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ABSTRACT

Noting that there is a significant gap between the number of young children eligible for Medicaid and the number actually enrolled, this report describes a year-long effort to promote collaboration between local Head Start grantees and county Medicaid offices in New Jersey. The primary goal of the project was to define and implement policies and practices that streamline the enrollment of Head Start Children in Medicaid. The Head Start and Medicaid partnership in Newark, New Jersey, was used as the model. The project aimed to reduce the number of low-income preschoolers who either lacked health insurance benefits or who lacked comprehensive benefits and were, in effect, underinsured. Enrollment in Medicaid was also expected to improve access to health services for these children. Two very disparate groups worked to systematically establish better communication and a productive working relationship. This report describes the lessons learned from this process, the tangible accomplishments of the project, and several recommendations for state-level policy. A copy of a special report on the health of New Jersey's children is included. The report examines the health status and needs of New Jersey's children as well as some of the underlying problems contributing to poor access to care. It also traces key state proposals and legislation designed to address the health care needs of children in New Jersey. (AA)

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HEAD START AND MEDICAID

MAKING THE CONNECTION

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HEAD START AND MEDICAID

MAKING THE CONNECTION

The Final Report of the Head Start/Medicaid Collaboration Project

A Project of
Association for Children of New Jersey
Head Start/State Collaboration Project

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Funded by the Hite Foundation

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Introduction

This report describes a year-long effort to promote collaboration between local Head Start grantees and county Medicaid offices in New Jersey. The primary goal of the project, spearheaded by the Association for Children of New Jersey and the Head Start/State Collaboration Project, was to define and implement policies and practices that streamline the enrollment of Head Start children in Medicaid. A model for the success of a partnership among Head Start and Medicaid was already in operation in Newark (see Appendix A), and part of the impetus for the project was to find ways to encourage similar success among Head Start programs around the state. This is expected to result in the reduction in the number of low-income preschoolers who either lack health insurance benefits or who lack comprehensive benefits and are, in effect, underinsured. Enrollment in Medicaid is also expected to improve access to health services for these children.

This project broke new ground by working with two very disparate groups to systematically establish better communication and productive working relationships. In most cases, Head Start and Medicaid staff had never before worked together to articulate mutual goals and formulate joint work plans. The lessons learned about this process and the tangible accomplishments of the project will be discussed in this report. However, the local policy and procedural changes adopted as a result of the project will need to be in place for a longer period of time before their effectiveness can be properly evaluated. Additionally, several recommendations for state-level policy changes emerged from discussions with Head Start and Medicaid staff and are presented here. Achieving these program improvements will require further discussion with state administrators and policymakers.

The Need for this Project

The Medicaid program can provide a vital link between many low-income children and the health care they need. In addition to the health insurance coverage provided under Medicaid, enrolled children are also eligible to receive significant preventive care and treatment through the Early and Periodic Screening ,Diagnosis and Treatment Program (EPSDT). This program offers a full package of preventive screenings, immunizations, and laboratory tests, as well as periodic check-ups and medically necessary follow-up. Children can receive these services through public clinics or private physicians who are enrolled as Medicaid providers and can bill Medicaid for their services. New Jersey, like many other states, is moving toward delivering Medicaid services through a managed care system. Conversion to this system will raise many questions about how best to ensure that children are enrolled and receive the services they need. These issues are being addressed through related work underway at the Association for Children of New Jersey. (See *New Jersey's Children and Health Care* report, attached)

In recent years several key federal laws have been enacted to expand Medicaid coverage for children from low-income working families. Prior to 1989, health care coverage under Medicaid was available primarily to children receiving public assistance through Aid to Families with Dependent Children (AFDC). While these children still are automatically enrolled in Medicaid,

AFDC is no longer the primary criterion for Medicaid eligibility. Under federal guidelines, children under age six can now qualify for Medicaid if they are from families with incomes below 133 percent of the poverty line, $16,385 for a family of three and $19,684 for a family of four in 1994. (In New Jersey individuals not on AFDC who qualify for Medicaid under these rules are enrolled in a program called NJ Cares.) Low-income working parents who are not on welfare are unlikely to know that Medicaid rules have changed and that their children may now qualify.

There is a significant gap between the number of young children eligible for Medicaid and the number actually enrolled in the program. The Center on Budget and Policy Priorities in Washington, D.C. has recently completed an analysis of Census data which indicates that nationwide, 2.6 million children with family incomes below 133 percent of the poverty line are eligible for Medicaid but are not receiving it. About half of these children are uninsured. The other half have some private health insurance coverage, but in many cases that coverage is less comprehensive than what they could receive under Medicaid and EPSDT.

Since the Head Start income eligibility guidelines are lower than the Medicaid guidelines (100 percent and 133 percent of the poverty line, respectively) and at least 90 percent of the children enrolled in Head Start must come from families below the poverty line, nearly all Head Start children are eligible for Medicaid. Yet, the latest national Head Start data indicates that one-third of Head Start children lack Medicaid coverage. New Jersey Head Start data for 1993 mirrored this finding.

In its Health Access for Children project, ACNJ found a similarly poor record of Medicaid enrollment among AFDC and WIC families in Newark. In a non-scientific but nevertheless revealing survey taken at county welfare offices, health clinics and hospitals, project organizers found that more than 40% of children eligible for both Medicaid and WIC were not receiving benefits from both programs. Even more startling, two of every five children go to a hospital emergency room as the *only* source of medical treatment. (See Table 1 for details.) While Head Start facilities were not included in the Health Access for Children survey, there remains ample indication of the need for communication and cross-referrals among programs serving essentially the same Medicaid-eligible children.

With the demise of national health care reform, at least for this year, there is no chance that universal health insurance coverage will be achieved. The Medicaid program will remain the primary mechanism for financing health care coverage for low-income children. **This makes efforts to link eligible children with Medicaid more crucial than ever.**

Head Start As A Testing Ground

In addition to the fact that nearly all Head Start children are income eligible for Medicaid, there were several reasons for choosing the Head Start program as the vehicle for designing and testing strategies for improving the Medicaid application and enrollment process.

The Head Start program is well positioned to determine why eligible children are not enrolled and to work with individual families to overcome barriers to the enrollment process. The Head Start philosophy places primary importance on the needs of the whole child, on the delivery of developmentally appropriate comprehensive services and on parent involvement. To carry out these goals the Head Start Program employs staff who focus on health, social services and parent involvement.

Head Start programs are well established in the community and are experienced in working with other service providers on behalf of the children and families they serve. Staff participate in pre-service and in-service training to strengthen their knowledge of benefits available to families. Parents are offered workshops in which they learn about available services.

The advantages of improved practices and procedures for linking children with the Medicaid program that prove effective will have a ripple effect. Every year Head Start enrolls a new group of children and, with increased federal appropriations, the total number of children enrolled in New Jersey will increase. Given the family-oriented nature of Head Start, efforts will be made to ensure that not only the Head Start child, but all siblings under age six are linked with Medicaid. Practices established in Head Start can be adapted to other early childhood programs. In New Jersey, the Good Starts program is a likely target for replicating new practices, since like Head Start it is a comprehensive early childhood program.

Phase I: Developing Collaboration Plans

In order for Head Start and Medicaid programs to effectively coordinate procedures, staff of each program must have working knowledge of how the other program operates, its basic rules and regulations, and its capacity for flexibility. The Head Start/Medicaid Collaboration Project began with the assumption that this understanding would need to be developed.

The project's goals were pursued in two phases. Of the state's 21 counties, 20 Head Start/Medicaid teams participated in Phase I. During this phase ACNJ and the Head Start State Collaboration Project jointly convened a series of regional meetings of Head Start grantees and county Medicaid personnel. Invitations to the meetings were issued from the Governor's office, which conveyed the importance and urgency of full participation.

A team of facilitators, not affiliated with either Head Start or Medicaid, was hired to lead discussions. The team was perceived as unbiased and non-judgmental. The team was briefed on program basics and supervised by ACNJ, but was fully responsible for leading discussions, assisting in formulating collaboration plans and for arranging follow-up meetings.

The facilitators used a guide developed by ACNJ (see Appendix B) as a format for the discussions. The goal was to produce a written collaboration plan that contained specific outcomes. The plan was required to:

- indicate how joint information-sharing and joint training among programs would be achieved;

- devise a system for simplifying and coordinating Head Start/Medicaid intake procedures; and

- formulate a method for streamlining referrals from Head Start to Medicaid and vice versa.

The facilitators used the set format for each of the discussion sessions. After brief introductions and a clear statement of the goals of the meeting, the appropriate program representatives described the basics of their respective programs. Each representative described the program's scope of service, eligibility requirements, intake process and the potential barriers to Medicaid application. The purpose was to develop a basic understanding of each program and to identify common procedures and possible ways to help both programs meet requirements. The discussion techniques used were brainstorming, identifying areas of agreement, and delegating responsibilities to appropriate members of the groups when more information was needed. Collaboration plans were formulated from these discussions.

Draft collaboration plans were submitted by each of the twenty county groups. The plans included a wide range of activities aimed at fostering cooperation between the two programs. The plans are the tangible result of an arduous group process in which members reached consensus and committed to restructure their usual methods of operation. Listed below, in order of the frequency mentioned in the twenty plans, are the specific activities to which participants agreed:

- Head Start and Medicaid will each select a staff person to act as a liaison so that all inquiries, referrals and related matters can be directed to one person. (20)

- Head Start and Medicaid will share written materials about their respective programs so that parents can be apprised of available benefits. These materials could include flyers, newsletters, brochures, and videos that can be made available to clients in waiting rooms, at meetings, and through mailings. (19)

- Medicaid will consider conducting in-service training for Head Start staff and/or parents on application procedures and eligibility for receiving Medicaid services. (Two Head Start programs mentioned that they will conduct information sessions on Head Start for Medicaid staff.) (19)

- Medicaid will send checklists which indicate the forms of documentation that are acceptable and required for Medicaid enrollment to Head Start programs. (11)

- Head Start staff will assist parents in the Medicaid application process. (11) Additionally, Head Start staff will track the family through the Medicaid

application process; they will check that all appropriate documentation is assembled and submitted.

- Head Start will design a release form for Head Start parents which authorizes the Head Start and Medicaid programs to share information necessary to facilitate Medicaid enrollment. (10)

- Medicaid will make application forms available at Head Start program sites. (5)

- Medicaid will assign eligibility workers to take Medicaid applications at the Head Start site and/or check eligibility. (4)

The following activities were mentioned in fewer than four collaboration agreements:

- Head Start will provide Medicaid with a list of Head Start staff to contact when questions arise about particular applicants.

- Head Start will alert appropriate Medicaid staff (supervisory) about families having difficulty with Medicaid eligibility workers.

- Head Start will include information on NJ Care in its original contact with parents.

- Head Start will contact Medicaid to verify status of clients' applications.

During the discussions, issues related to the state's role in facilitating Medicaid enrollment were raised. These will be discussed later.

Phase II: Follow-up in Targeted Counties

In Phase II of the project, additional discussion sessions with the Head Start and Medicaid representatives were conducted with selected counties. The goal was to assist these county teams in implementing the collaborative agreements. These discussion groups met in three regional clusters:

- Northern: Sussex and Warren

- Central: Essex

- Southern: Salem, Gloucester and Cumberland

The selection of counties for follow-up took into account geographic distribution, urban/rural distribution and the level of interest both Medicaid and Head Start participants expressed in implementing the collaboration plans. Groups not selected for the Phase II discussion received follow-up phone calls to track the progress of their collaboration plans. They also received a mailing every eight weeks to update them on the activities being pursued by other groups around the state.

The Northern Group

The Northern group had begun implementing its collaboration plan prior to the second discussion session. Head Start staff had received Medicaid training and had begun alerting parents about the availability of Medicaid and the application process. This was done by distributing written materials and by informing parents about Medicaid during one-to-one interviews. The Head Start program reported an increase in the number of families who applied for Medicaid; Medicaid representatives reported that since Head Start had begun to screen families for eligibility, more appropriate referrals were made. Medicaid agreed to train new Head Start staff when necessary. A major goal for this group is to establish a local dental clinic that will treat Medicaid patients. There is a lack of dental specialists in the area and Warren County has no dentist who will see Medicaid patients. The group is now attempting to secure a one-time grant of $30,000 to purchase equipment for a Medicaid Dental Clinic.

The Essex County Group

The Essex County group moved to formalize its relationship by establishing itself as the Essex County Head Start / Medicaid Collaboration Project. The group resolved to work with Association for Children of New Jersey to secure funds to continue the discussion process for an additional year. The group made some progress on compiling and sharing a complete list of contact persons representing each program and on getting Medicaid informational brochures ready for distribution to Head Start programs. A Medicaid training session was planned for Head Start staff. Head Start staff was given a sample Medicaid application to review before the training. The list of documents need to verify eligibility is being revised and will be provided later.
The group also considered the benefits of a computer program called Medi-America. This system is being used by Orange Memorial and UMDNJ to take Medicaid applications.

The Southern Group

The Southern group had begun to implement its collaboration plan prior to the second meeting. Brochures and flyers had been exchanged and information-sharing meetings had taken place. Participants opted to add an appropriate question to the Head Start Needs Assessment form in lieu of creating a separate Head Start release form. Transportation services remain a critical issue in these rural counties. Head Start transportation services have been used to transport children to health care providers. A public bus route, which goes from the County seat to the office of social service and the clinic, has now been approved in Gloucester County.

Lessons Learned From the Guided Discussion Process

This project marked the first time that Head Start grantees and county Medicaid agencies met to set specific goals for working together more efficiently and to help both programs respond more effectively to the needs of children and families. Although it was not uncommon for Head Start health and social services staff to make referrals to Medicaid in the past, this had been going on without a full appreciation of Medicaid's guidelines and procedures. Likewise, Medicaid staff was generally unfamiliar with the philosophies of the Head Start program and the resources that can be summoned to assist individual families in gaining access to benefits.

The Head Start/Medicaid collaboration process established a foundation which included basic technical understanding of each program, a mutual respect for the abilities and constraints of program staff, and a commitment to amend practices where possible to streamline the Medicaid application and enrollment process. By being more open to change, staff of both programs found their jobs easier and families were better served.

The key to the success of this process was the role of the outside facilitator. The facilitator had no prior relationship with either the Head Start or Medicaid program and was perceived as someone who was learning along with the group. The initial discussion sessions faced great obstacles. The groups had never met before and there was a high degree of skepticism. (Head Start generally viewed the county welfare agency staff as impersonal and prone to subjecting applicants to unreasonable regulations and overly rigid rules; Medicaid staff generally held that Head Start would not understand the pressures for quality control in making eligibility determinations. Clients in general are viewed as noncompliant and unresponsive.)

The successful outcome of the initial discussions could have been thwarted by a number of fears, not the least of which was the fear of criticism. The facilitator deflected such negative possibilities. The facilitator directed the conversation, absorbed hostilities, engendered mutual respect, motivated cooperation and pressed for practical resolutions. Since the discussion was clearly focused on one specific issue and a tangible outcome was expected -- a written collaboration plan -- the facilitators were able to help each group successfully meet the goal. The first sessions ended with a high degree of satisfaction and this set a positive tone for the rest of the process. Although some negative attitudes persisted and a few county groups declined further technical assistance, there was a very high degree of participation and satisfaction.

The biggest criticism of the process was that all stakeholders were not included in the discussion groups. The most serious omission was the absence of health care providers. They are obviously essential players in this system and there was a sense that, had they been included, they would have cooperated. Because the provider perspective was missing, no clear vision of how to improve relationships with providers emerged and no specific goals were set.

A representative from the NJ Department of Human Services, the state agency with jurisdiction over Medicaid, attended a few of the meetings. This was extremely helpful and, in hindsight,

should have been built into each discussion. Every group had recommendations for improving state policies.

Guidelines for Procedural Changes in Head Start

Through the efforts of the county-level discussion groups, strategies emerged for facilitating the enrollment of Head Start children in Medicaid. Collectively, their ideas suggest a recommended protocol for how Head Start can most effectively connect children to Medicaid. While most of the procedural changes would require the cooperation of the county Medicaid office, the changes themselves would be made by Head Start. With appropriate testing, this protocol could be a model for Head Start programs nationally as a way to fulfill the Head Start health performance standards.

Specific Head Start Performance Standards that will be met more effectively by establishing a Medicaid training program for staff and by assisting families by providing Medicaid outreach and enrollment are as follows:

- Section 1304.3-1

  The general objectives of the health services component of the Head Start Program are to:

  (a) Provide a comprehensive health services program which includes a broad range of medical, dental, mental health and nutrition services to preschool children, including handicapped children, to assist the child's physical, emotional, cognitive and social development toward the overall goal of social competence.

  (b) Promote preventive health services and early intervention.

  (c) *Provide the child's family with the necessary skills and insight and otherwise attempt to link the family to an ongoing health care system to ensure that the child continues to receive comprehensive health care even after leaving the Head Start program.* (emphasis added)

- Section 1304.3-6 Health Education

  (a) The plan shall provide for an organized health education program for staff, parents and children which ensures that:

  (1) *Parents are provided with information about all available health resources;*(emphasis added) ...

These recommendations will improve a Head Start program's ability to meet these performance standards.

Recommendations for Staff/Parent Training:

- Establish a training program on eligibility requirements and application procedures for staff of both Head Start and Medicaid. Include provisions for training new staff.

- Maintain current checklist of Medicaid income eligibility guidelines and a list of documents required to verify eligibility.

- Conduct parent meetings on available health care programs including Medicaid, NJ Cares and managed care services.

- Maintain liaison with Medicaid agency to facilitate interagency communication so that programs can stay abreast of policy and procedural changes and more effectively assist families.

Recommendations for Providing Assistance to Families:

- Include information about Medicaid and NJ Cares in recruitment and intake materials.

- Determine whether child is receiving Medicaid at time of Head Start enrollment. Ask parent to sign a release form to allow the facilitation of the Medicaid application process.

- Obtain Medicaid and NJ Cares applications and make them available at the Head Start program.

- Assist parents in completing Medicaid applications, assembling all appropriate documentation and delivering this information to the Medicaid office. Accompany parent to face-to-face interview if necessary. Monitor the process.

State Level Policy Recommendations

The state should take all necessary measures to support the efforts of Head Start and other early childhood programs that wish to facilitate participating children's enrollment in Medicaid.

- **Enable working parents to apply for Medicaid without having to visit the Medicaid office for an interview. Two strategies can be used to accomplish this:**

  1. The state can allow Medicaid applications to be mailed in. Twenty states now allow this. In some cases the state Medicaid agency trains staff of community-based agencies to properly complete applications to minimize errors. Head Start staff can be receive such training. (Several county teams mentioned in this report are beginning to implement such training; the mail-in option would create an incentive to participate in this training because the added advantage to parents would be significant.)

  2. The state can encourage county Medicaid agencies to expand the types of settings in which eligibility workers are outstationed. Early childhood programs can be made a priority. Currently, Medicaid is required to outstation eligibility workers in federally funded community health centers and disproportionate share hospitals. However, the law does not prevent a Medicaid program from outstationing eligibility workers in other settings. Since many eligible children are likely to be participating in Head Start and other early childhood programs, outstationing eligibility workers in these settings would result in more children being linked to Medicaid. The state of Georgia is currently pursuing this strategy.

- **Improve the readability of the Medicaid application.** The comprehension level of the Medicaid form should be adjusted to account for applicants with low reading levels. Also, the state should invest in getting Medicaid applications and promotional materials translated into languages other than English. In addition to Spanish, the languages should include those spoken by large segments of the Medicaid-eligible population.

- **Allow early childhood programs to enroll as Medicaid providers or subcontract with existing providers for the purpose of conducting outreach and enrollment activities.** As providers or subcontractors, these programs can bill Medicaid for helping parents complete Medicaid applications and for informing them about Medicaid-related services. A number of states, including Louisiana, Connecticut, California, Rhode Island and Washington provide various opportunities for this type of billing.

- **Allow early childhood programs to obtain Medicaid reimbursement for transportation to take enrolled children to Medicaid services.**

- **Consider allowing Head Start programs to make Medicaid presumptive eligibility determinations.** Since nearly all Head Start children meet the income

eligibility guidelines for Medicaid, allowing Head Start programs to make presumptive eligibility determinations would facilitate these children receiving critical preventive services like immunizations and health screenings. The process would work in the same way that community health centers now serve as Medicaid outstations, making presumptive eligibility determinations for pregnant women. Once a child is determined presumptively eligible, he or she could begin receiving Medicaid and EPSDT services immediately. A final eligibility determination would be made pending income verification. There is a very high likelihood that Head Start children would meet Medicaid requirements.

- **Make available to parents a list of Medicaid providers who are open to taking new patients.**

- **Recruit new Medicaid providers.**

- **Increase the reimbursement rate for Medicaid providers.** ACNJ has filed a class action lawsuit to increase reimbursement rates, reduce paperwork and speed up payment to providers. With these improvements to the Medicaid system in New Jersey, it will also be easier to recruit doctors and dentists to serve Medicaid clients.

- **Ensure that Medicaid Managed Care systems do not preclude delivering services to children through early childhood programs.** The shift to Medicaid managed care systems raises questions regarding how screenings and other preventive services can be delivered in the early childhood setting. Since this may often be the setting which is most efficient, state contracts with managed care providers should stipulate how this can be arranged. (How early childhood programs could bill for services, and whether prior approval for certain services would be necessary are issues to be resolved.)

Table 1: Health Access for Children Project Survey of Newark Medicaid-Eligible Children

Responses	Percentage of Eligible Children
Receive Medicaid	66.90%
Among Households with Children Under Age 6	
Receive ***both*** Medicaid and WIC	58.80%
Receive ***neither*** Medicaid nor WIC	12.60%
Receive Medicaid ***only***	4.90%
Receive WIC ***only***	23.60%
Use Emergency Room as ***sole*** source of medical treatment	42.10%

A total of 371 surveys were administered to heads of households: 189 were administered at county welfare offices, 98 at various health clinics and hospitals and 84 at various child care centers in the City of Newark. The purpose of the survey was to provide the Health Access for Children project with an understanding of how families fare in the current health care delivery system in Newark.

The Leaguers Head Start Satellite Clinic

A model for the sucessful partnership of Head Start and Medicaid is currently in operation at a Leaguers Head Start site in Newark. With funding from The Prudential Foundation, the Leaguers and the Newark Community Health Center opened the Leaguers Head Start Satellite Clinic, a full-service health care clinic, in 1993. Now operating at full capacity, the clinic's success is due in large measure to its ability to use its connection with the Newark Community Health Center, a federally qualified health center, to offer providers full cost reimbursement for medical and medically-related costs (such as transportation) through Medicaid.

Located at the Head Start site, Medicaid enrollment is made as easy as possible for Head Start parents. Furthermore, full reimbursement enabled the center to attract and retain doctors, nurses and other health professionals to staff the center.

The Leaguers Head Start Satellite Clinic exemplifies the "best case" scenario for Head Start/Medicaid collaboration. Even though establishing a health clinic on site may not be possible for every Head Start program, the principles that went into its creation -- full cooperation among the right community groups, aggressive enrollment of eligible children in Medicaid, and strong recruitment of local Medicaid providers -- can be replicated to some degree in virtually any community.

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Facilitating Head Start/Medicaid Collaboration
Discussion Guide for Small Group Sessions

Participants:

Head Start health and social services coordinators and representatives of County Welfare Agencies responsible for administering Medicaid (AFDC and New Jersey Care) have been invited to attend one of three regional meetings. After a brief introduction, small groups will convene by county for discussion.

Goal of Discussion Session:

The purpose of the discussion session is to foster a mutual understanding of Head Start and Medicaid services and create a framework for collaboration to ensure improved access to health services for Head Start children.

Participants will explore opportunities for improving information-sharing, streamlining intake and other program procedures and scheduling joint activities. Emphasis should be placed on modifying practices and/or incorporating special activities that will prove beneficial to **both programs and the families they serve.**

Participants will formulate a draft collaboration plan indicating how these opportunities will be pursued on a local level and specifying which parties will take responsibility for implementing various aspects of the plan. This plan is intended to be a working document which will guide the next steps of the collaboration process.

Discussion Outline

Facilitators will raise the following issues for consideration. The substance of each part of the discussion will be synthesized and form the basis of the draft collaboration plan.

A. **Representatives of Head Start program and County Welfare Agency will briefly describe their programs' scope of services.**

Facilitator: Point out that these programs are designed to serve the same populations. How can information about the services offered by each program be communicated to both the staff and clients of each? Are there opportunities to attend staff training? Are there opportunities to meet directly with parent groups? Are brochures, flyers, other informational/recruitment materials available? If not, could useful items be developed? Are there critical times of the year when distribution of such materials would be most effective?

B. **Representatives of Head Start and County Welfare Agency will describe program eligibility requirements and intake procedures.**

Facilitator: Ask a representative of each program (Head Start, AFDC, New Jersey Care) to "walk

through" the intake procedure from the client's perspective. Probe for details such as: Is an appointment necessary? How long will I have to wait for an appointment? What do I need to bring with me? What happens during the meeting? How do I know I've been accepted into the program? How will I know if my application is declined? If it is declined, what then? What about recertification? Who is responsible for ensuring that various aspects of the process are accomplished?

As the discussion unfolds, take note of similarities and differences in procedures, documentation required, etc. Are there ways to coordinate and/or simplify these processes?

C. **Participants will describe potential barriers to application in either Head Start or Medicaid.**

Facilitator: Encourage participants to think about/recall specific examples of problems encountered by families when they attempt to access information or services about either Head Start or Medicaid. Discern whether the problem(s) mentioned commonly occur. Discuss potential ways the problem(s) could have been solved. Is it possible to modify procedures to prevent the particular problem from reoccurring?

D. **Participants will explore ways to streamline the referral and (Medicaid) recertification process.**

Facilitator: What is the most feasible way to establish a system of regular communication between the Head Start and Medicaid Programs in your community? Identify a liaison in each program. How can families be prepared for the application process? Is prescreening possible? Is there a checklist of items to bring for verification? Can a "trouble-shooting" mechanism be devised?

E. **Participants will discuss how families can be linked to health care providers.**

Facilitator: Where do families currently access health services? Is there a directory of Medicaid providers in the community? To what extent do the Head Start and County Welfare Agencies currently work with health care providers in the community? Are there opportunities for information-sharing and collaboration?

F. **Summarize key issues that have emerged from the discussion and identify next steps.**

Facilitator: Reiterate major points of discussion related to each question. Clarify points of agreement and disagreement. Specify issues/activities that will be pursued by both parties. (These should be incorporated into the draft agreement.) What other input is needed to flesh out the agreement? What resources are needed to accomplish the tasks outlined in the draft agreement?

Specify who is responsible for follow-up. Can a subsequent meeting date be set?

E. **Formulate a Statement of Commitment to Collaboration**

Facilitators: Guide the group in drafting a simple statement declaring an understanding for the need to collaborate to improve communications and services to children and families. (A basic agreement on this point will be necessary to proceeed with specifying joint plans and activities) At this point the commitment can be very broad; it can be refined and elaborated later on in consultation with other key individuals.

DRAFT COLLABORATION PLAN:

County Welfare Agency

Name: _____

Address: _____

_____

Phone: _____

Liaison: Name _____

Title _____

(If more than one County Welfare Agency, use reverse side.)

Head Start Program

Name: _____

Address: _____

_____

Phone: _____

Liaison: Name _____

Title _____

(If more than one Head Start Program, use reverse side.)

A. Statement of Commitment to Collaboration:

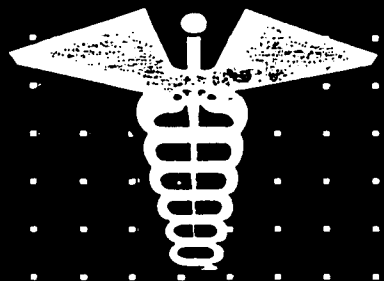
The activities described below are aimed at formalizing the commitment to collaboration between the local Head Start Program and the County Welfare Agency. For each section, specify activities to be undertaken, by whom, and during what time period. Identify resources needed to implement these activities and specify whether these resources currently exist or if they must be developed.

1. **Activities to share information about Head Start and Medicaid services with staff and families of both programs:**

2. **Activities to coordinate and/or simplify intake procedures:**

3. **Activities to streamline referrals to either Head Start or Medicaid and recertification for Medicaid:**

4. **Activities to link families to health care providers:**



NEW JERSEY'S CHILDREN AND

Health Care

A SPECIAL REPORT FROM
ASSOCIATION FOR CHILDREN OF NEW JERSEY'S
HEALTH ACCESS FOR CHILDREN PROJECT
AND
THE NEW JERSEY CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS

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NEW JERSEY'S CHILDREN AND

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This report was prepared by Karin Booker,
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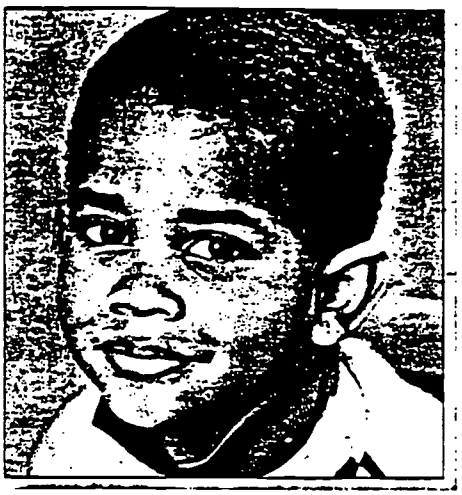
While national health care reform is debated, far too many children will continue to go without health coverage. Over 10 million children in the U.S. lack health coverage today, and one in four will be uninsured at some time in 1994. Currently, 827,000 New Jersey residents are uninsured. Of this number, 160,000 are children who lack coverage for health and dental benefits.[1] Significantly, the vast majority of the uninsured live in families who work. In fact, 90% of this population represent families in which one or more persons is employed at least on a part time basis.[2]

The importance of quality health care for children cannot be overemphasized. When children lack adequate preventive and primary care, all facets of their lives are impacted — not just their physical health and needs. Undetected and untreated health problems often impair the ability of youngsters to learn and excel. Primary and preventive health care for children, then, are essential to school readiness and ongoing success.

The Association for Children of New Jersey (ACNJ) is currently implementing the *Health Access for Children Project*, a two-year pilot funded by The Prudential Foundation and Victoria Foundation described later in this report. In addition, with the support of the National Association of Child Advocates, ACNJ and the New Jersey Chapter of the American Academy of Pediatrics have formed a partnership to improve the health and well-being of our state's children. This special report is a joint effort designed to present a number of issues related to health care for children. It examines the health status and needs of New Jersey's children, as well as some of the underlying problems contributing to poor access to care. This report also traces key state proposals and legislation designed to address the health care needs of children in New Jersey.



How Healthy are New Jersey's Children?

Despite public and private efforts to improve the health status of children in New Jersey, many of our youngsters continue to suffer from largely preventable health problems.

- Over 1,500 babies were born to women lacking prenatal care in 1991. (NJ Kids Count 1993)

- The percentage of low birth weight babies of all live births is 7.5% - 1 out of every 13 babies. (NJ Kids Count 1993). This rate is at least twice as high for black infants.

- New Jersey's infant mortality rate was 8.8 per 1,000 live births in 1991. For black infants, this rate was more than doubled. (NJ Kids Count 1993)

- New Jersey ranks 10th nationally for its relatively high child death rate of 24 per 100,000 children — with injuries being the most significant cause of death in all age groups. (National Kids Count 1994)

- In 1991, only 50.2% of New Jersey's youngsters had been fully immunized by age 2. Age-appropriate immunizations were and remain significantly low for Blacks and Latinos in urban areas. This was most likely reflected in the disproportionately high numbers of Black and Latino children who contracted measles during the 1991 measles outbreak. (NJ DOH, Epidemiology Unit)

- About 600 births each year are to HIV-infected women in New Jersey. Of this number, 25-33% (150-200) will contract AIDS. In 1991, 482 AIDS cases were recorded for children 0 to 12; 87 cases were recorded for youth 13 to 19. Across all age categories, 500 cases of HIV infection were recorded. (NJ DOH, AIDS Unit)

- .2% of all children in the state will contract a sexually transmitted disease (STD). In 1991, a total of 3,671 STD cases were reported among children from 0 to 19. (NJ DOH, Infectious Disease Unit)

Why Do So Many Children Lack Access to Health Care in New Jersey?

Many children in New Jersey continue to face difficulties in accessing primary and preventive medical services. This is largely due to multiple obstacles that create physical, financial, social, and/or cultural barriers for those seeking medical attention. For instance, lack of adequate health insurance coverage is a critical problem in New Jersey, particularly for working families. Rising costs of medical care can also present a barrier, making services unaffordable for many families.

For families receiving Medicaid, insufficient reimbursement rates deter many professionals from becoming Medicaid providers; this often means difficulties for families when searching for physicians, dentists, and specialists who accept Medicaid. Furthermore, the physical environment and geographical location of health facilities can sometimes present obstacles. Long waits in crowded, noisy waiting rooms sometimes discourage individuals from seeking care; likewise, having to travel long distances to receive services can be extremely cumbersome when transportation is limited or unaffordable. Finally, sociocultural differences can make accessing services difficult for many families without aggressive measures that address diversity, such as multilingual staff and literature.

Improved Access Means Better Care

Ensuring that children receive preventive medical care is essential. When health problems are identified early, treatment can follow — resulting in cost savings and, more importantly, healthier children. Although the benefits of prevention are evident, far too many children in New Jersey are simply not receiving the health care they need.

State data reveals that in 1991 180,000 persons were admitted to hospitals for illnesses that could have been prevented with ongoing access to primary and preventive care services. (DOH Report of the Advisory Panel on Federal Health Care Reform)

At any given time, more than 800,000 people in New Jersey will go without health coverage, 12.3% of whom are under the age of 65. (Ibid.)

Of the approximately 827,000 uninsured persons in New Jersey, 160,000 of them are children. (Ibid.)

Of the nearly 400,000 children eligible for Medicaid, only 27% obtain dental services from 400 dentists statewide. (Leusner)

The next section provides a broader description of barrier issues. It is not all-inclusive, but does highlight some of the most significant obstacles facing children and families today.

LACK OF HEALTH INSURANCE

There are approximately 827,000 persons in New Jersey who lack health coverage. Significantly, about 160,000 are children in New Jersey who lack any form of medical coverage. It is not surprising that most uninsured families fall in low income brackets, and that the number of the uninsured increases as income decreases. Department of Health data shows that 2 of every 3 uninsured persons live in families whose incomes are below 300% of the federal poverty level.[3]

It is significant to note that the vast majority of these families are tied to the workforce, either in low-paying part- or full-time employment. According to State Department of Health data, 90% of all uninsured families have 1 or more family members who are employed at least on a part-time basis. A breakdown of data shows that of all families in New Jersey:

- 9.5% with at least 1 full-time worker are uninsured, representing 60% of uninsured individuals.
- 23% with at least 1 part-time worker are uninsured.
- 19% having no employed family members are uninsured.[4]

Even children whose families have some type of health insurance are not always completely covered to receive preventive services. In the case of New Jersey's Medicaid program for instance, state Medicaid staff indicate that only a little over a quarter of all Medicaid eligible children receive dental services, and about the same number receive federally mandated health screenings.[5]

Also, of all New Jersey residents under age 65, Hispanics are disproportionately uninsured. Although they comprise only 9% of the total population, 21.9% of Hispanics are uninsured, as compared to 15.9% of Blacks and 9.78% of Whites; the remaining 23.1% represent other unspecified groups by the State Department of Health.[6]

AFFORDABILITY

Approximately 11% of children in New Jersey live below the federal poverty level.[7] For their families and many more families who work in low-wage jobs without adequate health coverage, affordability of health care is a critical issue. It is imperative that provisions such as sliding fee scales and exemptions from co-payments be included in whatever health reform proposal is passed. Without these types of provisions, many impoverished and low-income working families will continue to seek care for largely preventable health problems in expensive emergency rooms.

INADEQUATE PROVIDER REIMBURSEMENT AND AVAILABILITY

Medicaid reimbursement rates in New Jersey are dismally low. Coupled with the rising costs of health care, low reimbursement fees often create disincentives for medical professionals to serve Medicaid populations. For example, there are only two pediatric oral surgeons in the state who accept Medicaid — in New Brunswick and Irvington. Currently, physicians only receive $14 to $16 for a routine office visit, compared to the average $51 private rate. Dentists are only reimbursed $6 for routine oral exams, compared to a median private rate of $22. In fact, dentist fees have only increased twice since the Medicaid program began in 1968.[8]

PHYSICAL ENVIRONMENT OF FACILITIES

Families who rely on public health facilities for medical care are often faced with lengthy waiting times and crowded waiting stations. For those in rural areas of the state, the location of health care facilities can sometimes present difficulties for families, particularly when modes of transportation to medical facilities are limited and the cost of transportation is unaffordable.

SOCIOCULTURAL BARRIERS

Language differences can sometimes present barriers to health care for families, particularly if a medical facility lacks bi- or multi-lingual staff and written materials, like standard forms and informational pamphlets. For families who are immigrants, this is an even bigger challenge. Not only are there differences in language, but issues of distrust and fear of 'the system' can create significant barriers for these populations. Similarly, courtesy of staff and respect for clients are essential to attracting and retaining families, particularly given the persistent stigmatic treatment of families who are receiving or are eligible to receive financial and medical assistance.

Health Care Reform Efforts in New Jersey

New Jersey has launched its own health care reform efforts statewide to improve access to quality health services, while attempting to contain rising costs of health care. For instance, Health Access New Jersey is a subsidized insurance program that has been created for low-income working families and the temporarily unemployed. In addition are the Health Care Reform Act of New Jersey, eligibility expansions in the Medicaid program, and the establishment of managed care networks, which are all described below.

I. Health Care Reform Act of New Jersey

On November 30, 1992, three health care and insurance reform bills were passed in New Jersey: the Health Care Reform Act of New Jersey, and the Individual and Small Group Health Insurance Reform Acts. The passage of this legislation stemmed from three concerns: "(1) increasing numbers of uninsured people, most of whom are in the workforce; (2) dissatisfaction with heavy government regulation of the hospital industry; and (3) the need to find an alternative to finance charity care without increasing taxes."[9]

The overall goal of this legislation is to ensure universal access to health insurance, regardless of pre-existing conditions or demographic characteristics. Insurance would be made more available and affordable for individuals and small groups by requiring community rating and open enrollment, and by providing subsidies for families up to 300% of the federal poverty level. All insurance carriers must offer five (5) standard benefits packages, which include a basic health benefits plan (with primary and preventive care services), a managed care plan, and three plans of enhanced benefits of proportionally increasing actuarial value. Also, a new source of funding for hospital charity care is built into the legislation, which gradually shifts over a four-year period from hospital payments to subsidies for health insurance for uninsured persons who are either employed or temporarily unemployed.[10]

Since implementation of the act:

- 6 Of the 20 insurance companies writing standard health care policies in New Jersey have lowered their prices in the last year.
- More than 50,000 new individual policies have been written since last August — almost a quarter of which are designed specifically for an individual or family uninsured during the previous six months.[11]

II. Medicaid: What Is It?

Created in 1965 as Title XIX of the Social Security Act, the Medicaid program is jointly administered by the federal government, under the direction of the Health Care Financing Administration, and state governments. The federal government pays no less than 50% of program costs, and states operate as third-party payers, directly reimbursing providers who submit a bill for services rendered. Although there is variability among state Medicaid programs due to flexibility to define limits on coverage, all state Medicaid programs are required to provide beneficiaries with a standard set of health care benefits. Standard Medicaid benefits packages include inpatient and outpatient hospital services, physician services, rural health clinic

services, lab and x-ray services, skilled nursing facility and home health services for persons over age 21, family planning services, and nurse-midwife services. Well-child care is also provided, as are preventive services under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program for eligible children under age 21.[12]

Medicaid was originally intended to offer an additional benefit for those eligible for welfare assistance — specifically, the Aid to Families with Dependent Children (AFDC) Program, a cash assistance program for women and children; and the Supplemental Security Income (SSI) program, a cash benefits program for the aged, blind, and disabled individuals. Because of eligibility criteria for these categorical programs, the Medicaid program is not available to every poor person. In New Jersey, however, criteria for eligibility has been expanded to cover more low-income children whose families may work, but are still either underinsured or uninsured. The next section describes Medicaid eligibility expansions to date.[13]

Medicaid Eligibility Expansions.
Today in New Jersey, Medicaid is available to:

- pregnant women and infants up to age one whose family earnings are under 185% of the federal poverty level ($22,800 for a family of three)

- children up to age six whose families earn under 133% of the federal poverty level ($16,392 for a family of three)

- children under age 10 and 10-year-olds born after September 30, 1983 whose families earn under 100% of the federal poverty level ($12,324 for a family of three)

- all children under age 19 and their parents who meet the eligibility limits for AFDC.

The remaining challenge is ensuring that any persons who are eligible to receive Medicaid and want to participate in the program are actually enrolled and receive the medical and dental services to which they are entitled.

Managed Care: A New Direction

Defining Managed Care

Managed care is a term used to describe health care systems that integrate the financing and delivery of appropriate health care services to covered individuals by arrangements with selected providers to furnish a comprehensive set of health services. The method of payment is by capitation, or a fixed fee per person for a specific period of time without regard to the number of visits. There are various types of managed care organizations including Health Maintenance Organizations (HMOs), Preferred Provider Organizations, Exclusive Provider Organizations, and Point of Service Plans. The fastest growing type of managed care organization is the HMO.

The following are excerpts from ***What Legislators Need to Know About Managed Care*** produced by the National Conference of State Legislators.

A Managed Care Glossary of Terms

Capitation: A method of payment for health services in which a physician or hospital is paid a fixed, per capita amount over a specific period of time for each person served, regardless of the actual number or nature of services provided to each person.

Fee-for-Service: The traditional method of paying for medical services whereby a physician or other practitioner bills for each encounter or service rendered. This system contrasts with salary, per capita pre-payment systems, in which the payment is not changed with the number of services actually used.

Health Alliance: An organized group of individuals and/or local businesses who have joined together to purchase health care coverage.

Indemnity: Benefits paid in a predetermined amount in the event of a covered loss.

Managed Competition: A theory of health care delivery in which a large group of consumers choose among health plans that offer similar benefits; competition is based, therefore, on cost and quality.

Portability: The ability to take your current health coverage arrangement with you if you move or change jobs.

Primary Care: The point when the patient first seeks assistance from the medical care system; also, the care of the simpler and more common illnesses. The primary care provider usually also assumes ongoing responsibility for the patient in both health maintenance and treatment.

Utilization Review: A mechanism used by some insurers and employers to evaluate health care on the basis of appropriateness, necessity, and quality. For hospital review, it can include preadmission certification, concurrent review with discharge planning, and retrospective review.

Types of Managed Care Systems

1. **HMO - Various HMO models are:**

Group Model: A type of HMO with medical centers where many different health services are provided in a central location. Physicians and staff of a group model HMO usually treat HMO members only.

Individual Practice Association (IPA): A type of HMO in which a partnership, corporation, or association has entered into an arrangement for provision of their services. Physicians provide care in their own offices and serve HMO members as part of their regular practice.

Direct Contract: Under the direct contract model, HMOs contract with individual physicians (rather than an IPA) to care for members.

Network Model: This model expands the network of providers by contracting with various group practices or with independent physicians organized into small groups, in addition to the providers who are employees of the HMO. Compensation is provided by capitation, or discounted fees.

Staff Model: A type of HMO in which physicians are salaried employees who provide their services exclusively to HMO enrollees. This type of HMO is similar to the group model.

2. Preferred Provider Organization (PPO): An arrangement whereby a third party payer contracts with a group of "preferred" medical care providers who furnish services at lower than usual fees in return for prompt payment and a certain volume of patients.

3. Exclusive Provider Organization (EPO): A more rigid type of PPO that requires the insured to use only designated providers or sacrifice reimbursement altogether.

4. Point of Service (POS): Often known as open-ended HMOs or PPOs, these plans encourage the use of network providers, but permit insured individuals to choose providers outside the plan at the time service is rendered.

Medicaid Managed Care

The New Jersey Department of Human Services is beginning to contract with private HMOs to establish a statewide Medicaid managed care system for AFDC and AFDC- related beneficiaries. Recipients will be mandated to enroll as a family in an HMO. SSI and DYFS populations may voluntarily join a Medicaid-serving HMO. HMO providers with state contracts to date are: HIP/Rutgers; US Healthcare; Mercy Health Plan of NJ on behalf of HMO Blue; and the Garden State Health Plan, a voluntary HMO for Medicaid recipients.

Through a mandatory managed care system for Medicaid recipients, New Jersey hopes to improve access to and continuity of care, as well as conserve State monies. The Department of Human Services has stated that its goals are to:

1. enhance access and availability of health care services;
2. promote rational patterns of medical and health service utilization;
3. ensure quality of care within managed care programs; and,
4. establish cost-effective managed care programs.[14]

Over the next 2 years, all counties will be phased in using a 6 month enrollment period. A three-tiered phase-in approach will be used:

Tier 1: 194,000 AFDC clients will be phased in from Camden, Gloucester, Hudson, and Essex counties.

Tier 2: 153,000 AFDC clients will be phased in from Passaic, Union, Middlesex, Mercer, Atlantic, Monmouth, Bergen, and Cumberland counties.

Tier 3: 53,000 AFDC clients will be phased in from Cape May, Burlington, Hunterdon, Sussex, Warren, Somerset, Ocean, Morris, and Salem counties.

Assistance with enrollment will be provided by State-sponsored Health Benefits Coordinators (HBCs). The role of these HBCs will be four-fold:

- To conduct client outreach by providing each client with an enrollment package and a letter that includes a program explanation, a listing of available HMOs, the client's pre-nominated HMO, an HBC toll-free phone number, and a brochure detailing HMO options.

- To conduct client education by providing assistance via a statewide toll-free telephone center, controlling HMO marketing efforts, and conducting seminars, community events, and health fairs.

- To conduct client enrollment by providing and assisting with enrollment forms, as well as the pre-nomination and assignment processes.

- To conduct client follow-up by assisting individuals with inquiries, complaints and grievances.[15]

For more information regarding Medicaid managed care, contact Dan Walsky at the State Office of Managed Health Care Services at 609-588-2705.

Fact: About 19,000 of Medicaid's 600,000 clients of all ages are already in some form of managed care in New Jersey.[16]

Key Issues Of Concern

The State is proposing to guarantee health coverage via managed care health plans, including mandatory Medicaid managed care for AFDC beneficiaries. There are several fundamental issues that have consistently been problem areas in other states with managed care networks. The discussion below highlights some of these key issues.

1. Ensuring Client Access

It is clear that simply having health insurance does not guarantee that an individual will receive medical care. This has already been evidenced in many ways in New Jersey, including documented high emergency room use for non-emergent, acute care among Medicaid beneficiaries, as well as the experience of the Garden State Health Plan.

Barriers persist, so it is important that the State address and curtail many of these obstacles to access before full implementation of a statewide managed care system.

Client access means that the health care delivery system must hold no physical, financial, social, or cultural barriers for those seeking medical attention. An easily accessible, client-friendly system of managed care must address potential barriers such as: language differences; staff courtesy and client respect; length of waiting times at medical facilities; facility locations, particularly if modes of transportation and travel expenses are limited for families; and the physical environment of facilities.

2. Ensuring Quality

Because managed care seeks to improve efficiency and contain costs, we are concerned that, without some form of quality assurance, quality of health care services will be compromised for New Jersey's residents, especially low-income populations. Efficiency and cost containment do not have to come at the expense of quality. There is a need to monitor and improve quality of medical services. Without oversight, all of us will pay in terms of added financial costs, legal liability, and ethical liability. Therefore, the State is urged to employ an independent utilization review process for quality assurance that entails the following components: an independent quality assurance audit; an internal grievance procedure clearly instituted by all HMOs and managed care networks; patient satisfaction studies so that families being served can be heard; and, a community-based review board.

3. Ensuring Comprehensive, Coordinated Services

Failure to coordinate services creates unnecessary duplication, lack of communication, and critical service gaps. All of these factors impact significantly on a client's ability to access services. Too often, families are forced to navigate a fragmented system of health care. Failure to provide coordinated services that are also comprehensive places families at greater risk of poor health outcomes, and the State ends up paying exorbitant costs for the consequences of unmet needs — emergency room treatment for preventable illnesses, drug-addicted infants, and so on. More emphasis must be placed on prevention and early intervention through comprehensive, coordinated services. For instance, coordination of Medicaid managed care with early intervention and EPSDT services should be maintained. Also, we want to be assured that HMOs will offer enrolled families comprehensive benefits packages that not only include traditional medical services, but also referrals, follow-up, and health education.

4. Ensuring Client Choice

In the case of Medicaid managed care, there is a growing concern that the client's ability to choose plans and providers will be limited for families receiving AFDC. Under the State's proposed plan, families will be sent written materials regarding the Medicaid managed care program, HMO options, and enrollment deadlines. Upon receiving these materials, it is up to the client to seek to enroll in an HMO, either by clients calling up the HMOs themselves, or by calling or visiting a state-sponsored Health Benefits Coordinator. Upon enrolling, the use of medical and dental services will only be on terms permitted by a client's HMO. If clients fail to enroll by State deadlines, HMOs will be chosen for them by a designated Health Benefits Coordinator.

There are two (2) concerns here: First, can families be thoroughly informed about all of their HMO options AND then make an informed decision by current State deadlines? Without clear communication and follow-up, we are concerned that some families will fail to choose an HMO and will be assigned to an HMO that may or may not be ideal for their family situation. Second, for those families currently enrolled in Medicaid fortunate enough to have a primary care physician whom they respect and trust, the new system may disrupt sound patient-provider relationships. This is because by being limited to HMO-affiliated providers, families will no longer be able to seek care from any Medicaid provider of their choice, which may include providers with whom families have already forged patient-provider relationships.

5. Ensuring Client Outreach and Health Education

Outreach and education are essential components of any health care delivery system, particularly for traditionally vulnerable families who may have greater health risks and more complex social service needs. With the exception of Medicaid recipients enrolled in the Garden State Health Plan (a voluntary HMO for the Medicaid population), managed care is very different from the way most families receiving Medicaid currently access health care. They will need to be kept informed about services on a regular basis and how to access them through an HMO. In addition, systems are most effective when service providers consistently respect and respond to families of varying socioethnic backgrounds. Therefore, it is important that outreach and education strategies address the cultural and language diversity of families and communities.

6. Ensuring Marketing Controls

Although the State Department of Human Services has prohibited HMOs from offering financial incentives to Medicaid families, it will allow these HMOs to directly market their plans and services. Other states like Tennessee have made similar provisions, yet have experienced problems with inappropriate and deceptive marketing practices, ranging from threats against families to cut off AFDC payments, to the offer of rewards to marketing representatives who sign up families. The documented experiences of other states with fraudulent marketing strategies by managed care systems highlights the need for clearly established and enforced marketing standards.

7. Avoiding "Provider Squeeze"

Because managed care is partially founded on cost containment goals, we believe that all managed care plans should include incentives that will encourage providers to emphasize preventive and primary care services. Many states with managed health care systems have learned that placing too much risk on direct providers can mean strong incentives to underserve enrollees. When physicians are faced with inadequate fees for providing services and are forced to "cut back", it can mean withholding primary care and limiting specialty referrals. Consequently, provision of quality health care is sacrificed. To avoid this, the State must give careful consideration to the adequacy of its proposed capitation rate under Medicaid managed care, as well as the possibility of integrating risk sharing into the State plan.

Ensuring the Essentials

As child advocates and concerned health providers, we must ask: How will women, infants, and children in New Jersey be affected by health care reform? Will the needs of our children and families sufficiently be met? Below are fundamental principles against which all national health care reform proposals should be measured. They are based on key standards of health care access promoted by the American Academy of Pediatrics, National Association of Child Advocates, and Children's Defense Fund.

Universal coverage: All children should have access to the same class of care, regardless of their parents' income, employment status, or geographic location.

Make pregnant women, infants, and children a top priority: If implementation requires phasing-in, all children and expectant mothers should be covered within the first year of passage.

Remove financial barriers: All children through age 21 and pregnant women should be guaranteed financial access to health care. Cost barriers such as deductibles and co-payments for children and pregnant women should be removed to help ensure full utilization of preventive and early intervention programs.

Comprehensive, coordinated services: A broad range of primary, preventive, acute, and long-term services should be provided for physical, mental, and dental health needs. Incentives to link health services with supplementary services, such as nutritional programs, should be promoted.

Aggressive tools to ensure access for the underserved and medically fragile: Access for high-risk populations should be ensured by creating and funding a broad range of outreach, case management, and support services that are culturally sensitive.

Portable coverage of services: Benefits plans with all the services that children and pregnant women need should be continuous even if a family moves or a parent changes jobs.

Provider incentives: There must be incentives to recruit and retain health practitioners in medically underserved areas and to increase the number of clinics and health care facilities in these areas.

Systems Reform: As stated by the American Academy of Pediatrics, "[A]dministrative simplicity, medical liability relief, and the development of a pediatric-based relative value scale are necessary cost-containing measures."

Insurance Reform: Pre-existing condition exclusions should be eradicated, and community rating should be required.

PREVENTION SAVES MONEY AND LIVES

Improving the delivery system to focus on prevention would mean healthier youngsters and more productive adults. It would also save a lot of money. Consider this:

For every $1 spent on childhood immunization, at least $14 is saved in the treatment of preventable diseases.[17]

It is estimated that between $14,000 and $30,000 in annual health care costs are saved when a low birthweight birth is prevented by prenatal care.[18]

Children who receive regular health check-ups have overall medical bills that are 10% lower than those children who go without preventive care.[19]

About Our Partnership

The New Jersey Chapter of the American Academy of Pediatrics (NJ/AAP) and Association for Children of New Jersey (ACNJ) have formed a partnership as part of the State Child Health Access Project (SCHAP) sponsored by the Washington, D.C.-based National Association for Child Advocates. The purpose of SCHAP partnerships is to combine the expertise of child advocates and pediatricians to:

- Improve access to health care for uninsured and underinsured children and pregnant women by ensuring comprehensive health insurance coverage for these populations;

- Address current state level child health care access issues, and advocate for state policy actions which will provide coverage for all children, particularly for those with special needs;

- Prepare for the expected policy changes to be brought about by national health reform, and design strategies to assure that national reforms address children's needs when implemented in the State of New Jersey.

NJ/AAP and ACNJ have developed a joint plan of action steps:

1. Expanding and improving health access and care for children. Activities under this component include:
   a. conducting a needs assessment and analysis
   b. defining benefits and accountability issues for the State health care system
   c. developing a position paper defining problems and proposed solutions
   d. promoting public information efforts
   e. pursuing administrative and legislative advocacy
2. Monitoring state implementation of the Emergency Medical Services for Children Act.
3. Collaborating further on ACNJ's Child Health Month Project.
4. Developing this joint newsletter on maternal and child health care reform issues and other public information efforts for statewide dissemination.

ACNJ Health Access For Children Project

At a Glance

SYSTEM ASSESSMENT

Purpose:
To identify the strengths, weaknesses, and gaps in Newark's health care system

Expected Outcomes:
A complete inventory of public & privately sponsored children's health services in Newark

A survey of low-income parents, health service providers, and CBO staff

An analysis of survey findings

A parent's guide to children's health services in Newark

MANAGED CARE INFORMATION AND OUTREACH

Purpose:
To develop educational materials about managed care systems and services for parents and agencies

Expected Outcomes:
Monitoring state efforts to implement a managed care model for Medicaid

Spring Managed Care Forum/ informational meeting

Development of a managed care brochure for parents

Possible video on managed care plans, services, and general public health issues

HEALTH AND CHILD CARE PARTNERSHIPS

Greater integration of child care centers in outreach and education efforts

CO-LOCATION OF MEDICAL SERVICES

Purpose:
To develop medical services' offices in non-traditional settings such as child care centers, housing developments, and welfare offices

Expected Outcomes:
Implementing commitments from the Newark Welfare Office, Department of Health and Human Services, and United Hospital to co-locate an EPSDT clinic at the S. 15th St. welfare office in Newark

Implementing commitments from the Newark Housing Authority and UMDNJ to co-locate an EPSDT clinic in the Stella Wright Homes complex in Newark.

Exploring possible co-location of WIC and other services at these and other sites

AAP PARTNERSHIP

Purpose:
To effectively address child health care access issues and health policy changes on the state level

OUTREACH AND SERVICE COORDINATION CAMPAIGN

Purpose:
To increase both Medicaid enrollment and usage of EPSDT services

Expected Outcomes:
Outreach materials will be developed with the Center on Budget and Policy Priorities and the project steering committee. Materials will be geared to child care providers, WIC staff, and community health center administrators

Development of dissemination network and plan

Greater integration of CBOs in outreach and education efforts

ADMINISTRATIVE REFORM

Purpose:
To address crucial areas in need of administrative or policy reform

Expected Outcomes:
Technical assistance will be provided by the National Association of Child Advocates and the Center on Budget and Policy Priorities

Feasible alternatives to problematic rules procedures and forms

Opportunities for greater coordination of benefit programs

Additional Information

For further information on these and related topics, you can contact the following individuals and organizations:

Association for Children of New Jersey
(201) 643-3876
Ciro A. Scalera, Executive Director
Karin Booker, Coordinator, Health Access for Children Project

American Academy of Pediatrics/New Jersey Chapter (609) 393-3350
Carlo Melini, M.D., Past President and Government Affairs Liaison

National Association of Child Advocates
(202) 828-6950
Eve Brooks, Executive Director
Judy Shaw, Director of Child Health Advocacy

END NOTES

1. New Jersey Department of Human Services (DHS). "The Uninsured in New Jersey (Under Age 65)."

2. New Jersey Department of Health (DOH). "Report of the Advisory Panel on Federal Health Care Reform", June 24, 1994.

3. Ibid.

4. DOH, "The Uninsured in New Jersey (Under Age 65)."

5. Leusner, Donna. "Dental Aid Gains for Needy Children but $30 Million Cost is Questioned." The Star Ledger, 4 June 1994.

6. DOH, "The Uninsured in New Jersey (Under Age 65)."

7. NJ Kids Count 1993.

8. Leusner.

9. DOH, New Jersey Department of Health (DOH). "Health Care Reform in New Jersey: New Jersey P.L. 1992", c.160, 161, 162.

10. Ibid.

11. DOH, Advisory Report.

12. Hill, Ian T. "The Role of Medicaid and Other Government Programs in Providing Medical Care for Children and Pregnant Women", *The Future of Children*, Winter 1992.

13. Ibid.

14. New Jersey Department of Human Services/ Division of Medical Assistance and Health Services. "Medicaid Managed Care", 20 May 1994.

15. Ibid.

16. Leusner.

17. Washington, D.C., U.S. Accounting Office, 1992.

18. U.S. Department of Health and Human Services.

19. Children's Defense Fund, 1991.

Bibliography

American Academy of Pediatrics.
Washington Reports, 1993-1994.

The Annie E. Casey Foundation.
Kids Count Data Book 1994: State Profiles of Child Well-Being.

Association for Children of New Jersey.
New Jersey Kids Count 1993: State and County Profiles of Child Well-Being.

Child Health Action Management Plan, Mayor's Advisory Council on Child Health. "Medicaid Managed Care in New York City: How Will Children Fare?", December 1993.

Childhood Immunization: Opportunities to Improve Immunization Rates at Lower Cost. Washington D.C.: U.S. Accounting Office, 1992.

Children's Defense Fund.
The State of America's Children 1991. Washington, D.C., 1991.

Freund and Lewit. *"Managed Care for Children and Pregnant Women: Promises and Pitfalls", The Future of Children, Health Care Reform* Vol. 3, No. 2, 1993.

"Health Care Reform: Where Do Children Fit in the Puzzle?". *A Special Report from Georgians for Children*, No.2, April 1994.

Healthy People 2000: National Health Promotion and Disease Prevention Objectives. Washington D.C.: U.S. Department of Health and Human Services, 1991.

Hill, Ian T. "The Role of Medicaid and Other Government Programs in Providing Medical Care for Children and Pregnant Women", *The Future of Children*, Winter 1992.

Leusner, Donna. "Dental Aid Gains for Needy Children but $30 Million Cost Is Questioned", *The Star-Ledger*, 7 June 1994.

New Jersey Department of Health. "Health Care Reform in New Jersey: New Jersey P.L. 1992", c.160,161, 162.

New Jersey Department of Health. "Report of the Advisory Panel on Federal Health Care Reform", 24 June 1994.

New Jersey Department of Human Services/Division of Medical Assistance and Health Services. "Medicaid Managed Care", 20 May 1994.

New Jersey Department of Human Services. "The Uninsured in New Jersey (Under Age 65)".

Scalera, Ciro A. "The ABCs of Managed Care", *Community Initiative*, vol.3, no. 3, summer 1994, The Prudential Foundation.

"What Legislators Need to Know About Managed Care," National Conference of State Legislators, April 1994.

Data from the following individuals and agencies:

American Association of Retired Persons (1986)
Nancy Fiorentino, NJ Department of Health (DOH)
National Association of Child Advocates
Blue Cross/Blue Shield Association (1988)
Health Insurance Association of America (1992)
Children's Defense Fund Data Sheets, 1994
John Jacobi, Esq.
NJDOH/Epidemiology, Infectious Disease, AIDS Units
The Segal Company (1992)

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