions. While states with a SCHIP Medicaid expansion must provide the same coverage available to other children enrolled in Medicaid, states with SCHIP stand-alone components have a wide range of options to use in designing their benefit packages, including the benefits available under a state's Medicaid program. SCHIP stand-alone components must cover basic benefits such as physician services, inpatient and outpatient hospital services, and laboratory and radiological services. However, states have discretion to provide optional benefits such as prescription drugs and hearing, mental health, dental, and vision services on a more limited basis, or not at all.

⁶Recognizing the variability in state Medicaid programs, the statute allows a state to expand eligibility up to 50 percentage points above its existing Medicaid eligibility standard. For example, Connecticut covers children up to 300 percent of the FPL for SCHIP.

⁷As of April 7, 2000, 15 states had stand-alone SCHIP programs, 18 states had combination programs, and 23 were expanding coverage exclusively through Medicaid, according to HCFA. Most states chose stand-alone components for additional control over expenditures. A state with a SCHIP stand-alone component may limit its annual contribution, create a waiting list, or stop enrollment once the funds it budgeted for SCHIP are exhausted. See *Children's Health Insurance Program: State Implementation Approaches Are Evolving* (GAO/HEHS-99-65, May 1999).

States with SCHIP stand-alone components are required to coordinate with Medicaid, other public programs, and private insurance. One coordination provision requires states to initially screen all SCHIP applicants for Medicaid eligibility to ensure that Medicaid-eligible children are enrolled in Medicaid—a process called “screening and enrollment.”⁸ States must specify in their SCHIP plans how they have established a system that identifies, refers, and enrolls eligible children in the appropriate program. HCFA recently proposed regulations for SCHIP that emphasize the need for states to facilitate enrollment of eligible children by offering outreach activities and enrollment mechanisms similar to those in Medicaid. HCFA encouraged but did not require states to streamline and coordinate their outreach efforts, applications and processing time requirements, enrollment options and enrollment sites; and to use continuous and presumptive eligibility for both programs.⁹

Medicaid and SCHIP differ in some of their eligibility determination requirements. Although self-reporting of required information is allowed by both programs, Medicaid has post-eligibility requirements for verification of income and assets through the use of an income eligibility verification system; Medicaid also requires an applicant’s SSN. For both programs, non-citizens are required to document their immigration status or to have their immigration status verified. While states are allowed to require documentation from families to determine eligibility, HCFA noted, in its September 1998 guidance to state Medicaid directors, that states have the flexibility to determine documentation requirements.

Medicaid and SCHIP Use Similar Outreach Mechanisms, but Enrollment Practices and Benefits Differ

Medicaid and SCHIP programs are similar in terms of their outreach mechanisms, but differ in the way they enroll children and the scope of the benefits they offer. With regard to outreach, the states in our sample employ a variety of approaches to inform families about the health coverage programs available, and to assist them in the application process. More than one-half of the states report using similar outreach mechanisms for Medicaid and SCHIP—such as toll-free hotlines, posters, and

⁸See sec. 2102(b)(3)(B) of the Social Security Act.

⁹Continuous eligibility allows states to provide beneficiaries with continuous enrollment in the Medicaid and SCHIP programs for up to 12 months without requiring an eligibility redetermination. Using presumptive eligibility, states have the option of extending immediate Medicaid or SCHIP coverage to children until a formal determination of eligibility is made.

brochures. However, states differed in the extent to which they combined their outreach strategies for the two programs. While some states found it useful to combine such efforts, other states (such as Kansas and Pennsylvania) mostly preferred a separate SCHIP outreach approach. These states indicated that separate outreach strategies are intended in part to overcome potential enrollment barriers that may exist due to the perceived stigma of Medicaid in their states.

The amount of state money allocated or spent on outreach for each program also differed considerably. Among the states able to provide amounts for both programs, two states indicated that more was allocated or spent for SCHIP outreach than for Medicaid outreach. For example, Colorado estimated \$10,000 in Medicaid outreach funds and about \$700,000 budgeted for SCHIP. In contrast, Utah reported more spending for Medicaid outreach (\$716,000) than for SCHIP (\$50,000). (Additional details on the outreach mechanisms and states' spending on outreach are available in app. I.)

In many states in our sample, applying for Medicaid requires more self-reported information, documentation from families, or both to determine eligibility than for SCHIP. Although 7 of the 10 states use, or are moving toward using, a joint application for Medicaid and SCHIP, the eligibility determination requirements were often not the same for the two programs. In fact, for Medicaid, most states required additional information, documentation, or both that was not required for SCHIP. For example, two states—Arkansas and Utah—required families to document assets for Medicaid, but not for SCHIP. One state—Alabama—required income to be documented for Medicaid, but not for SCHIP. In addition, two states—Arkansas and New York—required in-person interviews for enrollment in Medicaid, whereas SCHIP applications could be completed by mail.¹⁰ Of the 10 states, four states offered continuous eligibility—regardless of changes in family income or circumstances—for SCHIP but not Medicaid, while one, New York, offered it for Medicaid but not SCHIP. Recertification requirements were more similar for the two programs than states'

¹⁰While in-person interviews will still be required for Medicaid, New York plans to ease the process through "facilitated enrollment," which will begin in April 2000. Funded by the state, facilitators in community-based settings (such as hospitals, clinics, schools, and libraries) will be delegated the authority to conduct the required face-to-face interviews. The intention is to make it possible for families to be interviewed during hours convenient to their work schedules, including evenings and weekends.

application and eligibility requirements, although one state required an interview for Medicaid but not SCHIP. (See app. II for additional details.)

While all of the states in our sample have established policies and procedures to ensure that Medicaid-eligible individuals are enrolled in Medicaid rather than SCHIP, the ease with which children were enrolled in Medicaid varied. Some of the states used a central clearinghouse in which Medicaid workers, other state employees, and/or private contractors processed SCHIP and Medicaid applications jointly.¹¹ In those states in which the Medicaid and SCHIP staffs were located separately, the applications were often transferred by mail. In three states—Alabama, California, and New York—applicants with incomes below SCHIP requirements were allowed to choose whether their application would be processed for Medicaid.¹² Additionally, in 6 of the 10 states—Alabama, Arkansas, California, New York, Pennsylvania, and Utah—additional steps were required to complete a Medicaid application. (See app. III for additional details.)

Our review of five optional benefits (dental, hearing, mental health, prescription drugs, and vision) shows that while states' SCHIP programs offer many of the same benefits as Medicaid, SCHIP programs place more limits on these services than Medicaid programs do. Most commonly, mental health and vision benefits are more limited under SCHIP than under Medicaid. For mental health care, eight of the states in our sample limit the number of outpatient visits or inpatient days allowed per year. Colorado does not cover dental benefits under SCHIP, and seven states—Alabama, Arkansas, Kansas, New York, North Carolina, Pennsylvania, and Utah—limit selected dental services, primarily orthodontics. In addition, while all 10 of the states in our sample cover hearing screening examinations, at least three states place limitations on hearing services. For example, Arkansas' ARKids First program does not provide hearing aids. Finally, four states in our sample—Alabama, Colorado, New York, and North Carolina—have limitations on all five of the optional benefits. (See app. IV for additional details.)

¹¹In contrast to SCHIP, which does not limit eligibility determination to particular employees, state or county employees must make eligibility determinations for Medicaid according to federal law.

¹²Beginning in April 2000, New York's joint application will not allow applicants a choice; referrals to and enrollment in the Medicaid program will be automatic.

Agency and State Comments

We provided HCFA and Medicaid and SCHIP program officials from the 10 states in our sample an opportunity to comment on this report.

HCFA officials concurred with our findings. In doing so, HCFA stressed the importance of outreach activities for both Medicaid and SCHIP programs and noted guidance it had provided to states in an effort to simplify Medicaid eligibility and better coordinate activities between SCHIP and Medicaid. HCFA further said that, while variation exists across states with regard to outreach mechanisms, progress has been made over the past few years. In particular, HCFA believes that SCHIP outreach efforts have inspired Medicaid outreach for the first time in many states. HCFA also stated that screening and enrollment procedures could be accomplished more effectively in some states, and that reviews of these procedures have been an important component of HCFA's reviews of state programs. In addition, HCFA stated that the differences between Medicaid and SCHIP application procedures—specifically in-person interviews and additional reporting and verification requirements—could be eliminated largely by states under existing law. The full text of HCFA's comments appears in app. V.

HCFA and states' Medicaid and SCHIP program officials provided technical comments and additional information, which we have incorporated where appropriate.

As agreed with your office, we plan no further distribution of this report until 7 days from its date of issue, unless you publicly announce its contents. We will send copies of this report to the Honorable Nancy-Ann Min DeParle, HCFA Administrator, and other interested parties, and we will make copies available to others on request. If you or your staff have any questions regarding this report, please contact me at (202) 512-7114 or Carolyn Yocom at (202) 512-4931. Other contributors to this analysis were Catina Bradley, JoAnn Martinez, and Deborah A. Signer.

Sincerely yours,

A handwritten signature in cursive script that reads "Kathryn G. Allen".

Kathryn G. Allen
Associate Director, Health Financing
and Public Health Issues

Medicaid and SCHIP Outreach Activities

The states in our sample employ a variety of outreach approaches to inform families about the health coverage programs available and to assist them in the application process. Such approaches range from toll-free hotlines to radio and television advertisements to community involvement. More than half of the state officials in our sample indicated that they have similar outreach mechanisms in place for both programs. Despite the reported similarities, however, the existence of similar outreach mechanisms for both Medicaid and the State Children's Health Insurance Program (SCHIP) does not necessarily illustrate the utility or effectiveness of the mechanisms in place. For instance, while one state noted it maintained toll-free hotlines for both programs, the phone lines differed considerably, with one permitting callers to request that an application be sent to them by mail, while the other instructs the caller to apply at the local county assistance office. Other differences between Medicaid and SCHIP outreach include the use of media such as radio and TV for SCHIP, as well as the existence and use of SCHIP Internet sites that provide program information and, in some instances, allow individuals to download applications.

A HCFA official informed us that the agency has been encouraging states to combine outreach mechanisms for SCHIP and Medicaid. While efforts are underway to coordinate Medicaid and SCHIP outreach, some differences exist in the extent to which some states combine their Medicaid and SCHIP outreach strategies (fig. 1).

**Appendix I
Medicaid and SCHIP Outreach Activities**

Figure 1: Extent of Combined Outreach for Medicaid and SCHIP in 10 States

Outreach Strategy	Extent of Combined SCHIP/Medicaid Outreach Strategies ^a									
	Alabama ^b	Arkansas	California	Colorado ^c	Florida	Kansas	New York	North Carolina	Pennsylvania	Utah ^d
Toll-Free Hotline			■	■	■		■	■		■
Posters										
Brochures		■	■	■		■	■			■
Radio Ads		■								
Television Ads		■								
Billboards or Bus Ads	▨	▨	■	■						
Internet		■	■				■	■		■
Schools		■	■	■	■	■	■	■	■	■
Community	■	■	■	■	■	■	■	■	■	■

- All or Nearly All
- Most
- Some/Half
- None
- ▨ Not Applicable

^aThe responses generally reflect answers from both SCHIP and Medicaid officials. However, where reported information varied in any way between Medicaid and SCHIP, responses from SCHIP officials only are noted above, and the differences are described in the footnotes below.

^bAn Alabama Medicaid official indicated that some of the toll-free hotline efforts and brochures are combined with SCHIP, given that the phone line refers people to SCHIP and then mails out SCHIP brochures. Additionally, Alabama Medicaid indicated that most community efforts are combined because all Medicaid outreach workers provide information about both programs.

^cA Colorado Medicaid official reported that some of the toll-free hotline efforts and brochures are combined, while for school or community involvement, Medicaid is not combined with SCHIP.

^dUtah reported that it uses a mix of strategies in that some printed material and information phone lines are combined, while others are not.

Source: GAO Survey of States, Mar. 2000.

Even when outreach efforts are not formally combined, advertising for one program may also reach children eligible for the other program. For example, Utah officials asserted that an outreach campaign targeting a SCHIP or Medicaid population could not be confined to that discrete population. According to these officials, a campaign targeting Medicaid will identify children eligible for SCHIP, and outreach aimed at SCHIP families

will discover individuals potentially eligible for Medicaid. Therefore, outreach strategies, whether distinct or combined, may reach families eligible for either program. Medicaid and SCHIP officials in Kansas similarly indicated that SCHIP advertising also reaches children who are eligible for Medicaid. However, Kansas is beginning to streamline SCHIP and Medicaid into one program under the same name. While the state is not currently coordinating most outreach mechanisms between SCHIP and Medicaid, efforts are underway to adopt a seamless approach.

In six states that reported separate outreach spending or allocations for SCHIP and Medicaid, differences did exist in the extent to which they were able to identify and report outreach efforts—and in the amounts of spending. Some examples follow.

Two states indicated that more funds were available for SCHIP outreach than for Medicaid. Colorado estimated \$10,000 in state spending for Medicaid outreach brochures, and about \$700,000 budgeted for SCHIP. Pennsylvania reported that \$500,000 in state funds has been allocated for Medicaid outreach compared to \$808,250 in state funds for SCHIP.

Two states reported spending more for Medicaid outreach than for SCHIP. Utah identified \$716,000 for Medicaid outreach spending, which includes the cost of outstationed workers who also process SCHIP applications. For SCHIP, the state reported \$50,000 in state spending on outreach.¹ New York also reported spending more for Medicaid once federal funds were added into the total. In particular, the state reported spending \$11.7 million in federal funds associated with welfare reform for Medicaid outreach to children and families; coupled with state spending of \$1.2 million, Medicaid outreach spending was much higher than SCHIP, which reported \$3.38 million in state spending for outreach.

Two states were able to provide data on outreach spending for only one program. Alabama reported \$359,738 in total SCHIP outreach spending, with \$77,380 in state spending, but indicated that such information on Medicaid outreach is not currently available. Arkansas reported \$400,000 in

¹Utah indicated that there are significant costs that are not tracked directly because outreach is considered an important component of the normal way of doing business. For example, workers will go to health fairs and other activities to provide information on Medicaid, SCHIP, and other programs.

state spending for its regular Medicaid program, but could not provide spending amounts for its ARKids First program.

The remaining four states did not delineate spending within each program, but rather provided a combined dollar figure for both Medicaid and SCHIP outreach. For instance, California officials reported that the state spent about \$10 million relating to education and outreach for SCHIP and Medicaid.² Florida also provided a combined outreach figure of \$550,000 in state funds for both programs, Kansas reported \$1.1 million for both programs, and North Carolina indicated that the state spent more than \$1.3 million in federal, state, and grant funds for SCHIP and Medicaid outreach, \$129,250 of which was state funding.

²California further noted that total spending for the state's joint outreach campaign is \$21 million annually in state and federal funds.

Application and Eligibility Determination

In addition to supporting combined outreach efforts, HCFA has been encouraging states to combine Medicaid and SCHIP enrollment efforts as much as possible. The agency reported providing technical assistance and has issued guidance about ways to best accomplish the coordination of enrollment. While 7 of the 10 states in our survey currently use, or are about to use, a joint application, HCFA's monitoring visits to states also emphasized the importance of looking beyond the joint application forms and into the requirements associated with each program.¹ In the 10 states we surveyed, eligibility determination requirements for both information and documentation were typically not the same for Medicaid and SCHIP.

Medicaid and SCHIP differ in some of their eligibility determination requirements, mostly in requiring the state to verify self-reported information for Medicaid applicants.

¹The seven states in our survey with joint applications are Alabama, California, Colorado, Florida, Kansas, New York, and North Carolina. At the time of our study, New York was planning to begin using a joint application statewide in April 2000; previously it had conducted a pilot test of a joint application in New York City and other locations in the state. The remaining three states have separate applications. Arkansas plans to implement a joint application in July 2000. Pennsylvania contracts with seven different health plans to administer SCHIP throughout the state, and each of the contractors uses a different application. Utah SCHIP has a Medicaid addendum form for applicants who appear Medicaid-eligible, although applicants may submit the additional information needed for Medicaid in any format. According to HCFA, the vast majority of states with stand-alone or combination programs rely on joint applications.

Both Medicaid and SCHIP allow applicants to self-report their income and assets for purposes of eligibility determination. However, once an applicant is determined eligible for Medicaid, states are required to have an income and eligibility verification system that is used to verify an applicant's income and resources by requesting information from other federal and state agencies.² States have the authority to eliminate asset tests for Medicaid.³ SCHIP has no income or asset verification requirements. Social Security numbers (SSN) are required for Medicaid applicants but not for SCHIP applicants.⁴

The states in our survey generally required the same information about income and age of the child for both programs. However, most states required more information for Medicaid than for SCHIP on other items. For example, Arkansas, Colorado, and Utah required information about assets for Medicaid, but not for SCHIP. Two states—Alabama and Arkansas—required information about the parent's SSN even when the parent was applying for a child, while none of the states we surveyed required this information for SCHIP.⁵

Similarly, 5 of the 10 states required more documentation from families for Medicaid than for SCHIP on one or more eligibility criteria. For example, although most states required families to provide documentation of income for both programs, Alabama required income to be documented for Medicaid, but not for SCHIP. Alabama, New York, and Utah also required applicants for Medicaid to document deductions from income, such as deductions for childcare, while this was not generally required for SCHIP. Two states also required documentation of assets for Medicaid but not for SCHIP (Arkansas and Utah), and two states required documentation of the child's SSN for Medicaid but not for SCHIP (Alabama and New York). (See

²See 42 CFR 435.940 through 435.965.

³See sec. 1902(r)(2) and 1931 of the Social Security Act. If a state dropped its asset requirement after March 31, 1997, and wants to claim enhanced matching funds for eligible children as a result of this change, it will need to ask about assets to determine which children are eligible for the SCHIP-enhanced match.

⁴Sec. 1137(a)(1) of the Social Security Act requires SSNs to be supplied only by Medicaid applicants and recipients. On September 10, 1998, HCFA issued guidance for states that reiterated these requirements and noted that SSNs of nonapplicant relatives are not required.

⁵Alabama Medicaid officials noted that they do not deny a child's application if the parent's SSN is not provided, but that they prefer to have it to verify family income.

**Appendix II
Application and Eligibility Determination**

fig. 2.) In some cases, states have more than one Medicaid application and the documentation requirements can vary significantly. For example, in addition to its joint Medicaid/SCHIP application for children, Florida has a Medicaid application for families that includes food stamps and cash assistance; using this application requires documentation of income, assets, income deductions, and SSNs, as well as an in-person interview. Utah, in addition to its shortened Medicaid application for children, also has a more extensive application form for families applying for Medicaid and other programs.

Figure 2: Additional Information and Documentation Required for Medicaid in 10 States

State	Eligibility Criteria					
	Income Deductions	Assets	Child's SSN	Parents' SSN	Citizenship	Age of Child
Alabama	■	■	a	b	c	■
Arkansas	■	■	■	b	■	■
California	■	d	■	d	■	■
Colorado	■	■	■	d	c	■
Florida ^e	b	■	■	■	f	■
Kansas	■	■	■	■	■	g
New York	■	■	■	d	■	■
North Carolina	h	■	■	■	■	■
Pennsylvania	■	■	■	d	i	■
Utah	■	■	■	d	■	■

- Documentation Is Required for Medicaid, but Not for SCHIP
- Information Is Self-Reported by the Applicant for Medicaid, but Not for SCHIP
- Same Requirement Essentially for SCHIP and Medicaid
- Neither SCHIP nor Medicaid Has this Requirement

^aAlabama Medicaid noted that it can sometimes obtain this information from its state verification and exchange system.
^bAccording to state officials, the application is not denied or held up if the family does not provide this information.
^cThe state requires this information only if the applicant is a noncitizen.
^dThe state requires this information only if the parent is applying for Medicaid.

Appendix II
Application and Eligibility Determination

^eThe Florida responses in our table reflect requirements only for applications submitted through the joint Medicaid and SCHIP application process.

^fIf the child is not a citizen or if citizenship is in question, the state requires documentation of immigration status.

^gSCHIP has more requirements than Medicaid.

^hA North Carolina Medicaid official told us that the application is not held up if this information is not provided.

ⁱA Pennsylvania SCHIP official told us that citizenship documentation is required for SCHIP only if citizenship is in question.

Source: GAO Survey of States, Mar. 2000.

The states' applications reflected several strategies for handling the different requirements for eligibility determination under the two programs. State strategies included (1) requiring additional follow-up from Medicaid-eligible applicants (for example, Alabama, New York, Pennsylvania, and Utah); (2) asking SCHIP applicants for information not required by the program (for example, Colorado's application asks for asset information, although asset information was required only for Medicaid; and Alabama, Arkansas, and Colorado applications ask for both the child's and parent's SSNs); (3) indicating that some questions were optional (for example, California's joint application indicates that SSNs are not required for SCHIP); and (4) indicating that some sections of a joint application related to only one program (for example, Colorado).

Of the 10 states, four offered continuous eligibility for both Medicaid and SCHIP (Alabama, Florida, Kansas, and North Carolina).⁶ Five other states offered continuous eligibility for SCHIP but not Medicaid (Arkansas, California, Colorado, Pennsylvania, and Utah), while New York offered it for Medicaid but not for SCHIP. Most states provided for 12 months of continuous eligibility when it was offered, except in Florida, where Medicaid children under age 5 had 12 months of continuous eligibility and Medicaid children over age 5 and all SCHIP children had 6 months of continuous eligibility.

Under current Medicaid law, without the continuous eligibility option, states must recertify the eligibility of a Medicaid beneficiary whenever the beneficiary's financial circumstances change.⁷ Recertification requirements

⁶Continuous eligibility allows an applicant to remain eligible for Medicaid, regardless of any changes in circumstances, for a specified period of time.

⁷Recertification requires applicants to report any changes in financial circumstances to the Medicaid or SCHIP program, in contrast to continuous eligibility.

for Medicaid and SCHIP were more similar in the states we surveyed than application and eligibility requirements. Nine states required recertification after 12 months for both programs. Florida required recertification after 12 months for Medicaid and after 6 months for SCHIP. The most common methods for recertification involved mailing a form or a new application, but New York also required an interview for Medicaid recertification but not for SCHIP. Nearly all states required information about income for Medicaid and SCHIP; several states required information about income deductions, primarily for Medicaid. Arkansas and Utah required information about assets for children applying for Medicaid. Alabama's Medicaid program also required information about the child's and parent's SSNs, citizenship, and age of the child.

Screening and Enrollment

While all of the states in our sample have established policies and procedures to assure that Medicaid-eligible individuals are enrolled in Medicaid rather than SCHIP, the ease with which children were enrolled in Medicaid varied. Some of the states used a central clearinghouse in which Medicaid workers, other state employees, and/or private contractors processed SCHIP and Medicaid applications jointly. Six states—Colorado, Florida, Kansas, North Carolina, Pennsylvania, and Utah—implemented a variety of approaches to ensure that Medicaid-eligible applicants were automatically enrolled in or referred to Medicaid. For example, Kansas and North Carolina utilized an eligibility system that simultaneously screens and enrolls children in Medicaid or SCHIP. Even though Pennsylvania does not have one standard SCHIP application, the state has evoked an “any form is a good form” policy, whereby it transfers all applications for Medicaid eligibility determination. In Utah, the SCHIP program contracted with the state Medicaid agency to determine Medicaid and SCHIP eligibility and to enroll applicants in the appropriate program.¹ Three states—Alabama, California, and New York—allowed applicants the option of not being enrolled in Medicaid.² The remaining state, Arkansas, required applicants to submit separate applications for Medicaid. (See table 1.)³

¹Utah has a Medicaid addendum form for the SCHIP application for applicants whose family income is in the state’s eligibility range for Medicaid. The applicants may submit the additional information in any format. If this information is not provided, the application cannot be considered for either SCHIP or Medicaid.

²New York’s joint application will make referrals to the Medicaid program automatic.

³While Arkansas is working on a combined form, the state currently has separate applications for its ARKids First program, which covers Medicaid-eligible children, and ConnectCare, which covers Medicaid-eligible children and adults. In the event that an ARKids First applicant appears to be eligible for ConnectCare, he or she is notified and sent an application. The applicant may apply for ConnectCare or instead choose to enroll in the ARKids First component of the state’s Medicaid program.

**Appendix III
Screening and Enrollment**

Table 1: Enrollment Practices for Medicaid and SCHIP in 10 States

States	If SCHIP applicant appears Medicaid-eligible			Additional steps required for Medicaid
	Automatic enrollment in Medicaid	Notification of potential Medicaid eligibility	Applicant can "opt-out" of Medicaid	
Alabama			X	Documentation, telephone interview
Arkansas		X ^a		New application (ConnectCare), documentation, appear for an interview
California			X	Self-reported information, documentation ^b
Colorado	X			None
Florida		X		None
Kansas	X			None
New York			X ^c	New application for Medicaid, documentation, appear for an interview ^d
North Carolina	X			None
Pennsylvania		X		Self-reported information, documentation
Utah		X		Self-reported information, documentation

^aIn Arkansas, the individual must submit a separate application for Medicaid.

^bCalifornia commented that in the event the entire joint Medicaid/SCHIP application is completed, no further documentation would be required. However, the application indicates that some information is only necessary for Medicaid; in the event an applicant was seeking SCHIP eligibility, additional information and documentation would be required for Medicaid if the applicant was deemed ineligible for SCHIP.

^cUnder New York's new joint application, applicants will no longer be able to opt-out of consideration for Medicaid.

^dWhile New York will still require in-person interviews for Medicaid eligibility determinations, it will ease the process through "facilitated enrollment," which will begin in April 2000.

Source: GAO Survey of States, Mar. 2000.

Finally, some of the states in our sample reported that SCHIP screening and enrollment policies have been an effective means of reaching Medicaid-eligible children. For example,

- Alabama reported that approximately 40,000 SCHIP applications were referred for eligibility determination for Medicaid during the program's first fiscal year,⁴
- California reported that over 54,000 SCHIP applications were referred for eligibility determination for Medicaid from April 1999 through March 2000, and
- North Carolina reported enrolling approximately 37,000 children into the Medicaid program for state fiscal year 1999.

⁴Alabama implemented its SCHIP program in February 1998.

Benefits

SCHIP limitations on benefits represent a departure from those offered to children under Medicaid, primarily because of Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), which covers any service or item that is medically necessary. While nine of the states in our sample cover all five of the selected optional benefits (prescription drugs, and vision, mental health, hearing, and dental services) many of those services are covered on a limited basis. (See table 2.) For example,

- Colorado does not cover dental benefits under SCHIP and seven states—Alabama, Arkansas, Kansas, New York, North Carolina, Pennsylvania, and Utah—limit dental services, primarily orthodontics.
- Similarly, a number of states place limitations on vision and hearing benefits. Most commonly, states limit the number of eyeglasses or hearing aids allowed per year.
- Four states—Alabama, Colorado, New York, and North Carolina—have service limits on all five benefits. However, a North Carolina SCHIP official asserted that its Medicaid and SCHIP benefit limitations are essentially the same because the state uses an internal review process for SCHIP children to determine whether service needs that are beyond the scope of coverage cited below are medically necessary.

Table 2: SCHIP Coverage Limitations on Optional Benefits in 10 States

Optional benefits	State	Coverage limits on benefits for SCHIP ^a
Prescription drugs	Alabama	Require generic unless no equivalents are available
	Arkansas ^a	No limitations cited
	California	No limitations cited
	Colorado	Require generic unless no equivalents are available
	Florida ^b	Require generic unless no equivalents are available or brand name is medically necessary
	Kansas ^c	No limitations cited
	New York	Medically necessary prescriptions only; no experimental drugs
	North Carolina	USDA-approved drugs only; no experimental drugs
	Pennsylvania	No limitations cited
	Utah	Medically necessary prescriptions only; no experimental drugs ^d

Continued

**Appendix IV
Benefits**

Optional benefits	State	Coverage limits on benefits for SCHIP^a
Vision	Alabama	One exam and one set of glasses/year
	Arkansas	One exam and one set of glasses/year
	California	One set of glasses or contacts/year
	Colorado	\$50 annual maximum toward purchase of vision hardware
	Florida ^b	One set of glasses every 2 years
	Kansas ^c	No limitations cited
	New York	One set of glasses/year ^e
	North Carolina	One set of glasses or contacts/year
	Pennsylvania	Two sets of glasses/year
	Utah	One exam every 24 months for eye refractions, examinations
Mental health	Alabama	Inpatient: 30 days/year; outpatient: 20 visits/year
	Arkansas	No inpatient psychiatric care; outpatient limited to \$2,500/year
	California	No limitations cited
	Colorado	Inpatient: 45 days/year; outpatient: 20 visits/year
	Florida ^b	Inpatient: 30 days/year; outpatient: 40 visits/year
	Kansas ^c	No limitations cited
	New York	Inpatient: 30 days/year; outpatient: 60 visits/year
	North Carolina	Prior approval needed for both inpatient and outpatient visits; outpatient visits limited to 26 visits/year; additional visits covered if approved in advance
	Pennsylvania	Inpatient: 90 days/year; outpatient: 50 visits/year
	Utah	Inpatient: 30 days/year; outpatient: 30 visits/year
Hearing	Alabama	Screening and hearing aids only
	Arkansas	Screening, no hearing aids
	California	Screening and hearing aids
	Colorado	Hearing screening and hearing aids up to \$800/year
	Florida ^b	Routine screening and hearing aids
	Kansas ^c	No limitations cited
	New York	One exam/year ^f
	North Carolina	Screening covered; prior approval is necessary for hearing aids
	Pennsylvania	One hearing aid set per year
	Utah	One exam every 24 months and hearing aids

Continued from Previous Page

**Appendix IV
Benefits**

Optional benefits	State	Coverage limits on benefits for SCHIP^a
Dental	Alabama	Two checkups/year with cleaning; \$1,000/year maximum
	Arkansas	No orthodontics
	California	No limitations cited
	Colorado	Not covered
	Florida ^b	No limitations cited
	Kansas	No orthodontics
	New York	No orthodontics
	North Carolina	No pulling of impacted teeth
	Pennsylvania	No cosmetic or orthodontics
	Utah	No orthodontics, crowns, or root canals

Continued from Previous Page

^aFor Arkansas, the benefit limitations cited in this table are for the ARKids First program, which is separate from the state's regular Medicaid program. The benefit package for Arkansas' SCHIP Medicaid expansion program is the same as Medicaid's.

^bBenefits for Florida's Healthy Kids program are reflected in the table. The state's MediKids program and the Children's Medical Services Network for children with special health care needs use Medicaid benefits.

^cWhile there are no apparent limitations on prescription drugs, vision, mental health or hearing for Kansas SCHIP, the medical services must be deemed medically necessary by the managed care contractors.

^dUtah's SCHIP plan language explicitly states that the fact that the provider may prescribe, order, recommend, or approve a prescription drug, service, or supply does not, of itself, make it an eligible benefit, even though it is not specifically listed as an exclusion. A prescription must be medically necessary regardless of the relief the drug provides for a medical condition.

^eNew York supplies additional lenses and frames if medically necessary.

^fNew York provides additional exams for hearing deficiencies.

Comments From the Health Care Financing Administration



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: April 11, 2000

TO: Kathryn G. Allen
Associate Director, Health Financing and Public Health Issues
General Accounting Office

FROM: Nancy-Ann Min DeParle 
Administrator
Health Care Financing Administration

SUBJECT: HCFA Response to Draft Report
"Medicaid and SCHIP: Comparisons of Outreach, Enrollment Practices and
Benefits" GAO/HEHS-00-86R

Thank you for the opportunity to review the draft report to Congress assessing the degree of coordination between Medicaid and the State Children's Health Insurance Program (SCHIP) in ten States. As you know, expanding health insurance to vulnerable Americans has been a long-standing goal of the Clinton Administration and we appreciate the Congress' continued interest in these important programs. We also appreciate GAO's acknowledgment of the progress HCFA has made in coordinating SCHIP and Medicaid programs.

Although the GAO's report makes no specific recommendations, HCFA generally concurs with the findings of this report.

We appreciate the opportunity to review the draft report. We are committed to continuing our efforts to work with States to ensure that every child eligible for free or low-cost health insurance receives it.

Comments of the Health Care Financing Administration
on the General Accounting Office (GAO) Draft Report, Medicaid and SCHIP:
Comparisons of Outreach, Enrollment Practices, and Benefits

General Comments

The creation of the State Children's Health Insurance Program and its promise of access to health care for millions of young Americans is one of the greatest achievements of the Clinton Administration. SCHIP has prompted the largest expansion of health insurance for children since Medicaid was created in 1965. By September 1999, just two years after SCHIP was enacted into law, nearly two million children had been enrolled. This is an enormous achievement for States and for the federal government.

In creating SCHIP, both Congress and the President anticipated that outreach efforts for SCHIP would undoubtedly carry over to children eligible for Medicaid. In addition, Congress specifically required States to screen all children who apply for coverage and to enroll Medicaid-eligible children in Medicaid. Although there are no national data on the number of children who have been enrolled in Medicaid as a result of SCHIP-related activities, many States anecdotally report that SCHIP outreach and coordinated application processes for SCHIP and Medicaid have led to enrollment of a significant number of children in Medicaid.

It is not enough, however, to simply rely on SCHIP outreach and application procedures to identify Medicaid-eligible children. Targeted outreach is needed for both SCHIP and Medicaid and States must have systems in place to ensure that the children who are identified as Medicaid-eligible are actually enrolled in the program. According to estimates developed based on 1997 data, more than four million low-income uninsured children were eligible for Medicaid but not enrolled. That is why consistent, persistent outreach and enrollment efforts are critical to the success of these programs.

The States and the federal government have made significant progress in finding and enrolling children. The enactment of SCHIP and the coordination requirements in the SCHIP law have prompted States to undertake new efforts focused on Medicaid outreach and to reexamine their Medicaid enrollment procedures. As a result, much more is being done to inform families about the availability of Medicaid coverage and to streamline the application process. Most States now rely on shortened, mail-in applications to enroll children in Medicaid and no longer consider assets as a condition of Medicaid eligibility for children. In addition, many States have also limited the number of documents families must provide to verify their children's eligibility. States with stand-alone or combination SCHIP programs have also focused considerable attention on developing application procedures that coordinate enrollment between Medicaid and SCHIP; many States have established relatively seamless systems of coverage.

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Federal Involvement

HCFA has encouraged these outreach, simplification and coordination efforts both through our review and approval of States' SCHIP plans and through our Medicaid and SCHIP guidance to States. We have provided the following letters:

- January 14, 1998 - Reaching Immigrant Children
- January 23, 1998 - Outreach and Enrollment
- September 10, 1998 - Eligibility Simplification and Social Security Numbers
- November 23, 1998 - Screen and Enroll Requirements
- January 5, 2000 - Funding for Medicaid Outreach and Simplification

HCFA has included similar encouragement for outreach, simplification and coordination efforts in the preamble and proposed SCHIP regulations set forth in the Notice of Proposed Rule Making (NPRM) issued on November 8, 1999, on programmatic issues.

HCFA has worked with the National Governors' Association to create a toll-free hotline (1-877-KIDS NOW) and other materials to reach all low-income families with information about both Medicaid and SCHIP. We have encouraged States to make Medicaid eligibility processes as simple for Medicaid as they are for SCHIP. We have reminded them that federal funds are available for Medicaid and SCHIP outreach activities. And, as the GAO report notes, we have proposed SCHIP regulations which urge States to use continuous and presumptive eligibility for both programs, and to coordinate their outreach efforts, applications, enrollment options and enrollment sites.

Over the next several months, HCFA will continue and expand efforts to promote joint outreach, simplified enrollment and redetermination procedures and ensure that the coordination requirements in the SCHIP law are met in effective and efficient ways. We will do this by continuing to provide technical assistance to States on the options available, as well as the requirements under federal law, by focusing on these options in our SCHIP site visits. As of April 5, 2000, HCFA and HRSA staff have conducted SCHIP site-visits in almost half the States. These visits have taught us a great deal about what States have done to promote enrollment in Medicaid and SCHIP, and we, in turn, have shared these best practices with other States. In addition, HCFA will provide further guidance to States on these matters in the form of the final SCHIP regulations and letters to State Medicaid and SCHIP directors.

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The FY 2001 President's Budget

The President's budget includes several proposals that would further enhance States' ability to increase enrollment in Medicaid and SCHIP. These proposals would:

- Expand the types of entities that can determine a child to be presumptively eligible for Medicaid. States could use additional entities than those that are currently permitted, such as public schools, child care resource and referral centers, and child support enforcement agencies, to determine presumptive Medicaid eligibility for children;
- Allow State Medicaid and SCHIP agencies to access information about children who participate in the Free and Reduced Price School Lunch program to enhance efforts to enroll additional children, because many of the children who participate in the school lunch program also meet the eligibility criteria for Medicaid and SCHIP;
- Provide \$10 million in mandatory funding for competitive grants to States to improve coordination among programs such as Medicaid, SCHIP, TANF, Food Stamps, and the Welfare to Work grant program that are addressing the needs of the homeless. Grants would be awarded to as many as seven States; and
- Require States to align their SCHIP and Medicaid eligibility rules for income-related children's eligibility groups in three areas: 1) The application process (mail-in, phone-in, electronic transmission, elimination of face-to-face interview requirements, etc.); 2) Use of the same (or no) asset tests; and 3) 12-month eligibility re-determinations. Over 40 States have already taken some of these steps to make enrollment in Medicaid as easy as enrollment in SCHIP.

Response to Findings

The first general finding of this report is that while the 10 States in the sample employ similar outreach mechanisms for Medicaid and SCHIP, there was variation in the degree to which the efforts were combined and in the amount of funds allocated to each program.

While we agree that these differences do exist, it is important to note the progress that has been made over the past few years. SCHIP has inspired Medicaid outreach for the first time in many States. In addition, the concept of coordination of outreach activities between Medicaid and SCHIP, particularly for States

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establishing entirely separate, stand-alone SCHIP programs, will require a period of transition. While some States still have work to do, several States have made great strides in this area, often in conjunction with other administrative simplification activities, like using the same name and application for both programs. Finally, we suggest that the fact that some States may have spent more on outreach and publicity for their SCHIP programs may be due in part to the fact that SCHIP is new; and States creating stand-alone SCHIP programs need to introduce families and providers to the new program.

We believe it is important to make clear that the differences between the Medicaid and SCHIP application procedures -- specifically in-person interviews and additional reporting and verification requirements -- can be eliminated largely by States under existing law. We are troubled that, in some States, Medicaid is significantly more burdensome for families to access. Federal Medicaid law does not require in-person interviews. It does allow States to eliminate asset reporting and verification and permits self-declaration of all eligibility factors other than immigration status. Several States have already taken these steps. HCFA's proposed SCHIP regulations reinforce the need for States to coordinate administrative activities for both programs by encouraging states to simplify and coordinate application forms and enrollment sites; simplify or limit documentation where possible; and to utilize the presumptive eligibility option.

Regarding the third general finding, we share GAO's concern that the "screen and enroll" policy, which is a fundamental element of the SCHIP statute, could be implemented more effectively in some States. Effective coordination between Medicaid and stand-alone SCHIP programs helps to ensure that children eligible for coverage are not falling through the cracks and that limited SCHIP funds are used to cover newly-eligible children.

As the GAO report suggests, States' success in achieving coordination is closely related to the degree to which they have simplified the Medicaid enrollment process. Stand-alone States that use joint application forms that have additional requirements for Medicaid-eligible children (e.g. additional forms, additional verification and/or an in-person interview at the welfare office) will have greater difficulty coordinating their Medicaid and SCHIP enrollment procedures. Medicaid-eligible children in these States are likely to lose out on coverage opportunities. In addition, complicated and time-consuming application requirements can be confusing to families and undermine efforts to eliminate any stigma that might be attached to Medicaid.

Effective and efficient implementation of the "screen and enroll" requirement is a priority for HCFA. We spent a considerable amount of time with States during the initial review of the States' SCHIP plans (as well as the review of amendments) working to ensure an

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adequate screen and enroll process. HCFA is currently in the process of reviewing States' implementation of this requirement. In some States, we reviewed the implementation of the SCHIP "screen and enroll" procedures in our TANF/Medicaid reviews, and we continue to review these procedures in all States through the ongoing SCHIP site-visits. As noted above, this is also a major topic covered in our proposed SCHIP regulations.

HCFA continues to work with the States to find new and innovative mechanisms that are compatible with the administrative structures operating in their States to ensure that all eligible children are enrolled promptly in the appropriate program. Although coordination problems do exist in some States, we believe that it is important to recognize that State processes are continuing to evolve as is evident by the changes being adopted in New York that are described in the GAO report. We have seen a high level of creativity in States' efforts to find ways to coordinate stand-alone SCHIP programs with Medicaid. States have experimented with mechanisms such as co-location of eligibility workers and electronic transfers of eligibility information as a means of expediting the process.

The final area of consideration in the GAO's 10-State survey of the States was a comparison of benefit packages for the two programs. In light of the other issues considered in this report, we assume that the benefit comparison was intended to focus attention on one of the reasons why it is important that Medicaid-eligible children are enrolled in Medicaid. As noted in the report, States have often covered the same types of services as are required in Medicaid, although, in many cases, the scope of the benefits offered in a stand-alone SCHIP program is more limited than the scope of the benefits available under Medicaid. This is an important point, but it is important to also recognize that the SCHIP statute affords States a significant amount of flexibility in this area. Overall, given the flexibility granted under the statute, we believe that States have gone a long way toward structuring their SCHIP benefits in a way that recognizes the value of a comprehensive benefit package in promoting positive child health outcomes.

In conclusion, we appreciate the GAO's efforts in this area and look forward to working with the GAO and Congressman Dingell to identify and resolve barriers that may exist for children eligible for coverage under either Medicaid or SCHIP. We believe that the enormous progress made by so many States under both SCHIP and Medicaid underscore that it is indeed possible to coordinate outreach, streamline enrollment procedures, and create seamless systems of coverage. HCFA remains committed to working with States to eliminate barriers to coverage and to meet our mutual goal of covering all eligible children.

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