



Managing Medicaid Take-Up

Building Administrative Capacity for CHIP and Medicaid: Image, Outreach, and Organization

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Study Highlights

Though often portrayed and publicized as distinct from Medicaid, state level CHIP program design and implementation tends to bring both programs closely together.

- ❖ Federal law provides states with various options in structuring their CHIP programs. States can use CHIP to expand existing Medicaid programs, they can create their own freestanding separate state-only CHIP program, or they can combine both approaches. A review of state experiences shows that regardless of the approach utilized, states tend to rely on the existing Medicaid bureaucracy for program management. In many states, CHIP is part of reinvented Medicaid systems that have been reorganized to minimize welfare stigma and to reach newly eligible populations.

Promotion and outreach efforts rely on networks of institutions and organizations to increase capacity to attract and retain eligible beneficiaries for both CHIP and Medicaid.

- ❖ Under CHIP, states have pursued a variety of outreach approaches. Public institutions, such as schools, health clinics, health departments, and local welfare offices have joined with nonprofit community service organizations to publicize the program. Because the law requires that Medicaid eligibility be first determined for those applying for CHIP, this has created a link between the programs resulting in increasing enrollment for both programs.

It has taken time and effort to develop complementary CHIP and Medicaid structures and processes in the states. While there have been many advances in creating “integrated” and “seamless” systems, there remain challenges.

- ❖ There are always counter-currents to success. Policymakers, administrators, and stakeholders should be aware of the continuing and potential challenges to coordination. Important work remains to be done in smoothing differences in eligibility procedures and client redetermination. Nonetheless, increased enrollments in both Medicaid and CHIP suggest that important steps have been taken to build capacity in expanding and extending publically funded health insurance to children and families.

Introduction

Effective CHIP implementation requires the pursuit of “seamlessness” between CHIP and other publically funded health insurance programs, most notably Medicaid. Complementarity is sought in outreach and application efforts, enrollment and case management procedures, and covered services and benefits. Where coordination is absent, criticism abounds. The issues and consequences are very familiar — disconnections in eligibility determination procedures that result in a lack of coordination between Medicaid and CHIP application reviews, differing coverages and services for children enrolled in different programs within the same family, and provider uncertainty about billing and reimbursement are common complaints. Attention is also paid to successful efforts to develop new integrative processes, such as joint application procedures, uniform coverages and services under the programs, coordinated redetermination and re-enrollment practices, and positive provider relations. Both the success and failures of new program processes have been widely discussed and reviewed (see U.S. General Accounting Office 1999, 2000, 2001, Shenkman et al. 2002, Dick et al. 2002, Thompson 2002). One dynamic, however, that has received less attention involves the relationship of administrative structures responsible for CHIP and Medicaid operations.

This management brief examines the coordination of CHIP and Medicaid administration at the state level through a comparative review of experiences of 18 states that have been the subject of ongoing research by the Rockefeller Institute of Government since 2000. This brief is one in a series that examines important management issues in Medicaid systems. This analysis reveals three important dimensions to the evolution of CHIP and Medicaid in recent years. First, for purposes of marketing and publicity, CHIP is often portrayed and presented to the public as a distinct program that is separate from Medicaid. Second, contrary to such portrayals, CHIP programs have been tightly

integrated into existing Medicaid structures — even in those states that have “state only programs.” This is reflected in formal institutional arrangements and in more informal collaborative arrangements that are emerging through outreach and enrollment efforts. Third, this complex relation of image distinction and program integration has a positive effect on capacity building for publically funded health insurance systems at the state level.

Structures and Processes in CHIP and Medicaid Management

When CHIP was initiated in 1997, there was some doubt as to what paths states would take in administering the program. States had the choice of three program options, each of which appeared to have benefits and drawbacks (Rosenbaum et al. 1998). Some states elected to closely ally CHIP with Medicaid by fashioning the new program as an expansion of the older program. Other states established CHIP programs as separate and standalone arrangements putatively distinct from Medicaid. Others pursued a combined approach that expanded Medicaid for some children and created a new CHIP program for other children. Originally, the program path that a state would take was often framed as an either/or situation. Medicaid expansion, for example, offered the advantages of building on existing systems but posed a danger of creating an entitlement that the state would have to deliver on and raised the risk of creating a stigma-laden image of a new welfare program for the poor (Rosenbaum et al. 1998). A separate state program offered to indemnify the state from long-term fiscal obligation and helped to disassociate CHIP from welfare, but at the same time posed challenges for establishing new administrative arrangements to implement the program (Rosenbaum et al. 1998).

Early congressional studies found that states were pursuing program options somewhat equally (U.S. General Accounting Office 1999). This trend

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Table 1. CHIP Enrollment in 2002 FY 2nd Quarter

<i>State</i>	<i>Enrollment (January-March 2002)</i>
Arizona	63,049
Colorado	43,609
Florida	273,952
Georgia	171,033
Kansas	28,185
Maryland	103,989
Michigan	47,240
Missouri	84,290
New Jersey	100,629
New York	594,521
Ohio	126,656
Oregon	25,166
Tennessee	4,721
Texas	560,588
Utah	28,607
Washington	7,621
West Virginia	22,904
Wisconsin	36,671
TOTAL	2,323,431
TOTAL U.S.	3,819,697

Source: U.S. Department of Health and Human Services, 2002. SCHIP FY 2002 2nd Quarter Enrollment Report. <http://cms.hhs.gov/schip/fy02sger.pdf>. Figures reflect total of all enrollments ever recorded in the 2nd quarter of the 2002 federal fiscal year.

has held. We find that states have been very adaptive and innovative in making use of existing administrative structures for Medicaid to implement CHIP while at the same time creating a distinct identity for the program. Regardless of form, most states have opted to portray CHIP as something new and distinct. And, as we shall see, regardless of form, most states have elected to build their CHIP programs within existing administrative structures while at the same time capitalizing on opportunities to enhance the capacity of semi-formal networks and collaborations among those interests and organizations with a stake in publically-funded health insurance.

As Table 1 illustrates, the eighteen states in this study offer a good representation of the CHIP population. As of early 2002, these states accounted for approximately 61 percent of the national enrollment. As Table 2 illustrates, these states are also representative of the various options that have been adopted by the states. The evolution of the CHIP program illustrates the diversity of the states in the American federal system. In terms of basic design elements, nine of the eighteen states currently have “separate” state only CHIP programs which are distinct from Medicaid programs. Five states have combined programs, which utilize both a Medicaid expansion and separate state program. Four states have elected to use the expanded Medicaid option which provides coverage under CHIP for families with income levels that might exclude them from Medicaid. Of our sample, two states, West Virginia and Texas, have recently moved from combined systems to separate state programs. One state, Maryland, has moved from an expansion to a combined system. Table 2 outlines CHIP arrangements in the 18 states as of July 2000 and September 2002.

States Participating in the Study

<i>Arizona</i>	<i>Colorado</i>	<i>Florida</i>
<i>Georgia</i>	<i>Kansas</i>	<i>Maryland</i>
<i>Michigan</i>	<i>Missouri</i>	<i>New Jersey</i>
<i>New York</i>	<i>Ohio</i>	<i>Oregon</i>
<i>Tennessee</i>	<i>Texas</i>	<i>Utah</i>
<i>Washington</i>	<i>West Virginia</i>	<i>Wisconsin</i>

Table 2. CHIP Program Types

<i>State</i>	<i>As of July 1, 2000</i>	<i>As of September 1, 2002</i>
Arizona	Separate	Separate
Colorado	Separate	Separate
Florida	Combination	Combination
Georgia	Separate	Separate
Kansas	Separate	Separate
Maryland	Medicaid Expansion	Combination
Michigan	Combination	Combination
Missouri	Medicaid Expansion	Medicaid Expansion
New Jersey	Combination	Combination
New York	Combination	Combination
Ohio	Medicaid Expansion	Medicaid Expansion
Oregon	Separate	Separate
Tennessee	Medicaid Expansion	Medicaid Expansion
Texas	Combination	Separate
Utah	Separate	Separate
Washington	Separate	Separate
West Virginia	Combination	Separate
Wisconsin	Medicaid Expansion	Medicaid Expansion

Sources: U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, 2002. U.S. Department of Health and Human Services, Health Care Financing Administration, 2001. Individual state field reports from the Rockefeller Institute of Government Medicaid Take-Up Study.

There are different motives for program design, but the ideal of creating a separate identity for CHIP is key. In some cases, political motivation appears to have been at work in establishing new programs rather than in strengthening or expanding existing programs. It has been long understood that gaining recognition for something new is a better path to headlines and visibility than building on that which already exists. Fiscal concerns are another major factor in seeking separateness. A separate CHIP program minimizes financial risk to states. Because CHIP is not an entitlement, there is no obligation for states to continue to provide the service if

federal funds are exhausted. Under Medicaid expansion arrangements, the states might still be obligated to provide coverage even in the absence of federal monies. The issue of welfare stigma is also a motivating factor in program design. It is a multidimensional issue, including not only clients' perceptions of welfare, but also general concerns regarding existing bureaucratic arrangements. Medicaid agencies have not traditionally been seen as the most effective stewards of public dollars nor the best payers of services.

Though often portrayed and publicized as distinct from Medicaid, state level CHIP program design and implementation tends to bring both programs closely together. While for reasons of appearance a distinct identity for CHIP is pursued, in many circumstances administrative arrangements for both programs are shared — even in those states that run “separate” CHIP programs. Implementation also brings the programs closer together through outreach and enrollment efforts. Reorganization and reform efforts pursued in the 1990s helped to shape the foundation for CHIP program design and administration.

In many states, Medicaid bureaucracies experienced significant reorganizations prior to CHIP. For example, Wisconsin, Michigan, and New York restructured program arrangements in association with welfare reform. Since 1996, New York’s Medicaid program has been part of the state’s Department of Health (Liebschutz 2001). In Michigan, the state’s Medicaid bureau, the Medical Services Administration, was transferred from the Department of Social Services to a new Department of Community Health (Weissert 2001). In Wisconsin welfare functions were reorganized under a Department of Workforce Development and Medicaid was reorganized under the Department of Health and Family Services (Kaplan 2001).

These reorganization efforts were driven in part to minimize the welfare stigma attached to the receipt of Medicaid and other publically funded health insurance benefits. These efforts evolved in concert with important changes in the Medicaid program that expanded eligibility to working families and medically needy individuals who existed outside of the traditional welfare base of the program. CHIP provided a new service line for these reorganizations, further strengthening the move to self-standing systems set apart from the traditional welfare bureaucracy. For example, in 1999 the state of Georgia combined its Medicaid, women’s health, public employee insurance, and state health planning agency under the aegis of the Department of Community Health (Ellen-Duke and Rich 2001). New York, which had preexisting programs that provided insurance for children in low-income families, redesigned administrative arrangements to better comport with the new requirements of the

CHIP program (Liebschutz 2001). Like other states, Oregon began to redesign its health and human service programs with the advent of welfare reform. Part of this redesign included separating Medicaid administration from traditional welfare functions. When CHIP emerged, policymakers reasoned that “with an independent Medicaid system already in place, it made sense to include the CHIP program in the Office of Health Plans [the state’s Medicaid agency]” (Freedman et al. 2001, p. 6).

Administrative Structures in CHIP and Medicaid: More Convergence, Less Divergence

Health and human services reorganizations and the advent of CHIP have resulted in a variety of administrative arrangements under which CHIP and Medicaid are administered. Greater variety exists in administrative arrangements beyond those suggested by the taxonomy of Medicaid expansion, separate state, and combined CHIP programs. In the four states with expansions we find that, as expected, program management is carried out by the Medicaid agency. Interestingly, in three of these cases, it is a newly reorganized or reinvented Medicaid agency that is carrying out this function. As noted above, Wisconsin’s Medicaid agency was reorganized as a result of welfare reform. Tennessee’s changed with its headlong move toward managed care arrangements and broadbased eligibility expansion. A similar trend occurred in Missouri. In short, reinvented Medicaid systems made it easier to overcome stigma issues related to welfare and welfare bureaucracies.

What is very notable is that regardless of program option, CHIP is in most cases administered by the Medicaid bureaucracy. This holds for separate CHIP programs in both combined and separate state program situations. While there may be a distinction between the CHIP and Medicaid programs by Divisional or Bureau jurisdiction, they are part of the same Departmental structure. Of the 14 states that make up the state-only or combined programs, 12 have their CHIP programs housed in the Medicaid bureaucracy. Table 3 outlines these arrangements.

**Table 3: Administrative Arrangements for SCHIP
As of July 2001**

	<i>Part of Existing Medicaid Bureaucracy</i>	
	<i>YES</i>	<i>NO</i>
State Only Program	Arizona Colorado Georgia Kansas Oregon Utah Washington	West Virginia
Combined Program	Maryland Michigan New Jersey New York Texas*	Florida

* Texas has converted to state only, but functions are still in the state Medicaid agency.

It is common for both Medicaid and CHIP program management to be vested in a single administrative entity. This would seem natural in those states that have fashioned CHIP as a Medicaid expansion. But it can also be found in other states where CHIP is a standalone program or where there is a combined approach utilizing both Medicaid expansion and a separate state program. Thus in Oregon, which features a separate stand-alone CHIP program, the Office of Medical Assistance Programs, part of the Department of Human Services, operates both the Medicaid and CHIP programs (Freedman et al. 2001). In designing the program, “eligibility determination, capitation, and claims service payments were developed to piggy-back onto the existing” Medicaid program (Freedman et al. 2001, p. 6). Such integration appears to be the key to making systems complement each other. In New Jersey, a combination of state, CHIP, and Medicaid programs has been described as “seamless” due in no small part to the integration of both programs within a single agency and under the NJ Family Care Program. The state built CHIP into the existing Medicaid program due primarily to “program management and maintenance concerns” (Roper 2001, p. 5).

Only one state-only programs in our study has CHIP administrative functions located outside of the Medicaid bureaucracy. In West Virginia, the CHIP program is nominally located in the Department of Administration — which, among other things, is responsible for the state’s public employee insurance system. However, in practice, most program efforts and functions are carried out by the state’s Department of Health and Human Resources, home of the state’s Medicaid agency, the Bureau for Medical Services, and the state’s welfare agency, the Bureau for Children and Families. Bureau for Medical Services personnel were crucial in developing the state’s CHIP program and continue to play an important role in coordinating eligibility and enrollment policies. The Bureau for Families and Children is tasked with most outreach and enrollment functions — a role that it carries on in tandem with Medicaid enrollment and case management (Plein 2001).

Florida is the only combined program in our study that vests administrative functions outside the existing Medicaid system. It has a combined CHIP program, a Medicaid expansion for children ages 1 through 4, and a separate state program for

children 5 through 18. The program has a complex administrative structure that vests oversight control in both the Department of Health and a non-profit organization called the Florida Healthy Kids Corporation. The former has responsibility for the Medicaid expansion program while the latter has responsibility for the standalone program for older children. Responsibility for the separate state program is nominally located outside of the Medicaid agency. However, a closer look at administrative arrangements reveals that the traditional Medicaid bureaucracy, the Department of Health's Agency for Health Care Administration, is a key player in the implementation and management of the state's standalone program (Crew 2001). In January 2002, the governing body of all of the state's CHIP and Medicaid programs for children recommended that administrative functions be further centralized under the Agency for Health Care Administration (Kidcare Coordinating Council 2002).

What's in a Name? Image and Structure

System changes have been pursued in concert with image changes for Medicaid and other publically funded health insurance programs. The CHIP legislation itself, rather than being an extension or expansion of Medicaid, signifies the importance of image and symbol in American politics and public opinion. The pursuit of separateness in CHIP was motivated in part to minimize any sense of welfare stigma that might be associated with receipt of benefits and coverage. Efforts to present CHIP as a separate benefit have been useful. There is much to be said of "what's in a name." What's important to note is that structural changes already underway, as a result of reorganized Medicaid programs and systems, helped to reenforce the image of CHIP as a health insurance program and served to distance it from "welfare."

Prior to CHIP, in many states Medicaid programs were being renamed in an effort to veil their association with welfare and public assistance. Such efforts often went hand-in-hand with reorganizations that either separated or distanced Medicaid agencies from traditional welfare systems. An association with "welfare" was perceived

as detrimental to outreach efforts aimed at expanding populations to nontraditional Medicaid populations, such as low-income families and pregnant women. In many states, Medicaid has been renamed with more generic and family-oriented titles. For purposes of outreach and publicity Medicaid is no longer Medicaid in many states. Thus, for example, we have Missouri's MC+ program, Maryland's HealthChoice, New Jersey's NJ FamilyCare, Tennessee's TennCare, New York's Child Health Plus program, Kansas' HealthWave, and Florida's Kidcare. In many of these states, CHIP program and Medicaid program identification is being blended, resulting in a more generic image of publically funded or supported health insurance. The notion of "what's in a name" is clear from field research conducted in Missouri that found that, "Although employees of the Division of Family Services (which deals directly with clients) and the Division of Medical Services use the term Medicaid, it is *not* used in any of the outreach materials" (Mueser et al. 2001, p. 25).

In states where Medicaid was renamed or reorganized prior to CHIP, efforts to minimize stigma appears to have had some success. Distancing from the welfare system no doubt eased some of the challenges of enrolling families and lessened anxiety faced in waiting rooms. In Wisconsin, our field research found that among local officials "the general belief is that clients who go to a clinic with a Medicaid card are treated no worse than clients who bring a commercial insurance card" (Kaplan, 2001, p. 17). In Texas, this led one local level advocate to note that there is "a growing recognition among government officials that Medicaid and CHIP are health programs, and the de-linking of Medicaid from TANF is having a positive effect on take-up" (O'Shea et al. 2001, p. 25). In Oregon, welfare stigma is not a major concern due to the fact that Medicaid, which is called the Oregon Health Plan, has been separate from the traditional welfare system for some time (Freedman et al. 2001). In such an environment, it is easier to market CHIP.

Across our states we find a conscious effort to promote CHIP as an insurance program. Field level observations in New York are typical, where it was noted that CHIP was being marketed as "an insur-

ance, not a welfare program” (Liebschutz 2001, p. 16). By partnering with retail chains and supermarkets in promoting CHIP, Texas has sought to minimize the welfare connotations of the new program (O’Shea et al. 2001). Analysis conducted by administrators in Texas found that “clients see CHIP ‘like regular health insurance,’ and prefer it to Medicaid participation, due at least in part to the stigma associated with Medicaid” (O’Shea et al. 2001, p. 25). Kansas, too, has consciously framed its CHIP effort as an insurance program (Johnston 2001). Again, it is important to note that states already have experience in this area because of efforts already underway to market Medicaid as an insurance program.

Collaboration and Cooperation: New Semiformal Arrangements

The importance of enrollment outreach for publically funded health insurance predates the CHIP program. Medicaid eligibility expansions in the 1980s and 1990s opened the program to new populations that had not been part of the traditional system. These expansions called for outreach and marketing efforts by states (Selden et al. 1998, Ku et al. 2000, Lykens and Jargowsky 2002). The importance of outreach was intensified in the wake of changes accompanying the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, which “disconnected” or “delinked” eligibility for welfare from Medicaid. The fears that eligible families would become separated from the Medicaid system were realized as many families left the welfare rolls in the late 1990s (Burke and Abbey 2002).

As a result, in recent years Medicaid and CHIP program administrators have faced the dual challenges of connecting the newly eligible and reconnecting the traditionally eligible to publically sponsored health insurance programs. In order to do this, states have enlisted agencies, organizations, and groups to get the word out on both the CHIP and the Medicaid programs. In doing so, the network of institutions and individuals involved in these programs has expanded, creating greater program capacity to attract and retain eligible benefi-

ciaries. State experiences reveal the different approaches that have been used.

One innovative approach is to rely on coordinating organizations that foster community collaboration. For example, in Georgia some outreach efforts are coordinated by a nonprofit group called Family Connection to promote community level collaboratives that enlist local government and community service organizations to promote Medicaid and CHIP (Ellen-Duke and Rich 2001). A similar effort is seen in West Virginia, where local Family Resource Networks play a facilitative role in promoting CHIP enrollment through collaboratives and cooperative efforts that involve state health and human services field offices, family courts, local schools, and nonprofits (Plein 2001).

Unlike Medicaid, CHIP allows enrollment and eligibility functions to be carried out by nongovernmental entities. Ostensibly, the purpose of these functions is to bring individuals into the CHIP program, but a very beneficial byproduct is to bring children and families into the Medicaid system. Federal law requires that applicants first be reviewed for Medicaid eligibility before being allowed to enroll in the CHIP program. In essence, nongovernmental organizations involved in CHIP help to expand the administrative capacity of Medicaid by acting as liaisons for enrollment and outreach. Evidence of this positive relationship can be seen in increasing enrollments in Medicaid that have followed CHIP implementation (Burke and Abbey 2002). In short, CHIP has helped to broaden the foundation of agencies and organizations engaged in Medicaid outreach and promotion. For example, in Texas local community-based organizations have been contracted to coordinate outreach and enrollment activities (O’Shea et al. 2001). Florida takes a regional approach, relying on nongovernmental entities to manage CHIP outreach and enrollment. The state has also made use of contracted enrollment brokers who have outreach responsibilities for both Medicaid and CHIP (Crew 2001). Other states have followed a similar pattern of retaining the services of enrollment and outreach management firms to coordinate activities for both programs. Besides Florida, among the states that have relied on these organizations are

Georgia, Michigan, West Virginia, and, until recently, Kansas.

Another cooperative approach is to enlist other state programs and agencies to assist in outreach efforts. Thus, for example, Colorado, Maryland, Utah, and West Virginia have coordinated with the federally funded free and reduced-price meals programs in public schools. It is common for CHIP program materials to be included with information regarding the meal programs that are distributed at the beginning of the school year. Among the states, Colorado serves as a good illustration of how far-reaching such cooperative arrangements can be. In addition to partnering with the free and reduced-meals program, CHIP outreach efforts are conducted in coordination with other nutrition and special needs programs, such as the Women, Infants, and Children (WIC) program and the surplus food commodities program (Goggin 2001).

New cooperative and collaborative efforts have been assisted greatly by public funding and philanthropic support. These resources have proved crucial to state outreach efforts for CHIP and Medicaid, and in turn building the capacity of the publically funded health insurance system. Many states have drawn on federal dollars dedicated specifically to Medicaid outreach. Many states have also benefitted from the financial support and expertise of various foundations and philanthropic organizations that promote outreach through collaborative programming. Foremost among these have been the Covering Kids initiative of the Robert Wood Johnson Foundation, which has seen considerable presence in the study states. In Missouri, a statewide coalition was established that included directors from seven agencies to assist in CHIP program implementation (Mueser et al. 2001). In New Jersey, state agencies have partnered with over 28 organizations to promote outreach and enrollment (Roper 2001). In Michigan, the Covering Kids initiative has helped to create innovative collaborations for outreach with court system and tribal governments (Weissert 2001). In Maryland, public service announcements were created through the partnerships with the Robert Wood Johnson Foundation and televised statewide. In addition, the state has benefitted from a spillover effect of similar publicity campaigns in

the District of Columbia (Barnow and Buck 2001). In Utah, the Covering Kids initiative has helped not only with outreach, but in developing more integrated enrollment forms to help in program coordination (Bryner 2001).

The development of semiformal administrative arrangements for Medicaid and CHIP through cooperative and collaborative efforts reflect trends in both theory and practice. For some years now, scholars and academics have been advocating greater interaction and collaboration among agencies and between governmental and nongovernmental actors. Such cooperation is seen as critical to effective program design and implementation at all levels of government (Khademian 2002). Such arrangements can be the product of informal relations, but also more structured arrangements that rely on contracts and agreements to create new hybrid organizations or systems (Cooper 2002). Collaborative approaches have been put into practice in a variety of contexts associated with health and human services, including welfare reform (Rich et al. 1999). A review of the experiences of the states in this study reveal that the level of formality and strength among these relations varies. But some level of cooperation is likely useful. New relationships and new players have helped to redefine Medicaid and CHIP as publically funded health insurance programs and have expanded the network of administrative actors involved, while preserving an important place for existing Medicaid systems as well.

Change Takes Time: Learning by Doing and Adjustment on the Front Lines

There will always be a need to give attention to achieving and maintaining smooth and integrated coordination between Medicaid and CHIP programs in the states. One of the most pernicious issues involves managing eligibility processes for these two programs. A recent analysis of the 18 states that are the focus of the Rockefeller Institute study shows substantial variation in levels of coordination of this most essential part of program coordination (Thompson 2002). The study finds that states pursuing the Medicaid expansion option un-

der CHIP have tightly integrated systems characterized by such attributes as joint application forms and common eligibility workers. Among states utilizing either combined or separate-state programs, the record is mixed. According to Thompson (2002), three states, Kansas, Oregon, and West Virginia, have been quite successful at integrating their eligibility systems for CHIP and Medicaid. They have achieved this by following arrangements seen in Medicaid expansion states. Interestingly, all three are separate-state programs. However in two of the states administrative functions for CHIP are housed in the existing Medicaid structure. For reasons explained earlier in this report, West Virginia, while nominally having administrative functions housed outside of the Medicaid bureaucracy, actually relies greatly on the existing health and human services system.

As Thompson (2002) notes, better integration of enrollment and eligibility determination is one area in need of attention in furthering the goals of Medicaid and CHIP. Another area deserving attention involves state and field-level program coordination. States rely on a variety of institutional arrangements to deliver health and human services. Some arrangements rely on local operations that are carried out by state field offices. In other circumstances, field implementation is a local government responsibility. In addition, there has been more reliance on nongovernmental entities that are contracted to enroll clients and manage cases.

Decentralized arrangements sometimes raise problems that are well known to public managers and administrators. These include failures of communication and differences in administrative priorities. For example, while Colorado has made important gains in integrating Medicaid and CHIP application forms and procedures, communication between state government and the local government agencies responsible for program implementation has at times been lacking (Goggin 2001). In New York, where Medicaid funding is shared between the state and local governments, CHIP has been implemented in an environment where relationships have sometimes been tense between levels of government. The point of friction involves program costs and fiscal obligations (Liebschutz 2001). Early in its CHIP experience, Kansas saw

some confusion over the role of its contracted enrollment broker in program operations (Johnston 2001). This problem has played out in other states as well, such as Florida and Texas.

Coordination between state level and field level initiatives is not reserved only to those states that rely on local governments or contractors for program implementation. In Georgia, some field offices of the Department of Family and Children “seemed relatively unaware” of community outreach programming for CHIP and Medicaid (Ellen-Duke and Rich 2001, p. 37). Field reports from other states that rely on field operations, such as Kansas and West Virginia, suggest that Georgia’s experience is not unique. Coordination between state operations at central and field levels may be further exacerbated in those circumstances where welfare reform has seen a division of Temporary Assistance for Needy Families and Medicaid/CHIP responsibilities between agencies (Bryner 2002). In these states, there may be a need to more actively inform those administering welfare-to-work programs about the various options afforded by publically funded health insurance programs. In a few instances, our field research suggests a defect in program design that may hinder the goal of helping families transition off welfare. For example, in Georgia concern has been expressed that those responsible for administering TANF and interested in keeping caseloads low may have limited interest in promoting Medicaid enrollment (Ellen-Duke and Rich 2001). In Utah, state welfare offices do not provide CHIP application services (Bryner 2001).

There are always counter-currents to success. The price that is sometimes paid in innovation and initiative is delay and confusion. While we can make generalizations about overall achievements, we should not overlook specific circumstances where there have been problems and difficulties. These are the byproducts of program development and experimentation. Because the implementation of CHIP is an ongoing process, we can expect the pace of success and development to vary among the states and among localities within the states.

Conclusion

Now five years old, the Children's Health Insurance Program marks an important development in the history of publically funded health insurance in the United States. Its development and implementation follows some of the defining characteristics of American politics and federalism. For purposes of publicity and marketing, CHIP has been widely characterized as a "new" and "distinct" program. However, actual implementation and management of the program follows along lines that are familiar and established. Existing administrative systems, especially Medicaid bureaucracies, have played a key role in managing the CHIP program. Through experience and adjustment, CHIP has evolved to complement and strengthen existing publically funded health insurance systems. It has also helped to promote and reinforce efforts to build on formal administrative structures by involving other governmental as well as nongovernmental agencies and organizations in collaborative and cooperative effort. For those involved in and interested in the CHIP experience, a number of lessons emerge. These can be summarized as follow:

First, programs are not developed nor managed in a vacuum. Prior reform and reorganization set the stage for CHIP implementation. In many circumstances, reformed and reorganized health and human service systems established a foundation for CHIP design and implementation at the state level. A redefinition of Medicaid aimed at disassociating it from the traditional welfare system was underway in a number of states prior to CHIP. This made it easier to market Medicaid to new target populations, and set the stage for similar efforts with CHIP. Reform helped changed both the structure and image of means-tested publically funded health insurance.

Second, image is not everything, but it is important. In an effort to disassociate the program from a "welfare stigma," CHIP has been presented as a new form of insurance rather than a government entitlement. In many states this builds on previous marketing programs aimed at redefining the image of Medicaid. In many circumstances, this allows states to portray and publicize publically

funded programs as health insurance services rather than welfare benefits. As a more diverse cross-section of the American public is served by these programs, the need for program identity that more clearly reflects the intent of purpose of programs becomes apparent.

Third, change takes time. It has taken time and effort to develop complementary CHIP and Medicaid structures and processes in the states. Furthermore, the goals of seamlessness have yet to be totally satisfied. There is always room for improvement. The evolution of these programs have not been without controversy and disappointment. In the first years of the program, some states were more successful in launching CHIP than others. Program growth and development has resulted from the hard lessons of implementation and experience. It has only been in recent months that a number of states have begun to post notable gains in program outreach and enrollment.

Fourth, capacity building is an ongoing enterprise. The CHIP program experience highlights the importance of expanding the scope of administrative and organizational actors involved in promoting and managing publically funded health insurance for children and families. Program successes illustrate the importance of collaborative and cooperative efforts among agencies and between governmental and nongovernmental interests.

These and other lessons serve to remind us that CHIP has been implemented in a complex and dynamic environment. Much of this context has been set by the variety of state conditions that have allowed for different approaches to be developed. The 18 states that have been the subject of this Management Brief reveal that while many common traits in program design and implementation are shared, the experience of each is distinct. The benefits of comparing and sharing experiences from each other are important not only to understanding how administrative arrangements have evolved with CHIP, but also in gaining insight into what future courses of action might be taken in managing and extending publically funded health insurance systems in our society.

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The mission of the American Federalism group is to help fill this gap. The Group conducts research on trends affecting states and serves as a national resource on issues such as welfare reform, and Medicaid Managed Care for public officials, the media, public affairs experts, researchers, and others. The Group is directed by Tom Gais, who has spent the last decade analyzing state and local issues with federalism. Jim Fossett oversees research in the area of public health programs.

This Report

Christopher Plein, Associate Professor of Public Administration at West Virginia University, wrote this report. Institute field researchers from the states in the study obtained enrollment data and qualitative information. Michael Cooper, the Rockefeller Institute's Director of Publications, did the layout, with assistance from Michele Charbonneau.

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