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Seven Steps Toward State Success in Covering Children Continuously

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In March 2006, the National Academy for State Health Policy (NASHP) convened a small invitational symposium on child health coverage. The symposium, *Continuously Covering all Kids: State Action and Ideas for the Future,* was supported by the David and Lucile Packard Foundation and the Robert Wood Johnson Foundation.

A select group of state and national public and private sector experts were invited to review progress and generate ideas for further achievements in covering all children and youth continuously. The ideas and perspectives in the conversation included those of state health agencies, foundations, managed care organizations, research groups, and the federal government.

NASHP designed the symposium to have two distinct sets of discussions. During the first half day, participants reviewed and discussed recent progress and remaining barriers for states in reducing numbers of uninsured children and youth. During the second half day, participants generated and discussed ideas about restructuring child health coverage to move closer to a goal of covering all children and youth continuously. NASHP will issue a paper discussing these latter ideas in the future.

Over the past decade, with the implementation of the State Children's Health Insurance Program (SCHIP), expansions in Medicaid, and state and local innovations in outreach, enrollment, and renewal, states have achieved many successes in increasing health coverage for children. The push to enroll children in SCHIP has led to increased enrollment levels in Medicaid as well.[1] Nationally, the rate of uninsurance among children has declined from 15.0 percent in 1997 to 11.2 percent in 2005, even as rates of employer sponsored insurance have declined.[2]

Despite this progress, much work still needs to be done to increase the number and proportion of children and adolescents who have health insurance coverage – public or private – on a continuous basis. Disparities in child coverage still exist among socio-economic levels,

with children from families with lower incomes experiencing lower rates of insurance. Coverage disparities also exist across racial and ethnic groups. In 2004, 21.1 percent of non-White Hispanic children, 13 percent of Black children, 9 percent of Asian children, and 7.6 percent of non-Hispanic White children were uninsured. A greater percentage of older children also tend to be uninsured compared to younger children, and immigrant children have higher levels of uninsurance than native and naturalized citizen children. Over the past few years, employer-sponsored insurance for children has decreased at a higher rate than for adults. Overall, more than 60% of those children who are uninsured are eligible for public programs such as Medicaid or the State Children's Health Insurance Program (SCHIP), but are not enrolled. Reasons for not being enrolled can include lack of awareness, difficulty completing the necessary paperwork, or "churning," which occurs when children are repeatedly dropped and re-enrolled due to short eligibility periods, lengthy re-enrollment processes, and complex paperwork.[3]

This brief summarizes key suggestions which emerged during the symposium discussion about lessons learned over the past decade of state efforts to increase rates of child health coverage. These ideas do not necessarily reflect the opinions of all symposium participants, but rather themes in the discussion. Meeting highlights are supplemented with additional information from the current literature, and examples from states.

KEEP ENROLLMENT AND RENEWAL PROCEDURES SIMPLE

Research and anecdotal accounts from symposium participants indicate that the biggest hurdle to getting and keeping children on public programs such as Medicaid and SCHIP is the complexity of the enrollment and renewal process. Therefore, one key to keeping children and youth covered is to keep the enrollment and renewal process simple – that is, minimize the barriers to completing an application or renewing coverage. This makes it easier to get children on the rolls and to keep them on. Reducing the amount of documentation and providing mail-in or phone-based alternatives to in-person application and renewal are some of the ways in which these processes can be simplified.

Symposium experts believed that the two most important simplifications that are available to states for federal child health coverage programs are 12 month continuous eligibility and administrative or "passive" renewal processes. According to NASHP survey data, as of 2005, 16 states with Medicaid expansion SCHIP programs were using 12-month continuous eligibility standards, allowing families to retain coverage for a full year, regardless of changes in income or other factors. In addition, nearly all separate SCHIP programs (27 out of 33) were using continuous eligibility.[4] Instituting a continuous eligibility policy reduces an agency's administrative load, since staff does not have to request and process verification data as frequently. Continuous eligibility also allows families to develop and maintain an ongoing relationship with a medical home for their children. This aids in receiving preventive services that are cost-effective and critical to healthy child development, without disruptions in care caused by income fluctuations.

Some experts reported promising results when they focused on improving renewal outcomes by evaluating and updating the application and renewal processes. For example, Louisiana's Medicaid/SCHIP program implemented policies and procedures which streamline the renewal process and prevent coverage disruption. Caseworkers now search the benefits database to see if families are receiving benefits from other programs. If they are, the caseworker can automatically verify income and continue coverage without interruption. In cases where verification is still required but an applicant isn't able to provide income information, data from the state's Department of Labor confirming reported wages can be used to prevent dropped coverage.[5]

In early 2006, Illinois began a new administrative renewal process for many children enrolled in Medicaid and SCHIP. A family is sent a pre-printed renewal form and is only required to return the renewal form if there are changes to report. These changes can also be reported by phone. Proof is required when changes in income or financial support (child or spousal) occur.[6]

Symposium participants stressed the potential administrative savings of simplification – such as the reduced cost of mail and of closing and opening cases. A study comparing New York's simplified Medicaid/SCHIP application process developed after September 11, 2001, to the original, relatively complex Medicaid/SCHIP application process found that savings of approximately 40% could be achieved using the streamlined, one-page application developed after 9/11.[7]

Further evidence of the importance of simplification strategies can be found in examining the results when these strategies are rolled back. Shortened eligibility periods requiring more frequent renewal and increased demand for verification documents often result in the loss of coverage for children who qualify for services. Texas instituted a number of changes to its Medicaid and SCHIP programs after budget cuts, including requiring application renewal every six months instead of every twelve, and enforcing a 90 day post-eligibility waiting period. A Kaiser Family Foundation study found that the resulting 29% decline in SCHIP participation, occurring less than a year after the new procedures were implemented, was largely attributable to the new enrollment barriers.[8] Washington State's former combination of a shortened eligibility period (from twelve to six months) and a more frequent, burdensome income verification requirement led to more than 40,000 people losing coverage in a little over a year. In Wisconsin, a new requirement that applicants submit income verification documents as well as proof of insurance status from their employer led to an 11.3% enrollment decline in four months.[9]

COMMUNITY-BASED EFFORTS ARE KEY TO ENROLLMENT

Although there is not yet sufficient rigorous evidence to show what works best, experts at the symposium pointed to community-based outreach and enrollment assistance as particularly effective in getting and keeping children covered. A growing body of research supports this conclusion.

The experience of California's Children's Health Initiatives (CHI) is an example of this. As of May 2006, CHIs in 18 counties, with six more counties in the planning stage, are working to cover all children in families with incomes under 300% of the Federal Poverty Level (FPL), using locally-funded programs for children who are not eligible for Medi-Cal or Healthy Families (California's Medicaid and SCHIP programs). Evaluation of CHI programs in San Mateo and Santa Clara counties found that enrollment in Medi-Cal, Healthy Families, and Healthy Kids, the county-based coverage provider, spiked after the initiative began, and that much of the enrollment spike was attributable to community-based outreach efforts. Parents surveyed by evaluators reported finding out about Healthy Kids at their child's school, community clinics, health fairs, through their social workers, and by word of mouth. Evaluators identified "coordinated outreach" among community outreach and advocacy groups as well as health and social services agencies as an important tool for getting and keeping children covered.[10, 11]

In Massachusetts, the state contracts with community organizations and legal aid offices, which enroll children and families in health coverage, food stamps, WIC and other programs. The importance of community-based outreach was made clear by the amount of "churning," or repeated loss and gain of coverage, that occurred when outreach was cut in the early 2000s. Efforts to reverse that trend have been put in place.

In Illinois, the state pays community-based organizations that assist in the completion of Family Health Plan applications a $50 "technical assistance payment" for each application that leads to a new member. The state hopes to increase the number of qualified applications submitted to the state, thus increasing the number of children enrolled in Medicaid and SCHIP.[12]

USE TECHNOLOGY TO COORDINATE PROGRAMS AND REDUCE ADMINISTRATIVE BURDENS

Technological resources, including state computerized information networks and the Internet, can be used to reduce workloads for parents and Medicaid and SCHIP staff. Sharing information among programs with similar eligibility requirements, creating universal application forms that can be used to gain access to multiple programs, and giving parents the option of using online application resources are good ways of streamlining the process and making sure that children will get access to the coverage they need.

California has implemented ExpressLane, a program that uses information on benefit recipients – on file from other public programs – to identify those who are likely eligible but not enrolled in Medi-Cal or Healthy Families. The multi-faceted program allows information in the WIC, food stamp, and school lunch programs to be used to contact and enroll families and children who are unenrolled. ExpressLane programs have been implemented in 14 school districts in 12 counties in California.[13, 14]

Massachusetts has a "Virtual Gateway" where a single online electronic form is used to enroll residents – including children – in many programs, including Medicaid, food stamps, WIC, subsidized child care, early intervention, hearing screening, and more.[15] The technology provides intake and referrals, enrollment and eligibility, service delivery, program administration, and fiscal oversight.[16] Hospitals and community health centers in Massachusetts can also check for any pre-existing insurance coverage for low-income patients, and if none exists, immediately enter Medicaid application data online. This has helped reduced the burden to the public of paying for a large, uncompensated care population.[17] In December 2005, an independent group surveyed health-care providers about the virtual gateway and found that the gateway not only made the job of frontline workers easier and significantly reduced the time necessary for an eligibility determination, but also improved the experience of most Massachusetts residents in applying for benefits.[18]

In Pennsylvania, the Commonwealth of Pennsylvania Access to Social Services ("COMPASS") provides on-line screening and applications for Medicaid and SCHIP, adultBasic, food stamps, school lunch program (as a pilot), cash assistance, energy assistance, and home and community-based services. COMPASS screening presents questions depending upon what programs the applicant requests to be screened for and then provides the full applications if the individual wants to proceed. COMPASS also adapts to meet the applicants' needs, so someone interested in health coverage only will not receive questions that are only relevant for other programs. Also, the on-line applications help remove errors having to do with processing handwriting, and reduce the paperwork burden for agencies. A newer version of COMPASS allows on-line application renewals and permits individuals to review their benefits through their "My COMPASS" account.[19]

Alabama's Department of Public Health uses Automated Data Integration (ADI) to share application information among the state's child coverage programs: ALL Kids (SCHIP), Medicaid, and the Ala-

bama Child Caring Foundation (ACCF). The agency also makes an effort to have forms available widely and in different formats, including mail-in forms, web-based applications, and pre-printed renewals. This use of technology has increased efficiency by shortening the amount of time needed to process applications.[20]

Beyond those mentioned in the symposium, other states also have initiated similar systems. In Utah, the "Utah Clicks" site allows families to learn about and apply online for many programs for children, including Medicaid, early intervention, prenatal care, and medical, behavioral and mental health evaluations.[21] An on-line screening process uses information submitted by the parent to suggest programs that may be of interest to the family, then allows parents to complete and submit application forms to the various programs online, or to print and mail them. The tool is available in English and Spanish.

CHANGE AGENCY CULTURE

The culture within agencies responsible for child health coverage, from management to front-line caseworkers, is critically important. Numerous symposium participants asserted that "internal marketing to staff is vital," so that staff "can take more pride" in their role in helping children and families obtain coverage. Emphasis on paperwork and process, or the "culture of eligibility," instead of on the mission of covering children, can result in negative experiences for both staff and clients, and missed opportunities for useful communication and service provision. Symposium experts mentioned a number of ways of changing agency culture and engaging and motivating front-line staff:

- Make the *goals* of the program clear. Goals might include keeping children covered by reducing churning, enrolling more children, reducing case closures for purely procedural reasons, reducing the percentage of uninsured children within the state, or making a difference in families' lives.
- Change the *language* used to describe applicants and enrollees. Language like "customers" can professionalize and create an atmosphere of service.
- Provide *training* and back up materials for all staff. Keeping staff up to date on new developments and simplified procedures can help with enrollment and retention.
- Create *systems* to implement and facilitate the monitoring of simplified procedures and new rules, thus enabling true change to take effect.
  Provide the *tools* for workers to do their job well, such as links to on-line verification and enrollment systems, so that basic processes can be completed more efficiently.

ENGAGE LEADERS WHO CAN ARTICULATE A CLEAR VISION

Symposium participants emphasized that visible and high level leadership is a critical ingredient to success; in other words, "[states] need to have a champion for coverage." Governors are critically important in making an investment in children's coverage and keeping it strong. Other champions, such as state legislators or Medicaid or SCHIP program directors, also can determine a program's success. As one symposium participant noted, the most important step is to "set the goal," and policy development flows from there.

A number of governors have personally taken on the goal of coverage for children. In 2006, Illinois' Governor Blagojevich initiated the "AllKids" program to provide health coverage for every uninsured

child in the state. Massachusetts, under Governor Romney, passed a health insurance reform bill that will mandate coverage for everyone by mid-2007. In Pennsylvania, Governor Rendell proposed a "Cover All Kids" initiative to expand SCHIP as part of his 2006–07 state budget proposal. Governor Kulongoski of Oregon is a champion for the "Healthy Kids Plan," which is to go before the state legislature in 2007.

Community leaders also can be a powerful and influential force in attaining coverage for children. One of the symposium participants held that interest in children's coverage is "broad but not deep," and suggested that those groups in the community who have special interest in the issue, especially those who are uninsured themselves, might be a strong force for mobilizing that broad interest.

Providing coverage to children may be politically popular *and* relatively inexpensive, which may appeal to many politicians at the state level. Governors and legislators may be looking for "big ideas" that are not too costly, and the "covering children" idea could, when implemented properly, fulfill that need. Illinois' "All Kids," for example, is a tiered-premium program that replaces the state's Medicaid and SCHIP programs. All Kids is estimated to cost $1,059 per child per year for children who are fully covered by the state.[22, 23]

ENGAGE PARTNERS

Partnerships between state agencies and businesses, schools, foundations, and community organizations can increase efficiency, minimize workloads for everyone, and prevent children in need of services from falling through the cracks.

Schools are often a first place to look for a partnership. However, in many cases, partnering with schools can be difficult, since such a partnership often involves time and resources on the schools' part, which may be perceived to detract from the schools' main education mission. Some of our symposium experts found that schools are often more interested in partnering when there are financial and other incentives for them. For example, the Child Nutrition and WIC Reauthorization Act of 2004 instituted a system of "direct verification," in which school systems can use participation data collected from other programs, including Medicaid, to determine National School Lunch Program eligibility, instead of having to contact the family directly for documentation.[24, 25] There are two main incentives for schools to rely on programs such as Medicaid for verification. First, it is likely that by using Medicaid to do a "data match," fewer children will lose school-lunch benefits. Second, if schools are able to get matches through Medicaid and other programs, they are rewarded by having to do less verification the next year, which saves time. The USDA Food and Nutrition Service has distributed more than $4 million in state grants to help implement the verification/data-match program.

Further, federal Title I education funding for schools may in part be distributed based on the enrollment of children in Medicaid.[26] Title I, part of the Elementary and Secondary Education Act (ESEA), provides funding for schools that serve low-income students, and is given to the majority of the country's public schools. Sometimes, other state-based funding formulas are based on the Title I funding formula.[27] Therefore, combining the application and verification processes among programs such as Medicaid or SCHIP and the National School Lunch Program can maximize efficiency by reducing workloads for school and agency staff, and benefit not only children and families, but schools and agencies as well.

As one symposium participant pointed out, Medicaid and SCHIP managed care organizations (MCOs) also may have a direct interest in enrolling children in public insurance programs as it benefits their bottom line. MCOs have a financial incentive to keep members from repeatedly falling off the rolls. Disruptions in preventive care can result in increased costs when acute care becomes necessary. In some states, MCOs are not allowed to directly enroll members, so partnerships between MCOs and community organizations are very important for reaching families who might otherwise be unaware of their eligibility.[28]

The local business community also can be helpful in reaching parents. Focusing outreach efforts in places such as neighborhood grocery stores, day-care centers, beauty salons, and other local businesses that may provide services or employment to eligible families can be a cost-effective way to reach a lot of people.[29] Small businesses and parents are generally very supportive of these efforts.

Meeting participants also suggested partnerships with philanthropic organizations. Foundations can bring issues to the forefront by conducting public opinion research, and can deliver results that can help state and local agencies determine the best ways to proceed with their efforts. For example, in Arizona, St. Luke's Health Initiatives (SLHI) organized Arizona ChoiceDialogues, a series of citizens' discussion groups involving randomly selected participants to discuss state health-care reform options, followed by stakeholder discussion groups including citizens, government officials, and community leaders. The meetings allowed for public opinion to be voiced and captured, and for policy makers to work with the community on developing a coverage plan that would likely have public buy-in.[30]

MARKETING IS ESSENTIAL

Experts at the symposium agreed that marketing is essential for successful efforts. Getting the word out to everyone – parents and families; Medicaid and SCHIP staff; community leaders; and legislators and decision makers – is vital for achieving coverage for children. Everyone needs to understand the problem of uninsurance among children and what programs such as Medicaid and SCHIP can do to solve the problem. Different groups will be interested in different aspects of the problem and proposed solutions.

A 2003 review of SCHIP programs found that most states used a variety of marketing techniques to get the word out about their programs, including tactics such as renaming their program to sound more appealing or more like commercial health plans; using different types of media – TV, radio, print ads, and promotional materials – with messages in a variety of languages; and developing targeted messages to appeal to the needs and concerns of the population. These targeted messages include emphasis on affordability, on the peace of mind that comes with obtaining coverage for your children, on simplicity of enrollment, and on the level of choice and personalization that SCHIP coverage confers over clinics, e.g., that children will have their own primary care physician. Delivering targeted messages to the public through media and community partners resulted in significant increases in public awareness, as measured through independent evaluations.[31] Such increases in public awareness, coupled with outreach and enrollment efforts, can lead to greater levels of coverage.

When marketing to the general public, one participant said it is easiest when you have a clear message such as "covering all kids." Another participant noted that in his community rather than focusing on getting families to sign up for *insurance*, they focused on the access to *care* that children

would be able to get if they enrolled. Information disseminated to the community focused on preventive physical, dental, and mental health care, and addressed insurance coverage after the child was connected to sources for health care. This "front of the door / behind the door" approach puts the emphasis on care and coverage for all children (front of the door), to mobilize public sentiment. The functional or "behind the door" details follow once commitment to coverage has already been established.

When garnering support from legislators and other decision makers, one participant suggested, it is useful to relate the experiences of states and other localities. Since cost savings are important for states, governors and other state officials may be particularly interested in hearing about the successes of state programs from a savings perspective. Small business alliances, community health partnerships, and other such groups could be good resources for these kinds of experiences.

CONCLUSION

There are as many state approaches to covering children as there are states, so it is difficult to comprehensively, yet concisely, summarize tips for increasing coverage in a discussion that includes representatives from a number of different states, agencies, and organizations. Our experts came up with additional ingredients for success other than those featured above, such as the importance of support from federal agencies, the need to watch out for relaxed attitudes once progress is made, and the need to persevere over time. It seems clear that one of the most important ingredients to success is communication – among states, so that ideas that work can be shared; with parents and families, so that children can continue to be enrolled and renewed; and among community partners and leaders, so that the common goal of seeing all children covered can be realized through collaborative efforts. As one of the symposium members put it, "Getting to the finish line is possible... when you build it right, kids will come."

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Notes

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