Maximizing Enrollment in Utah:
Results from a Diagnostic Assessment of the State's Enrollment and Retention Systems for Kids

Maximizing Enrollment for Kids Diagnostic Assessment Reports

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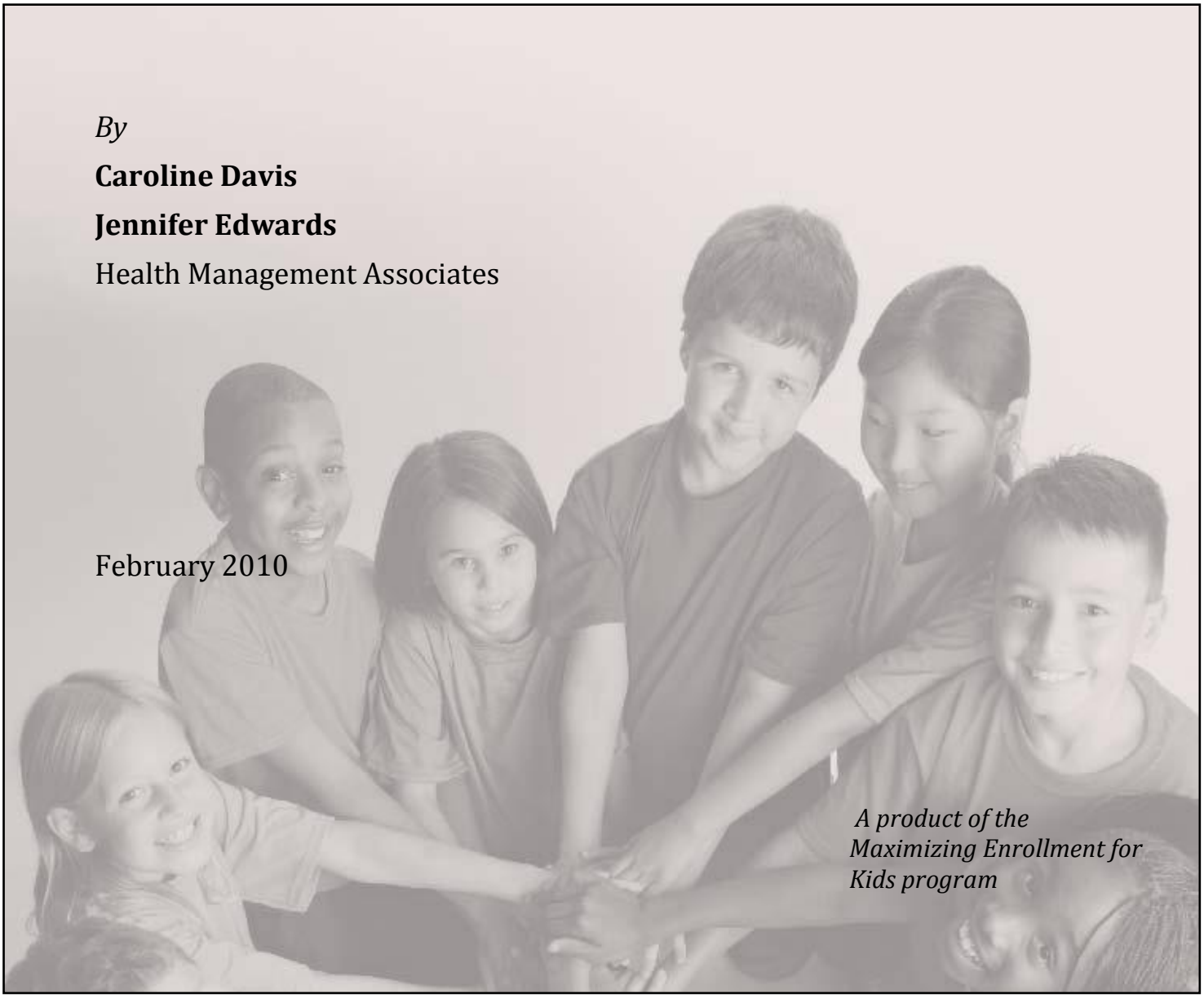

February 2010

A product of the Maximizing Enrollment for Kids program

NATIONAL ACADEMY for STATE HEALTH POLICY

Robert Wood Johnson Foundation

This report is a product of the Maximizing Enrollment for Kids program, a $15 million initiative of the Robert Wood Johnson Foundation (RWJF) to increase enrollment and retention of children who are eligible for public health coverage programs like Medicaid and the Children's Health Insurance Program (CHIP) but not enrolled. Under the direction of the National Academy for State Health Policy (NASHP), which serves as the national program office, Maximizing Enrollment for Kids aims to help states improve their systems, policies and procedures to increase the proportion of eligible children enrolled and retained in these programs.

Acknowledgements

The authors wish to thank the Robert Wood Johnson Foundation (RWJF) for its support of this report and in particular Deborah Bae, Program Officer, Brian Quinn, Program Officer, and Andrew Hyman, Team Director and Senior Program Officer. We also thank the many state Medicaid and CHIP officials in each of the eight states participating in the Maximizing Enrollment for Kids program who participated in interviews, provided extensive program data and background materials and completed detailed questionnaires and process maps contribute to this assessment. This report could not have been completed without their participation and enthusiasm.

Additionally, we are indebted to the Utah program staff, supervisors and managers who met with us during site visits and to state officials in public health, social services, education and other agencies, as well as advocates, providers and leaders of community-based organizations and foundations who provided their perspective and insights. In addition to the specific individuals who participated in the diagnostic assessment process listed in Appendix I, the authors would like to offer appreciation for the hard work and diligent responses of the Utah Maximizing Enrollment for Kids team members, including Nathan Checketts, Bev Graham, Emma Chacon, Heidi Petersen, Kolbi Young, Yvette Woodland, and Gayleen Henderson. The diagnostic assessment and this report benefited from the support and input of a number of individuals at NASHP including Catherine Hess, Alice Weiss, Alan Weil, Neva Kaye, Maureen Hensley-Quinn, Jennifer May and Amanda Wyatt; as well as key external advisers of the Maximizing Enrollment for Kids program.

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Executive Summary

In February 2009, Utah was selected as one of eight grantees of the Robert Wood Johnson Foundation's (RWJF) *Maximizing Enrollment for Kids* program, with the goal of helping states to improve the enrollment and retention of eligible children in Medicaid and the Children's Health Insurance Program (CHIP). In the first year, the National Academy for State Health Policy (NASHP), which is serving as the National Program Office on behalf of the RWJF, collaborated with Health Management Associates (HMA) to conduct a baseline assessment of each state's systems, policies, and processes for enrolling and retaining children in coverage. The assessment of each state included reviewing state's reports and policies, conducting onsite interviews with stakeholders and administrators in children's health insurance programs, and reviewing published research about the impact of policies on coverage. This report synthesizes the information gathered, distilling the state's current strengths, challenges, and opportunities for improvements in Utah's enrollment and retention of eligible children.

Findings

Utah's Medicaid and CHIP programs are undergoing major changes that will improve the programs for families, streamline application and renewal processing, and provide new information to staff managing those programs. In the past two years, Utah has taken significant steps towards achieving Governor Huntsman's goal to enroll at least half the uninsured, eligible children by 2012. Important policy changes in 2008 and systems upgrades in 2009 lay the groundwork for improvements in enrollment and retention of eligible children. Based on the site visit interviews, review of materials provided by Utah, and prior knowledge of best practices across the states, we have identified the following themes from the diagnostic assessment:

- **With the legislature's decision in 2008 to permanently open CHIP enrollment, state officials, advocates, and families became much more optimistic about the promise of coverage for low-income children in Utah.** Previously, CHIP enrollment had been closed to new applications for 24 of the last 36 months. Families had been discouraged, and eligibility workers had little to offer families with incomes above Medicaid levels. The decision to keep enrollment open, even during a national recession, has invigorated staff and advocates and contributed to a sense of momentum around making other improvements in enrollment and renewal processes.
- **Utah is trying new approaches to making Medicaid and CHIP accessible for eligible families.** Eligibility and renewal processes are newly consolidated with the Department of Workforce Services (DWS), which is experimenting with simplifications to the application and the local enrollment process. As an example, a new joint application for CHIP and Medicaid benefits has a one page tear off sheet applicants can fill out to begin the application process. Department of Health and DWS workers are attending community events, and going into different venues with a new CHIP van to talk with families.

- **Utah has invested in new information systems to reduce paperwork and make eligibility and renewal processes more efficient. The added information capacity will also provide data needed by state officials to monitor and improve eligibility and enrollment processes.** DWS launched "eFind," an on-line data brokering system, in 2004. With eFind, eligibility workers are able to check 18 different data sources (e.g., Social Security, Vital Statistics, HEAT, etc.) with one search in lieu of requiring families produce documentation of income and U.S. citizenship. In addition, Utah is poised to launch a new eligibility determination system, known as "eREP," later this year. Like the system it is replacing, eREP is the eligibility system for many of Utah's public assistance programs including, Medicaid, CHIP, TANF, Food Stamps, and Child Care. The new system is expected to reduce errors and improve the consistency of eligibility determinations. Online applications will eventually be linked directly with the eligibility system, reducing staff time devoted to data entry. The State anticipates eREP will be able to merge information from other programs (e.g., National School Lunch program) to identify eligible but unenrolled children, a high priority for the coming year.
- **Utah could become a national leader in partnering with schools.** Utah is working closely with the schools to develop partnerships to identify and enroll eligible children. This work is occurring on both the district level to connect School Lunch enrollees with health insurance as well as the statewide level through the State's new electronic student record (known as the "Digital Bridge"). This effort was initiated by a legislator who is also a school teacher, who recognized the linkage between health and school performance.
- **Utah has relatively few community partners to help families with application and renewal processes.** Utah's advocacy community is small, and there are few community-based organizations (CBOs) that conduct outreach activities or provide application assistance to families. The State's own eligibility workers play an active role in outreach and application assistance, but prior work has shown the importance of community enrollment by people familiar and trusted. Recognizing the importance of engaging community partners, the State has worked closely with a key CBO (Comunidades Unidas) to reach eligible but unrolled children in the Latino community. DOH also planned to provide outreach grants to selected CBOs, but these funds were eliminated as part of the 2008 budget process. Although the State has some collaboration with Native American communities to enhance enrollment, both parties have expressed interest in helping more Native American families enroll their children in coverage.
- **Because of the recent history of enrollment closures and other competing priorities, up until now DOH has not invested in analyzing data about Medicaid and CHIP to guide program improvements.** It does appear that the IT infrastructure can support analyses that would be helpful to the State in its work to manage and improve the programs, including examining enrollment and disenrollment patterns longitudinally based on a child identification number regardless of program. Additional analysis about key aspects of the program (e.g., disenrollment reasons, churning trends) as well as an understanding of which outreach strategies are successful (e.g., school-based outreach, eligibility staff participation at outreach events) also would help the State to assess enrollment and retention barriers.

Based on our understanding of Utah's current practices, systems, and administrative structure, the following recommendations, briefly highlighted here and described in more detail below, may hold the most promise in helping Utah move closer to its coverage goal:

- Produce data to guide future program changes and outreach efforts.
- Learn more from families who have tried to enroll and retain coverage about what worked and didn't work for them. Also speak with families who appear eligible but have not applied for coverage to learn what shapes their decisions.
- Continue and expand partnerships with the Utah State Office of Education (USOE) and schools.
- Consider expanding outreach activities, including adding new partners.

Introduction

As many as five million children in the United States may be eligible for but not enrolled in Medicaid or CHIP programs in their state and a third are estimated to have been covered in the last two years. *Maximizing Enrollment for Kids*, a national program of the Robert Wood Johnson Foundation (RWJF), aims to address these problems by helping states improve the identification, enrollment and retention of eligible children. Directed by the National Academy for State Health Policy (NASHP), *Maximizing Enrollment for Kids* is a $15 million initiative that RWJF launched in June 2008. In support of enrollment and retention goals, the initiative also aims to establish and promote best practices among states.

To achieve these goals, the program includes:

- A standardized diagnostic assessment of participating states' enrollment and retention systems, policies and procedures;
- Individualized technical assistance to help states develop and implement plans to increase enrollment and retention of eligible children, consistent with the findings of the assessment, and to measure their progress; and
- Participation in peer-to-peer exchange to share information regarding challenges and discuss solutions and effective strategies with other states.

Through a competitive application process, eight states were selected to receive four-year grants of up to $1 million to participate in the program: Alabama, Illinois, Louisiana, Massachusetts, New York, Utah, Virginia, and Wisconsin. This paper reports on the diagnostic assessment of Utah.

The economic and political environment at the time of this assessment (March - June 2009) provides important context for understanding children's health insurance program status and the opportunities highlighted in this report. During the development of the assessment protocol in late 2008 and throughout the Spring of 2009, the United States was in a deep recession with high unemployment leading to a greater demand for public health insurance coverage. State budgets were greatly depressed, two-thirds of states were facing budget shortfalls, and the outlook was for worse shortfalls for the next three years. There was an enormous tension in most states about how to maintain access to public health insurance programs and still balance their budgets.

In early 2009, Congress passed the American Recovery and Reinvestment Act (ARRA) to help buffer the impact of the recession on individuals and states. Medicaid relief for 2009 was included, contingent upon states not reducing Medicaid eligibility levels from 2008 levels. About the same time, Congress passed the Children's Health Insurance Program Reauthorization Act (CHIPRA) a law continuing the Children's Health Insurance Program (CHIP). It expanded funding to states that meet enrollment and retention performance incentives. Each of these factors—the recession, ARRA and CHIPRA—were part of the backdrop of the state assessments.

Methodology

NASHP has partnered with Health Management Associates (HMA) to complete the Diagnostic Assessment phase of the program. In consultation with NASHP, HMA designed and administered a set of data collection and interview protocols to complete an assessment of the strengths, weaknesses and potential opportunities associated with each participating state's enrollment and retention systems, policies and procedures and external environment.

The diagnostic assessment centers on six areas:

- Enrollment and Renewal Simplification and Retention Policies
- Coordination between Medicaid and CHIP and Other State Agencies
- Analytic Capacity for Program Management and Decision-making
- Client-Centered Organizational Culture
- Non-Governmental Partnerships and Outreach
- State Leadership

In March 2009, information was collected from each state in advance of onsite interviews. Each state provided annual or progress reports on Medicaid and CHIP; trend data on program enrollment and disenrollment, and the number of uninsured children; policy and procedure manuals related to enrollment and renewal; process flow charts for enrollment and renewal; interagency agreements that would affect enrollment and renewal, such as with a sister agency that conducts intake interviews; and contracts with third party vendors who handle enrollment, retention, or a call center.

Each state was then asked to fill out a 20-page questionnaire that requested states to describe key components of its enrollment and renewal practices and outcomes. The questionnaire addressed the six themes identified above.

Based on the findings from the pre-site visit materials and questionnaire, an interview guide was developed to be used during a two day site visit in each state. During the visit to each state, interviews included state program staff as well as people outside the program whose views would help identify current strengths of the program and new opportunities to cover and retain more children. The type of people interviewed included: the Governor's health policy director, state legislators or staff of the legislative health care committees, policy advocates, organizations that work directly with families in completing applications, officials from sister agencies or bureaus, such as public health, and health plans involved in enrollment and retention. The names of interviewees in Utah are listed in Appendix I.

The findings in this report are based on information collected from the state, a recent review of the literature,[1] and experience from our work in numerous states, to distill the opportunities states have to improve enrollment and retention of children in coverage. While many opportunities were identified, this report highlights those we thought would have the greatest impact on children's coverage and be administratively and politically feasible.

Findings across all eight states' assessments will be published in a separate report.

[1] Victoria Wachino and Alice M. Weiss, "Maximizing Kids' Enrollment in Medicaid and SCHIP: What Works in Reaching, Enrolling and Retaining Eligible Children," National Academy for State Health Policy for Robert Wood Johnson Foundation, February 2009. Accessible at: www.nashp.org/files/Max_Enroll_Report_FINAL.pdf.

About Utah's Health Insurance Programs for Children

According to the Utah Department of Health's "Utah Health Status Survey", approximately 75,900 children (eight percent of children) in Utah lacked health insurance in 2008. The Current Population Survey uninsured estimate for 2007-2008 is slightly higher, at 10.6 percent. Of the uninsured children, about 55,000 (nearly three-quarters) appeared to be eligible for Medicaid or CHIP.[2] Low-income children are more likely to be uninsured than other children in the state: 16.5 percent of children in families with incomes below 200 percent of the federal poverty level (FPL) were uninsured, compared to ten percent of all children.

Medicaid and CHIP are separate programs in Utah, both administered by the Utah Department of Health (DOH). Medicaid covers children from birth to age five in families with income up to 133 percent FPL and children ages six to 19 with family income up to 100 percent FPL. An asset test is applied to children age six and older applying for Medicaid. Parents also are eligible for Medicaid, but only if family income does not exceed 42 percent FPL. CHIP covers children up to 200 percent FPL who do not qualify for Medicaid and do not have private insurance. Premiums are required for families whose incomes are between 101 to 200 percent FPL. Annual CHIP enrollee out-of-pocket spending (premiums plus cost-sharing) is limited to five percent of family income.

Utah offers a premium subsidy program for low-income adults and for children who are otherwise eligible for CHIP and who have access to employer-sponsored health insurance (ESI). Utah's Premium Partnership for Health Insurance (UPP) subsidizes premiums up to $100 per child per month ($120.00 if the plan includes dental benefits) with CHIP funds, or $150 per adult per month with Medicaid funds.

Enrollment in Public Health Insurance Programs

Over 231,000 children in Utah were covered by Medicaid or CHIP in 2007, including 300 children enrolled in the UPP. Appendix II displays monthly enrollment trends for children for the past five years. Medicaid and CHIP enrollment slowed and then declined from 2005 to 2007 due to the closure of CHIP to new applicants for 23 months between the period of May 2004 to June 2007, and due to a strong economic period in Utah. CHIP enrollment is expected to rise in 2009 as a result of 2008 legislation prohibiting the future closing of enrollment. Medicaid enrollment fluctuates along with CHIP enrollment because families often cannot accurately assess their eligibility for Medicaid versus CHIP. When CHIP enrollment rises as a result of the new policy, Medicaid is likely to rise too.

Retention rates in the two programs are similar with about 59 percent of children staying in their current program when they renewed in 2007.

[2] Utah Health Status Survey, Office of Public Health Assessment, Utah Department of Health, 2009. In counting the uninsured but eligible population, the survey cannot take into account eligibility exclusions such as recent private insurance, eligibility for the state employee benefit plan, the state's asset test, or immigration status.

Recent Initiatives to Expand Insurance Coverage

In 2008, the Utah Legislature passed several bills that affect children's coverage:

- House Bill 326 mandated that CHIP remain open to new enrollment;
- House Bill 133 established a framework for health reform and expanded premium assistance support; and
- House Bill 364 directed DOH, the DWS, and the Office of Education to collaborate on using the National School Lunch Program to identify uninsured children.

Leadership and Political Context

Medicaid and CHIP were originally managed by two different offices within the Department of Health, but in 2004, the two programs were consolidated in the Division of Health Care Financing. There were two state agencies that handled enrollment processes until 2007, when responsibility for all health insurance enrollment was added to the responsibilities of the Department of Workforce Services (DWS), which also manages eligibility determinations for other public benefits such as cash assistance, food stamps, and child care subsidies. DWS operates 36 Employment Centers located across the state as well as a centralized call center.

Political leaders in Utah represent a spectrum of beliefs about health insurance coverage for children, including those believing in public guarantee of coverage and those believing public coverage is a stepping stone to self-sufficiency. In this context, CHIP has enjoyed strong and consistent support. There also is strong interest in public-private approaches to coverage, such as premium assistance. Utah has enjoyed a supportive Governor, but he was just appointed to serve as U.S. Ambassador to China, and the Lt. Governor, whose vision about health care was not discussed during the site visit, will soon be sworn in as Governor.

Applying for and Renewing Coverage

Two applications can be used by families to apply for children's coverage. Families can choose a unified public benefits application which determines eligibility for health insurance, cash assistance, and food stamps. Alternatively, they can choose a shorter health insurance-only application which can be used for Medicaid, CHIP, UPP, or the Primary Care Network (a limited benefit program for adults). Families can complete either type of application on paper or online via the Internet, including accessing the online application at a DWS Employment Center. Applicants usually complete a phone interview with staff at the DWS call center. During the call, the interviewer reviews data already available in state data systems and informs applicants of any further information and documentation needed to complete their application.

Coverage must be renewed at least annually for CHIP and Medicaid. DWS eligibility staff will conduct phone renewals if the family can be reached, or send a pre-populated renewal form by mail. Data were not available on the percent completed by phone. Renewals must be completed (including submission of the form, if required, and any required documentation) by the end of the month of renewal.

Priorities Identified by the Grantee

In the grant application, the State identified the following priorities, which will be considered along with opportunities identified in this report, as the State works with NASHP to plan the use of grant funds:

- Maximize enrollment of eligible children in Medicaid, CHIP and UPP by removing administrative barriers to enrollment and retention;
- Streamline the application process;
- Simplify renewal process and improve client education;
- Integrate school lunch data with the State's eligibility system to identify eligible but unenrolled children; and
- Evaluate multicultural outreach to develop best practices.

Findings from the Diagnostic Assessment

1. Enrollment and Renewal Processes and Policies

Current Approach to Enrollment

Utah has given families a variety of ways they may apply for children's coverage. Families can complete a unified public benefits application which determines eligibility for health insurance, cash assistance, and food stamps. Alternatively, families can use a new Department of Health application for all public health insurance programs, introduced in October 2008. The health form is considerably shorter than the full public benefit application. In addition, for families using this form at outreach events, a front page has recently been added which the family can submit by itself to initiate the health insurance application process. In addition, Utah has two Web-based applications that mirror the paper applications: "UtahClicks" can be used to apply for health insurance while "UtahHelps" is the unified public benefits application.

CHIP applicants use the online application at a higher rate than Medicaid applicants, with more than 50 percent of CHIP applications being submitted online, compared to 40 to 45 percent of all applications combined. The remaining applications are submitted on paper either by fax or mail (8 percent) or in person (approximately 50 percent) at one of the DWS Employment Centers located across the State. Some applicants apply in person at a DWS Employment Center either because they want assistance with the application or they are primarily looking for unemployment or cash assistance benefits. At the Employment Centers, applicants are given a choice on how to apply. The majority choose to apply online and are given assistance as needed. These applicants are directed to a workstation where they complete the application online. Recently, DWS eligibility workers added an intake screening step to help people apply for those programs they are most likely to be eligible for, and avoid unnecessary work in completing forms.

In addition to the DWS Employment Centers, there are 54 outstationed DWS workers who are available at provider sites, and assist people with applications. These outstationed workers and other DWS and Department of Health staff are available to attend community events to answer questions and assist in the application process. DOH reports the outstationed eligibility workers are valuable resources. As discussed below, DOH also conducts statewide outreach with its new "CHIP Van."

PHONE INTERVIEW

Whether the application is submitted on paper or electronically, most families complete a phone interview with DWS's centralized call center. The eligibility workers at the call center use Utah's "eFind" system, which is an innovative, Web-based tool that searches 18 separate data sources (e.g., wage, unemployment, child support, Vital Statistics data). If eligibility criteria such as income and citizenship can be documented through eFind, families do not have to provide further documentation to complete the application. If information cannot be found electronically, the eligibility worker will request any needed documentation from the family. The worker also can inform the family whether they will owe a premium (for CHIP).

ELIGIBILITY DETERMINATION PROCESS

The application process is designed to take no more than 30 days, although workers can grant an additional 30 days, or longer if needed, when the applicant is making a "good faith effort" to submit any missing information. For applications received submitted by mail or internet, the applicant is instructed by mail to contact the call center within 10 days to schedule the phone interview. If the applicant fails to schedule an interview, a second notice is sent out and the applicant has 20 days to schedule an interview before the application is auto-denied. If the applicant calls to schedule an interview, the worker will attempt to gather as much missing information as possible during the call. In the event additional verifications are required, the applicant is notified of the missing verifications and must return them within 10 days, unless they request additional time, or the case is denied. Once the application and documentation are reviewed by the worker, applicants are notified of their eligibility decision.

APPLICATION DENIAL RATES

Utah could not provide data on the number of Medicaid applications that were initiated but not completed, but they did report that 29 percent of CHIP applications were denied for failure to complete the full process. Among denied applications, incomplete information was a leading cause of denial. Fifty-seven percent of the Medicaid denials and 69 percent of the CHIP denials were due to incomplete information. Eligibility workers do enter a denial reason in the system, but the current codes are too generic to provide much insight into what could be improved. For example, "failure to complete the process" could mean the applicant failed to complete the application form or provide required documentation.

CHIP PREMIUMS

Families enrolled in CHIP are required to pay premiums based on a sliding scale. Families with incomes between 101-150 percent FPL are charged $30 per quarter per family, and families with incomes between 151-200 percent FPL are charged $75 per quarter per family. The State mails premium notices during the first weeks of February, May, August and November. Families are billed for the current quarter. Premium payments are due within one month of the invoice. Families who fail to pay the premium are terminated from the program and charged a $15 late fee. They can be reinstated within the month following the "closure month" if they pay the premium and late fee. Nonetheless, about 12 percent of CHIP families lose coverage each quarter for failure to pay the premium.

USE OF E-MAIL TO CONTACT CLIENTS

Applications collect applicant e-mail addresses (although it is labeled as an optional field on the medical-only application). When available, workers use e-mail to communicate with families, particularly when the address on file is not valid. Utah also allows customers to submit required verifications to their worker via e-mail. However, workers do not use email to send confidential or identifiable information to customers.

Current Approach to Renewal and Retention

Children's coverage must be renewed at least every twelve months for Medicaid and CHIP. Eligibility periods of less than 12 months for Medicaid are assigned if the household circumstances are likely to change frequently. The process for both programs is largely the same, except some CHIP families are eligible for a simplified renewal (described below). In the month prior to the renewal month, DWS workers receive a list of enrollees due to renew, and they call the family to complete an eligibility review. The worker reviews the information in the family's case file and makes any necessary updates including income information. If the income information is within the eligibility range and confirmed by a match with eFind, the renewal is complete. If the family reports income information that cannot be confirmed through electronic data matching, the family must provide documentation. Staff did not know how often families are reached by phone and able to complete a paperless renewal. Families also may seek assistance with renewals at the DWS Employment Centers.

If the eligibility worker does not reach the family by phone, a pre-populated renewal form is mailed no later than 10 days prior to start of month of renewal. Customers have 40 days to return the form and any needed documentation. Eligibility workers will again try to reach the family by phone if the form or documentation are not returned. Eligibility is terminated if the process is not completed by the end of the month of renewal.

"SIMPLIFIED RENEWAL" OPTION

Some CHIP families are eligible for "simplified renewal." Prior to initiating contact with the family, the worker reviews the case file and determines whether any changes have been reported that may affect eligibility. If no changes have occurred or been reported during the 12 month certification period and the worker has no reason to believe the child may no longer qualify for CHIP (e.g., family income is not close to 200 percent FPL), a pre-populated renewal form is sent to the family. The family only has to respond if anything has changed; otherwise, the system automatically extends eligibility for another 12 months. State staff estimates that approximately 10-20 percent of CHIP renewals are handled through the simplified renewal process. They did not yet have data on how this initiative was affecting the overall retention of eligible children.

DISENROLLMENT RATES AND DISENROLLMENT REASONS

DOH reported that approximately 41 percent of both Medicaid and CHIP children disenroll during the year.[3] According to State staff, children remain enrolled in Medicaid for an average of nine months, and 4-5 percent of Medicaid and CHIP enrollees leave the program each month.

As noted above, the State captures denial reason codes, but they are fairly general categories and the data is not considered reliable. DOH conducted a CHIP disenrollment survey in 2007 which found that 40 percent of respondents left because they obtained other health coverage (e.g., employer-sponsored health insurance or Medicaid); 21 percent left because their income exceeded CHIP levels; 11 percent did not complete the necessary paperwork; 5 percent did not pay premiums; and 5 percent believed they no longer qualified for the program.[4] Utah also does not track the number of children who are disenrolled from either program and subsequently re-enroll within a defined timeframe, but the information is available.

[3] Utah defined retentions based on the number ever disenrolled/number ever enrolled. It is not based on renewals.
[4] Disenrollment surveys often do not represent a cross-section of all disenrolled families. Non-respondents may have different outcomes.

New Initiatives

Later this year, Utah will implement eREP, a new eligibility system, replacing the current eligibility determination system (known as PACMIS). Eventually, eREP will link the online application directly with the eligibility system. In addition to this administrative streamlining, the system will be programmed to produce new, better communication with families. eREP is likely to have better capacity for merging other information, such as Free and Reduced-Price School Lunch data, which is discussed below.

In 2007, Utah made a significant change in the Medicaid and CHIP programs' administrative structure by consolidating the eligibility and renewal functions in DWS. Previously, DOH and DWS both had responsibility for eligibility determination. According to the State, by consolidating eligibility and renewals with DWS, families seeking health as well as other social service benefits no longer have to visit two separate offices to apply for benefits.

In early 2009, the legislature raised CHIP premiums for enrollees in the highest income group (between 151-200 percent FPL) from $60 to $75 and imposed the $15 late fee for families who fail to pay premiums on time.

Strengths

Utah's application and renewal processes have a number of features that promote coverage and enhance enrollment opportunities for eligible children:[5]

- **Ability to apply online.** Online applications are generally more accessible than paper and, because of embedded logic, online applications are usually more complete and accurate than paper applications, which means the eligibility review takes less time. However, the State has not attempted to quantify these impacts.
- **Multiple applications.** Using two different applications increases flexibility for Utah families who may have differing needs. The short, medical-only application with the tear-off sheet can minimize applicant burden. On the other hand, a single application for multiple public programs can help the State identify people who did not know their children are eligible for health insurance, such as people seeking unemployment benefits.
- **Third-party data matching.** Using eFind in lieu of paper documentation can be expected to increase the proportion of families who complete the application and renewal processes, as missing documentation has been shown in other states to be a leading reason for incomplete applications.
- **Application assistance available.** If they need help, applicants can receive assistance at DWS Employment Centers or from outstationed DWS eligibility workers. Application assistance is also available with selected community partners.

[5] While the strategies listed here appear to promote coverage and enhance enrollment and renewal, the impact of these strategies has not been systematically evaluated. Additional strategies that were not forthcoming in the assessment may also contribute to successful enrollment and renewal.

- **Communication with families.** Eligibility workers make several attempts to reach families by phone, avoiding some of the problems of lost mail, incorrect addresses, and unopened mail. Utah's innovative use of email provides another mechanism for eligibility workers to communicate with families.
- **Streamlined administrative structure.** Medicaid and CHIP enrollment is handled by a single agency. The recent merging of DOH and DWS eligibility workers may help simplify family burden because they can now go to a single location to apply for benefits. With the economic downturn, eligibility workers reported that more families are seeking employment-related benefits who may be unaware of the availability of health coverage programs for children prior to visiting an Employment Center. Eligibility staff works with these families to determine whether they are likely eligible for Medicaid or CHIP coverage and to submit applications for those who are.
- **DWS commitment.** DWS is committed to improving customer service by utilizing technology and proactive approaches to identify and implement streamlining and system improvement opportunities.

Challenges

The following features may impede enrollment or retention of eligible children in coverage:

- **Data needed.** High application denial rates and low retention rates suggest many families are interested in covering their children but are unable to make their way through administrative processes. However, lack of detailed information about Utah's experiences and the impact of Utah's processes and policies hindered our ability to reach conclusions about the reasons families do not enroll or retain coverage. Data on each of the following would have allowed a more complete assessment:
  - Use of each method of application;
  - Application completion rates, by method;
  - Use of third-party data matching;
  - Impact of premiums on retention;
  - Percentage reached by phone at renewal;
  - Reasons for denials;
  - Reasons for disenrollment; and
  - Rates of re-enrollment of disenrolled children at 3 and 6 months post disenrollment.
- **Asset test.** Research indicates that asset tests are seen as a deterrent to applying for benefits. Asset test also delay eligibility and add to the complexity of the application process for families as well as eligibility staff.[6]

[6] Victoria Wachino and Alice M. Weiss, "Maximizing Kids' Enrollment in Medicaid and SCHIP: What Works in Reaching, Enrolling and Retaining Eligible Children," National Academy for State Health Policy for Robert Wood Johnson Foundation, February 2009. Accessible at: http://www.nashp.org/files/Max_Enroll_Report_FINAL.pdf.

- **CHIP premiums.** The majority of CHIP enrollees pay a premium. While no data was provided assessing the impact of premiums on CHIP enrollment levels, premiums have been found to have a negative impact on enrollment and retention rates.[7] The recent increase in the CHIP premium and imposition of a late fee also could lead to enrollment declines, as some other states have experienced.[8] Information on the impact of the new change would be beneficial.
- **Medicaid eligibility period.** Families must complete the Medicaid redetermination process at least every twelve months. Requiring clients to renew coverage more often than each year increases the complexity of the renewal process which increases the risk that families will fail to retain coverage.
- **DWS Consolidation.** While consolidating responsibility for eligibility and renewal processing under DWS helps to streamline Utah's organizational structure, it is unknown whether this change has had any negative consequences for Medicaid and CHIP clients. In particular, the DWS eligibility workers have traditionally been "generalists" who help clients apply for a variety of social service and health benefit programs rather than specialize by program. DWS's recent initiative to create teams who specialize in health insurance programs indicates that the State is rethinking its "generalist" strategy.

2. Interagency Coordination

Current Approach

CURRENT APPROACHES TO MEDICAID AND CHIP COORDINATION

Utah's organizational structure for children's health programs is similar to other states where functions are performed by different state agencies, and a high degree of coordination is required to make the functioning seamless for families. Medicaid and CHIP are separate programs managed by a single agency, the Department of Health (DOH). Not only is eligibility in a separate agency, DWS, but that agency has local offices across the state, which can lead to variability in how policies and processes are implemented.

In terms of information systems, Utah has some distinct advantages over other states with separate programs. The State uses a single eligibility system for both programs, and each child is assigned a unique client identifier that is used across all health care as well as social services programs. This should give the State good information about transitions between Medicaid and CHIP, a problem discussed with us in other states. DOH staff noted that in the past, movement of children from CHIP to Medicaid has required documentation of citizenship status, [9] but they were not sure how many children successfully completed the transition. Post-CHIPRA, however, this will no longer be the case as the State can enroll the child on Medicaid while required citizenship documentation is pending.

[7] See discussion of the impacts of premiums on Medicaid and CHIP enrollment in Wachino and Weiss, "Maximizing Kids Enrollment."

[8] Laura Summer and Cindy Mann, "Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences and Remedies," The Commonwealth Fund, 2006. Accessible at: http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2006/Jun/Instability-of-Public-Health-Insurance-Coverage-for-Children-and-Their-Families--Causes--Consequence.aspx.

[9] Under the Deficit Reduction Act of 2005 (DRA), all Medicaid applicants must document their citizenship status.

CURRENT APPROACHES TO COORDINATION BETWEEN HEALTH INSURANCE AND OTHER PUBLIC PROGRAMS

DOH coordinates with a limited number of other state agencies that also serve children. Families receiving child care services are matched against DOH eligibility files to identify uninsured children for outreach purposes (income eligibility for child care services (185 percent FPL) is nearly the same as for CHIP). DOH also performs a match against Food Stamps (now called SNAP) enrollment, and just 10 percent of SNAP enrollees are not already covered. The ten percent have been sent a postcard in the past, explaining the availability of health insurance. Currently, SNAP enrollees still must apply for Medicaid, but the State could use CHIPRA's Express Lane Eligibility provision to use eligibility for SNAP to streamline eligibility for Medicaid.

Significantly, Utah is embarking on a collaborative effort on two fronts with the State Office of Education (SOE) to identify and enroll uninsured, eligible children in health care coverage. Initiated with state legislation (House Bill 364), DOH has begun working with Utah's 40 school districts and SOE to identify children enrolled in the Free and Reduced-Price School Lunch (FRSL) program who lack health insurance. After the work with the local districts was underway, the State learned about a SOE initiative that offers the possibility of identifying uninsured children through a statewide basis. Each effort is discussed below.

Because each school district tracks school lunch enrollment independently, DOH surveyed the districts to determine the data collected and how it is captured (e.g., in an Excel spreadsheet) to understand whether sufficient data elements are available that would enable a match with DOH enrollment data. Further, they have identified four school districts willing to pilot a data match with FRSL in the 2009-2010 school year.

DOH worked with SOE to add a question to the FRSL application to identify children needing health insurance coverage. This change is ready to be used for the 2009-2010 school year. DOH staff noted the question wording will likely need refinement in future iterations. In addition, SOE is developing a statewide electronic student record, known as the "Digital Bridge." While the Digital Bridge will not include information about FRSL participation, DOH is working with the Digital Bridge vendor to explore adding information about health insurance status. If captured, this information could be uploaded to eREP and used to identify eligible but uninsured children. Because the Digital Bridge is a statewide system, it would alleviate the need to work with each individual school district to track FRSL enrollment and provide for a single, automated data match between SOE and DOH.

Strengths

- **Collaboration between Medicaid and CHIP staff.** DOH staff who manage Medicaid and CHIP have a good working relationship. Roles are clearly defined, and coordination appears to be working.
- **Collaboration between DOH and DWS appears to support the enrollment and retention of children.** Staff from the two agencies appear to share a common goal of simplifying and streamlining to enroll more eligible families and help them retain coverage.
- **Single client identifier.** The ability to track children across programs using a single client identifier provides Utah with the ability to analyze Medicaid and CHIP enrollment trends as well as additional eligibility matching opportunities with other public benefit programs.

- **Linkage with statewide school data.** With an interface to SOE's Digital Bridge, Utah could be the first state to fully match school and health insurance data. Though it is uncertain how many children will ultimately be enrolled, the lessons learned will be beneficial to Utah and many other states.
- **Linkage with individual school districts.** Progress in several local school districts may soon yield useful information about the potential to use schools for outreach in Utah.

Challenges

- **Linkage with WIC.** Like many other states, Utah has not yet explored potential eligibility matching with the Supplemental Nutrition Program for Women, Infants, and Children (WIC), which is also housed in DOH. WIC covers enrollees with incomes up to 185 percent FPL, similar to Utah's CHIP eligibility level, and it would be worth exploring the overlap between the Medicaid, CHIP, and WIC populations for possible streamlining or to develop an express lane enrollment process. A 2003 pilot project in California found that partnering with WIC increased enrollment in Medicaid and CHIP and reduced the number of WIC participants who lack insurance.[10]

3. Analytic Capacity for Program Management and Decision-Making

Current Approach

Utah's eligibility determination system, PACMIS, has historical enrollment data for Medicaid back to 1988 and for CHIP back to 1998 (the program's inception). The system also includes data on denials and disenrollments of children. In addition, a data warehouse contains useful information for studying insurance patterns, and an annual statewide insurance survey provides information on the uninsured. This information can be a valuable resource to the state as it tries to streamline and simplify coverage. It is particularly well-suited to understanding churning trends, because of the unique identifier that will allow the state to examine movement in and out of coverage over time. Because of recent periods that CHIP has been closed to new enrollment, this type of analysis would have had limited value to the State (the primary barrier being so evident), but going forward, analysis of churning rates should provide useful information about barriers to coverage.

New Initiatives

While many states continue to use outdated information systems, Utah is in the process of replacing PACMIS with a new, rules-based system, known as eREP, which will be implemented in 2009.

[10] Wendy Jacobson, Kristen Testa, Dawn Horner with Laurie True and Diana Woloshin, "Closing Health Insurance Gaps for Children: WIC Can Make It Happen, Findings from a Southern California Pilot Project," The Children's Partnership and California WIC Association for The California Endowment, May 2003. Accessed at: http://www.calwic.org/docs/reports/TCP-WIC_report.pdf.

Strengths

- **Availability of data.** Utah has access to good data on Medicaid and CHIP enrollees, including enrollment and disenrollment history. Use of a single client identifier further enhances Utah's ability to track enrollment and disenrollment trends over time.

Challenges

- **Additional data and analysis needed.** More analyses could be performed to monitor the effectiveness of the programs in enrolling and maintaining coverage, as well as transferring children between programs. In addition, the uncertainty about Medicaid and CHIP enrollment figures (noted earlier) needs to be addressed for the State to use it effectively for program management.
- **Denials, disenrollment, re-enrollment data.** More readily available and complete data on reasons for denials and disenrollment as well as re-enrollment rates could help the state to design new simplifications in the future.

4. Client-Centered Organizational Culture

Current Approach

Utah's choice of application type and location, use of phone calls and e-mail rather than letters, and third-party data matching are examples of the ways in which Utah has made Medicaid and CHIP accessible to eligible families. Eligibility workers believe the recent move to co-locate health insurance with employment-related benefits has helped them reach families who did not know they or their children are eligible for health insurance.

Advocates interviewed noted that DWS historically has had a "gatekeeper" attitude regarding enrollment and retention, particularly in the rural regions of the State. However, they had not heard specific complaints recently.

DWS has been conducting trainings and orientations for eligibility workers that focus on providing clients with a customer-friendly experience. In fact, customer service and prevention, which includes pro-active eligibility, are two of DWS's five strategic goals. DWS has recognized that applicants for health insurance might require more specialized assistance, and created health insurance teams at many sites to work with clients. In addition, DWS has created specialized teams among the eligibility workers to best meet customer needs, including teams comprised entirely of Spanish-speakers and teams who work with refugee populations. Further, workers use customer e-mail addresses, in addition to home/mailing addresses and phone numbers, to ease communication.

As noted earlier, DWS has 54 outstationed eligibility workers located in health care settings, larger school districts, and other key enrollment sites around the state. In addition, staff at DWS Employment Centers conducts outreach activities. They attend community events (e.g., health fairs) and distribute information about programs and to assist with applications at the event.

Because the CHIP program has wider public acceptance than Medicaid, DOH focuses its outreach and marketing activities on CHIP, but understands and expects that many children eligible for Medicaid are reached and enrolled through this outreach. Advocates, however, expressed concern that the lack of focus on Medicaid may lead to fewer children enrolling in coverage. In 2007, Utah launched a "CHIP Van" to conduct statewide outreach and enroll as many children as possible. Since August 2007, 502 applications have been collected directly through the van.

New Initiatives

DOH and DWS are working to improve Medicaid and CHIP enrollee communication. For example, PACMIS used to send letters to clients for each change made in the system, but the State reprogrammed PACMIS to put all letters into the same envelop so the client only receives a single piece of mail. Once eREP is implemented, Utah will be able to send a single letter that covers multiple issues. The State also is working to improve the text of all letters and notifications to make them more reader-friendly. State staff observed that the notices, in particular, are fairly technical in nature.

Strengths

- **Multiple entry points.** Utah's one-stop approach (by locating all eligibility workers within DWS) and on-line applications were designed to be user-friendly and not require assistance.
- **DWS eligibility workers.** Notwithstanding DWS's traditional "gatekeeper" orientation, most advocacy groups interviewed were satisfied that DWS workers are customer-focused and work hard to meet families' needs.

Challenges

- **DWS consolidation.** As noted earlier, the State has not assessed the impacts of consolidating all eligibility staff under DWS nor whether the DWS sites carry a welfare stigma that may deter eligible families from applying. The potential loss of health program expertise also may have a negative impact on Medicaid and CHIP families.
- **Data on enrollee experience**. Utah lacks information about program enrollees' experience with the eligibility and renewal processes (either before the DWS consolidation or afterwards).
- **Performance standards.** DWS supervisors' performance is measured based on application/renewal timeliness and processing standards. State staff acknowledged that this may hinder DWS staff's ability to embrace a customer-oriented culture that focuses on improving enrollment and retention.

5. Non-Governmental Partnerships and Outreach

Current Approach

Overall, Utah's policy and advocacy community is relatively small. Further, there are relatively few CBOs that engage in application assistance activities. The only group the State contracts with for outreach and enrollment assistance is Communidades Unidas (CU), a CBO focused on the Latino

population, to conduct targeted outreach and education, including door-to-door outreach activities. There is no data on their effectiveness, and CU staff was not available during the site visit or via phone. While the 2008 state budget included funding for DOH to provide "mini-grants" to community-based organizations (CBOs) to improve multi-cultural outreach and client education about health insurance, these funds were eliminated in the Fall 2008 special legislative session. Federal funding may help fill the gap.

Efforts to partner with the Native American population have been mixed. State staff recognize the importance of outreach to Native Americans who represent less than 1 percent of Utah's population but have very high rates (over 60 percent) of uninsurance. The CHIP Van has attended some events on the reservations, and the Indian Health Advisory Board (which is staffed by Medicaid and CHIP staff) advises DOH on issues related to Native Americans, including Medicaid and CHIP. To increase outreach and enrollment in Medicaid and CHIP, DOH has offered enrollment assistance, but State staff report that tribal leadership has requested funding (rather than staff) in order to conduct the eligibility determination process.

The State does communicate with a variety of advocacy groups through the Covering Kids and Families Coalition, which is very interested in the linkage between health insurance and data collected by schools.

New Initiatives

Voices for Utah's Children is exploring partnering with the 13 Mexican "Home Town Clubs" located in Salt Lake City. These organizations serve as community-gathering places for local Hispanics and offer the ability for individual contact locations considered safe-havens for this population.

Strengths

- **Advocacy partnerships.** The State has good relationships with Utah's key advocacy organizations, and advocates interviewed recognized the State as a valued partner with strong program leadership.
- **State staff.** State staff is more involved in outreach activities than many other states. State staff reported having held many successful outreach events like the enrollment marathon (an "enroll-a-thon") with eligibility staff, their own staff, and with other community partners. The State tracks the type and location of each event, the number of applications collected, and the number of families they talk to.

Challenges

- **Small CBO community.** Utah has relatively few CBOs. While this may not be easily addressed, engaging community organizations in outreach, enrollment and retention activities

has been shown to improve program enrollment.[11] Further, it does not appear that Utah's managed care organizations (MCOs) or providers are heavily involved in retention, although other states have found this to be a valuable strategy.[12]

- **Low rates of enrollment among Native American and Hispanic children require more deliberate outreach efforts.**

6. State Leadership

Current Approach

Utah's political leadership is supportive of coverage for children. Governor Huntsman is committed to reducing the number of eligible but uninsured children by half by 2012, and the legislature has a Health System Reform Task Force which is examining opportunities for coverage. The Governor's Child and Family Cabinet Council looks at a variety of issues affecting Utah's children and families, including health care. Council members include the Governor and the executive directors of every relevant state agency, including DOH, DWS, and DOE. According to State staff, health program enrollment is a priority for this group. In addition, the Governor's office receives monthly enrollment data and holds regular meetings (often monthly) on health reform and enrollment maximization. The legislature is updated as requested regarding health coverage. According to State staff, this usually occurs two or three times per year.

Utah has a conservative group of legislators who emphasize the need for personal responsibility in health and human service policies and programs. They tend to favor public-private or market approaches to coverage. One interviewee commented that the legislature views CHIP as a program designed to help families transition to self-sufficiency.

Significantly, the legislature passed several bills in 2008 related to health coverage:

- House Bill 326 – Mandated that CHIP remain open (the State has had to close enrollment for budget reasons during prior years) and increased ongoing funding available to CHIP. Several interviewees described this as making CHIP an entitlement program.
- House Bill 362 – As noted earlier, this bill required DOH, DWS and SOE to collaborate closely and identify children who qualify for the school lunch program but lack health insurance coverage.
- House Bill 133 – Established a legislative task force to examine the current health care system (setting the stage for health reform). This bill also allows UPP members to obtain access to employer-sponsored coverage without having to wait for open enrollment and directs DOH to seek federal approval to expand UPP to include individual policies.

[11] See, for example, Laurie E. Felland and Andrea M. Benoit, "Communities Play Key Role in Extending Public health Insurance to Children," Center for Studying Health Systems Change, 2001 (accessible at: http://www.hschange.com/CONTENT/377/); Michael J. Perry, "Promoting Public Health Insurance for Children," *The Future of Children* 13, no. 5, Spring 2003 (accessible at: http://www.princeton.edu/futureofchildren/publications/docs/13_01_12.pdf); and Christopher Trenholm, "Expanding Coverage for Children: the Santa Clara County Children's Health Initiative," Mathematica Policy Research, Inc., 2004 (accessible at: http://www.mathematica-mpr.com/publications/pdfs/chiexpandcov.pdf).

[12] See, for example, Pat Redmond, "Medicaid and SCHIP retention in Challenging Times: Strategies from Managed Care Organizations," Center on Budget and Policy Priorities, 2005 (accessible at: http://www.cbpp.org/archiveSite/9-13-05health.pdf).

- House Bill 131 – Established the "mini-grants" for private entities that provide community-based services to low-income populations and to people underserved by the health care system. As noted above, however, these grants were eliminated in the Fall 2008 special legislative session.

As of early 2009, the State's budget had not suffered as badly as some other states', and eligibility, benefit, and rate reductions were not under consideration at the time of the assessment. As of Fall 2009, state officials report ARRA prevented Medicaid eligibility cuts for adults. Some Medicaid benefits (primarily adult and dental) were cut, and many provider rates were reduced. Of note for children, a special add-on for Medicaid's dental rates for children was eliminated. There were no major eligibility benefits or rate reductions for CHIP.

New Initiatives

In the most recent Utah legislative session (which concluded earlier in 2009), both houses passed separate legislation eliminating the five-year waiting period for Medicaid and CHIP enrollment for certain legal immigrants. While the bills did not make it to conference, Utah's advocacy community is hopeful that the legislation will be enacted next year. Advocates estimate that such a change could result in the enrollment of an additional 1,000 children legally residing in the U.S.

Strengths

- **Legislative support.** Most recent legislative activities demonstrate strong support for children's coverage. In particular, one advocate described requiring CHIP to remain open to enrollees as a "sea change." This change not only decreases the number of uninsured but also counteracts some of the uncertainty with which the program may have been viewed by eligible families.
- **Detailed level of engagement**. A number of legislators are engaged in coverage policy at a detailed level, including championing legislation to create linkages between the schools, Medicaid and CHIP.
- **Gubernatorial support**. Governor Huntsman was clearly engaged in efforts to expand coverage. He set an enrollment target and tracked progress towards getting all eligible children enrolled.

Challenges

- **Gubernatorial transition.** As of this writing, the Governor's office is in transition as Governor Huntsman was appointed U.S. Ambassador to China in August 2009. The former Lieutenant Governor has assumed the governorship, but it is too early to know whether he will be a strong supporter of children's coverage.

- **Immigration policies.** Advocacy organizations interviewed commented on Utah's stringent immigrant policies (e.g., undocumented residents are not permitted to apply for a driver's

license, and local police can choose to enforce federal anti-immigration laws). Although there is no direct tie to children's coverage, families may be reluctant to apply for coverage, and mixed status families may be particularly hesitant about any contact with the State.

Opportunities

Based on our understanding of Utah's current practices, systems and administrative structure, the following opportunities could help the State realize its goal of expanding coverage to eligible children:

Produce data to guide future program changes and outreach efforts. Utah has a rich set of Medicaid and CHIP eligibility data available for analysis, and DOH could make greater use of existing data to understand the remaining barriers to coverage.

1. To better understand disenrollment and churning:
    a. Conduct an analysis of the characteristics of children who have been enrolled in Medicaid or CHIP but are now disenrolled. Analyze the reasons for disenrollment, including differentiating between administrative (e.g., failed to document income) and eligibility (e.g., gained private insurance) reasons, and hassle factors (e.g., failed to pay premium).
    b. Identify children who might still be eligible and identify changes that could have kept them in the program. Consider targeted outreach to re-enroll them, while making changes that eliminate the barriers they faced.
    c. Analyze the number of children who are churning – that is, who leave Medicaid or CHIP and return within three (or six) months. Look for particular predictors of churning that are amenable to change, such as premium levels. Determine whether children who use services are churning and consider using contact with the health system as an occasion for renewing eligibility.
    d. Explore the possibility of broadening streamlined renewal.
2. To better understand barriers faced by new applicants:
    a. Determine, if possible, the likely eligibility of children who start but do not complete an application (ie, abandoned applications), assuming sufficient information for these children is retained in the system. This analysis could be used to understand the most common reasons applications are abandoned.
    b. Determine the characteristics of children who apply on paper, in person, or online. Look for patterns (e.g., are people who need assistance non-English speakers or immigrants?) that may help plan future outreach efforts.
3. Design standard reports to allow DOH and other interested parties to track information routinely that will contribute to coverage policies. Enrollment, retention and churning data would be valuable at both a statewide and regional level. Other important data stratifications would include premium level, age, race/ethnicity, and health status. Transparency can help gain support for the program.
4. Measure the impact of any recent or upcoming policy changes and outreach activities (e.g., the increase in the CHIP premium, school enrollment events).

Learn more from families who have tried to enroll and retain coverage about what worked and didn't work for them. Also speak with families who appear eligible but have not applied for coverage to learn what shapes their decisions. Focus groups could be useful for getting at the following types of questions, as well as market testing new ideas:

- What barriers do consumers experience in applying for and renewing coverage (e.g., attitudes and beliefs about health insurance; willingness to pay for health insurance; fear of government; unwillingness to enroll in a government program; etc.)?
- Is it better to retain a "medical-only application" and an "all public programs" application, or is it better to consolidate into one application? Is the one-page screener application useful? Effective?
- Does variation across DWS offices in terms of application assistance provide insights about current and future enrollment and retention strategies (e.g., self-service with intern to assist clients vs. paper vs. full assistance)?
- Is there a market for premium assistance given that less than half of Utah's employers offer health insurance to their employees; or should Utah be exploring options for providing premium assistance to private health insurance or COBRA plans?

Continue to expand partnerships with SOE and schools.

1. Look for new opportunities in the DOH-SOE partnership; for example, consider whether new CHIPRA rules (as CMS releases its guidance) will permit more streamlined eligibility determination and enrollment with the FRLP.
2. Document the lessons learned from the Fall 2009 school lunch pilot, to help guide future expansions. Efforts such as these can be delayed for many reasons (e.g., work on data sharing agreements, designing new outreach materials, evaluating the implementation and outcomes), and it will be important to identify and address barriers as they arise.

Consider expanding outreach activities, including adding new partners. The CBO community is fairly small, and CBOs and consumer advocates have a fairly limited involvement in identifying and enrolling eligible children.

1. Given the limited availability of CBOs and advocates, there may be a greater role for community health centers, hospitals, and health plans to play in outreach and enrollment. Each type of organization benefits from children covered continuously, which may make this a win-win solution for the State to help expand outreach and improve enrollment and retention.
2. Many states have worked with CBOs that work with specific target populations (e.g., ethnically-based, geographically-based) to find and assist eligible families. While the "mini-grants" were eliminated, DOH should still look for opportunities to build relationships with organizations such as the Mexican "Home Town Clubs" and with the Native American tribes. In the latter case, the State will need to explore how best to address tribal concerns about the eligibility and retention processes. DOH also could consider reviving the mini-grants (depending on resource availability) to support existing CBOs or encourage the development of new CBOs.

Appendix I:

Diagnostic Assessment Interview Participants

Name/Title	Organization
Michael Hales, Medicaid Director	DOH
Nathan Checketts, CHIP Director and Assistant Medicaid Director	DOH
Emma Chacon, Director	Bureau of Access, DOH
Aaron Eliason, Contract/Grant Analyst	Bureau of Access, DOH
Norman Thurston, Health Policy & Reform Initiatives Coordinator	DOH
Bev Graham, Director	Bureau of Eligibility Policy, DOH
Gayleen Henderson, Research Consultant	Bureau of Access, DOH
Nan Streeter, Director	Maternal and Child Health Bureau, DOH
Yvette Woodland, Medical Program Manager	DWS
Brent Newren, Eligibility Office Manager	Metro Employment Center, DWS
Carol Good, Paul Dihahn, Brenda Duvall, Eligibility staff	Metro Employment Center, DWS
The Honorable Jim Dunnigan	Utah House of Representatives
The Honorable Kory Holdaway	Utah House of Representatives
Sheila Walsh-McDonald, Health Care Advocate	Salt Lake Community Action Program
Judi Hilman, Executive Director	Utah Health Policy Project
Lincoln Nehring, Medicaid Policy Director	Utah Health Policy Project
Karen Crompton, Executive Director	Voices for Utah Children

Appendix II:

Data on Utah Children's Enrollment in Medicaid and CHIP

Table 1. 5-Year Enrollment Trends for Children

	Number of Children				
	2003	2004	2005	2006	2007
Medicaid Enrollees					
Total	165,265	176,931	183,810	180,263	170,771
New	78,257	80,268	80,603	73,579	72,801
Disenrolled	62,049	67,019	71,501	76,521	71,100
SCHIP Enrollees					
Total	35,482	36,147	47,770	51,119	48,057
New	9,887	10,426	25,531	17,304	17,562
Disenrolled	9,773	13,523	13,921	20,221	19,591
Retention Rates					
Medicaid	62.45%	62.12%	61.10%	57.55%	58.37%
SCHIP	72.46%	62.59%	70.86%	60.44%	59.23%

SOURCE: UDOH Data Warehouse, 2009

Table 2. 5-Year Uninsured Trends for Children

Uninsured Children	2003	2004	2005	2006	2007
All uninsured children	56,900	66,800	71,300	89,500	87,800
Eligible but not enrolled	42,100	48,600	52,400	67,800	59,800

SOURCE: UDOH Data Warehouse, 2009

Table 3. Characteristics of Children by Insurance Status and Eligibility for Public Programs

	Number of Children				
	Total Children	Total Insured	Total Uninsured	Uninsured, Eligible for Public Program** (200%)	Enrolled in Public Coverage
Age					
0-5	331,026	301,291	29,736	13,150	59,189
6-18	563,271	498,521	64,749	31,702	73,302
Race/Ethnicity					
Hispanic	130,003	103,113	26,891	18,304	31,613
White, NH	716,502	654,124	62,379	21,876	92,301
Black, NH	NA	NA	NA	NA	NA
Asian, NH	NA	NA	NA	NA	NA
Other/Mult, NH	26,660	22,460	4,200	4,200	6,341
TOTAL	894,296	799,812	94,484	44,852	132,491
Poverty***					
0-99%	95,229	77,944	17,285	17,285	46,925
100%-199%	186,635	159,069	27,567	27,567	50,468
200%-299%	209,200	186,849	22,351	--	9,807
> 300%	397,418	371,734	25,684	--	24,891
TOTAL	888,481	795,596	92,886	44,852	132,090

SOURCE: SHADAC estimates of CPS-ASEC 2008 and 2009
**Eligibility defined as below 200% FPL. This is different than eligibility as defined in statute
*** Poverty estimates apply to the poverty universe: all unrelated children under the age of 15 have been excluded.ble e
NA: Not enough sample to provide estimates
NH: Non-Hispanics