

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

*A Maximizing Enrollment for Kids Diagnostic Assessment Series*

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*A product of the  
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*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.*

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# Executive Summary

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*In February 2009, Wisconsin 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 the 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 improvement in Wisconsin's enrollment and retention of eligible children.

## *Findings*

Wisconsin has taken significant steps toward reaching the Governor's goal that at least 98 percent of the state's population has access to affordable health insurance. Health care reforms enacted in 2007 and implemented as BadgerCare Plus (BC+) beginning in 2008 expanded coverage to all uninsured children regardless of income level, further raising the visibility of the program and reducing stigma. Based on site visit interviews, review of materials provided by Wisconsin, and knowledge of best practices across the states, the following themes emerged:

- **Wisconsin is a leader in making its health insurance programs seamless and transparent for the public.** As part of Wisconsin's 2008 health care reforms, the Department of Health Services (DHS) consolidated Wisconsin's health care and nutrition programs under a single health care safety net called "ForwardHealth." DHS also consolidated eligibility criteria across 20 categories of family coverage. The state's ACCESS website portal further facilitates coordination across the spectrum of ForwardHealth programs and other agencies. The ACCESS portal provides eligibility information, application tools and account management for applicants, community partners and providers.
- **Achieving the full potential of the ACCESS website portal for online enrollment (and renewal) requires key changes: expanding and empowering the pool of community partners and adopting policies that can make online enrollment a paperless system.** It appears that for some clients one-on-one assistance may be essential to navigating the online application. Wisconsin has made concerted efforts to expand the pool of "community access points" by engaging providers and community organizations to become authorized enrollment assisters and participate in express enrollment for children and pregnant women. Community partners also need tools, such as the ability to scan and submit verification documents with applications, and Wisconsin is making plans for this to occur.
- **Families will be more successful in enrolling if the burden of verification is shifted from families to the state.** Like other application models, online applications typically require the applicant to take additional steps to provide proof of income or citizenship/identity. This creates a risk that an application will be delayed or denied for being incomplete. This issue will

continue with the introduction of online renewals, which are significantly higher in volume than applications. Shifting the burden from families to the state to produce verification of required information, and otherwise reducing the follow up steps required to complete an application, are necessary to maximize enrollment of eligible children. This will also reduce the number of children who are disenrolled due to a procedural closure rather than for being ineligible.

- **Expectations that parents actively participate in renewal may be impeding the state's pursuit of strategies that would improve retention.** Parents are expected to play an active role in renewal, and officials view parents' non-compliance as the primary cause of churning.
- **Data that describe reasons for denials and case closures are not being effectively utilized to help in program simplification and streamlining.** Local Income Maintenance (IM) agencies do not have access to information about denials and terminations for the purposes of process improvement, and state officials are finding the data inconsistent and difficult to use for program management purposes.

Based on our understanding of Wisconsin's current practices, systems and administrative structure, we believe the following may provide the best opportunities for the State to move closer to its goal of maximizing coverage to eligible children:

- Further enhance the convenience and ease of use of online enrollment.
- Study churning patterns in BC+ and develop strategies to reduce churning rates.
- Develop a long-term strategy for improving accountability of local IM agencies through creation of standardized performance measures, including measures of procedural denials and closures.
- Consider reducing renewal burdens for families.
- Strengthen DHS's communication feedback loop with providers and advocates.

# Introduction

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*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 Wisconsin.

The economic and political environment at the time of this assessment (March - June 2009) provides important context for understanding the status of children's health insurance programs and the opportunities emphasized 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 about the next three years. There was an enormous tension in most states about how to maintain access to insurance and still balance the budget.

On February 4, 2009, Congress passed the Children's Health Insurance Program Reauthorization Act (CHIPRA), a law reauthorizing the Children's Health Insurance Program (CHIP) until 2013, increasing funding for the program and outreach activities for eligible but unenrolled children and creating new financial incentives for states that increase enrollment and adopt key enrollment simplification strategies. Two weeks later on February 17, 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 2008, 2009 and 2010 was included, contingent upon states not reducing Medicaid eligibility levels from 2008 levels.

The tension of the recession and the opportunities to obtain new funding for simplifications and expansions serve as a backdrop for the state assessments.

# Methodology

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*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 covering key components of enrollment and renewal practices and outcomes outlined in 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 Wisconsin are listed in Appendix I.

The findings in this report are based on information collected from the state, a recent review of the literature,<sup>1</sup> 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 also be administratively and politically feasible.

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

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<sup>1</sup> 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](http://www.nashp.org/files/Max_Enroll_Report_FINAL.pdf).

# About Wisconsin's Health Insurance Programs for Children

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*Generous eligibility standards* paired with robust enrollment strategies contribute to Wisconsin having one of the lowest rates of uninsured children in the country. The latest federal statistics estimate Wisconsin's uninsured rate for children to be 5.8 percent.<sup>2</sup> According to the most recent annual state survey, five percent of Wisconsin's children were uninsured in 2007, down from eight percent in 2006.<sup>3</sup> The uninsured rates were higher for black children (seven percent) compared to white children (four percent) in 2007, and for children in poor families (eight percent), and near poor families (between 100 percent and 199 percent of FPL) (ten percent) compared to children in families with incomes 200 percent of FPL and above (three percent). (See Appendix II, Table 2).

Wisconsin implemented major health care reforms in 2008 to expand access to health insurance to children, pregnant women, low-income parents and caretaker relatives, young adults exiting foster care, and self-employed and farmer families. The health insurance programs for these groups are collectively known as BadgerCare Plus (BC+), and include coverage for children through age 18, regardless of income. Children in families with income below 200 percent FPL pay no premium. Children in families with incomes at or above 200 percent FPL pay a sliding scale premium. For children above 300 percent FPL, families must pay the full cost of BC+. The state also extends BC+ eligibility to non-citizen, pregnant women under 300 percent FPL, and their "unborn children," through two months after the last date of pregnancy. Crowd-out provisions exclude some children from families with incomes over 150 percent FPL, who have access to employer-sponsored insurance (ESI). However, these children can qualify for BC+ by meeting a spenddown.

In April 2009, presumptive eligibility was expanded to allow providers to enroll children ages 1 through 5 with incomes at or below 185 percent FPL; children ages 6 through 18 at or below 150 percent FPL, and children under age 1 with family incomes at or below 250 percent FPL.<sup>4</sup> Also in 2009, Wisconsin began the rollout of the BadgerCare Plus Core Plan, health insurance for childless adults under 200 percent FPL.

Additionally, Wisconsin offers a Health Insurance Premium Payment (HIPP) program for families enrolled in BC+ who have access to employer-sponsored insurance. The state will pay the employee's share of the premium, deductibles, coinsurance, and services not covered under the employer's plan if it is more cost-effective rather than enrolling the family into a BC+ health plan. As part of the BC+ health care reforms, HIPP was expanded to all BC+ families.

## ***Enrollment in Public Health Insurance Programs***

Enrollment of children in BC+ has increased since eligibility for coverage was expanded in February 2008. At that time, enrollment was just under 300,000. By March 2009, enrollment exceeded 354,000. Eighty-eight percent of enrolled children have a family income below 150 percent FPL. Fewer than 3 percent of enrolled children are in income groups that require premium payment. (See Appendix II, Tables 1 and 3).

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<sup>2</sup> KFF State Health Facts, 2007-2008, CPS analysis.

<sup>3</sup> 2007 Family Health Survey, Bureau of Health Information and Policy, Division of Public Health, Wisconsin Department of Health Services.

<sup>4</sup> Forward Health Update, March 2009, No. 2009-11.

## *Applying for and Renewing Coverage*

Wisconsin has a unified application and eligibility process for all BC+ programs. Applicants may submit an application via the Internet, by applying in person at their local income maintenance (IM) or tribal office, by mail, or over the phone with an IM worker. IM workers make an eligibility determination, which can not be completed until required verification is obtained. For applications submitted online or completed by phone, families may need to send required verification by mail or fax. Families may also obtain assistance completing an application from authorized community partners, such as public health department clinics, community health clinics, and advocacy organizations.

An annual renewal notice is mailed to families 45 days prior to the recertification deadline. BC+ members may respond to a renewal notice by mail, by visiting their local IM office or by phone. A parent or guardian of a covered child must contact the IM office in response to the notice within a specified period for the IM worker to begin processing a review. Otherwise, the IM office will send a termination notice. Terminated coverage can be reinstated without reapplying if the member responds with required information within the calendar month after enrollment ends.

## *Leadership and Political Context*

The Department of Health Services (DHS) administers BC+, which includes all of Wisconsin's public health insurance programs, including Medicaid and CHIP, as well as FoodShare, the state's Supplemental Nutrition Assistance Program (SNAP), formerly called Food Stamps. CHIP funding is used to expand the Medicaid program. The Department contracts with 72 local IM agencies, which employ county workers, and seven Native American tribes to conduct eligibility determinations and renewals for BC+.

The Governor and Legislature have a long tradition of championing access to health insurance coverage for children and families. The health care reforms initiated by Governor Doyle in 2006 that led to BadgerCare Plus passed the legislature with the expectation of being cost-neutral to the state budget, at least in the first few years, through administrative and other savings. Higher unemployment rates during this economic downturn, and perhaps an underestimate of eligible, uninsured children, combined with a strong marketing campaign have led to higher than expected enrollment in BC+. State budget challenges may lead officials to reduce provider payment rates or increase prior authorization requirements, but will not affect children's eligibility for coverage in BC+, according to DHS officials.

## *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:

### **Enrollment Strategies**

- Make the online application on the ACCESS website portal fully available in Spanish (now completed).

- Enable Community Partners to scan and submit documentation to county IM agencies.
- Conduct the state's next Family Health Survey with a larger oversampling of uninsured low-income children to further identify their geographic locations for future outreach efforts.
- Further engage providers and community partners in identifying and enrolling hard to reach groups including children of immigrant workers and rural families.

### **Renewal Strategies**

- Implement online BC+ renewal for children and families.
- Generate pre-populated renewal forms to make mail, phone or in-person renewal easier for families.
- Improve readability and clarity of application and renewal requirements so that parents can better comply with policies and regulations.
- Expand email communication to families through the Check My Benefits function of the ACCESS website.

# Findings from the Diagnostic Assessment

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## *1. Enrollment and Renewal Processes and Policies*

### **Current Approach to Enrollment**

Families can apply for children's coverage via the Internet, by applying in person at their local IM office, by mail, or over the phone with an IM worker. In mid-2004, Wisconsin launched ACCESS, an Internet portal for applying online to any of its public health insurance programs and assistance with food. As of February 2009, the Internet accounted for 39 percent of BC+ applications, while mail accounted for 15 percent. The proportion of applications submitted in person at a local IM agency accounted for 39 percent of applications as well. The monthly volume of phone applications has remained steady and comprised just 7 percent of applications since the start of ACCESS.<sup>5</sup>

### **30-DAY APPLICATION PROCESSING STANDARD**

In most IM agencies, an individual worker handles each case through the entire application and eligibility determination process. The state standard for an eligibility determination is 30 days, though the window can be extended 10 more days if the worker is waiting on information from the applicant. The worker must deny an application if verification of income or other required items is not provided within this timeframe.

### **ONLINE ENROLLMENT OPTION**

The ACCESS Internet portal allows individuals and authorized community partners to perform four activities related to enrollment:

- Identify programs for which family members are likely eligible,
- Apply for a program,
- Check the status of their benefits, and
- Report changes about their address, family composition, income, etc.

The "Am I Eligible?" screener directs clients through a series of questions about their income and family composition (including names of individual family members), using colorful icons and first names to help guide applicants in providing answers, and then returns a summary of which programs each individual, by name, is likely eligible for, as well as an estimate of any monthly premium that will be required. The summary also explains that individuals have a right to apply for any program they wish, regardless of screener results.

A separate tool "Apply for Benefits" is used to submit applications. Applicants may apply for BC+, FoodShare, Family Planning or Medicaid long-term care through the ACCESS website. A "progress" bar lets the applicant know the percentage of the application completed after each entry. An applicant may start, save and return to ACCESS to complete the online application at a later time after setting

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<sup>5</sup> From percentages that DHS provided in the pre-site visit interview. The DHS process map for applications provides a slightly different set of percentages: on-line 35 to 40 percent; mail-in: 35 percent; phone: 10 percent; in-person: 20 percent.

up an online account. Finally, applicants have the option of printing the summary of their submitted application or saving it in PDF format. If people prefer a paper form, they can get it from the DHS website or pick it up at a local agency, fill it out and submit by mail or in person.

The directions for applying online mention the agency's "need to get proof of some of the answers," noting that the applicant will need to "talk with a worker over the phone or in person" (for FoodShare applications) and that "your local agency will call you or send a letter about this."

## SHARED RESPONSIBILITIES FOR VERIFICATION OF REQUIRED INFORMATION

Unless submitted online, a caseworker manually enters data from the application or interactive interview into CARES, the eligibility system for all BC+ programs, FoodShare and TANF programs. An eligibility determination requires proof of social security number, citizenship/identity, income and, for some applicants, health insurance access and coverage. The IM worker must use all available data exchanges and available database queries to verify information rather than requiring the applicant to provide it. Data systems to which IM workers have access for conducting third-party data matching include:

- Employment;
- Unemployment benefits;
- Social Security;
- Birth query;
- DMV (Department of Motor Vehicles);
- SAVE (Systematic Alien Verification for Entitlements);
- KIDS (child support payment system); and
- interChange (MMIS fiscal payment system).

CARES can complete some of these electronic verifications but many of these systems do not automatically populate fields in CARES and must be initiated by IM workers. Wisconsin does not have data on the percentage of applications that are completed using third-party data matching, but they were able to report that it is common for IM workers to need to contact the applicant to acquire missing, unverified eligibility information. Caseworkers first attempt to reach the applicant by phone about required information, and if they cannot reach the applicant, they send a letter detailing the information or documents needed. The program recently revised beneficiary notices to improve readability and customer-friendliness.

According to BC+ policies and procedures, applicants may submit documentation "by mail, fax, e-mail, through another electronic device, or through an authorized representative." Currently, ACCESS does not have the capacity to allow members to send emails directly to their caseworkers. However, IM workers can receive emails from members using their regular email services. The policies also state that "...the member has primary responsibility for providing verification and resolving questionable information."

For applicants whose income appears to exceed 150 percent FPL, access to or coverage on ESI (Employer-sponsored insurance) must be determined before making an eligibility determination. DHS established a centrally administered Employer Verification of Health Insurance (EVHI) database,

which has information on 16,000 firms as of August 2009. If the employer's insurance information is not in the database, a request for information is mailed to the employer. Employers have 30 days to respond, but a caseworker has the ability to override a system's response or request an individual follow-up if information seems to be conflicting between an applicant and employer. Policies state that applicants should not be denied coverage based on a lack of employer verification of health insurance access.

## **EXPRESS ENROLLMENT FOR CHILDREN**

Reforms introduced with BC+ included expansion of presumptive eligibility, which in Wisconsin is called "express enrollment" and allows providers to temporarily enroll children and pregnant women who appear eligible for coverage. Originally, the program targeted children from families with incomes of 150 percent of FPL or below, but was expanded in April, 2009, to children ages 1 through 5 with incomes at or below 185 percent FPL and to children under age 1 with family incomes at or below 250 percent FPL.<sup>6</sup> Children from ages 6 to 18 remain eligible for express enrollment up to 150 percent of FPL.

Parents or guardians are asked to complete a regular BC+ application within 60 days of the date of the provider visit to avoid a gap in enrollment. If the application has been submitted but not processed before the end of the second month, the local IM agency extends temporary enrollment by one more month. A child who is signed up for BC+ through a provider but does not submit the application within the 60 day enrollment period, will face a 12-month lockout from express enrollment; however, the child's family can apply for ongoing enrollment at any time.

The proportion of children approved for express enrollment who complete the enrollment process and become insured appears relatively low based on available data. DHS data for 2008 showed the proportion of ongoing enrollments dropped from 46 percent in March 2008 to 15 percent in November and 16 percent in December. The rate of temporary enrollments that led to regular enrollment averaged 25 percent between February 2008 and February 2009. More recent data showed that the number of children approved for express enrollment was 410 in each of February and March, 2009, but was just 223 in June.

## **FIRST PREMIUM PAYMENT REQUIRED IN ADVANCE OF ENROLLMENT IN BC+**

For children applying for BC+ whose income is above 200 percent FPL—currently less than three percent (fewer than 10,000) of enrolled children—the first premium payment must be made before the eligibility can be confirmed. If a family fails to make the first premium payment within the allowable time period, coverage will be denied, with exceptions for "good cause" reasons. Maintaining BC+ eligibility includes keeping premium payments up to date, as long as income remains above 200 percent FPL.

In ongoing cases, children are automatically disenrolled for payment failure at the end of the month in which payment was not received. If a family remits the late payment within a 60-day grace period, the IM agency can reinstate eligibility. If no payment is made, a family is placed in a restrictive reenrollment period for 6 months. There are good cause reasons, such as a drop in income (below 200 percent FPL), that are grounds for immediate re-enrollment.

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<sup>6</sup> ForwardHealth Update, March 2009, No. 2009-11.

Premiums begin at \$10 per child for families between 200 percent FPL and 230 percent FPL and go up to \$97.53. Premium-paying members can make payments in cash, by check, money order, auto-debit and electronic fund transfers—all standard payment methods except credit card. HP Enterprise Services (formerly EDS) is the payment processing vendor statewide, and is responsible for tracking premium payments.

## **Current Approach to Renewal and Retention**

Families have the option of completing a child's annual BC+ review (renewal) by mail, in-person at their local IM office, or by calling their case worker. Most renewals (80 percent) are completed by mail or in person.

### **45-DAY RENEWAL WINDOW**

CARES automatically mails an annual renewal notice about 45 days before the anniversary of enrollment. The notice directs the parent or guardian to contact the IM office within 30 days to trigger the actual case review by the IM worker. (Applications will still be processed after that deadline, as long as they are received within a calendar month after the closure.) If the family does not respond, CARES will send a second notice indicating risk of closure. Subsequently, the case will be closed for either non-response or response that indicates the child is no longer eligible (e.g., if they have private insurance or aged out). Dane County staff reported that roughly half of all their cases close because clients fail to return necessary forms or provide information needed to verify income within processing time deadlines.

### **MAINTAINING COVERAGE**

If the parent or guardian responds to the renewal notice that they want to keep coverage, the IM worker reviews the case and may call the member to obtain any required but missing information, or may search a third-party data base. The review is similar to the application process, with items mandatory for verification limited to income, and health insurance access and coverage for children with family incomes above 150 percent FPL. If a family's income has risen above 150 percent FPL since the last eligibility determination, this information is transmitted to interChange (MMIS system supported by EDS) which will generate premium coupons to be mailed to the member, and coverage will continue as long as premium payments continue on a timely basis.

Wisconsin has implemented annual renewals for BC+ but not 12-months continuous eligibility. BC+ enrollees are required to report changes (e.g., new address, changes in living arrangements, or family composition) within 10 days. Income changes must be reported when income exceeds the following thresholds: 100 percent FPL, 150 percent FPL, 200 percent FPL, 250 percent FPL, and 300 percent FPL.

## **New Initiatives**

The Department expects the ACCESS portal to play a larger role in BC+ eligibility including adding an online renewal capability pre-populated with available client information. Plans are also underway to pre-populate mailed renewal forms and to use an interactive voice recognition (IVR) system.

According to Dane County officials, registered community partners will have the ability to scan citizenship/identity and income documents via self-service ACCESS kiosks by early 2010.

A full Spanish-language version of the ACCESS Internet portal is now available for all services and features.

## Strengths

BC+ has a number of features that promote coverage and enhance enrollment opportunities for eligible children:<sup>7</sup>

- **Eligibility for all uninsured children.** Expanding subsidized coverage for all uninsured children, regardless of income, promoted enrollment of eligible kids in a number of ways. It raised the visibility of the program for low-income families who may have believed their income was too high to make them eligible. Most of the newly enrolled children since the launch of BC+ have incomes below 150 percent FPL, and in fact, enrollment exceeded expectations. Not having income level limits allows promotion of an “all kids” marketing message, which in turn helps minimize any remaining stigma about BC+.<sup>8</sup>
- **ACCESS online portal.** The ACCESS portal provides eligibility information, application tools and account management for applicants, community partners and providers online, making the program and eligibility criteria transparent to potential applicants. ACCESS has strong support from BC+ stakeholders and its usage for enrollment has been steadily rising.
- **Simplified eligibility criteria.** Wisconsin eliminated a number of income tests, removed confusing income disregards and deductions and consolidated eligibility criteria across 20 categories of family coverage, with input from advocates and the public.
- **Third-party data matching.** IM workers can perform third-party data matches through a variety of information systems, as listed above. Information about the success rates on specific systems is not tracked.

## Challenges

Despite the many improvements and simplifications Wisconsin has implemented, the burden is still on the family to understand and comply with a number of remaining enrollment or renewal hurdles.

- **Application assistance.** A number of interviewees commented on the importance of having one-on-one assistance available to help clients navigate the online application. Based on an on-site demonstration, completing the application online appears to require some sophistication, despite the availability of a “Help” screen on each page. An ACCESS application takes between 40 and 60 minutes to complete. Wisconsin will likely need to expand the number of “community access points” to facilitate online enrollment and renewal.

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<sup>7</sup> The strategies listed here appear to promote coverage and enhance enrollment and renewal, and are being evaluated by University of Wisconsin in Madison Population Health Institute. Additional strategies not highlighted in this assessment may also contribute to successful enrollment and renewal.

<sup>8</sup> Katharine E. Wittgert. BadgerCare Plus: Medicaid and Subsidies Under One Umbrella. (Washington, D.C.: National Academy of State Health Policy, /Robert Wood Johnson Foundation, 2009)

- **Clarity of online application.** The on-site demonstration highlighted some of the confusion that applicants may experience interpreting some questions. This is particularly the case when an applicant is applying for both BC+ and FoodShare since the latter requires more detailed and personal information. The trade off of making it convenient for families to enroll in both BC+ and FoodShare simultaneously—for which Wisconsin is a national leader—is that the more invasive questions related to SNAP benefits may detract some applicants from completing the application. Wisconsin has employed focus groups to test ACCESS questions in efforts to reduce requests for information to the minimum required.
- **Documentation requirements.** Online enrollment requires applicants to provide proof of income or citizenship/identity, and online renewal will require updated proof of income. At both junctures, documentation can create another opportunity for an application to be delayed or denied for being incomplete.
- **Completion rates for online applications.** A few interviewees speculated that ACCESS online applications are incomplete more often than paper applications; however, data do not exist to explore this issue.

A strong emphasis on parental responsibility is a barrier to further streamlining renewal.

- **Approach to reducing churning.** Churning is viewed by state officials as primarily a problem of parental non-compliance. Complexity of the process is a secondary issue. Strategies, therefore, emphasize enhancing compliance, for example mailing out a renewal form with pre-populated information rather than reducing the parents' role by exploring administrative or passive renewal. Paradoxically, not opening letters and notices from the agency was mentioned as a common reason why children become disenrolled. State officials report that an online review workgroup is looking into more passive and triaged approaches to renewal.
- **Active renewal.** The agency's philosophy is that parents should play an active role in renewal. Active renewal by parents prevents BC+ from making monthly managed care payments for children who are no longer eligible, or not aware of their active status.
- **Lack of continuous eligibility.** DHS officials expressed interest in exploring 12-month continuous eligibility for all children; currently it is available only for infants up to age one. State officials' preliminary analysis indicates that Wisconsin needs a statutory language change to allow all children to have 12 months of continuous eligibility. Research from other states suggests that additional spending associated with continuous eligibility may be offset by decreases in administrative costs associated with churning, and that it also promotes continuity of care, an important aspect of quality.<sup>9</sup> Wisconsin could study the experiences of other states with continuous eligibility that have implemented administrative functions to ensure that children who move out of state or age out are appropriately disenrolled.
- **Approach to income documentation.** Five years ago DHS had a self-declaration of income policy, but it was discontinued due to a high FoodShare error rate.

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<sup>9</sup> Program Design Snapshot: 12-months Continuous Eligibility, Center for Children and Families, March, 2009. <http://ccf.georgetown.edu/index/cms-filesystem-action?file=strategy+center/ceprogram+snapshot.pdf>

- **Decreasing rates of temporary enrollment that leads to regular BC+ coverage.** It is important to understand why the portion of children with approved express enrollment that subsequently applied for regular Medicaid declined from a peak of 46 percent in March 2008 to 16 percent by December 2008, based on data provided in the pre-site visit questionnaire. An examination of trends prior to the rollout of BC+, and since December 2009 may reveal whether this has been part of a larger trend, and whether outcomes have leveled off, reversed or continued. Of those children temporarily enrolled, the requirement of completing a full application may be a barrier to formal enrollment in BC+ after temporary enrollment ends. Additionally, some families may not fully understand that express enrollment is temporary.
- **Administrative costs of premium requirements.** More information is needed about the cost of administrative efforts to administer and collect premiums compared to the benefits, as failure to pay premiums may be a significant cause of disenrollment among families required to pay them. Local officials described the process as time-consuming for eligibility workers and burdensome to enforce for such a small percentage of clients. Virginia found that the administrative costs of collecting premiums in CHIP was greater than the total amount collected in premiums; the state paid \$1.39 for every \$1.00 collected.<sup>10</sup>

## *2. Interagency Coordination*

### **Current Approach**

#### **COORDINATION OF HEALTH INSURANCE, NUTRITION AND PUBLIC HEALTH PROGRAMS WITHIN DHS**

As part of Wisconsin's 2008 health care reforms, the Department of Health Services consolidated Wisconsin's health care and nutrition programs under a single umbrella called "ForwardHealth." ForwardHealth includes BC+, which itself is the brand name for family Medicaid programs, BadgerCare (Wisconsin's CHIP program), and Healthy Start (for children under age 6). ForwardHealth also includes the family planning waiver and FoodShare, Wisconsin's SNAP program, which is administered by DHS. As noted earlier, eligibility determinations for BC+ and FoodShare are made in the same eligibility system (CARES).

As a result of reorganization under DHS there is greater potential to coordinate eligibility determinations across programs than there was previously. Currently, 93 percent of children eligible for FoodShare are enrolled in Medicaid, and 60 percent of children eligible for BC+ (Medicaid) are enrolled in FoodShare. Similarly, coordination with WIC applications may identify more eligible children.

WIC office staff determine eligibility for WIC program, which has similar income eligibility levels as BC+. DHS officials expressed interest in improving the opportunities to enroll eligible children in BC+ when they come to the attention of WIC case workers. Adoption of the express lane eligibility option created under CHIPRA, may make coordination even easier. Local public health departments are also active partners with BC+ staff in outreach and application assistance through the ACCESS portal.

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<sup>10</sup> Laura Summer and Cindy Mann. *Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies.* (Washington, D.C.: The Commonwealth Fund, 2006).

## COORDINATION BETWEEN DHS AND OTHER STATE AGENCIES

DHS officials identified the child care assistance program, housed in the Department of Children and Families (DCF), as a potential source for identifying and enrolling eligible, uninsured children into BC+. At least 80 percent of children eligible for child care may also be eligible for BC+.

Program officials would also like to explore access to state income tax data as another source for identifying uninsured, eligible children to enroll in BC+.

## COORDINATION WITH SCHOOLS

The Covering Kids and Families coalition has been working with selected school districts on a three-year pilot (the CHILD project) to connect children eligible for the free and reduced school lunch program to BC+. Approaches vary by school district because Wisconsin's school districts are decentralized, fairly autonomous entities. Some efforts have included a place on the school lunch application to indicate health insurance status, while others simply refer identified, eligible children to the local IM agency for assistance. Interviewed DHS officials were somewhat familiar with the CHILD project but not directly involved in it.

## Strengths

The DHS organizational and information system infrastructures are well-organized to maximize opportunities to identify and enroll children eligible for BC+ through other programs.

- **Coordination with nutrition programs.** Including FoodShare and other nutrition programs in the ForwardHealth umbrella and the ACCESS portal sends an important signal to stakeholders and clients that nutrition is an integral part of health. The coordination also greatly increases the likelihood that families seeking enrollment in one program will have an opportunity to enroll in the other.
- **ACCESS portal links within and across agencies.** The ACCESS portal further facilitates coordination across the spectrum of ForwardHealth programs and other agencies. DHS has made considerable efforts to include links on its ForwardHealth website pages to other DCF programs. There may be opportunities to have DCF add links from its website pages to the BC+ or ACCESS website.
- **WIC program is part of DHS.** Because the WIC program is part of DHS and interest in coordination is high, express lane enrollment may be an efficient way to enroll WIC enrollees in BC+. A 2003 pilot project in California found that partnering with WIC can increase enrollment in Medicaid and CHIP, and fewer WIC participants reported having no insurance.<sup>11</sup>
- **Positioned to extend a single identifier across programs.** DHS has a single identification number, or Master Customer Index (MCI), for matching clients across all ForwardHealth programs. The agency appears to be in a strong position to pursue its interest in extending the MCI to other DHS programs and to other social service programs as well. Doing so could

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<sup>11</sup> Wendy Jacobson, Kristen Testa, Dawn Horner, 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](http://www.calwic.org/docs/reports/TCP-WIC_report.pdf).

provide efficiencies in identifying children eligible for BC+ through other programs such as WIC, child welfare, child care assistance, W-2 (TANF). The agency has a strong partnership with its ACCESS contractor, Deloitte, to help facilitate such an endeavor.

## Challenges

- **There is a need for more information on potential benefits and resource demands of data matching.** Wisconsin has identified a number of coordination opportunities, but has not yet conducted preliminary matches between programs to determine the number of children who would benefit, the level of effort required by the state, and the possible costs. Such information would be valuable for the state to ascertain before proceeding with large-scale data matching efforts.
- **School-based outreach has many challenges.** With Wisconsin's low uninsured rate for children, most eligible but uninsured children in BC+ may already be known to the system, but experiencing a time uninsured because of churning—a problem that coordination is not well-targeted to solve. Using the schools and/or the Free and Reduced School Lunch program to identify eligible but uninsured children requires extensive outreach, as we have seen in Illinois and New York. Given the variation and often complete lack of electronic capabilities at the local level, as the CHILD project has demonstrated, the potential of school-based data as a source of reliable information for identifying eligible, uninsured children may be limited without a statewide electronic student record. However, Wisconsin may want to follow progress being made in Utah to implement this approach.

## *3. Analytic Capacity for Program Management and Decision-Making*

### Current Approach

As part of their regular public communication about the status of BC+, DHS publishes reports on monthly enrollment figures including by age, poverty level, premium payment, and other categories such as continuously eligible newborns. Information is also available about the mode of applications and use of ACCESS, as described in Section 1 to allow officials to monitor statewide trends in how applicants submit applications.

### MONTHLY DENIAL AND CLOSURE REPORTS

DHS officials reported that while data exist to track application completion and abandonment rates, they are not routinely making use of it for program management.

DHS hasn't been monitoring closure and denial reasons in a structured way. While there are many codes in CARES and they all are standard and defined, case workers at local IM agencies may not be following the same process to note all reason codes affecting family's eligibility. To be used for program management and analysis, these codes would need to be standardized to distinguish procedural denials and closures from those due to a determination of ineligibility.

## INFORMATION ABOUT CHURNING

DHS officials do not routinely track rates of re-entry of children who are disenrolled for reasons not related to loss of eligibility, a problem known as churning. The most recent data available were from 2003 to 2005, in which a special study found that 27 percent of children in Medicaid/BadgerCare lost their eligibility and had a gap in coverage. The average gap in coverage for Medicaid/BC children was 5 months and the median gap was 3 months. These figures are consistent with those found in studies of churning in other states.

## ANALYTIC CAPACITY BY COUNTY

DHS also lacks other types of management information about local IM enrollment and renewal operations, and information available is not considered reliable.

## UNINSURED RATES

Since 1989, the Department has administered the Wisconsin Family Health Survey (FHS) on an annual basis. The FHS surveys a random sample of families via a telephonic interview. Because Wisconsin has made great strides in covering low-income children (the estimated uninsured rate of children is about 2 percent<sup>12</sup>), the survey sample size is not sufficient to capture reliable data on the remaining uninsured low-income families in the state. As a result, the Department relies on anecdotal reports from advocates about the characteristics of the remaining children who may be eligible but not enrolled, many of whom are believed to be citizen children in migrant or immigrant families.

## Strengths

Wisconsin appears to have significant analytical capacity from the CARES eligibility system and its ACCESS portal to develop performance measures and management reports that could be valuable tools for informing program leadership, communicating with local supervisors and establishing performance goals for local IM agencies and Native American tribes.

- **Capacity to track application and retention metrics.** Because all ForwardHealth programs function under the single CARES eligibility system, which assigns a unique identifier to each client, DHS should have the capacity to longitudinally track important metrics related to retention, such as the percentage of children who reapply for BC+ within 60 or 90 days after their case is closed. DHS officials expressed interest in measuring procedural closures. Through the ACCESS portal and CARES, DHS is able to track modes of application submissions over time, and has the capacity to use this information for planning and resource allocation purposes.

## Challenges

DHS does not have a history of working closely with local IM offices in setting performance and reporting standards. Lack of accountability is hindering DHS efforts to assess the successes and failures of current processes and make uniform improvements.

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<sup>12</sup> Family Health Survey, 2007. Available at <http://dhs.wisconsin.gov/stats/familyhealthsurvey.htm>.

- **Standardizing measures across local IM offices.** Creating new measures and standardizing current measures could improve understanding of application and review barriers, and identify opportunities to simplify and streamline processes, improving enrollment and retention of children. Incremental changes that build on short-term successes could be an effective strategy, with a long-term commitment from program leadership. However, one DHS official stated that piloting changes in a few local IM agencies is not a useful exercise for testing statewide changes because differences among local agencies would not permit results to be transferrable.
- **Maximizing use of existing data.** Although it has the capacity to use data for program management, DHS is not currently using data to its fullest capacity.
- **Need for data about uninsured children.** Lack of concrete information about uninsured children poses challenges, as DHS officials indicated in their MaxEnroll grant application. They identified oversampling low-income children in the state’s survey of uninsured as a priority. The recent release of American Community Survey data may shed further light in this area.

## 4. *Client-Centered Organizational Culture*

### Current Approach

The implementation of the ACCESS portal, the many health care reforms embedded in the BC+ program, and the expanded role of providers and community organizations in application assistance have made Wisconsin’s health insurance programs for children more visible and more convenient for families to gain access to an application and to apply for the program.

Internally, DHS has made efforts to change its language to more customer-friendly terms such as referring to recipients as “members” and changing presumptive eligibility to “express enrollment.” However, terms such as “adverse actions” are still part of the vernacular.

### ACCOUNTABILITY FOR COUNTY IM OFFICES

County and tribal Income Maintenance (IM) workers handle eligibility and renewal for BC+. They are the face of the ForwardHealth programs DHS administers. While Wisconsin has made BC+ a popular public health insurance program, separate from welfare—in a state that was the model for national welfare-to-work reforms—DHS officials recognize that some IM workers and local agencies still view themselves as gatekeepers, rather than enrollment facilitators.

DHS’s primary tool for program accountability is a contract with each IM agency. The contract requires new IM employees to participate in training developed and provided by DHS or its contractors, and experienced IM workers to participate in annual refresher courses. IM agencies are also required to submit to DHS on a quarterly basis standardized customer feedback forms completed by applicants or members. Results are included in an annual IM Agency performance evaluation.

DHS does not hold local IM agencies accountable for performance based on maximizing enrollment or retention of eligible children. Performance standards related to BC+ are limited to “timely case processing” and payment accuracy standards. Dane County IM supervisors reflected these expectations in their conversations during the site visit. Failure to comply with contractual standards or requirements may lead DHS to require a corrective action plan.

## MILWAUKEE COUNTY

The state's experience with Milwaukee County revealed the worst-case scenario of an accountability system for local IM agencies that, contractually speaking, responds only to failure. DHS is taking over local operations in Milwaukee County as a result of a settlement agreement stemming from a class-action lawsuit that found failures in administration of FoodShare, Medical Assistance and BadgerCare Plus in the county. Penalties had been assessed earlier, but "didn't work" according to one state official.

## EFFECTS OF CURRENT ECONOMIC ENVIRONMENT

The economic downturn is taking a toll, as local agencies experience an increase in workloads at the same time that revenue and staff levels are stagnant or declining. Interest in policies or procedures that could make enrollment and renewal more streamlined for BC+ members was tempered by concerns among IM staff that such changes would lead to increased workloads at a time when counties are struggling with a "record number of unduplicated cases." Administrative renewal strategies were generally not viewed as a means to increasing efficiencies, even though some states have found they have decreased churning, thereby reducing workloads.

## New Initiatives

The BC+ expansion to childless adults is carried out by the Enrollment Services Center (ESC), which is a centrally operated entity staffed by state employees and vendor staff. Childless adults must apply for health and nutrition assistance online or by phone through the ESC rather than applying at a local IM agency. IM agencies may refer people to apply through ESC. From a processing perspective, the biggest innovation at ESC is telephonic signature: people applying via phone give a verbal attestation to information provided, which is recorded electronically and attached to their specific case. No mail-in applications are allowed. During the first months of ESC operation, about 86 percent of applications were received through ACCESS and 14 percent via telephone.

In Milwaukee County, due to a settlement agreement of the lawsuit, the Department is assuming direct responsibility for the administration of income maintenance programs. This project is being implemented in phases. In May of 2009, the Department staff started processing all applications submitted via ACCESS. In July of 2009, the Department assumed responsibility for the Change Call Center. On January 1, 2010, the Department will have direct responsibility of all income maintenance operations in Milwaukee county. The general principal of "direct responsibility" is that managers will be state employees and all other employees will be county employees. Childless adults residing in Milwaukee County, like other childless adults in the state, apply for benefits through the ESC.

## Strengths

The state takeover of Milwaukee County IM operations, while due to unfortunate circumstances, offers DHS an opportunity to create a new model of management accountability with a local office. The ESC could also provide valuable information about centrally managed enrollment processing where almost all interactions with applicants are either through ACCESS or via phone.

- **Ability to develop new performance metrics.** With direct authority over Milwaukee County IM employees, DHS could develop and test new performance metrics and management reports that are used to recognize and reward enrollment and retention of eligible children.
- **Milwaukee as a model for counties.** Experiences and results with Milwaukee could be used to advance more standardization across counties.

## Challenges

The state currently faces several barriers that inhibit its ability to affect the organizational culture of local IM agencies.

- **Independence of local agencies.** The lack of direct authority over local agencies contributes to turf issues among DHS, or local agencies or their association (as represented by the IMAC, the Income Maintenance Advisory Committee) that may impede efforts to standardize and streamline performance measures. However, there is an infrastructure in place for regular communication between DHS and IMAC that could be an avenue for these discussions.
- **Division of responsibility between counties and the State.** Commenting on the state taking over the most populous county's operations and directly managing the childless adult program, along with a trend toward online applications and community-based partners to assist applicants, one state official asked rhetorically, "What is the role of County government?" Another question that the state may face is how to work effectively with counties to ensure an efficient allocation of resources within communities and across the state. Supporting county-provider co-location partnerships, as described in Section five, may be one such example.

## 5. Non-Governmental Partnerships and Outreach

### Current Approach

#### EXPANDING THE POOL OF COMMUNITY PARTNERS

A growing network of more than 200 community partners (clinics, community-based organizations) conduct client outreach and provide application assistance across the state, help with verifications, and help answer general questions. These entities are a vital link between clients and the program, often more trusted by the client than the local IM agency. This is especially true for immigrant/mixed-status families who may not be comfortable approaching a government office to obtain social benefits.

With the expansion of Express Enrollment, the state has been recruiting qualified health care providers as well as community groups to enroll eligible but uninsured children. During the first six months of 2009, about 300 children per month enrolled through express enrollment.<sup>13</sup>

In a number of counties, the local agency out-sources IM workers to local provider sites under agreements with individual providers, in which the provider reimburses the local agency. Coordination in setting up and maintaining these agreements occurs on an informal/ad hoc basis. There is interest in expanding this model in Dane County.

<sup>13</sup> ForwardHealth Enrollment reports accessible at:

<https://www.ForwardHealth.wi.gov/wiportal/Tab/42/icscontent/Member/caseloads/enrollment/enrollment.htm.spage>.

## OUTREACH

DHS has been successful in working with community partners to implement targeted outreach efforts to promote and market new program features and expansions. For example, DHS worked with community partners to conduct a BC+ marketing campaign in 2008, which included distributing 500,000 pieces of marketing materials (e.g., brochures, wallet cards, posters, magnets, pencils) through various agencies and local providers.

## CHILD HEALTH ADVOCACY

Wisconsin's advocacy community considers the state to be a good partner in the work to expand health care coverage. The Department's usual practice is to convene an advisory panel on an ad hoc basis for a specific project, rather than regularly consult a standing committee or advisory group. For example, the Department created the BadgerCare Plus Advisory Committee to provide input during the programs' creation, but it no longer meets on a regular basis.

There is no formal, standing statewide advisory group or commission that provides advice to DHS on children's health insurance issues. While some feel the ad hoc, as needed approach is efficient and appropriate, others would like the state to create a standing advisory group to ensure regular access to program leadership, and more avenues for stakeholders to provide input and feedback. At the same time, DHS officials meet regularly with a variety of organizations and committees, such as the Medical Assistance Advisory Committee, the Clinical Advisory Committee on Health and Emerging Technology, and the Income Maintenance Advisory Committee and its subcommittees.

## New Initiatives

To improve BC+ outreach in rural areas and expand enrollment to hard-to-reach populations, DHS provided time-limited "mini-grants" to selected community partners starting in 2008. Participating organizations were eligible to receive \$50 for each successful application. At the time of the site visit, the Department was planning to allow participating organizations to use grant funds to offset related administrative costs as well, based on the way other contractors report their administrative expenses. The grants were scheduled to sunset in June 2009, and another round of state funding seems unlikely given the current budget situation.

## Strengths

DHS has a wealth of goodwill to draw upon from community partners, providers and advocacy groups.

- **Openness to advocate and public input.** DHS officials have a track record of being receptive to ideas from advocates for improving their public health insurance programs and incorporated extensive public input as BC+ was being designed.
- **Relationships with FQHCs.** DHS has good relations with provider organizations and safety net providers, namely federally qualified health centers (FQHCs), who believe they could be more effective partners with feedback on their efforts to express enroll or assist in the application submission of the children they serve.

- **Collaboration on CHIPRA opportunities.** The advocacy community is interested in supporting Wisconsin's efforts to maximize funding opportunities through CHIPRA.
- **School-based outreach partnerships.** A state official identified school nurses as a strong and well-respected voice for children's coverage because they are often on the front lines of serving uninsured school-age children. They are a valuable partner in school-based outreach initiatives.

## Challenges

- **The absence of more ongoing feedback loops for engaging stakeholders may undermine the state's efforts to include outside voices.**<sup>14</sup> Without a formal infrastructure for a regular exchange of information and concerns between DHS and advocates, the Department may miss opportunities to better understand and respond timely and effectively to families' concerns or needs. The lack of a standing BC+ advisory group may reflect an overall lack of organization among Wisconsin's advocacy groups, which are not viewed as cohesive. As one interviewee stated, "It's as good as it has needed to be." Others believe much more could be accomplished with better organization among the advocacy community itself. Advocates for the aging may serve as a potential model for children's health advocates.
- **State budget constraints prevent dedicated funding to community-based organizations for on-going outreach and application assistance, which could help reach populations who may be geographically, linguistically or culturally isolated.**
  - Migrant families in rural farm communities may not have access to news or media in their native language, and public service announcements about BC+ (e.g., radio) target urban centers.
  - Word of mouth through churches and ministries is a primary source of information for Hispanics.
  - Public institutions, such as libraries, which may offer Internet access are intimidating for some families.
  - Traditional county or community-based social services agencies may not offer services outside of work hours or transportation may be unavailable.

## 6. State Leadership

### Current Approach

Although BadgerCare Plus (BC+) has exceeded the state's budget projections during a time of economic hardship, Governor Doyle (D) remains fully committed to the program and his goal of providing access to insurance to 98 percent of Wisconsin's population. He "has a strong, moral belief that covering kids is the right thing to do," said one official. Program leadership anticipates budget cuts to BC+ but do not expect any changes to eligibility or expansion plans. Instead, the current budget debate is likely to result in provider rate cuts and/or more stringent prior authorization

<sup>14</sup> "Seven Steps Toward State Success in Covering Children Continuously," National Academy for State Health Policy. October 2006.

requirements. However, DHS officials expressed confidence that spending reductions would not result in any meaningful reductions in BC+ members' access to health care.

Policy changes and proposals tend to “percolate up” to the Governor’s staff from DHS leadership. The Governor relies heavily on DHS leadership for policy guidance. The administration works closely with the legislature to keep members informed of planned changes or concerns, regardless of whether they require formal legislative approval to implement. DHS staff produces a monthly report that includes BC+ enrollment statistics for the Governor and participates in in-person briefings as requested. For the legislature, DHS provides updates during hearings and on an “as-needed basis” via the Department’s legislative liaison. However, legislators’ perceptions of BC+ are influenced by feedback from constituents, and key stakeholders such as health plans, provider organizations and county officials.

State officials suggested incremental approaches, and changes that do not require a change in statute tend to be easier to achieve. “Making the business case” to show the cost-effectiveness of a proposed initiative is also very important to winning administrative and legislative support.

## New Initiatives

In the legislature, a bill was introduced and passed in the current session to allow children to remain on their parents’ health insurance until age 27.

## Strengths

Much of Wisconsin’s success in achieving high rates of insurance stems from a history of executive and legislative leadership that places a high value on insurance, particularly for children.

- **Longtime statewide commitment to public coverage.** The State has long considered government-sponsored insurance an important avenue of coverage for low-income children, which is recognized in its decision to make CHIP an extension of Medicaid rather than a separate program. BC+ enjoys a high level of recognition and support from the general public, providers and health plans.
- **Current political support for coverage expansions.** Governor Doyle and the Democratically-led legislature work well together. Despite significant budgetary constraints, both the administration and legislature remain supportive of continuing to build on the coverage expansions of BC+, including the childless adult expansion, which offers another statewide opportunity to promote the family of BC+ programs.

## Challenges

With the extensive expansions in eligibility as well as simplifications and streamlining that have resulted with the implementation of BC+, attention has been rightly focused on outreach and enrollment. Maximizing enrollment for eligible children will require more attention to barriers that families face maintaining and renewing coverage for their children.

- **Potential concerns about administrative renewal policies.** Examining results from other states may help to alleviate concerns about PERM requirements and potential over-payment of managed care premiums that may otherwise inhibit progress in reducing churning.
- **Concerns about crowd-out policies.** Because the state has a relatively high level of employer-based coverage, public crowd-out of private coverage is a concern. Crowd-out policies were narrowed in BC+ reforms, but child health advocates remain concerned that the simpler, more consistent crowd-out policies still impose a hardship on families who cannot afford ESI, even when it is offered.

## *Opportunities*

Based on our assessment of Wisconsin's current practices, systems and administrative structure, we have identified the following opportunities for maximizing enrollment of eligible children:

1. **Collect and analyze data on churning rates.** Study churning patterns in BC+ and develop strategies to reduce churning rates. Share information with the Governor's office and the legislature about the cost-benefit trade-offs to build political support for streamlining and simplifications.
  - a. Define measures for churning rates and develop a routine report on churning by county that can be used as a management information tool for discussion about its scope, causes and possible strategies to retain more eligible children.
  - b. Explore opportunities to maximize the use of third-party data sources to verify information required for determining eligibility in order to reduce opportunities for closures due to incomplete information.
  - c. Study the experiences of other states that have adopted administrative or other passive renewal strategies to better understand the trade-offs of administrative savings and greater continuity of coverage against higher payment error rates and premium payments. Make the business case to the Governor's administration for reducing churning.
  - d. Examine denials or closures based on premium payment failures, and study the cost-effectiveness of the revised premium payment policies.
  - e. Examine denials or closures based on access to private coverage, and study the cost-effectiveness of the revised crowd-out policies.
2. **Consider reducing renewal burden for families.** Model the effects of shifting the renewal burden away from families, such as through administrative or ex parte renewal. Some information on likely rates of retention can be gathered from other grantee states, including Louisiana, Illinois, and New York.
3. **Increase accountability of local IM agencies.**
  - a. Consider ways to build performance measures into the DHS-county contract that can be used to recognize and reward enrollment and retention of eligible children.
  - b. Implement standardized reporting of performance measures across county agencies that can be used in management reports as a performance improvement tool.

**4. Further enhance the convenience and ease of use of online enrollment.**

- a. Provide individuals and community partners the ability to scan and attach documents when submitting an application online, and or to email scanned documents.

**5. Consider ways to strengthen DHS's communication feedback loop with providers and advocates.**

- a. Consider alternative strategies for ensuring that advocates have regular, planned opportunities to offer feedback and solicit information about BC+.
- b. Work with providers to develop procedures that allow them to obtain access to information about the status of a case after completing an express enrollment, in exchange for following up with the patient to complete enrollment.
- c. Work with providers and advocates and other stakeholders to develop a way to reduce the efforts required by parents to formally enroll their children after applying for BC+ through express enrollment.

## Appendix I:

### *Diagnostic Assessment Interview Participants*

<b>Name/Title</b>	<b>Organization</b>
Jason Helgeson, Director, Medicaid	Department of Health Services (DHS)
Jim Jones, Deputy Director, Medicaid	DHS
Angie Dombrowicki, Director, Bureau of Enrollment Management	DHS
Vicki Jessup, Policy Section Chief, Bureau of Enrollment Management	DHS
Amy Mendel-Clemens, Section Chief, Outreach and Communications, Bureau of Enrollment Management	DHS
Jim Vavra, Director, Bureau of Benefits Management	DHS
Patrick Hickey, Director	Workers' Rights Center
Lynsey Ray, Program Development Director	Wisconsin Primary Health Care Association
Anthony Sis, Associate Division Manager	Economic Assistance & Work Services, Dane County Dept. of Human Services
Jon Peacock, Research Director	Wisconsin Council on Children & Families
Seth Mandel, Consultant	Deloitte Consulting
Bobby Peterson, Executive Director	ABC for Health, Inc.
Rachael Currans-Sheehan, Legislative Liaison	Department of Health Services
Coral Butson, Policy Liaison to DHS	Governor's Office

## Appendix II:

### *Data on Children's Coverage*

**Table 1. 5-Year Enrollment Trends for BadgerCare Plus**

	Number of Children				
	2003	2004	2005	2006	2007
Medicaid and SCHIP programs, adults and children					
Average Monthly Enrollment	475,591	485,727	491,348	498,087	559,879
Average Monthly Retention	404,617	404,267	409,231	418,667	529,289
Average Monthly Closures	44,305	45,978	46,762	48,797	36,018

*SOURCE:* Numbers shown were averaged from monthly data provided by DHS. Enrollment data extracted from the interchange system. These files are run the last Friday of every month. Retention and closure numbers were extracted from the Wisconsin CARES eligibility system.

*DEFINITIONS:*

Closure numbers were generated by using the number of individuals with a closure on file effective that month. The numbers may be overstated as individuals that changed subprograms are also reflected in these closures. Note that the 2008 monthly average excluded February because that month cases were "closed" as part of the conversion to the new BadgerCare Plus program.

Retention numbers were identified by looking at all open individuals in the current month and comparing that information to the open cases for the previous month.

**Table 2. 5-Year Uninsured Trends for Children (0-17)**

	Number of Children			
	2004	2005	2006	2007
Uninsured Children				
All uninsured children	34,000	38,000	48,000	31,000
Eligible but not enrolled	19,000 (uninsured, below 200% FPL)	23,500 (uninsured, below 200% FPL)	35,000 (uninsured, below 200% FPL)	31,000 (uninsured, no income limit since BC+ doesn't have an income limit for children)

*SOURCE:* 2007 Family Health Survey, Bureau of Health Information and Policy, DPH, DHS. Special tabulation for Milda Aksamitauskas. Prepared by Eleanor Cautley April 13, 2009.

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

	Number of Children							
	Total Children (Family Health Survey, 2007 data)	Insured All of Past Year (Family Health Survey, 2007 data)		Uninsured All of Past Year (Family Health Survey, 2007 data)		Uninsured, Eligible for Public Program (assuming uninsured children meet all non-financial rules, 2007 data)		Enrolled in Public Coverage (2009 March enrollment administrative data)
	Estimate	Estimate	C.I.*	Estimate	C.I.*	Estimate	C.I.*	
<b>Age</b>								
0-18	1,402,000	1,328,000	±30,000	35,000	±12,000	35,000	±12,000	354,767
<b>Race/Ethnicity</b>								
African Am./Black, Non-Hispanic	96,000	88,000	±13,000	3,000	±2,000	3,000	±2,000	N/A
White, Non-Hispanic	1,115,000	1,062,000	±34,000	27,000	±10,000	27,000	±10,000	N/A
Hispanic	82,000	70,000	±18,000	6,000	±5,000	6,000	±5,000	N/A
<b>Poverty</b>								
<100 FPL	133,000	122,000	±20,000	5,000	±5,000	5,000	±5,000	229,994
100% to 199% FPL	248,000	221,000	±27,000	10,000	±5,000	10,000	±5,000	89,327
200% to 299% FPL	286,000	274,000	±29,000	3,000	±3,000	3,000	±3,000	6,095 (200-250%)
300% + FPL	652,000	632,000	±37,000	16,000	±9,000	16,000	±9,000	3,480 (250%+)
Unknown	82,000	79,000	±16,000	1,000	±2,000	1,000	±2,000	N/A

**Notes on data from the Family Health Survey:** The Family Health Survey is a random sample telephone survey conducted each year by the Department of Health Services. A stratified random sample of all residential landline telephone numbers is called by trained interviewers during the months of February through December. An oversample of African American residents is part of each sample.

The adult who knows the most about the health of all household members is asked all of the survey questions, providing answers on behalf of everyone living in the household. During 2007, a total of 2,685 households were interviewed with an overall response rate of 49 percent. These households included 1,796 children under the age of 19.

The final cleaned data set was weighted to adjust for sampling rates, nonresponse, and multiple telephone numbers. The sample was then weighted (post-stratified) using official household population estimates for July 1, 2006.

Ethnicity and race information is collected according to federal Office of Management and Budget guidelines, allowing for multiple races and asking about Hispanic ethnicity prior to asking about race. The sample size for children under age 19 is sufficient to report non-Hispanic African American (n=178), non-Hispanic White (n=1,389) and Hispanic (n=92). Other race groups are too small to provide reliable estimates.

The survey includes several questions about total household income during the previous calendar year. The specific questions asked vary by number of household members, and are designed to provide information about household poverty levels (i.e., annual income in relationship to household size). This survey measure of poverty status approximates the federal poverty guidelines (published annually in the Federal Register). The 2006 federal poverty guidelines, for example, define poverty for a family of three as an annual income below \$16,600, while the Family Health Survey defines poverty for a household of three as an annual income below \$17,000. About 5 percent of households refused to answer the income questions, and some information was imputed for another 5 percent.

In 2007, the sample ages 0-18 included 196 children below 100 percent Federal Poverty Level (FPL), 322 children in households with 100-199 percent FPL, 368 children at 200-299 percent FPL, 796 children at 300 percent or greater FPL, and 114 children with insufficient information to code poverty status.

Compared to results from the 2007 American Community Survey, the Family Health Survey underestimates poverty among children in Wisconsin. The ACS estimates that 14.4 percent of children under age 18 were poor in 2007 (about 187,000 children) while the FHS estimates 10 percent were poor (about 129,000 children). This difference is likely due to several reasons, including larger incomes among respondents as compared to non-respondents, the lack of cell-phone-only households in the sample, and perhaps a tendency to overestimate total household income on the part of some respondents.

Respondents are asked a number of questions about current health insurance coverage as well as coverage over the past 12 months. Children who had continuous health insurance coverage (of any type) through the past 12 months are estimated in the table (“Insured All of Past Year”) along with children who had no insurance at all for 12 consecutive months (“Uninsured All of Past Year”).

**Notes about BC+ income:** In BadgerCare Plus, gross income is used to determine eligibility. Here are several examples of types of income that are not included in the countable income when determining eligibility for BC+: Adoption Assistance; Combat Pay; Disaster and Emergency Assistance; Earned Income of minors; Jury Duty Payments; Kinship Care; Life Insurance policy dividends; Payments to Native Americans; Refugee Cash Assistance; Student Financial Aids; Tax Refunds (Income and EITC).