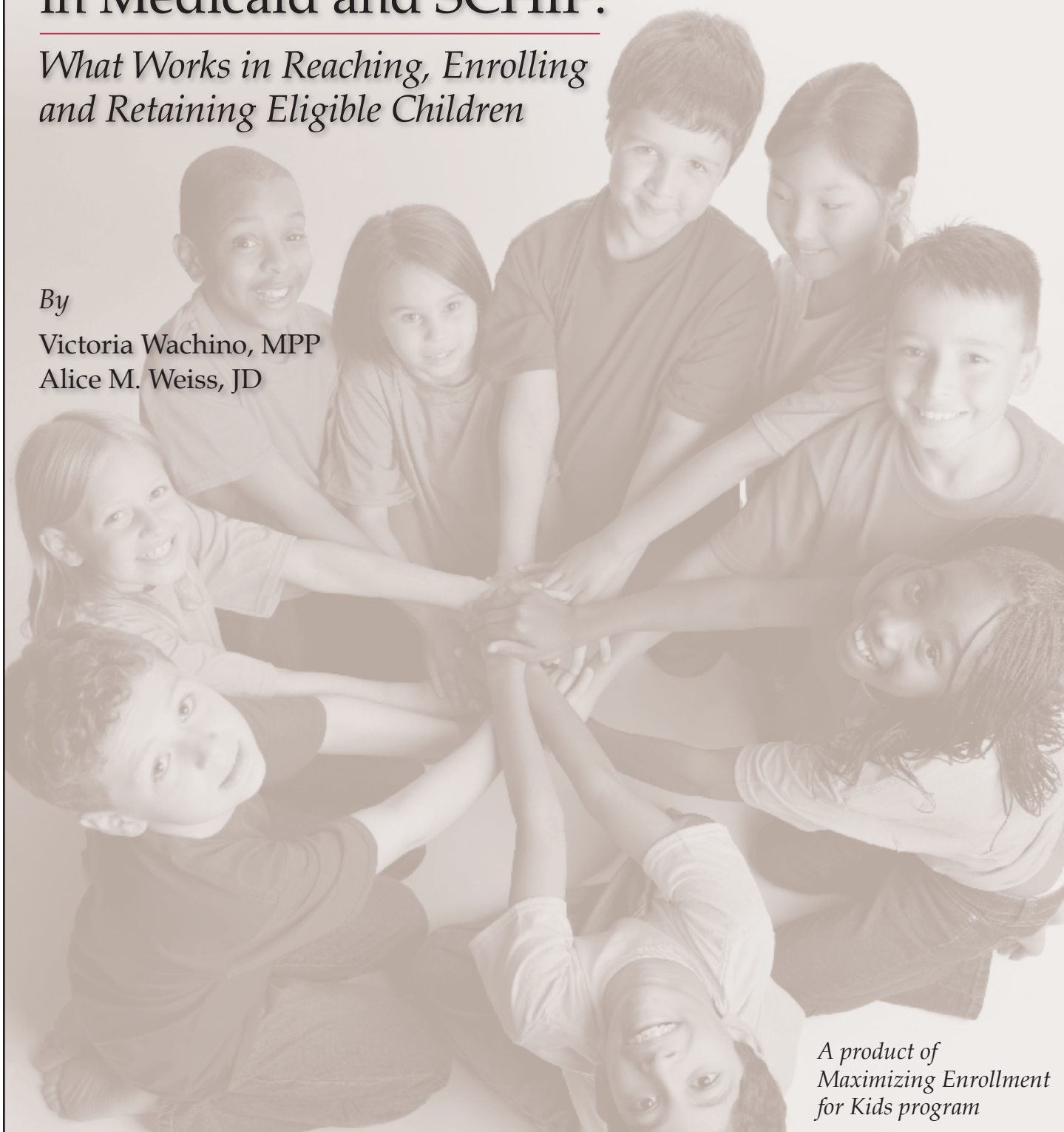*February 2009*

Maximizing Kids' Enrollment in Medicaid and SCHIP:

What Works in Reaching, Enrolling and Retaining Eligible Children

By

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There is significant interest in reducing the number of uninsured children in the United States. A key part of achieving this goal is ensuring that all uninsured children who are eligible for Medicaid and the State Children's Health Insurance Program (SCHIP) enroll and maintain coverage for as long as they qualify. Although the proportion of eligible children who are enrolled in Medicaid and SCHIP increased between the late 1990s and the early part of this decade, today nearly two-thirds of the uninsured children in the United States remain eligible for Medicaid or SCHIP but are not enrolled.

Many states are working actively to increase enrollment of eligible children in public health coverage programs and want to adopt new strategies to do so. States are seeking the most effective approaches for enrolling eligible children. To assist states, NASHP has worked to offer information and analysis that states can apply as they develop and implement new policies in this arena. In 2006, NASHP convened a symposium of state and national child health coverage experts from the public and private sectors to focus on lessons learned over the decade since SCHIP was enacted. From these conversations, NASHP identified seven key themes that participants stressed were essential to advancing continuous coverage of children through Medicaid and SCHIP. These ideas were summarized in a 2006 NASHP issue brief, *Seven Steps Toward State Success in Covering Children Continuously* (hereinafter referred to as *Seven Steps*).

Available research suggests states can make small policy changes that can have a big impact on enrollment of eligible children.

This paper revisits the ideas summarized in the *Seven Steps* brief to provide more concrete information for states seeking to take the next step in enrolling more uninsured children who are eligible for Medicaid or SCHIP, but not enrolled. To do this, NASHP reviewed the research literature and interviewed key state and national experts. The goal of this work was to determine which strategies, among those identified in *Seven Steps* and others, have been identified through research, experience and expert opinion to be most effective in helping states identify, enroll and retain eligible children.

This paper intends to inform state efforts, but because there are shortcomings in the research evidence that is available, definitive guidance is lacking. Not all of the *Seven Steps* strategies have been evaluated in available research. Strategies vary in the degree to which they have been analyzed and the degree to which their impact is quantifiable. The methodologies and analytic rigor of individual studies vary, and consequently their results do not always provide concrete evidence on which policy decisions can be based. In many cases, states implement multiple strategies at roughly the same time, making the unique impact of a single strategy impossible to discern. Finally, whether a strategy is successful depends a great deal on the political, administrative and financial circumstances of a state, as well as on the needs of a state's population of low-income children. For these reasons, the research presented here should not be considered dispositive; state officials will want to consider carefully which strategies are appropriate to their state's needs. Additional research is needed on a number of these strategies to help states find their way forward.

Key Findings

The paper's key findings with respect to each of the seven key themes identified in 2006 are:

1) Keep Enrollment and Renewal Procedures Simple

Since SCHIP was created, states have focused their efforts on simplifying the enrollment and renewal processes for children and families in Medicaid and SCHIP as a means of reaching more eligible children. Research and state experiences support the idea that simplifying enrollment and renewal processes can promote enrollment of eligible children, reduce unnecessary loss of coverage and promote continuous coverage for children. Key enrollment strategies that have shown some promise according to research and expert opinion include simplifying the application process, reducing income and eligibility documentation, eliminating asset tests, adopting presumptive eligibility and coordinating Medicaid and SCHIP eligibility processes. The research also provides substantial evidence that requiring premiums has a negative effect on enrollment, particularly for children in lower-income families. There is also some evidence that indicates imposing waiting periods limits enrollment.

Experts also described simplifying the renewal process as being critical to efforts to promote enrollment of eligible people in public programs. Allowing annual renewals and 12-month continuous eligibility, adopting administrative renewal processes, and policies making it easier for children to transition between Medicaid and SCHIP were all described as key to helping eligible children maintain coverage. The research literature, most of which pertains to SCHIP, supports the importance of simplifying the renewal process.

2) Community-Based Outreach is Key to Increasing Enrollment

Community-based organizations and institutions like schools, community health centers, health plans and local and religious organizations play a key role in outreach and enrollment and can capitalize on families' existing relationships and trust. Assistance from community-based organizations can provide a vital link to Medicaid and SCHIP for families who face language, cultural, literacy or numeracy barriers, live in remote areas, need extra assistance or do not trust government. Much of the research literature focuses specifically on community-based organizations' assistance in completing and submitting applications that some community organizations provide to families, which the research implies and experts describe to be a highly effective strategy to promote enrollment of eligible children.

3) Use Technology to Coordinate Programs and Reduce Administrative Burdens

Use of information technology is an emerging and promising area of opportunity for states seeking to increase enrollment of eligible children in public programs, according to experts, although its impact has not yet been well documented. Information technology and exchange can support and advance state policy goals to reduce barriers to enrollment. The two types of technology changes states are most often pursuing are online applications and data sharing with other agencies. Most states are pursuing online applications to some degree, with 38 of 41 states that responded to a recent NASHP survey offering online applications, although far fewer allow submission and eligibility determination electronically. A number of states are improving their electronic data sharing and matching with other programs that serve low-income populations, like the National School Lunch Program (NSLP), the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), food stamps and

cash assistance. Sixteen out of 38 states that responded to a recent NASHP survey reported they link their online coverage applications to other programs. Other states are implementing data exchange to identify and contact potential enrollees.

4) Change Agency Culture to Promote Enrollment Goals

Experts agree that reorienting the culture of state agencies is crucial to the success of state efforts to improve enrollment of eligible children. A number of states have worked to change the culture of eligibility agencies, which traditionally focuses on adherence to procedures over promoting enrollment of all eligible individuals. Conducting "internal marketing" to promote the goal of enrolling eligible families to agency staff, educating eligibility workers about the challenges that low-income families face and changing the incentives and expectations that guide eligibility workers' performance are all considered vital components of changing agency culture. Although the impact of these efforts is difficult to quantify, at least one state, Louisiana, has made a concerted effort to change agency culture and has seen agency administrative burdens diminish, application processing times fall and efficiency increase.

5) Engage Leaders Who Champion the Goal of Covering Children

Research and expert opinion indicate that high-level leadership is critical to successfully increasing enrollment of eligible children in Medicaid and SCHIP. Governors in a number of states have made covering children a major policy priority, and having that high-level public commitment underpins all other efforts to enroll eligible children. The leadership of state legislators, community leaders and state Medicaid and SCHIP directors is also key. Engaged state leaders have provided a central voice to inform the public about the availability of health coverage, gain support for new policies in the legislature, convey clear messages and goals to supporting agencies, execute any administrative changes needed to support the goal and leverage additional resources to identify and enroll eligible children.

6) Engage Partners to Help Achieve Coverage Goals

Partnerships between states, community organizations and institutions like schools, health plans, hospitals, foundations and businesses play an important role in helping to cover uninsured children, according to research and state experience. These organizations often have community relationships that make it easy for them to contact eligible families, educate them about the availability of programs and help them apply. This role can be especially helpful to reach members of diverse language and racial and ethnic groups. According to the research, community partnerships have helped children apply for health coverage; partnerships with schools have played an especially important role in helping children enroll in Medicaid and SCHIP.

7) Use Marketing to Promote Enrollment in Public Programs

In some cases, marketing can help propel successful efforts to enroll eligible children in Medicaid and SCHIP. Large-scale marketing (i.e., broadly publicizing the availability of health coverage), including advertising through radio, television and print media, as well as promotional materials, can help build awareness of Medicaid and SCHIP and of children's potential eligibility. The research evidence with regard to these types of marketing strategies was mixed. In some studies, marketing activities like media campaigns seem to have contributed to an increase in phone calls to toll-free information lines or to applications submitted in some states. In several other studies, they have not been found to have a significant impact. There is also evidence, derived both from experts and the Congressionally-mandated SCHIP evaluation, that large-scale marketing was more effective in the early years of SCHIP

implementation, when awareness of the program needed to be built, than it is today. Some researchers have suggested that targeted outreach to specific groups is more effective than large-scale marketing. In addition, marketing efforts tied to eligibility expansions for higher-income children or parents have proven effective in enrolling more uninsured children who were previously eligible for Medicaid or SCHIP but not enrolled.

Assisting States in Moving Forward to Cover Children

States have prioritized increasing health coverage for children, and many are working actively to increase enrollment in Medicaid and SCHIP as a central part of their efforts. As they move forward, states face key challenges, including uncertainty about which strategies will be most effective. States have limited resources and often require evidence of a strategy's effectiveness before they can commit to investing financial or staff resources in a policy change. Importantly, many states lack sufficient data to inform their efforts. NASHP interviewed key state officials and policy experts to identify what types of assistance would be most helpful to states as they move forward. Recommendations included helping states:

○ Better understand state-specific strengths and weaknesses in enrolling and maintaining coverage for eligible children in order to guide improvements.

○ Improve data collection and analysis to improve understanding of target population characteristics, monitor the impact of policy and system changes and measure progress.

○ Plan and design system improvements, including streamlining eligibility, enrollment and renewal.

○ Coordinate with other programs and change agency culture.

○ Learn from each other and jointly problem-solve through forums for cross-state exchange of experiences and best practices.

Many states are ready to take the next steps to ensure that all children who are eligible for Medicaid and SCHIP enroll and can retain coverage. With a strong state interest in covering children, and more than a decade's worth of experience in reaching and enrolling eligible children in public programs, new achievements in covering uninsured children are within states' reach.

This paper informed the development of the new RWJF program *Maximizing Enrollment for Kids*, which was announced in June, 2008. Through this project, NASHP, which serves as the National Program Office, hopes to demonstrate the effectiveness of different strategies discussed in the paper and help grantees and other states make meaningful progress in their efforts to cover more eligible but uninsured children in Medicaid and SCHIP.

States will face competing tensions as they try to maximize enrollment of eligible children, including uncertainty at the federal level about SCHIP reauthorization, funding and policies, and pressure from the current economic crisis. As states move forward, they will need more information to help them identify the strategies that are most effective. Additional research outlining the effectiveness of strategies discussed in this paper and emerging strategies, including the research related to the *Maximizing Enrollment for Kids* program, is needed to guide state progress. With these tools in hand, states can make real progress on lowering the number of uninsured children by maximizing enrollment of eligible children in Medicaid and SCHIP.

Introduction

Initiatives aimed at finding, enrolling and retaining low-income children[1] in Medicaid and SCHIP coverage are central to addressing the problem of uninsurance among children in America. Even though the proportion of eligible children enrolled in Medicaid and SCHIP has increased significantly since SCHIP was created in 1997, today eligible but unenrolled children still make up nearly two-thirds of the 8.9 million uninsured children in the United States.[2] To move forward in improving coverage rates among children, a critical step will be to help states ensure that uninsured children now eligible for Medicaid and SCHIP are enrolled.

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Maximizing enrollment of eligible uninsured children in Medicaid and SCHIP is key to ensuring that these children have access to preventive, primary and specialty care and that states can manage and measure quality of care for them, especially those with complex conditions or special health care needs. Promoting enrollment and retention in Medicaid and SCHIP also helps reduce the burden of uncompensated care on providers and can reduce the administrative costs of children cycling on and off of public coverage for states.

As discussed in this paper, maximizing enrollment in Medicaid and SCHIP is distinguishable from efforts to expand government-sponsored coverage to all children and the attempt to increase eligibility levels. The strategies discussed here are not targeted to change the landscape of the health delivery system for children, although their ultimate effect when implemented properly may make Medicaid and SCHIP coverage work better for children. Maximizing enrollment in this context means promoting policy, proce-dural and systemic changes that states can make to find, enroll and retain more of the eligible uninsured children who do not have other coverage options to meet their needs. While some believe sizeable policy changes are needed to make a real difference in enrolling eligible children, the steps discussed here focus on smaller policy changes which can nevertheless result in substantial increases in coverage.

States' Pivotal Role

States play a pivotal role in efforts to find, enroll and retain children in Medicaid and SCHIP. Although federal funds make up on average 57 percent of funding in Medicaid and 70 percent of funding in SCHIP and states are subject to minimum federal requirements, federal law gives states a fair amount of discretion to determine how families apply for and renew coverage, key factors that can affect whether eligible children are enrolled or not. State leadership is also critical in determining a state's success in enrolling eligible children. Many states have shown strong interest and implemented policies, procedures and systems to improve enrollment, but are looking for ideas and assistance on what works.

States also encounter competing pressures that can undermine their efforts, and success in maximizing enrollment can be costly. SCHIP's more favorable federal matching rate gives states a greater financial incentive to enroll children in SCHIP rather than Medicaid, but since roughly two out of every three low-

income uninsured children are only eligible for Medicaid, states may perceive a financial disincentive to enrolling more eligible children.[3] In addition, Medicaid and SCHIP have different structures that can raise different challenges for states. Medicaid provides an entitlement to coverage for people who are eligible, and states cannot impose an enrollment cap when spending increases beyond projections. This can make building support for enrollment maximization initiatives difficult when state budgets are constrained. SCHIP, on the other hand, does not provide an entitlement to coverage to children. States can impose enrollment caps in SCHIP, but such caps, which may be imposed as a result of shortfalls in state or federal funding, frustrate any effort to increase enrollment of eligible children. Furthermore, the current funding structure of SCHIP as a block grant with limited allotments to states may always prompt some restraint on states' behalf as they consider the possibility that federal funds will not support the enrollment gains they achieve.

States are also subject to federal policies that may undermine enrollment efforts. New initiatives to measure eligibility errors in Medicaid and SCHIP through the Payment Error Rate Measurement program can create a chilling effect on state efforts to adopt enrollment simplification strategies for Medicaid and SCHIP.[4]

More recent federal policy changes, including the Deficit Reduction Act of 2005 (DRA) citizenship and identity documentation requirements and the August 2007 CMS directive limiting state enrollment of new children above 250 percent of the federal poverty level (FPL), are also challenging state efforts to enroll eligible children in some cases. Uncertainty about federal funding for the SCHIP program when its current authorization expires on March 31, 2009, and proposed rules to limit Medicaid reimbursement for school-based outreach, rehabilitation services and other services have also given some states pause as they consider future investments in children's coverage.

To make progress, state efforts to maximize enrollment must operate within these constraints and offer greater benefits than risks. At the same time, state and federal policy innovations can tilt the scales in support of enrollment gains. While more research is needed on whether adopting new strategies has an adverse effect on state error rates, some states have responded to concerns about error rates by instituting audits to monitor their own progress. The Internal Revenue Service (IRS) has successfully used similar methods to test compliance among U.S. taxpayers for decades. States also are responding to documentation burdens created by the DRA by developing new methods to electronically verify vital information to lessen documentation burdens for individuals. In 2007 and 2008, a bipartisan majority of both chambers of the 110th Congress supported a version of the Children's Health Insurance Program Reauthorization Act (CHIPRA) that changed federal policies to encourage states to enroll more low-income children, lessening some of the financial disincentives that states perceive today. While the challenges states face are significant, they are surmountable. This paper assembles a number of ideas to help states progress, notwithstanding these challenges.

Seven Steps Toward State Success

Since the enactment of SCHIP over a decade ago, NASHP has supported and reported on the work of states in covering children. In 2006, NASHP initiated a review of what states have learned in the past decade by convening a symposium on child health coverage with state and national experts from public and private sectors. Symposium participants were invited to review progress and generate ideas for further achievements in covering all children and youth continuously. Participants' ideas were summarized in a 2006 NASHP issue brief, *Seven Steps Toward State Success in Covering Children Continuously* (hereinafter referred to as *Seven Steps*).

To assist states as they move forward to enroll more eligible children, NASHP has undertaken efforts to determine the most effective strategies for enrolling eligible children and to offer clear, usable information that states can apply in implementing new policies. This paper takes another step in these efforts by reexamining *Seven Steps* with a focus on how these strategies could be applied to continue state progress in enrolling uninsured children who are eligible for Medicaid or SCHIP. NASHP has reviewed the research literature and state experiences to determine the effectiveness of efforts to cover uninsured but eligible children. NASHP also sought advice from state and national experts on the most effective strategies for enrolling and retaining eligible children and experts' views on what additional help states need to move forward. NASHP's work on this paper was supported by the RWJF to explore new ways to support states in maximizing enrollment of eligible children in Medicaid and SCHIP.

Methods

NASHP used a variety of means to gather information for this paper. First, NASHP conducted a review of literature on the impact of state strategies to identify, enroll and retain eligible children since the inception of SCHIP in 1997. The results of this effort were reviewed by a group of six national expert advisors to NASHP's work on this project. In November 2007, NASHP conducted individual interviews with each of these key advisors and five state experts to discuss their views on the most effective strategies for enrolling and retaining eligible children and about the assistance states need most to move forward in their efforts. In addition, NASHP disseminated a brief questionnaire posing similar questions to state officials responsible for SCHIP and Medicaid programs and received responses from 13 states. More detailed information on the experts we consulted and the questions we posed appears in Appendices I and II. Although response to the questionnaire was more limited than we hoped, the information gathered provides a snapshot that enriches our understanding of these issues. NASHP also reviewed Medicaid and SCHIP policies now in place to help enroll and maintain enrollment for eligible children.

This paper begins with a brief discussion of why eligible children have not enrolled in Medicaid and SCHIP. The paper then reviews what we learned from our research and is organized according to the seven themes identified by the 2006 symposium:
1. Simplify enrollment and renewal procedures;
2. Conduct community-based outreach;
3. Use technology to coordinate programs and reduce administrative burdens;
4. Change agency culture;
5. Engage leaders who can articulate a clear vision;
6. Engage partners; and
7. Implement marketing strategies.

For each of these steps, the paper includes a discussion of what research, state experiences and expert opinion suggest about the effectiveness of different approaches in enrolling and retaining children. The paper concludes with a discussion of what types of assistance experts have indicated states may need to move closer to the goal of covering all children.

The parts of this paper that synthesize our review of the literature confirmed its limitations. Because there are shortcomings in the research evidence that is available, definitive guidance to inform state policies is lacking. Not all of the Seven Steps strategies have been tested or well-documented in research and additional research for all of the strategies discussed in this paper is warranted. The

research contained more information on enrollment and renewal simplification strategies than on the other strategies, so they are given more attention in this paper, but even in this area additional research would help inform states' efforts to enroll eligible children. Although this suggests a greater focus on enrollment and renewal simplification by researchers, providing more attention in this paper is not intended to and cannot imply these strategies are more effective given the absence of further study of other methods.

In addition, this paper did not evaluate the research studies that support its findings or try to evaluate the methodologies this research employed. The methodologies and analytic rigor of individual studies vary, and consequently their results do not always provide concrete evidence on which policy decisions can be based. There is little overlap among studies; therefore, the findings of one study are rarely replicated in other studies. Strategies vary in the degree to which they have been analyzed and their impact is quantifiable. The overwhelming majority of the studies on which this report relies evaluated the impact particular policies had on enrollment. Ideally, one would want to measure whether a particular strategy had an impact on reducing the number of uninsured children in a state, which is the ultimate goal of promoting enrollment in Medicaid and SCHIP, but few studies offer this analysis. In addition, states often implement multiple strategies at the same time, making the unique impact of a single strategy difficult to discern. States also implement strategies as other changes take place, such as changes in economic conditions, further complicating efforts to isolate their impact. Finally, whether a strategy is successful frequently depends on the political, structural and administrative circumstances of a state.

For these reasons, the research presented here should not be considered dispositive. State officials will want to consider carefully which strategies are appropriate to their state's needs, preferably by closely examining the studies referenced in this report. The paper is a representation of what we know today, but also aims to encourage research and evaluation to guide the promising strategies of tomorrow.

Why Are Eligible Children Not Enrolled in Public Programs?

To understand which state strategies are most effective in enrolling eligible children in Medicaid and SCHIP, it is important to understand why many children who are eligible for these programs are not enrolled. The research literature on the reasons why some eligible children are not enrolled suggests that key factors include:

○ **Families' Knowledge or Perceptions of Medicaid and SCHIP**. Although most parents are aware that Medicaid and SCHIP exist, parents can be confused about whether their children are eligible. Some studies suggest that parents may be confused about changes in eligibility for Medicaid and SCHIP related to a child's age.[5] In addition, some parents of uninsured children with special health care needs who are eligible for Medicaid or SCHIP may believe they are ineligible because they had previously applied for Medicaid or SCHIP and had either been denied coverage or lost coverage once they had it.[6] A significant share of parents whose children have not enrolled report that their children do not need or will not benefit from these programs, in part because these parents consider their children to be relatively healthy.[7] Although there has been concern that "stigma" or the perception of Medicaid and SCHIP as "welfare" programs serves as a disincentive to enroll in these programs, the evidence may not support this concern.[8,9,10]

○ **Administrative Barriers to Families Completing the Application Process**. The Medicaid and SCHIP application and enrollment process can be difficult for families to navigate. Many describe the application process as challenging to complete, and some low-income individuals have expressed concerns about complicated application forms, being asked to answer "unfair" questions and confusion over application requirements.[11] Some parents also have expressed concerns about needing to supply personal information as part of the application process, and parents who reported having had a bad experience with the application process were reluctant to apply again.[12] In a survey of parents of children with special health care needs, less than half described the process of applying for Medicaid and SCHIP as easy.[13]

○ **State Challenges Maintaining Continuous Enrollment for Children**. Maintaining continuous coverage for children who have enrolled is also a significant policy challenge for states. The coverage renewal process appears to be a key point at which children lose coverage, although there are other reasons for losing coverage as well.[14] States are required by federal law to redetermine eligibility at least annually, although six states redetermine eligibility for children more frequently in Medicaid (while one additional state redetermines *income* eligibility more than once annually).[15] The reasons that children lose coverage at renewal include miscommunication between the state and families, families' inability to meet redetermination requirements and administrative errors. Some eligible children who lose coverage subsequently re-enroll within a relatively short period of time, which suggests that these children lost coverage despite remaining eligible for the program (a phenomenon that is sometimes referred to as "churning"). Some eligible children who lose coverage do not re-enroll.

Some studies have shown that significant numbers of eligible children are losing coverage during the renewal process, although estimates of the extent of these coverage losses vary. The 2007 Congressionally-mandated evaluation of SCHIP attempted to estimate average retention rates for children who remain eligible for SCHIP upon renewal of coverage based on data from 19 states gathered over six years. The evaluation estimated that between 31 and 98 percent of children who were eligible for SCHIP retained coverage at renewal, and that between 2 and 27 percent of children who were disenrolled from SCHIP in the studies considered for the evaluation were still eligible for

SCHIP coverage, although the evaluation noted that other surveys have estimated the disenrollment of eligible children rate as even higher, between 25 and 31 percent.[16] An earlier study of retention rates in eight states estimated a much higher rate of disenrollment of eligible children, finding that just less than half of children in SCHIP retained SCHIP eligibility at redetermination.[17] This apparently high rate of coverage instability has implications for children, families, states and providers.[18]

○ **Language and Cultural Barriers**. Confusion and barriers experienced by individuals and families in the application process can be especially acute and difficult to overcome for members of minority groups or individuals whose first language is not English.[19] Some immigrants are concerned that using health care services will cause them to be categorized as "public charges" and jeopardize their residency.[20] Translation problems, geographic barriers, and limited access to technology are also significant barriers for some groups, all of which can serve to deter enrollment among individuals and families for whom English is a second language.

○ **State Responses to Budget Pressures**. Although many states continue to press forward in their efforts to find and enroll more eligible children, a major challenge lies in the budget pressures states experience in economic downturns to trim public spending on Medicaid and SCHIP. The pressures brought about by economic downturns can be acute – as state tax revenues decline while enrollment in Medicaid and SCHIP increases – and states, unlike the federal government, must rebalance their budgets so they do not run deficits. The current economic crisis will likely pose significant challenges for states in maintaining enrollment, eligibility and benefits for Medicaid and SCHIP. Recent data suggests that as many as 44 states have faced or will face budget shortfalls either this or the next fiscal year as states face the bleakest economic outlook since the recession of 2001.[21] Some may cut back on eligibility expansions and simplifications designed to make enrollment in public programs easier, or may make cuts to existing eligibility standards. Other states may cut payments to providers or health plans, which can diminish access and make it harder for those enrolled to access services.

The current economic crisis will likely pose significant challenges for states in maintaining enrollment, eligibility and benefits for Medicaid and SCHIP.

These policy changes can have a nearly immediate effect on trimming enrollment and undermining confidence in public programs, but it is often hard to reverse these changes even when state economies rebound, leading to higher numbers of eligible children being uninsured. Changes that erode access to coverage can also further undermine families' trust in state agencies and programs, making it harder for states to find and enroll eligible families in the future.

○ **Uncertain Federal Funding and Restrictions**. Federal funding for children's coverage in Medicaid and SCHIP is still unclear despite movement in Congress towards reauthorization of SCHIP. States cannot predict whether SCHIP funding will continue, at what level or under what requirements. A number of states will face shortfalls in federal SCHIP funding in coming years and may become increasingly wary about committing to increasing SCHIP coverage. States are also concerned about the possible impact of a number of Medicaid rules promulgated in the past year, which could undermine federal funding for a number of services related to children's coverage, including school-based outreach and administrative services, rehabilitation services and targeted case management. Although Congress has acted to temporarily stop implementation of the Medicaid rules before April 1, 2009, states wishing to curtail their financial risk may still feel pressure to curb SCHIP and Medicaid enrollment despite their policy interest in expanding coverage.

Another factor complicating state efforts is an August 2007 CMS directive, which requires states that cover SCHIP-eligible children with family incomes above 250 percent of the FPL to meet new

requirements, including that states cover 95 percent of low-income children eligible for Medicaid and SCHIP. Research suggests as many as two dozen states may be affected by this directive, and many affected states are concerned that they would not meet the requirements if enforced.[22] CMS issued a statement in August of 2008 indicating they would not actively enforce the directive, but the directive has already had an impact on states' ability to expand eligibility under SCHIP and Medicaid.[23] Several states that had planned expansions for children above 250 percent had already been denied approval before August 2008 and others had postponed expansion plans. The directive has also been challenged in court by states and beneficiaries, but it is unclear whether the pending suits will provide clarity on implementation of the directive. How much the directive impacts states' enrollment efforts will depend on whether it remains in effect under oversight from the courts, a new administration and a new Congress.

TABLE 1.   *Reasons Low-Income Children Were Not Enrolled in Medicaid or SCHIP Programs in 1999*

Reason Child Not Insured	Percentage of Low-Income Uninsured Children*
Knowledge gaps	32.4 *(2.1)*
Had not heard of Medicaid/SCHIP	12.4 *(2.0)*
Did not inquire or apply because did not think child was eligible	17.7 *(1.3)*
Did not inquire or apply because lacked sufficient information about program	2.3 *(0.4)*
Administrative hassles	9.5 *(1.2)*
Enrolled in past year but not at present	17.8 *(1.7)*
Applied for coverage but not enrolled	11.0 *(1.0)*
Not needing or wanting program	22.1 *(2.1)*
Other main reason given	7.3 *(1.0)*
Sample size 2,485	

Source: 1999 National Survey of America's Families from the report, Genevieve Kenney and Jennifer Haley, *Why Aren't More Uninsured Children Enrolled in Medicaid and SCHIP?* (Washington, D.C.: The Urban Institute, 2001).

*Note: Standard errors are in parentheses. Percentages add up to more than 100 percent because respondents were allowed to choose more than one reason.

Premiums and Waiting Periods Can Negatively Impact Children's Enrollment

In 2007, 35 states charged premiums in their children's coverage programs.24 A growing number of states have adopted premiums for their children's coverage programs over the past decade for a number of reasons. Reasons often cited by states include an interest in promoting family investment in the coverage, a desire to lessen the stigma of coverage and make it more like private insurance, and a perception that charging premiums will lessen families' likelihood of dropping private coverage to enroll in more affordable public coverage, commonly referred to as "crowd out."

Research has examined the effect of premiums on children's access and enrollment. One study showed a strong association between premiums and enrollment in public programs, with an increase in public

premiums up to $10 resulting in a three-percentage point decline in public coverage among children whose family incomes were below 400 percent of the FPL.[25] A study that used four years of data from the Current Population Survey showed that for families with incomes between 100 percent and 300 percent of the FPL, results consistently indicate that raising premiums reduces enrollment in public programs, with some children picking up private coverage while others became uninsured. For a sub-set of near-poor children (with incomes between 100 percent and 200 percent of FPL), the magnitude of the effects of public program premiums appears greater, with larger reductions in public coverage. In addition, the results suggest that increases in public premiums may also have more pronounced effects on uninsurance when applied to children from minority backgrounds whose families have lower levels of educational attainment.[26]

The research literature reviewed for this report found that the negative effect that premiums have on enrollment and retention for children in SCHIP is comparable to other public programs. Studies looking specifically at states that increased SCHIP premiums are consistent with public program studies generally. When Arizona introduced new premiums for certain income categories into their SCHIP program in 2004, enrollment data indicates that the new premium reduced enrollment in the premium-paying group by 5 percent, or over 1,000 children. In Kentucky, a premium increase in 2003 resulted in reduced enrollment in the premium-paying group by 18 percent, or over 3,000 children.[27] In July 2003, premiums were increased in Florida's children's health insurance program by $5 per family per month. One study that examined the impact of this increase on enrollment duration indicates that families are sensitive to even a modest increase in premiums. After the increase took place, enrollment lengths decreased significantly, with a greater percentage decrease among lower income children than higher income children. Declines in enrollment length were also more pronounced based on a child's health status, with healthy children experiencing greater reductions in enrollment lengths.[28]

A review of the evidence that was conducted as part of the 2007 Congressionally-mandated evaluation of the SCHIP program for CMS (hereinafter referred to as the "2007 Congressionally-mandated SCHIP evaluation") found that families required to pay premiums are more likely to disenroll from coverage than families that are not.[29] The evaluation also found that "lockout" provisions that prevent families from re-enrolling once they have been disenrolled due to failure to pay premiums also appear to have a negative effect on retention. Premium payment policies and methods of collecting premiums (such as whether the states permitted grace periods or used simplified payment and collection processes) also have an impact on the degree to which children maintain coverage. The 2007 SCHIP evaluation noted that offering grace periods to families who did not pay premiums helped lengthen spans of enrollment. Other studies have found that waiting periods are also associated with lower rates of SCHIP takeup.[30]

On balance, these factors may contribute to some eligible children not enrolling in Medicaid or SCHIP and represent challenges states will likely confront as they try to cover more eligible children.

Seven Steps Towards Maximizing Enrollment of Eligible Children

This section revisits each of the Seven Steps themes to explore the most effective strategies for states to employ in order to identify, enroll and retain eligible children in Medicaid and SCHIP coverage. Each of these steps are presented with a discussion of the research, state experience and expert opinion that indicates whether a particular related strategy appears effective. In some cases, there is insufficient research to support a strategy or the strategy has only been tested in combination with other strategies. There is a section on page 39 at the end of the discussion of each of the seven themes that examines the impact of multiple strategies. The types of strategies are discussed here in the same order in which they were presented in *Seven Steps*.

1. Simplifying the Enrollment and Renewal Process

Since SCHIP was created in 1997, many states have focused their efforts on simplifying the enrollment and renewal processes for children and families in Medicaid and SCHIP as a means of reaching more eligible children. Research and state experiences since 1997 provide substantial evidence that simplifying enrollment and renewal processes can promote enrollment of eligible children, reduce unnecessary loss of coverage and promote continuous coverage for children.

The core principles driving state efforts to simplify administrative processes are an interest in making their systems more consumer-friendly, decreasing the complexity, burdens and barriers in the process and decreasing the number of steps needed to complete a process. In sum, the effect of simplification can be to improve state efficiency and to make it easier for individuals to navigate otherwise complex applications, enrollment and retention systems. As such, simplification is a broad term that can refer to a wide range of strategies, including shortening an application, providing joint applications for Medicaid and SCHIP, reducing citizenship or income documentation burdens, eliminating the need for individuals to apply for benefits in person and lessening the paperwork burden for individuals to renew coverage. However, it should be noted that not all simplification strategies necessarily have a positive impact on enrollment; for example, some states have found that a one-page application for SCHIP and Medicaid became too difficult and complicated for the average applicant to read and understand and decided to return to longer applications that were clearer in their instructions to readers. The ideas discussed here were indicated, either in *Seven Steps* or by research or experts, as simplification strategies. Some of these strategies also are relevant to other sections of this report.

Research and state experiences since 1997 provide substantial evidence that simplifying enrollment and renewal processes can promote enrollment of eligible children, reduce unnecessary loss of coverage and promote continuous coverage for children.
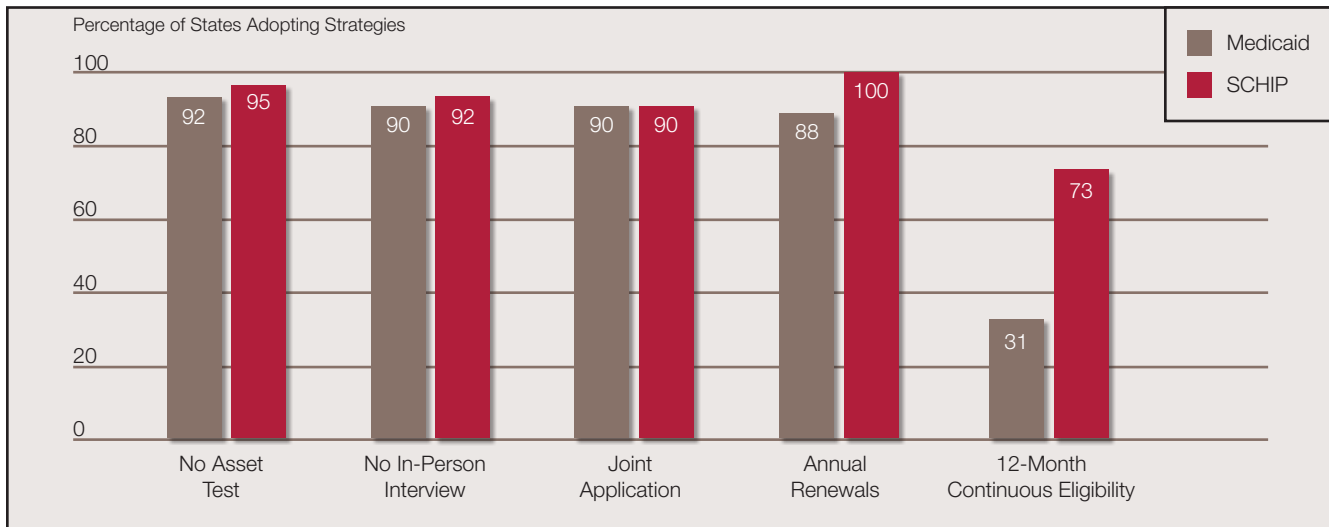
This section discusses state enrollment and renewal simplifications in turn.

A. ENROLLMENT SIMPLIFICATIONS

Available research indicates that keeping the enrollment process simple for families – by minimizing barriers to obtaining and maintaining coverage – can be central to facilitating enrollment of children in Medicaid and SCHIP. Enrollment simplifications also have the potential to help states and the federal government achieve administrative savings.

States vary in the extent to which they have adopted different enrollment simplification strategies, but most states have adopted three key strategies for both Medicaid and separate SCHIP programs: (1) elimination of the asset test; (2) elimination of in-person interviews; and (3) use of joint Medicaid-SCHIP applications. [31] Elimination of the asset test is the most accepted strategy among states: 95 percent of states (35 of 37 states with separate SCHIP programs) have eliminated the asset test for SCHIP and 92 percent (47 of the 50 states and the District of Columbia) have eliminated the asset test for Medicaid. Elimination of in-person interviews is the next most common strategy, with 92 percent (34 of 37 states) having adopted it in SCHIP and 90 percent (46 of 50 states and D.C.) having adopted it for Medicaid. Nine out of ten states with separate SCHIP programs (33 of 37 states) use joint applications for their Medicaid and SCHIP programs. Other enrollment or application simplification strategies are far less widely adopted.[32]

Table 2.   *Most Common Enrollment and Renewal Simplification Strategies for States*

Percentage of States Adopting Strategies

Legend: Medicaid, SCHIP

Strategy	Medicaid	SCHIP
No Asset Test	92	95
No In-Person Interview	90	92
Joint Application	90	90
Annual Renewals	88	100
12-Month Continuous Eligibility	31	73

Source: Donna Cohen Ross, Aleya Horn and Caryn Marks. *Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, January 2008).

Interviews with state experts and the results of our survey of state officials for this paper suggest that states believe enrollment simplification is an essential strategy for improving enrollment of eligible children. Most of the states that responded to our survey cited application simplification as one of the most effective means for enrolling more eligible children. Some states reported that improving coordination between Medicaid and SCHIP would be an effective strategy for enrolling eligible children. Specific strategies that were mentioned as being promising included having a common Medicaid/SCHIP application, coordinating program rules, online applications and more closely integrating agency staff and systems. Some states also expressed interest in either eliminating premiums in SCHIP or changing

the premium payment method to make premiums easier for families to pay as potentially effective enrollment simplification strategies.[33]

Most national experts interviewed for this paper also cited application simplification as a top strategy for states to enroll more eligible children. Experts interviewed cited simplifying the application process by allowing telephonic, mail-in or online applications as a promising strategy for enrolling children. A number of experts also cited the importance of improving coordination between SCHIP and Medicaid, eliminating asset tests, allowing self-attestation of resources and 12-month continuous eligibility requirements. Other ideas included eliminating face-to-face Medicaid interviews, simplifying eligibility requirements to provide the same eligibility levels for all Medicaid-eligible children, simplifying enrollment forms and reducing barriers created by the Medicaid citizenship and identity documentation requirements. The research literature has examined a number of specific strategies states have adopted to simplify enrollment, including:

Simplified Application Process

While most of the research merely documents the extent of state adoption of application simplification strategies, some studies show that application simplifications have a positive impact on enrollment of eligible children. A number of states have simplified their applications, eliminating unnecessary questions and making the applications easier for families to complete. As discussed above, nearly all states have stopped requiring parents of children applying for Medicaid or SCHIP coverage to apply in person and participate in a face-to-face interview with an eligibility worker. Many states also have allowed beneficiaries to apply for Medicaid and SCHIP by mail, over the phone, by fax or online. This makes the application process easier for working parents who have difficulty applying during conventional office hours or are reluctant to apply for coverage in state "welfare" offices.[34] (Online applications are further discussed in a later section of this report on states' use of technology.) The 2007 SCHIP evaluation reviewed data from three states over a five year period from FFY 1998 to 2002 and found that notable enrollment gains at the state and local levels occurred after application requirements were simplified in Ohio and online applications became available in Georgia.[35] However, the impact of these strategies is difficult to quantify because the strategies were employed in combination with other enrollment changes.

Citizenship Documentation Policies Challenging State Simplification Efforts

Some recent hurdles are also making it harder for states to cover eligible but unenrolled children. The Deficit Reduction Act of 2005 included new mandates requiring states to document the citizenship and identity of Medicaid applicants by reviewing, among other documents, original copies of birth certificates, passports or driver's licenses. These requirements undermine simplification efforts many states have undertaken in the past decade to improve enrollment of children. For example, most states have eliminated face-to-face interviews for Medicaid and SCHIP and some have allowed individuals to file applications electronically. But the citizenship documentation requirements add a new layer of complexity, making it more difficult for states to maintain simplified application and enrollment processes. Several states have reported that otherwise eligible citizen children are losing coverage as a result of this requirement. For example, Virginia reported that after the requirement took effect in July 2006, enrollment of children in health coverage fell by more than 9,000 as of February 2007.

Sources: Donna Cohen Ross, *New Medicaid Citizenship Documentation Requirement is Taking A Toll: States Report Enrollment is Down and Administrative Costs Are Up* (Washington, D.C., Center on Budget and Policy Priorities, March 2007); Presentation by Linda Nablo, Director, Division of Maternal and Child Health, Virginia Department of Medical Assistance Services, to Alliance for Health Reform, February 26, 2007.

By contrast, a 2004 study by Kronebusch and Elbel that used national data from the 2001 Current Population Survey to evaluate the impact of 14 different state policy variables on Medicaid and SCHIP enrollment raises questions about whether allowing applications to be submitted by mail or telephone improves enrollment. According to this study, which estimated the impact of a number of different simplification strategies on the likelihood of children enrolling in Medicaid or SCHIP, permitting mail-in or telephonic applications had no apparent effect on enrollment levels.

There is some evidence that simplifying the application process can promote state efficiencies. When Oregon reduced the number of steps for applying for Medicaid from 72 to 16, the time it took to enroll beneficiaries fell from 22 days to 3 days and the state's overtime costs for eligibility workers dropped, saving the state more than $28,000 a month.[36]

Reducing Income Documentation Burdens

Some states have diminished families' burden to provide documentation of income as part of the eligibility determination process when they apply for Medicaid and SCHIP coverage. Ten states do not require families to document their income at the time they apply for Medicaid coverage but instead verify the income that the applicant reports through data matching with other state systems, or in some states by auditing a sample of applications.[37] Eight states allow for such administrative verification of income when families apply for SCHIP.[38] The 2004 Kronebusch and Elbel analysis described above, which compared the impact of different Medicaid and SCHIP policies on enrollment in these two programs, found that reducing income documentation requirements increased the likelihood of children enrolling.[39] Moreover, some state experience suggests simplifying documentation requirements can also ease state administrative burdens and speed up the enrollment process. In Maryland, Baltimore city's application processing time fell after self-declaration of income was adopted.[40]

Eliminating Asset Tests

As discussed above, nearly all states have elected not to count a family's assets (such as a car or a savings account) in determining eligibility for children in Medicaid or SCHIP.[41] In a Kaiser Family Foundation (KFF) study based on interviews with officials in the nine states and the District of Columbia that had eliminated asset tests in 2000, state officials reported that eliminating the asset test allowed them to streamline the process of eligibility determination and make the enrollment process easier for families.[42]

States also said that dropping the asset test:

○ Improved eligibility worker productivity and reduced administrative costs. One state, Oklahoma, reported a savings of $1.2 million after it stopped its asset test, with administrative savings exceeding the costs of additional enrollment that occurred after the asset test was dropped.

○ Helped community-based organizations assist with outreach and applications.

○ Made adopting an automated eligibility system easier and helped change the culture of eligibility determination agencies, shifting their focus toward helping eligible families enroll and away from keeping the number of active caseloads low.

○ Did not cause eligibility error rates to increase.

Despite these positive findings associated with eliminating the asset test, the states studied by KFF reported that eliminating the asset test had a limited impact on enrollment. The likely reason for this is that few low-income families have assets. States indicated that the asset test therefore had little

impact on limiting eligibility, but did delay eligibility determinations and make the application process more difficult for families and agency staff. However, it was difficult for states to isolate the impact of eliminating the asset test because other changes to the application and enrollment process were made at the same time. [43] The 2004 Kronebusch and Elbel analysis that estimated the impact of several different state simplification strategies provides support for the view that requiring an asset test can be a barrier to enrollment. Their study determined that having an asset test requirement reduced the likelihood of children enrolling in coverage.[44]

Presumptive Eligibility

States have the option under federal Medicaid or SCHIP law to allow for temporary "presumptive eligibility" for children who appear to be eligible. States that take up this option can permit "qualified entities" (providers, schools, community based organizations, etc.) to enroll children who appear eligible into either Medicaid or SCHIP for about 60 days while the application process is completed. Fourteen states offer presumptive eligibility for children in Medicaid and nine of the 37 states with separate SCHIP programs offer it.[45] One study determined that presumptive eligibility was associated with higher takeup rates in SCHIP.[46] Another analysis that compared the impact of different Medicaid and SCHIP simplification strategies concluded that presumptive eligibility is among the strategies that have a positive impact on enrollment.[47]

Many experts interviewed for this paper highlighted the potential advantages of presumptive eligibility as a tool to enroll children into Medicaid and SCHIP quickly and simply at the point of entry to the health care system – in a doctor's office, hospital, school health clinic or at a community organization. However, some experts identified implementation challenges related to presumptive eligibility. Effective implementation requires careful administration, adequate funding and supportive systems. In cases where few providers are enlisted to enroll children as "qualified entities" or where states are not following up quickly on permanent enrollment for children, presumptive eligibility can fall short of its promise to enroll more children. Some state officials also have questioned the completeness and accuracy of information provided in the presumptive eligibility application process and have raised concerns that adopting presumptive eligibility could unnecessarily burden their administrative systems by requiring them to process both temporary and permanent applications instead of a single application. Some have suggested this could be addressed by using a standard application to determine presumptive eligibility for Medicaid or SCHIP.

Coordinating Medicaid and SCHIP Procedures

In the 37 states with separate Medicaid and SCHIP programs, transitioning between programs can require families to navigate two separate programs with two different sets of rules that are sometimes run by two separate agencies. This can be especially challenging for families if their children apply for one program but are eligible for the other program or if there are children in the same family who qualify for two different programs. Issues can arise at application and when younger children "age out" of Medicaid and become newly eligible for SCHIP. Federal law requires states to screen all children who apply to SCHIP for Medicaid eligibility and to enroll children in Medicaid if they are found eligible. This requirement is known as "screen and enroll" and can help prevent children from losing coverage if a parent applies to a program for which the child is not eligible, help children transfer from one program to another and ensure that Medicaid-eligible children receive Medicaid benefits and cost-sharing protections.[48]

To counteract disenrollments due to program transfers, some states with separate programs have

coordinated the two programs' eligibility rules to make renewal schedules and methods of counting income consistent or to permit eligibility workers to determine eligibility for both programs.[49] As discussed above, nearly 90 percent of states (33 of the 37) with separate Medicaid and SCHIP programs use a joint application for both programs to make applying easier for families.
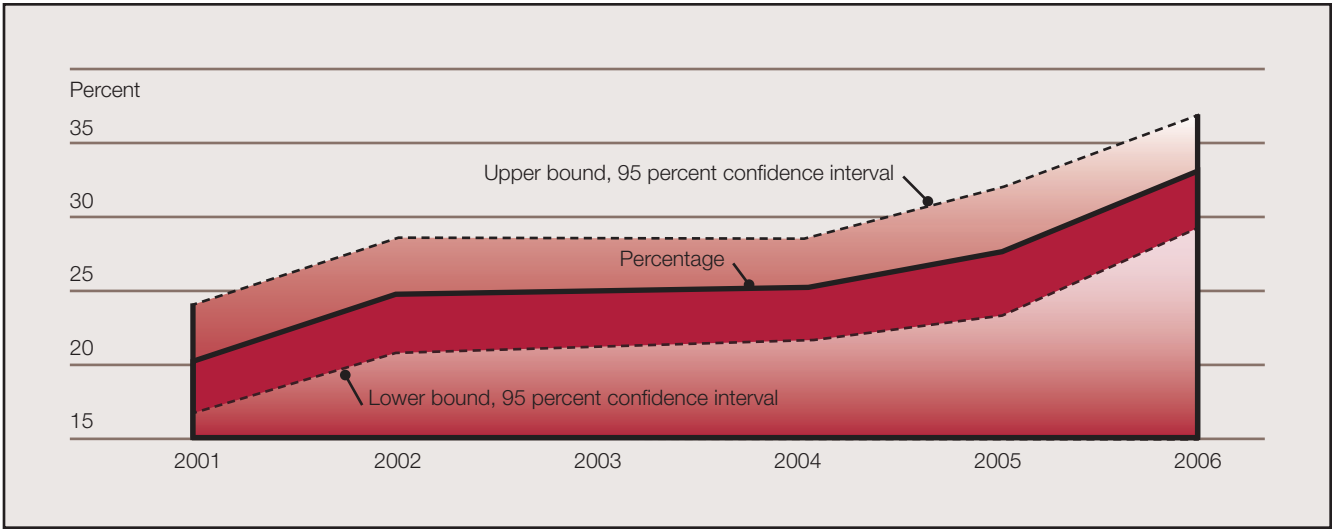
The research literature shows some positive effects on enrollment for states that have coordinated Medicaid and SCHIP rules and procedures. Virginia implemented a "No Wrong Door" policy in the fall of 2002, allowing applicants to complete a joint application for Medicaid and Family Access Medical Insurance Security or FAMIS (Virginia's SCHIP program) and submit the application either at the Department of Social Services office or the Central Processing Unit (which previously accepted only SCHIP applications). During the quarter this change was implemented in 2002, Virginia saw its quarterly new entries into Medicaid increase by 43 percent, from 16,000 to 23,000.[50] A case study of Virginia's experiences attributed most of this increase to the policy changes adopted at this time, notably the adoption of the No Wrong Door policy.[51] Indiana reported that having a joint Medicaid/SCHIP application form reduced its printing costs and cut in half the time state workers spent verifying information.[52]

B. RENEWAL SIMPLIFICATIONS

Although most states have simplified the application process for children to a greater extent than they have the renewal process, there is growing recognition that simplifying the renewal process is essential to maximizing enrollment of eligible children in public programs.[53] A recent study indicated that 42 percent of eligible but uninsured children had been enrolled in SCHIP or Medicaid during the prior year, underscoring the important role that state efforts to improve retention can play in increasing enrollment among eligible but uninsured children.[54] According to this study, the percentage of uninsured children having been enrolled for coverage in the prior year increased substantially from 2000 to 2006, indicating a trend is likely having a significant impact on the number of eligible but uninsured children.

In interviews for this paper, state experts reported they considered simplifying the renewal process an effective strategy for helping children to retain coverage. Many states felt that providing families with

TABLE 3.   Percentage of All Uninsured Children Who Had Been in Medicaid or the State
Children's Health Insurance Program (SCHIP) the Previous Year, 2001–2006

Percent

35

Upper bound, 95 percent confidence interval

30

Percentage

25

20

Lower bound, 95 percent confidence interval

15

2001   2002   2003   2004   2005   2006

Source: Authors' analysis of 2000-2006 linked samples from the Current Population Survey March Supplement from the article, Benjamin D. Sommers. "Why Millions of Children Eligible for Medicaid and SCHIP Are Uninsured: Poor Retention Versus Poor Take-up." *Health Affairs* Web exclusive 26 (July 26, 2007): w560-w567.

simplified or pre-populated renewal forms that the state filled out using existing information and which required the family to merely update any outdated or missing information was a promising approach. States also reported they are exploring new strategies to improve retention of coverage for eligible children at renewal and reducing "churning," or the extent to which children lose and then regain coverage. National experts agreed that improving retention is central to improving enrollment of eligible children. There was substantial support for increasing state adoption of 12-month continuous eligibility for both Medicaid and SCHIP and for simplifying the renewal process. National experts also stressed that a substantial number of eligible uninsured children are children who had been enrolled in Medicaid or SCHIP at some point in the prior year but lost coverage due to an administrative problem during renewal or were inadvertently dropped in transitioning between SCHIP and Medicaid because of income eligibility changes. Experts stressed that improving retention of eligible children at renewal will be a critical way for states to increase enrollment of eligible children overall.

There is significant support in the research that improving retention by simplifying the renewal process is a promising strategy for increasing enrollment of eligible children. The 2007 Congressionally-mandated SCHIP evaluation performed a meta-analysis of nine studies reflecting the experience of 22 states, finding that, overall, simplified renewal procedures, especially administrative renewal and guaranteeing continuous coverage, appear to increase retention in SCHIP.[55] This section describes the specific strategies that states have used to simplify the renewal process and the impact those strategies have had.

Annual Renewals and Continuous Eligibility

States have promoted stability in coverage for eligible children by requiring children and families to renew their coverage only once annually or by adopting policies that provide one year of continuous eligibility in Medicaid or SCHIP regardless of income changes; this essentially guarantees coverage to children who are determined eligible for one full year. Forty-four states and the District of Columbia require children to renew Medicaid coverage annually rather than every six months (while one state

requires income determinations every six months), and all separate SCHIP programs have annual rede-terminations. Fewer states guarantee continuous eligibility, with only 73 percent of states with separate SCHIP programs (27 out of 37 states) offering continuous eligibility and 31 percent of states offering this guarantee in Medicaid (16 out of 50 states and D.C.).[56]

Annual renewals and 12-month continuous eligibility appear to have had a significant impact on main-taining coverage for eligible children in Medicaid and SCHIP. The 2007 Congressionally-mandated SCHIP evaluation noted that administrative renewals, renewal simplifications and 12-month continuous eligibility were among the policies that helped promote enrollment in SCHIP.[57] The evaluation specifically noted that three studies involving nine states indicated that continuous coverage can delay disenroll-ment from SCHIP. In addition, a 2006 study of SCHIP enrollment patterns in six states found that states with 12-month continuous eligibility promoted children's enrollment in SCHIP for up to a full year (though it did not avert disenrollment at the end of the 12-month period).[58]

Washington State's experience changing its policies regarding 12-month continuous eligibility suggests continuous coverage can have a significant impact on enrollment and state administrative burden. When Washington made a number of changes to its Children's Medical Program in 2003 – which included discontinuing 12-month continuous eligibility, requiring families to instead renew eligibility every six months, increasing verification requirements and eliminating telephone renewals – enrollment fell by more than 30,000 children. The state also found the "churning" of eligible children off and on the program increased by 12 percent after six-month renewals were reinstated and other policy changes were made. When the state reversed these decisions in 2005, enrollment increased and returned to its previous levels. When six-month renewals were in effect, the costs of administering the state's Children's Medical Program increased, backlogs of applications and renewals were created and hospital charity increased.[59]

TABLE 4.   *Children's Enrollment in Washington's Public Insurance Programs, April 2002–October 2005*
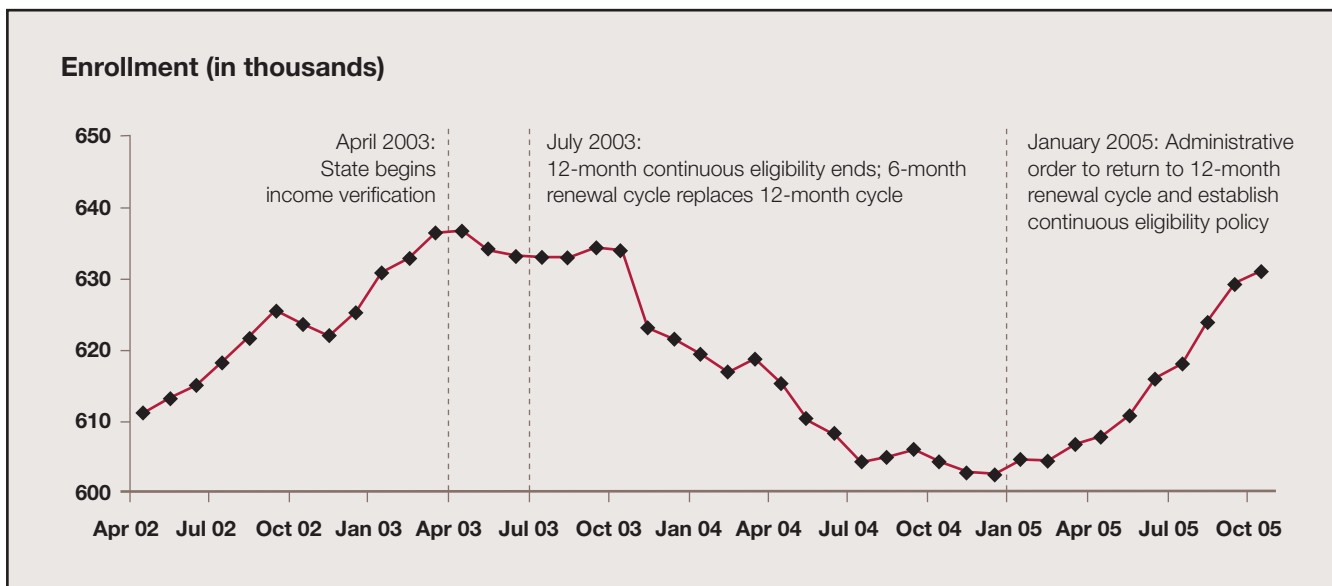
Source: Laura Summer and Cindy Mann. *Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies*, (New York, NY: The Commonwealth Fund, June 2006).

Administrative Renewal

Under administrative renewal policies, states simplify the renewal process for families by using information the state already has to minimize the requests for information to the family. In some cases, states allow families to renew coverage over the telephone, use technology to verify information through other databases that are available to the state or provide families with a prepopulated form to review and submit in order to renew coverage. Some states default to renewal unless they receive a renewal form that contains information disqualifying a child for coverage.

Administrative renewal is associated with increased retention in a number of studies. Two studies comparing states with administrative renewals with other states found a sharp increase in disenrollment during the renewal month among states without administrative renewal, while the states with administrative renewal had stable per-month disenrollment.[60] One study found that Florida's disenrollment of children at renewal increased after the state transitioned from administrative renewal to a renewal process requiring more action on the part of the families.[61]

Allowing "off-cycle" renewals, or when states permit families to renew through another contact with the state or at a provider or community-based organization prior to their scheduled redetermination date, is another strategy states are employing to lower the burden of renewal. There does not appear to be any empirical evidence demonstrating the success of off-cycle renewals in improving enrollment.

A policy that supports states' ability to implement administrative renewals is the elimination of a face-to-face interview as part of the renewal process. Most states have eliminated face-to-face interviews for renewals of coverage for children – 94 percent of states (48 out of 50 states and the District of Columbia) do not require face-to-face interviews for Medicaid renewals and 97 percent (36 of 37 states) do not require face-to-face interviews for SCHIP renewals.[62]

Most results from states that have implemented different forms of administrative renewal have been promising:

Once Arkansas began phone renewals and performed more intensive follow-up for incomplete renewals, the rate at which incomplete cases were closed fell from 25 percent to 6 percent.[66]

○ In 2001, Louisiana began "ex parte" renewal, using information from other state programs in advance of sending families a renewal form to complete. According to data the state provided to researchers, in one month in 2005, only one-third of Medicaid enrollees were required to submit renewal forms. The rest of the enrollees had ex parte renewals, in which contacting the family was not necessary, or coverage was renewed over the telephone. According to Louisiana, the proportion of children who retained eligibility at renewal increased from 72 percent to 92 percent between June 2001 and April 2005.[63] The proportion of enrollees who lost coverage due to failure to return forms also fell from 17 percent to 1 percent.[64] The state also found that it was less time-consuming for eligibility workers to obtain this information administratively than it was to process an application-based renewal or to open and close new cases.

○ In Michigan, eligibility worker productivity increased by 25 percent after self-declaration of income was permitted at renewal. Maryland experienced no change in error rates after it implemented self-declaration.[65]

○ Once Arkansas began phone renewals and performed more intensive follow-up for incomplete renewals, the rate at which incomplete cases were closed fell from 25 percent to 6 percent.[66]

○ Rhode Island, however, reported that providing families with filled out forms and asking them only to provide information on changes that took place since the last application or renewal had little impact on renewal rates.[67]

○ A 2002 study reported that when Florida's KidCare program sent families a preprinted renewal form and asked families to return the forms only if the information had changed, retention of coverage improved. Ninety-five percent of children remained enrolled in KidCare after renewal compared with 50 to 67 percent of kids who remained enrolled in some states with more onerous renewal policies.[68]

"Bridging" Transitions Between Medicaid and SCHIP Coverage

Some states have tried to make children's transitions between Medicaid and SCHIP coverage easier to prevent loss of coverage for eligible children both at renewal and as family status or income fluctuates throughout the enrollment period. Improving links between these two programs at renewal can have a significant impact on helping children maintain coverage. One study estimated that each year 27 percent of SCHIP enrollees, approximately one million children, switch to Medicaid, and 6 percent of Medicaid enrollees, roughly 1.4 million children, switch to SCHIP.[69] This means that as many as 2.4 million children may transition between Medicaid and SCHIP each year. Having a high degree of coordination between Medicaid and SCHIP has been found to be important in maintaining stable coverage for children.[70] There is also considerable evidence that SCHIP implementation had a "spillover effect" on Medicaid enrollment. This likely occurred for several reasons: SCHIP outreach identified

TABLE 5. *Disenrollment, Program Switching, and Dropout Among Children in Medicaid and the State Children's Health Insurance Program (SCHIP), 2001–2004*

	Percent Initially in Medicaid*	Percent Initially in SCHIP*	P value[a]
Disenrollment (n=8,473)			
Program-specific	34.3 (1.1)[b]	62.7 (2.1)[b]	<.001
Public insurance	28.0 (1.0)	35.9 (2.0)	<.001
Program switching (n=8,473)	6.3 (0.5)	26.8 (2.0)	<.001
Among public insurance disenrollees (n=2,404)			
Lost eligibility only	3.2 (0.5)	6.8 (1.6)	0.008
Acquired new insurance only	39.2 (2.1)	37.9 (3.4)	_[c]
Acquired new insurance and lost eligibility	12.9 (1.3)	11.9 (2.3)	_[c]
Dropped out	44.7 (2.1)	43.5 (3.4)	_[c]
Overall dropout among children in public insurance (n=8,473)	12.5 (0.7)	15.6 (1.5)	0.051

Source: Author's analysis of data from the Current Population Survey (CPS) March supplements, 2001 – 2004 from the article, Benjamin Sommers, "The Impact of Program Structure on Children's Disenrollment from Medicaid and SCHIP," *Health Affairs* 24, no. 6 (November/December 2005): 1611-1618.

*Note: Standard errors are in parentheses.

[a] *P* value of chi-square for null hypothesis that each variable does not differ across SCHIP and Medicaid children.

[b] Standard errors clustered at the household level: all estimates employee CPS household survey weights.

[c] Nonsignificant (*p*=.10).

Georgia Succeeds Through Medicaid-SCHIP Coordination

Georgia's insurance program for children, PeachCare, has demonstrated its success by an impressive growth in enrollment, from 48,000 in FY 1999 to more than 300,000 in FY 2005. A significant contributing factor to this success is the seamless enrollment and retention of Medicaid and SCHIP enrollees. Georgia not only used strategies that involved coordination of outreach and application processes, it also introduced a preprinted renewal form and administrative renewal process in 2001 for PeachCare enrollees and Medicaid enrollees who came in through PeachCare. Eligibility is renewed every 12 months for PeachCare children and every six months for children in Medicaid. An enrollment broker mails a letter to the family with preprinted information that the family has already supplied; families are only asked to call the hotline to update incorrect information or to disenroll their child. The single point of entry for many children into Georgia's public insurance programs, along with collaboration from agencies on outreach, joint applications and administrative renewal, contributes to the successful coordination between the programs. The substantial number of children who have applied for PeachCare in Georgia but were found eligible for Medicaid further demonstrates the efficacy of the alignment between Medicaid and SCHIP.[72]

Medicaid-eligible children; a "screen and enroll" provision required coordination between SCHIP and Medicaid during the initial application process; and Medicaid enrollment and renewal procedures were streamlined in states following SCHIP's lead. The study suggests that a similar process to "screen and enroll" at the renewal time could better facilitate the transfers between SCHIP and Medicaid.[71]

Coordination, or lack thereof, has been shown to affect the coverage status of SCHIP disenrollees after they leave the program. According to one in-depth study with 10 states, variability in program coordination has contributed to important cross-state differences in coverage of SCHIP disenrollees. In states with separate SCHIP programs, 37 percent of those who disenrolled were still uninsured after six months, compared with only 22 percent in Medicaid expansion states and 24 percent in combination programs. Lack of referral to and coordination with Medicaid appears linked to the discrepancies in coverage after leaving SCHIP and suggests the importance of coordinating extending coverage for children who do leave SCHIP.[73]

Increasing coordination between Medicaid and SCHIP by using joint renewal forms or synchronizing the programs' renewals can be an effective strategy to promote retention.

States have pursued different strategies to simplify the transition between Medicaid and SCHIP for children whose family income changes and consequently affects their eligibility during enrollment, as well as for children who transition from Medicaid to SCHIP as they grow older (a result of Medicaid's "stair step" eligibility structure). For example, California created a "bridge" program for children who are moving between Medi-Cal, the state's Medicaid program, and Healthy Families, its SCHIP program. Although the program does not automatically enroll a child who is losing coverage into the other program, it has had an impact. According to the state, about 25 percent of children in the Medi-Cal bridge program successfully transferred to Healthy Families, 44 percent re-enrolled in Medi-Cal using a different eligibility category and just under one-third lost coverage.[74] Increasing coordination between Medicaid and SCHIP by using joint renewal forms or synchronizing the programs' renewals can be an effective strategy to promote retention.[75] Other states have sought to improve transitions through automated referrals. When Iowa automated referrals of applicants from SCHIP to Medicaid, the number of referrals increased while the time it took to make referrals decreased.[76]

2. Conduct Community-Based Outreach and Application Assistance

In addition to simplifying the application and renewal process, states have performed substantial outreach to children and families to help them enroll in Medicaid and SCHIP. Outreach generally involves providing information to individuals to raise awareness of these programs, individuals' potential eligibility and assisting potential beneficiaries in enrolling or renewing coverage. Community-based organizations like schools, community health centers and local organizations play a key role in outreach and enrollment assistance because they can capitalize on families' existing relationships and trust. For families who face language or cultural barriers, live in remote areas, need extra assistance due to literacy or numeracy issues or do not trust government, assistance from community-based organizations can provide a vital link to Medicaid and SCHIP.

The research literature reviewed for this paper focuses primarily on the role of community-based organizations in performing application assistance and suggests that outreach efforts need to be carefully targeted in order to be influential and cost-effective.

In interviews with state and national experts for this paper, it was clear that experts have a high degree of confidence in community-based outreach as a means of enrolling eligible children in Medicaid and SCHIP. Building relationships with schools and community-based organizations like clinics and day care providers and working with application assistors were all cited by states as top strategies for

Community-based organizations like schools, community health centers and local organizations play a key role in outreach and enrollment assistance because they can capitalize on families' existing relationships and trust.

maximizing enrollment for children. States work with these organizations to promote awareness of public programs, distribute materials and conduct application assistance. States are interested in targeting outreach efforts to specific populations, like Latinos and Native Americans, as potentially effective strategies for reaching these groups. Most national experts also cited having states use community workers to find and enroll eligible children as a top strategy for enrolling eligible children.

This section of the paper discusses outreach and enrollment activities involving community-based organizations, but related elements of working with community-based organizations will also be discussed in later sections. Partnering with community organizations and others to promote enrollment is discussed later in Section 6. Marketing efforts that include outreach, advertising and media work are discussed later in Section 7. This organization of ideas reflects the manner in which these issues were discussed in *Seven Steps*.

Involving Community-Based Organizations in Outreach

Many states actively involve community-based organizations in helping to enroll eligible children. Massachusetts, for example, contracts with community organizations to enroll children in a number of programs, including health coverage, food stamps and WIC. The state found that when this outreach was reduced in the early part of the decade, "churning" of eligible enrollees increased. When several counties in California implemented Children's Health Initiatives (CHI), which worked to both expand insurance coverage to children below three times the FPL and implement extensive outreach efforts, enrollment increased for some of California's Medicaid, SCHIP and Healthy Kids programs. One study on Santa Clara County's CHI attributed part of its enrollment growth to the role of community-based organizations, including their role in providing application assistance.[77]

The evidence from the literature on the effectiveness of outreach generally shows that community-based outreach has had a positive impact on Medicaid and SCHIP enrollment. Most of this literature focused on the role of community-based organizations in providing application assistance. Although the exact size of the impact is not measured, the 2007 Congressionally-mandated SCHIP evaluation noted that the creation of the SCHIP program, combined with state efforts to improve outreach and simplify the enrollment process, made a definitive impact on providing health coverage to eligible children.[78] A study of California's Medi-Cal and Healthy Families outreach efforts in 2001 found that increased funding for outreach through application assistants, community-based organizations, schools, and a program targeting working families was associated with a six to seven percent increase in children's enrollment.[79]

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The positive impact of community-based outreach on enrollment of eligible uninsured children appears to be especially true for racial and ethnic minority populations or immigrant groups, because community organizations frequently have the trust of community members.[80] In addition, outreach through community organizations has helped increase enrollment in Medicaid for Latinos and Asians in California, according to one study.[81] Montana reported a 23 percent increase in enrollment of Native American children over a two-year period arising from increased outreach through community-based organizations like tribal health centers, Indian Health Service clinics and Urban Indian organizations. Montana's increase in enrollment for Native American children was more than twice the enrollment-rate increase of 9.5 percent for all children during the same two-year period.[82]

Application Assistance

In some states, application assistors help families apply for Medicaid or SCHIP by explaining eligibility rules and benefits, helping families fill out and submit forms and working with families on obtaining documentation. Application assistors can work at hospitals, clinics, or community-based organizations and help families complete applications, but they cannot determine eligibility.

States also can assign, or "outstation," eligibility caseworkers at certain locations outside of the state eligibility offices, like schools, community health centers, hospitals and other local organizations. Out-stationed workers *can* determine Medicaid eligibility. Generally, the evidence from the research literature suggests application assistance can be a very effective approach to enrolling uninsured children, especially when it is offered in concert with simplified application and renewal procedures:

○ Application assistance has helped a number of states reach diverse populations.[83] For example, when uninsured Latino families in Boston received community-based case management to reduce coverage barriers, the likelihood that these families obtained coverage increased from 57 percent to 96 percent.[84] With this model of case management, including application assistance, these families also were more than twice as likely to remain insured continuously for one year, more likely to obtain coverage faster and had a much higher level of parental satisfaction with the process of obtaining coverage. Researchers concluded that having bilingual case managers who were trained and dedicated to addressing barriers facing Latino children, serve as advocates for obtaining health coverage for children and assist parents with application completion were key to the success of this program.

They described this intensive, targeted case-management program as more effective than "tradition-al" outreach and enrollment efforts for Medicaid and SCHIP, which more passively relied on mailings, advertising and toll-free telephone lines and lacked direct assistance with enrollment.

○ A 2003 study by the Rockefeller Institute of Government compared the relative impact of outreach strategies through interviews with officials and reviews of documents and data in 18 states. The study found that conducting outreach through personal communication (in which someone provided information to prospective clients or assisted them with completing applications) had a "positive and significant" impact on Medicaid and SCHIP enrollment. According to the report, person-to-person outreach was especially effective when states also used brochures, Web sites and toll-free lines. The report noted the benefits of personal contact: that it "allows face-to-face interaction for the purpose of making customized presentations, answering questions, and explaining the application process." The report also noted that, while personal outreach is the most expensive of all outreach strategies, it is considered among the most effective.[85]

○ A study that used a 2001 state-wide California survey and administrative data to estimate the impact of outreach efforts found that funding outreach for application assistance, community-based orga-nizations (CBOs) and schools, application and enrollment support for families had a positive impact on Medicaid enrollment. However, this same study found that the number of sites that employed out-stationed Medi-Cal eligibility workers was not associated with an increase in Medicaid enrollment for kids. By contrast, the number of outstationed workers was associated with increased enrollment of adults and the reduction of uncompensated care for safety net providers. This same study found that a large scale media campaign was not effective, and the authors concluded, "All outreach strategies are not equally cost-effective."[86]

○ As part of an overall package of simplification strategies, New York State has employed facilitated enrollment whereby workers in community organizations and health plans help find and enroll hard-to-reach families, screen for eligibility, complete applications, supply documentation and perform the required face-to-face interview.[87] In 2005, facilitated enrollers submitted more than 500,000 applications.

○ In California, using application assistors increased the likelihood that applications were both com-pleted and approved for enrollment.[88] The state trained certified application assistants (CAAs), who could work with schools, providers and community organizations to help families in the community complete their mail-in applications and renewals. CAAs were paid for each successful applica-tion that they helped a family complete. Illinois uses a similar approach.[89] An analysis of outreach in California that was undertaken from 1998 to 2000, as the SCHIP program was being launched in that state, found that bilingual community-based application assistance helped increase enrollment in Medicaid.[90] The results of this analysis suggest that Spanish-language application assistance through community-based organizations increased enrollment of Latino children in Medicaid by nine percent; Asian-language application assistance increased enrollment of Asian children 27 percent. This study also found that health care providers were more successful at increasing enrollment than other types of community-based organizations. The analysis also estimated that the increase in Medicaid enrollment associated with the outreach efforts decreased avoidable hospitalizations for children. Mississippi found applications from Native Americans increased after the eligibility workers were outstationed at a reservation to help complete applications onsite.[91]

3. Use Technology to Coordinate Programs and Lower Administrative Barriers

Well-designed technologies have the potential to support state goals of overcoming barriers among programs, facilitating data sharing, speeding the application process and reducing errors, all of which can add up to faster, simpler enrollment that reaches more children and costs the state less to administer. There are also potential benefits from states' use of technological resources, including the internet and computerized information networks, to reduce burdens for families and state staff. Specific examples of strategies that can be employed to reduce administrative barriers for individuals and states include information-sharing among programs with similar eligibility requirements, creating universal application forms for different public programs and online applications.

State and national experts interviewed for this paper indicated support for states tapping into technology as an emerging resource for enrolling more eligible children. States are interested in moving forward with online applications to help enroll eligible children. State and national experts also expressed interest and support for improving technological supports for data coordination among state agencies to facilitate outreach, enrollment and renewal improvements.

However, states' use of technology for these purposes is still an emerging area, and the available research literature has not yet explored these systems' impact on enrollment. Instead, much of the research is more descriptive about state efforts and innovative initiatives. Although there are a number of technological innovations underway, this section focuses on two key areas more states are exploring: online applications and data sharing among agencies.

Online Applications

Much of state activity in the technological arena has focused on online applications. Thirty-eight of the 41 states who responded to questions regarding online applications in a recent NASHP survey said online applications for Medicaid or SCHIP are available in their state. While most states said that the application must be downloaded, two states reported that they currently also determine eligibility online. Five states reported that they allow online renewals.[92]

A number of states that have redesigned their eligibility systems to allow individuals to apply for multiple programs through one application process have seen positive effects:

○ In Pennsylvania, individuals can apply for and renew coverage for Medicaid, SCHIP, food stamps, cash assistance and other programs online, using the state's COMPASS application system. COMPASS accepts electronic signatures, so applicants never need to come into state offices. Renewals ask applicants to confirm information that is already in the system. The system minimizes the likelihood of errors due to handwriting. Pennsylvania also uses a Master Client Index system to store eligibility information across programs that eligibility workers can access easily, easing renewal and eliminating the need for beneficiaries to supply information that does not change.[93]

○ Massachusetts uses a "Virtual Gateway" through which application assistors can use a single electronic form to apply for Medicaid, food stamps, WIC, child care and other programs. Providers can access the system to determine patients' health insurance status and help uninsured people apply

for public coverage. A review of the gateway found that the system reduced the time it took to obtain an eligibility determination and improved individuals' overall experience of applying for benefits.[94]

○ Although upgraded eligibility systems can require a substantial up-front investment on states' parts, they can also generate long-term savings. Florida has implemented an eligibility redesign across its programs and has estimated savings of $83 million through its online application system that helps beneficiaries apply for several different programs. Arizona and New York have also estimated administrative savings associated with new systems.[95]

These systems can also speed up the application determination process substantially and make it easier for application assistors to help families complete their applications for coverage.

Sharing Data from Other State Programs to Identify and Enroll Children

Some states have begun using information from other programs that serve low-income populations, like the NSLP, WIC, food stamps and cash assistance, to identify and enroll low-income children in Medicaid or SCHIP. For example, 16 of the 38 states that responded to a NASHP survey reported that they link their on-line applications to other programs. SCHIP agencies reported that applications are linked to a variety of programs including Medicaid, the low-income energy assistance program and state-funded health coverage programs. Medicaid agencies reported that applications are linked to SCHIP, early-intervention programs for children ages zero to three and early Head Start. Utah, in particular, has an innovative online resource that reduces the burden on families applying for a state program by providing an integrated front-end interface for various types of assistance that are often disconnected. The Web site (www.utahclicks.org) allows families to learn about and apply for programs including Medicaid, Head Start and SCHIP, 24 hours a day, 7 days a week, in Spanish or English.[96] The ability of state computer systems to share information across programs quickly and accurately is central to their effectiveness.[97]

States have tried different approaches to enrolling or renewing coverage for Medicaid and SCHIP based on the applicants' participation in other programs. Although these efforts have not been comprehensively reviewed, some states have had success in using limited forms of automated or streamlined mechanisms to assist in enrolling or renewing coverage for eligible children:

○ Louisiana has used information technology to make the redetermination process easier for families by linking Medicaid data systems to those of the state agencies that administer food stamps and cash assistance and to state income-reporting databases. This process allowed the state to successfully renew eligibility for 60 percent of all redeterminations without contacting the parent. In addition, the percentage of all children whose coverage was dropped for procedural reasons fell from 25 percent to 4 percent.[98]

○ Vermont has used technology to improve data-sharing between the Medicaid and WIC programs. Since 1989, the state has used a single application process to evaluate eligibility for both. Consequently, 97 percent of Vermont children enrolled in WIC also have health coverage.[99]

○ California implemented accelerated, streamlined enrollment into Medicaid and SCHIP through an Express Lane eligibility program, using information from the NSLP application to provide presumptive eligibility for children who appear eligible. However, California found the process of identifying eligible children to be labor intensive for both schools and counties, requiring additional funding and staff to conduct outreach and complete applications. While the program has been successful

in enrolling more uninsured children into presumptive eligibility status, it has fallen short in ensuring that more children receive permanent, ongoing coverage. One of the issues California has faced is that a significant percentage (40 percent) of the children applying for coverage as a result of being identified through Express Lane were already enrolled in Medi-Cal or Healthy Families. These many applications from current enrollees create an administrative challenge which could be addressed through data matching, but the state's computer systems currently cannot perform this function. Another issue is that many families did not complete the additional paperwork that is required for a full eligibility determination, which meant that children lost coverage after their brief period of presumptive eligibility.[100]

Many states are piloting new programs to identify and enroll children using data from other programs. Further research will be warranted in the future to determine the most successful strategies for state efforts in this area.

4. Change Agency Culture to Promote Enrollment Goals

Research suggests the culture of state eligibility agencies can play an important role in improving enrollment of eligible children. Many state eligibility agencies have historically emphasized adherence to procedures over promoting enrollment of all eligible individuals. Changing the culture of eligibility agencies to ensure enrollment goals are supported at all organizational levels is an essential part of simplifying the enrollment and renewal process.

Seven Steps forum participants identified a number of strategies states might consider in redesigning agency culture to improve support for enrolling eligible children, including: 1) making the goals of the program clear; 2) changing the language agencies use to positive terms, such as describing individuals applying and enrolling as "customers" and stressing a culture of service; 3) training staff and keeping them informed about policy changes; 4) creating systems to implement and monitor new policies and procedures; and 5) providing the tools to improve eligibility workers' ability to perform well.

Changing the perspective of eligibility workers can improve parents' perception of whether the Medicaid or SCHIP agency will support their efforts to obtain coverage for their children.

Some of the state experts interviewed for this paper stressed the importance of agency culture in improving enrollment. One state expert cited her experience refocusing her state's eligibility worker culture as evidence of the dramatic changes states can reap when caseworkers are given opportunities to more directly interact with families and when the standards by which their performance is judged shift from closing cases to keeping children enrolled.

Although the research literature does not measure the impact of organizational culture change on enrollment, the experience of a number of states suggests that agency culture is a central piece of the puzzle of enrolling eligible children. In focus groups of parents of eligible children in California, parents expressed concern that during the application and enrollment process they were being "talked down to" or stereotyped.[101] These perceptions can have a negative impact on the likelihood that a parent will apply for coverage for his or her child. Changing the perspective of eligibility workers can improve parents' perception of whether the Medicaid or SCHIP agency will support their efforts to obtain coverage for their children.

Some states have reoriented their eligibility agency culture with positive results:

○ Louisiana implemented a top-to-bottom reorientation of eligibility caseworkers as part of its efforts to enroll more eligible children and address high rates of disenrollment at renewal. The state conducted "internal marketing" for caseworkers to explain why having health insurance is important to low-income people, provided opportunities for caseworkers to work outside of the office to help families enroll and rewarded caseworker efforts to enroll or retain coverage for more children. The state also changed professional standards for eligibility workers making them accountable for enrolling eligible individuals and maintaining their coverage. Louisiana's deputy Medicaid director told researchers: "All Medicaid eligibility management and first line supervisors were trained in the agency's new philosophy. This internal marketing was very important for everything that has followed."[102] Louisiana also changed its renewal policies to avoid unnecessary case closures and encouraged workers to avoid unnecessary disenrollments during the renewal process. The state says that these efforts have paid off and estimates that only one percent of eligible children do not retain coverage during the renewal process.[103] This goal was achieved without additional investments in staff and actually resulted in faster application processing and reduced burdens for caseworkers.

○ As part of a 2002 outreach campaign for Kansas's HealthWave program in 2002, the state recognized that it needed to shift agency culture to support its goal of enrolling eligible children. Historically, the agency's focus had been on keeping ineligible individuals out of public programs. The state provided social marketing training to staff and began discouraging describing HealthWave as a "social services" program. To support this goal, some local agency offices were given the authority to make decisions about how to conduct outreach in their communities.[104]

○ Pennsylvania has been working to change the culture of its CHIP agency and realigning expectations of eligibility workers to ensure that they are oriented toward helping eligible people get coverage and away from keeping ineligible people off the program. The state underscored the need to provide incentives to people who are making progress toward the goal of enrolling eligible children.[105]

5. Engage Leaders to Champion the Goal of Covering Children

Research suggests that high-level leadership within a state, particularly on the part of the governor, can contribute to a state's success in enrolling children in public programs. Publicly setting a goal of enrolling children is a fundamental ingredient for success. Other state leaders, including state legislators, Medicaid and SCHIP directors and community leaders, can play a significant role in promoting the visibility of the need for enrolling children.

A NASHP study of eight states with initiatives aimed at covering all children identified gubernatorial leadership as a key factor cited by state officials as important to helping states achieve the goal.[106] An evaluation of the RWJF *Covering Kids and Families* (CKF) initiative also identified state government leadership as an important component in whether states were successful in achieving and maintaining enrollment gains in health coverage for eligible children.[107] The evaluation found that the CKF coalitions had the greatest success in implementing strategies for covering more children if they included in their membership SCHIP and Medicaid officials with the authority to make program changes. The evaluation also found that successful states had "strong leaders who set the agenda and maintained the focus on goals and good communication among members."[108]

Research on recent state experiences underscores the importance of high-level leadership in promoting enrollment and retention of eligible children in Medicaid and SCHIP:

○ One review of four states working to promote stable coverage by preventing eligibility "churning" at renewal demonstrated the importance of high-level leadership and commitment. In two states that successfully promoted maintaining coverage for eligible children, Virginia and Washington, the states' governors issued executive directives supporting these goals. In Virginia, Governor Mark Warner, made a campaign promise to enroll eligible children in public programs. The review found that setting explicit goals of increasing enrollment and retention for the state encourages consideration of changes needed to support these goals. According to this review, "States operating under gubernatorial directives to increase enrollment and stability of coverage are better positioned to conduct comprehensive reviews of program renewal procedures, make changes and revisit policies when changes do not produce desired results."[109]

○ Studies examining the experiences of two states that made significant progress in enrolling eligible children, Virginia and Arkansas, noted that these states both had strong leadership at the state or local levels that focused on enrolling eligible children and expanding health coverage for children.[110,111] As one Virginia state official said in 2007 when describing the state's efforts to cover eligible children: "Leadership is key."[112]

○ In 2005, Illinois created the All Kids program, making Illinois the first state to enact legislation providing comprehensive coverage to all children. All Kids encompasses Medicaid and SCHIP and allows families that do not qualify for Medicaid or SCHIP to purchase coverage through the state. A recent study of states' experiences expanding coverage to children suggests that the governor's leadership was an important factor in passing legislation and promoting awareness.[113]

○ Additional states are working toward covering uninsured children with gubernatorial leadership. In 2008, at least 13 states had initiatives or plans for covering all children in the state, supported by gubernatorial leadership.[114] In Connecticut, Governor M. Jodi Rell has supported significant new outreach efforts to enroll uninsured children into the state's HUSKY program for children. Last year, the state reported that the number of children enrolled in HUSKY had increased by 5 percent in 10 months.[115] In Oregon, Governor Ted Kulongoski announced in 2007 a Healthy Kids plan to cover the state's 117,000 uninsured children.[116] New Hampshire Governor John Lynch has set a goal of enrolling more eligible children, and has followed up by increasing funding for outreach strategies.

In states with high-level leadership to cover children, state leaders have provided a central voice to inform the public about the availability of health coverage, gain support for new policies in the legislature, convey a clear message and goal to the agencies that are executing new policies, execute any administrative changes needed to support the goal and leverage additional resources to identify and enroll eligible children. Although leadership alone is not enough to promote significant new enrollment of eligible children, it can be very helpful in propelling enrollment efforts forward.

6. Engage Partners to Help Achieve Coverage Goals

Seven Steps forum participants identified state partnerships with access to a range of state and community agencies and organizations as playing an important role in covering uninsured children. Organizations cited include schools, community organizations, foundations, businesses and providers. State experts interviewed for this paper agreed that partnerships, particularly partnerships with schools, are an effective method of helping children enroll.

States are working with providers, schools, day care providers, community organizations, parent teacher associations, government programs like Head Start, community health centers, hospitals and tribal

TABLE 6. Examples of Community-Based Partners that Collaborated with States to Conduct SCHIP Outreach

Educational
- Schools and School Districts
- School-Based Health Clinics
- After-School Programs
- Local Universities
- Private K-12 Schools
- Professional Associations Representing Educators

Community-Based Organizations
- Big Brother and Big Sister Programs
- Children's Advocacy Organizations
- Local Philanthropic Organizations
- Legal Aid Offices
- Local Park Associations
- Neighborhood Associations
- Parent-Teacher Associations (PTAs)
- Voluntary Organizations Serving Immigrants and Refugees

Health Care Providers
- Community Health Centers
- Hospitals
- Immunization Clinics
- Individual Physician Offices
- Professional Associations (e.g., State Pediatric Association, State Dental Association)
- Minority Health Groups (e.g., the Interagency Farm Workers Coalition and the African-American Health Committee

Private Businesses
- Chambers of Commerce
- Child-Care Providers
- National Chains (e.g., Wal-Mart, K-Mart)
- Restaurants (e.g., McDonald's Franchises)
- Supermarkets
- Shopping Malls

Public Agencies
- Local Fire and Police Departments
- City Parks and Recreation Departments
- Municipalities
- National School Lunch Program
- Public Libraries
- State Department of Education
- State Department of Health
- State Department of Economic Security
- Women, Infants, and Children (WIC) Programs

Faith Communities
- Ecumenical Groups
- Faith-Based Charities
- Local Churches

Other
- County Fairs and Rodeos
- Tribal Organizations
- Covering Kids and Families Coalitions

Source: Susan Williams and Margo Rosenbach. "Evolution of State Outreach Efforts Under SCHIP," *Health Care Financing Review* 28 no. 4 (2007).

Note: SCHIP is State Children's Health Insurance Program

organizations. In addition, some states partner with managed care organizations (MCOs), which have a financial interest in keeping beneficiaries from "churning" on and off the program, to promote continuous coverage. These partnerships include educating families about Medicaid and SCHIP and assisting them in applying for the program.

An evaluation of the RWJF's CKF program suggests the value of partnerships to promote coverage. The evaluation found that state grantees believed that one of the essential criteria for effective outreach was that it be conducted through a trusted community organization. In addition, grantees reported that ensuring coordination with other organizations and state government efforts was essential.[117]

One of the clearest examples of the impact that partnering with community organizations can have is through application assistance, which is discussed earlier in this paper. In addition, the research literature illustrates the impact of state efforts to engage community partners in conducting outreach and assisting families:

○ According to one study, providing SCHIP applications to families in five geographically diverse hospital emergency rooms across the United States in 2001 and 2002 was associated with an increase in SCHIP enrollment three months later, including an increase for minority children. The study authors concluded that partnering with hospital emergency departments to hand out applications in emergency rooms can be an especially effective strategy for reaching minority children.[118]

○ Virginia focused on building local partnerships to help enroll eligible children in Medicaid and SCHIP. For example, it developed a school-based outreach program in Fairfax County, Virginia, that contacts families that do not report having health insurance on school emergency contact forms. In 2004, these efforts led to 1,400 Medicaid and SCHIP applications. Evaluators in Virginia attributed this success to leadership from the school superintendent, the dedication of school personnel and intensive follow up by outreach staff.[119]

… A school-based outreach program in Fairfax County, Virginia, contacts families that do not report having health insurance on school emergency contact forms. In 2004, these efforts led to 1,400 Medicaid and SCHIP applications.

○ MCOs in Rhode Island, Virginia and New York have helped members who are enrolled in Medicaid or SCHIP navigate the renewal process by placing reminder phone calls to families, ensuring that renewal forms are sent to the correct address and assisting members with the renewal process.[120]

○ Ohio partnered with schools and NSLP officials to begin a targeted health coverage outreach program for families enrolling in the school lunch program in 2001. The state sent notices to families receiving school lunch applications asking them to complete an application for Medicaid or SCHIP. The schools sent completed and returned forms to the state. In the first year of the program, nearly half of all families who requested applications received health insurance. Many other states have employed similar methods to identify children who may be eligible for Medicaid or SCHIP through the school lunch program. In general, states have found that follow up is critical and that allocating sufficient resources for this purpose is important for success.

○ Respondents to one survey at community health centers reported that they were more likely to perceive stigma at welfare offices than at other enrollment sites, underscoring the need to involve community partners in outreach and application efforts.[121]

In addition, state and local coalitions working together have played an important role in efforts to cover more children.[122] Working with stakeholder coalitions of providers, advocates and information technology specialists has also been described as helpful in overcoming organizational obstacles to integrated technology systems that can support a streamlined eligibility and enrollment process.[123]

Partnering with Schools to Perform Outreach

Schools are important partners for many states, and their role in performing outreach is well documented in the research literature relative to that of other institutions. States work with schools to conduct "back-to-school" campaigns, provide information and applications to families, identify eligible children who are not enrolled and in some cases provide application assistance. Many uninsured children who may be eligible for Medicaid or SCHIP are in school, making schools a prime conduit for

reaching eligible children for many states. School-based outreach and enrollment can be conducted through school nurses, who have consistent contact with children and see them at a time when they need medical care. School nurses can, for example, send insurance information home to families, add health insurance questions to mandatory health forms or host Medicaid/SCHIP sign-up events.[124] Nurses also can assist families with filling out applications and help them track applications as they progress through the system.

In some studies, states have described partnerships with schools as one of the most effective ways of reaching potential SCHIP enrollees, although states vary in the extent to which they collaborate with schools.[125] School-based outreach could be especially important to reaching eligible adolescents.[126] For children who are not yet in school, outreach can be conducted through child care agencies or Head Start programs. Some states reported enrollment surges as a result of "back-to-school" campaigns begun at the outset of the school year, although in some of these states campaigns were initiated at the same time as other policy changes.[127]

In December 2007, CMS issued a regulation prohibiting federal Medicaid reimbursement for Medicaid-related administrative activities performed by schools. These activities include outreach and enrollment assistance provided to Medicaid-eligible children. Instead, to address federal concerns about improper billing by states, CMS required that Medicaid personnel provide these services in order for them to be paid for by Medicaid. States and other groups have raised concerns that prohibiting funding for administrative activities will adversely affect state efforts to perform outreach and enrollment of eligible children through schools.[128,129] States have argued that Medicaid workers cannot match the efforts and assistance that school personnel are now providing and that state education budgets are too strained to continue the level of outreach now provided without Medicaid reimbursement. While this rule is subject to a moratorium on implementation until April 1, 2009, its future is uncertain. If the rule goes into effect, states are concerned it will undermine existing partnerships with schools to enroll children.

7. Marketing Efforts

Seven Steps participants viewed marketing – to policymakers, providers, parents and other stakeholders – as important to states' overall efforts to reduce uninsurance among children. Such marketing can be broadly described as promoting awareness of and support for public programs with target audiences including legislators, community leaders, providers and families. Marketing can include strategies to help the public understand and support the program generally or efforts to publicize the program to eligible children in light of changes, including eligibility expansions. While marketing efforts to reach and enroll eligible children in Medicaid and SCHIP can contribute to successful enrollment of eligible children, research is mixed on the cost-effectiveness of broad marketing efforts as a strategy for enrolling eligible but uninsured children.

Broad Marketing vs. Targeted Efforts

Large-scale marketing efforts to the public have been part of states' efforts to reach and enroll uninsured children since at least 1997, when SCHIP was created. Primary marketing strategies have included TV, radio, and print advertising, promotional materials and "rebranding" existing programs with new names. Multilingual marketing campaigns are also key to meeting the needs of many different populations.

Although many states interviewed for this paper strongly supported marketing as one of the most effective strategies for enrolling eligible children, other states and national experts were more circumspect. Some states described large-scale marketing as having been more effective for the early years of SCHIP; it is less effective now that the program is mature and there is greater public awareness of Medicaid and SCHIP. Instead, they argued, targeted marketing to harder-to-reach groups might be more effective. By contrast, none of the national experts cited marketing as one of the top strategies for enrollment, and some expressed skepticism about media campaigns in particular.

The Rockefeller Institute study suggested that targeted efforts to reach narrow, well-defined groups might be more cost-effective than more general media campaigns.

Research on the impact of marketing Medicaid and SCHIP to the public is mixed. States frequently report that the number of calls to application hotlines and the number of applications the state receives increase after they implement large-scale advertising campaigns. When Georgia undertook media coverage and introduced a Web site and online application, SCHIP enrollment increased by 19 percent in 2000 and 54 percent in 2001.[130] In a number of states that have employed multiple strategies to successfully increase enrollment of children, media campaigns have played a part (see Multiple Strategies text box, page 39). One study evaluating the impact of television ads found that a significant increase in callers occurred after television advertisements for SCHIP and Medicaid.[131]

However, other studies call into question the efficacy of broad marketing campaigns. A report on states' experiences with strategies to promote their health coverage programs found limited evidence that media campaigns in particular resulted in new applicants applying. The report noted that people who contacted the state about applying for Medicaid or SCHIP cited family, friends and television as sources of information.[132] One somewhat larger evaluation of the effectiveness of large-scale marketing in 2003 by the Rockefeller Institute of Government found that it has little impact. The Rockefeller Institute study compared the relative impact of outreach strategies through a literature review and case studies of 18 states and found that direct marketing did not have a significant impact on Medicaid and SCHIP enrollment, in part because it was not frequent enough to have a direct enrollment impact. The study's authors concluded that "in order to be effective, mass media advertising requires a budgetary commitment unlikely to be available in many social services contexts."[133] A study of outreach efforts to enroll children in Medicaid and SCHIP in California determined that a large mass-media campaign was not successful.[134] However, a separate analysis of the effect of advertising and community-based outreach in California found that advertising in English and Spanish had a small and delayed positive impact on enrollment.[135]

The Rockefeller Institute study suggested that targeted efforts to reach narrow, well-defined groups might be more cost-effective than more general media campaigns. The report concluded that to steward limited resources effectively, states might want to avoid large-scale media campaigns that require repetition (and therefore expense) in order to be effective in favor of communicating with narrowly defined target populations. The Congressionally-mandated evaluation of the SCHIP program suggests many states came to their own conclusions about the effectiveness of mass media and began to move away from it in later years:

States initially focused their outreach efforts on the general population to create broad awareness of SCHIP, but they gradually began to target those who were eligible but not enrolled (such as minorities, immigrants, working families, and rural residents)…Over time, most states focused on building partnerships with the community-based organizations that had access to 'hard-to-reach' populations. In addition, they shifted resources from mass media campaigns to local in-person outreach, including the use of mini-grants and application assistance fees to stimulate outreach and enrollment at the local level.[136]

These findings suggest that, although large-scale media campaigns may have been particularly effective in SCHIP's early years, more tailored and personal outreach strategies may be more effective at this stage of states' targeted efforts to enroll eligible children in Medicaid and SCHIP.

Eligibility Expansions

Expanding eligibility is not only a means of offering coverage to previously ineligible people – it also can be a key strategy to enroll more eligible children in Medicaid and SCHIP. States have found that expanding eligibility can lead to enrollment gains among unenrolled low-income children who were eligible for Medicaid or SCHIP prior to the expansion:

○ During the first year that Illinois implemented its "All Kids" coverage initiative, nearly 70 percent of the newly enrolled children had been eligible for Medicaid or SCHIP under the old eligibility standards.[137] Illinois found that the simplicity and clarity of providing a clear public message that "all children are covered" reached and helped enroll children who were eligible but unenrolled in Medicaid and SCHIP.[138]

○ Montana experienced a comparable increase in enrollment of previously eligible children with a more limited expansion of its CHIP program from 150 to 175 percent of the FPL in July of 2007 – 65 percent of newly enrolled children 11 months after the expansion had family incomes below 150 percent of the FPL.[139]

○ In a study of Santa Clara County's CHI, data indicates that the CHI (which is both an additional county-based health insurance program for children under 300 percent FPL who are ineligible for public programs and a comprehensive outreach effort) led to large enrollment increases in California's already established public programs, with over 9,000 children enrolling in Medi-Cal and 4,300 in Healthy Families in Santa Clara County. While it is not possible to parse out the individual effects of the two CHI approaches, the study suggests that both the expansion of eligibility and the active outreach were successful in reaching many children who were previously eligible for the state public programs.[140] Researchers concluded that enrollment increased by more than 13,000 children over the enrollment increase that would have taken place in the absence of the SCHIP, an increase of 28 percent.[141]

A number of studies have indicated that extending health coverage to parents also can increase the likelihood that a child enrolls in Medicaid or SCHIP.[142] One analysis, for example, found that Medicaid participation rates for children in states that offered parent coverage was roughly 24 percentage points greater than it was in states without such coverage.[143] Eighteen states, including the District of Columbia, covered working parents with incomes at or above the poverty line in January 2008.[144]

Multiple Strategies: Tracking the Impact When States Adopt Many Strategies at Once

Most often, states do not employ just one approach to increasing enrollment of eligible children, but instead adopt multiple strategies at the same time. For that reason, research on the impact of states' strategies tends to demonstrate the effect of multiple strategies implemented together, rather than showing the discrete effect of a single strategy. The research literature describes a number of states that successfully enrolled eligible children after implementing multiple simplifications of the enrollment and application process. For example:

• In Virginia, quarterly net enrollment in the state's Family Access to Medical Insurance Security (FAMIS) program increased from 40,000 to 80,000 children between 2002 and 2007 after the state simplified enrollment (by using a common Medicaid and SCHIP application and reducing verification requirements), allowed applications to be submitted at locations other than the Department of Social Services for SCHIP and Medicaid, improved coordination between Medicaid and SCHIP, suspended premiums, reduced waiting periods and expanded SCHIP eligibility.

• Georgia increased the number of children who enrolled in both Medicaid and PeachCare, its SCHIP program, after it made a number of simplifications between 1999 and 2005. Changes implemented during this period included adopting a joint Medicaid/PeachCare application, accepting applications by mail and the internet and unifying and simplifying Medicaid and PeachCare systems. In 2001, Georgia also permitted self-declaration of income and began carrying out administrative renewals for both Medicaid and PeachCare. Georgia's enrollment increased from 48,000 in 1999 to more than 300,000 in 2005.

• Starting in 2000, when Arkansas made a series of changes when it implemented its ARKids Medicaid and SCHIP expansions, enrollment in its ARKids program increased significantly. These changes included allowing a mail-in application, offering enrollment assistance at different sites (like hospitals and schools), conducting a media campaign, using a joint Medicaid/SCHIP application and allowing self-declaration of income.

• In 2000, Ohio expanded coverage modestly and made a number of application simplifications, including creating a family application and reducing verification requirements. Enrollment in the state's traditional Medicaid program subsequently increased 22 percent. Enrollment in the state's combined Medicaid/SCHIP program increased 25 percent.

Sources: Linda Nablo, "The Virginia SCHIP Experience," presentation at Alliance for Health Reform briefing, February 26, 2007; Rosenbach et al., p. 108-109; Walls et al. 2006; Wooldridge 2007; Cohen Ross and Hill 2003.

What States Need to Move Forward on Enrolling Eligible Children

States have recognized the political and practical appeal of increasing health coverage of children, and many are working actively to increase enrollment of eligible children in Medicaid and SCHIP, often as part of broader efforts to reduce rates of uninsurance among children and youth. As they move forward, states face key challenges. First, many states are uncertain which strategies will be most effective in achieving children's coverage goals. Second, states have limited resources and many require evidence of a strategy's effectiveness before they can commit resources for policy or process changes. Importantly, many states lack sufficient data to inform their strategy choices. Many have insufficient data to determine which children in their state are uninsured and to understand the causes of uninsurance and whether these children were previously covered under Medicaid or SCHIP. States also may lack data to enable them to track the impact of a policy or process change on enrollment.

NASHP interviewed state and national experts to identify what types of assistance experts believed would be most helpful to states at this critical juncture, where much progress has been made but a significant percentage of uninsured children are eligible. Specific recommendations included:

○ **Assessment of state-specific strengths and weaknesses**. Experts suggested that states receive assistance to help them assess their strengths and weaknesses in enrolling and maintaining coverage of eligible children. Given states' unique circumstances and needs, experts believed that giving states objective and critical feedback on where improvements are needed would help them better target limited resources.

○ **Stronger and more uniform data collection and analysis.** Experts said states need more and better data in order to understand the populations they are targeting, the impact of changes they make and to compare themselves with other states. In particular, data is needed about the enrollment and disenrollment of Medicaid- and SCHIP-covered children so states can track coverage and understand the reasons for breaks in coverage. Some states also expressed an interest in having eligibility and enrollment performance measures developed. A number of states also said they need data on the insurance status of their residents so they can identify trends, target populations and track changes over time. The review of the research literature supports the need for developing data systems and methodologies to help states measure enrollment, renewal rates, and changes over time.[145]

○ **Systems improvements**. A number of states are interested in streamlining eligibility processes but want technical assistance in designing and developing improved systems. They also want to learn from the experiences of other states and tailor new systems to their own state's needs. States expressed a need for technical assistance dealing with complex government systems where authority can be split across agencies or between a state and counties. States also are interested in technical assistance on innovations like electronic signatures, electronic verifications and data matching and sharing with other agency programs. National experts also believed that helping states implement IT improvements, including data systems that can integrate or match data, eligibility automation and online applications were the kind of assistance states needed most.

○ **Nuts and bolts assistance with implementing strategies in states**. States are seeking assistance on key methods of improving the enrollment process, including ways to simplify renewal, coordinate with other programs and change agency culture. A number of states suggested that it would be helpful to have access to additional research and focus groups to help develop outreach

messages and better understand why some families who are eligible have not yet enrolled in public programs. Some states also would like additional research to understand why people in some ethnic groups, in some geographic areas or at certain income levels are not enrolling in public programs, and to better understand cultural barriers. Finally, some states also are seeking technical assistance to make it easier for states and individuals to comply with citizenship documentation requirements.

○ **Facilitated cross-state learning.** Many states that NASHP interviewed expressed a strong interest in convening with other states to share information, experiences and best practices for enrolling eligible children in Medicaid and SCHIP. States cited their positive experience with the *Covering Kids and Families* initiative, but noted there has been significant staff turnover over the past few years and important changes that warrant further discussion. These states see state learning networks as providing critical assistance to staff, especially those working on outreach and enrollment for the first time. National experts also agreed that discussion between state policymakers would effect a flow of information that was among the most important of states needs.

Next Steps

Many states are ready to take the next steps to ensure that all children who are eligible for Medicaid and SCHIP can enroll and retain coverage. With a strong state interest in covering children, and more than a decade's worth of experience in reaching and enrolling eligible children in public programs, new achievements in covering uninsured children are within states' reach. States recognize and many are working to overcome longstanding barriers to families' enrollment in health coverage, including: addressing administrative barriers that make it difficult for families to complete the application process; ensuring that parents are aware of Medicaid and SCHIP and understand these programs' eligibility rules; overcoming language and cultural barriers; and maintaining continuous coverage during the renewal process.

On June 1, 2008, the Robert Wood Johnson Foundation issued a call for proposals for a new program to assist states in their efforts to enroll eligible but uninsured children called *Maximizing Enrollment for Kids*. Beginning in February 2009, *Maximizing Enrollment for Kids* will provide technical assistance and funding for up to eight states to help them better understand their strengths and weaknesses in their current enrollment and retention efforts, develop strategies and benchmarks for improvement, learn from other states and evaluate the success of their efforts. Through this project, NASHP, which serves as the National Program Office, hopes to demonstrate the effectiveness of different strategies discussed in the paper and help grantees and other states make meaningful progress in their efforts to cover more eligible but uninsured children through Medicaid and SCHIP.

States will face competing tensions as they try to maximize enrollment of eligible children, including uncertainty at the federal level about SCHIP reauthorization, funding and policies. The current economic crisis may undermine states' investments in children's coverage and will likely create more pressure for states to invest in high-impact strategies. While the primary focus of this paper has been on strategies states can undertake to improve health coverage for children, additional support from the federal government including through Medicaid funding and reauthorization of the SCHIP program, will advance efforts to enroll eligible children.

As states move forward, they will need more information to help them identify the strategies that are most effective. Additional research on the effectiveness of strategies discussed in this paper and emerging strategies, including the research related to the *Maximizing Enrollment for Kids* program, is needed to guide state progress. States also will likely need additional assistance to help them assess their unique needs, improve their data collection, implement systems changes, provide practical advice and help them learn from each other. With these tools in hand, states can make real progress on lowering the number of uninsured children by maximizing enrollment of eligible children in Medicaid and SCHIP.

1   In this paper, the term "children" is intended to include children at every age, including newborns and adolescents.

2   Julie Hudson and Thomas Selden, "Children's Eligibility and Coverage: Recent Trends and a Look Ahead," *Health Affairs* 26, no. 5 (2007): w618–w629 (published online August 16, 2007; http://content.healthaffairs.org/cgi/content/full/26/5/w618).

3   Chris Peterson, *Congressional Research Service Memorandum: Description of the Varying Estimates of the Number of Uninsured Children Eligible for Public Coverage* (Washington, DC: Congressional Research Services June 21, 2007), 3.

4   Victoria Wachino and Donna Cohen Ross, *Will the Payment Error Rate Measurement Program Affect State Efforts to Facilitate Enrollment of Eligible Children and Parents in Medicaid and SCHIP? A View From Officials in Seven States* (Washington, D.C.: The Henry J. Kaiser Family Foundation, February 2008).

5   Michael Perry, Evan Stark, and R. Burciaga Valdez, *Barriers to Medi-Cal Enrollment and Ideas for Improving Enrollment: Findings from Eight Focus Groups in California with Parents of Potentially Eligible Children* (Menlo Park, CA: Kaiser Family Foundation, 1998): 22.

6   Genevieve Kenney and Jennifer Haley, "Low-Income Uninsured Children With Special Health Care Needs: Why Aren't They Enrolled in Public Health Insurance Programs?" *Pediatrics* 119, no. 1 (2007): 65.

7   Genevieve Kenney and Jennifer Haley, *Why Aren't More Uninsured Children Enrolled in Medicaid or SCHIP?* Number B-35 in Series, "New Federalism: National Survey of America's Families" (Washington, D.C.: The Urban Institute, May 2001): 4.

8   Jennifer Stuber et al., *Beyond Stigma: What Barriers Actually Affect the Decisions of Low-Income Families to Enroll in Medicaid?* (Washington, D.C.: The George Washington University Center for Health Services Research and Policy, 2000).

9   Dahlia Remler and Sherry Glied, "What Other Programs Can Teach Us: Increasing Participation in Health Insurance Programs," *American Journal of Public Health* 93 no. 1 (2003): 67-74.

10 Perry, Stark, and Valdez.

11 Stuber et al., 9-10.

12 Perry, Stark, and Valdez, 24, 26, 38.

13 Kenney and Haley, *Low-Income Uninsured Children With Special Health Care Needs: Why Aren't They Enrolled in Public Health Insurance Programs?*, 63.

14 For example, some children may disenroll because their families fail to or cannot pay required premiums in SCHIP, because their family's income increases to exceed the eligibility level set by the state, or because the family acquires private insurance coverage.

15 Email communication from Donna Cohen Ross with author, December 16, 2008.

16 Margo Rosenbach et al., *National Evaluation of the State Children's Health Insurance Program: A Decade of Expanding Coverage and Improving Access: Final Report* (Cambridge: MA: Mathematica Policy Research, Inc., 2007): 26-28.

17 Ian Hill and Amy Westphal Lutzky, *Is There a Hole in the Bucket? Understanding SCHIP Retention* (Washington, D.C.: The Urban Institute, May 2003): xi, 10-11, 18. This study also estimated that between 10 and 40 percent of children lost coverage because their parents did not respond to renewal notices or submit renewal applications.

Karen Van Landegham and Cindy Brach, *Issue Brief No. 1: SCHIP Disenrollment and State Strategies* (Rockville, MD: The Child Health Research Initiative, Agency for Healthcare Research and Quality, 2002). Moreover, a 2002 study of children in SCHIP programs in four states in which a third of SCHIP-enrolled children lived found significant variation in the length of time in which children remained eligible. In two states, roughly 50 or 60 percent of children remained enrolled in SCHIP for a year. However, in the two other states, only 10 and 30

percent of SCHIP enrollees remained on the program for longer than 12 months. This study concluded that state redetermination requirements were causing large disenrollments in SCHIP. Notably, as many as one out of every four children whose coverage was terminated returned to the SCHIP program within two months.

[18] Laura Summer and Cindy Mann, *Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies* (New York, NY: The Commonwealth Fund, June 2006): 8-17.

[19] Glenn Flores et al., "How Medicaid and the State Children's Health Insurance Program Can Do a Better Job of Insuring Uninsured Children: The Perspectives of Parents of Uninsured Latino Children," *Ambulatory Pediatrics* 5, no. 6 (2005): 335.

[20] Gabrielle Lessard and Leighton Ku, "Gaps in Coverage for Children in Immigrant Families," *Future of Children* 13, no. 1 (Spring 2003): 103, 106.

[21] Elizabeth C. McNichol and Iris Lav, *State Budget Troubles Worsen* (Washington, D.C.: Center on Budget and Policy Priorities, updated December 2008): 1.

[22] John McInerney, Maureen Hensley-Quinn, and Catherine Hess, *The CMS August 2007 Directive: Implementation Issues and Implications for State SCHIP Programs* (Washington, D.C.: National Academy for State Health Policy, April 2008): Table 2.

[23] Kaiser Network of The Henry J. Kaiser Family Foundation, "Capitol Hill Watch: Some Democrats Respond to Bush Administration Decision Not To Enforce SCHIP Directive, Call on CMS To Stop Blocking States' SCHIP Expansion Plans," *Kaiser Daily Health Policy Report*, August 18, 2008. Retrieved December 12, 2008 http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=54011.

[24] Donna Cohen Ross, Laura Cox, and Caryn Marks, *Resuming the Path to Health Coverage for Children and Parents: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2006* (Washington, D.C.: Kaiser Family Foundation, January 2007)*: 11*.

[25] Karl Kronebusch and Brian Elbel, "Simplifying Children's Medicaid and SCHIP: What Helps? What Hurts? What's Next for States?" *Health Affairs* 23, no. 3 (May/June 2004): 233-246.

[26] Genevieve Kenney, Jack Hadley, and Frederic Blavin, "Effects of Public Premiums on Children's Health Insurance Coverage: Evidence from 1999 to 2003" *Inquiry* 43, no. 4 (Winter 2006/2007): 345-361.

[27] Genevieve Kenney et al., "Assessing Potential Enrollment and Budgetary Effects of SCHIP Premiums: Findings from Arizona and Kentucky," *Health Services Research* 42, no. 6 (2007): 2354-2372.

[28] Jill Herndon et al., "Public Premiums and Benefit Design" *Health Services Research* 43, no. 2 (April 2008): 458-477.

[29] Rosenbach et al, *National Evaluation of the State Children's Health Insurance Program: A Decade of Expanding Coverage and Improving Access: Final Report*: 38.

[30] Barbara Wolfe, Scott Scrivner, and Andrew Snyder, *The Devil May Be in the Details: How the Characteristics of SCHIP Programs Affect Take-Up* (Madison, WI: University of Wisconsin-Madison, Public/Private Ventures and State of Wisconsin, 2004): 20; Kronebusch and Ebel, 239.

[31] Cohen Ross, Horn, and Marks, *Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles:* Table 5.

[32] Ibid.

[33] Ibid. Thirty-four states charge some or all families premiums to participate in SCHIP at different income levels.

[34] Donna Cohen Ross and Ian Hill, "Enrolling Eligible Children and Keeping Them Enrolled," *Future of Children* 13, no. 1 (2003): 84.

[35] Rosenbach et al, 21-22.

[36] Judith Wooldridge, *Making Health Care a Reality for Low-Income Children and Families* (Princeton, NJ: Robert Wood Johnson Foundation and Mathematica Policy Research, Inc., 2007): 10.

[37] Cohen Ross, Horn, and Marks, 41.

[38] Ibid.

[39] Kronebusch and Elbel, 239, Exhibit 1.

[40] Cohen Ross and Hill, "Enrolling Eligible Children and Keeping Them Enrolled": 86.

[41] Cohen Ross, Horn, and Marks, Table 5.

[42] Vernon K. Smith, Eileen Ellis, and Christina Chang, *Eliminating the Medicaid Asset Test for Families: A Review of State Experiences* (Washington, D.C.: Kaiser Family Foundation, April 2001): i.

[43] Donna Cohen Ross and Laura Cox, *Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage to Children and Families* (Washington, D.C.: Kaiser Family Foundation, October 2004). Louisiana, however, has estimated that eliminating its asset test for parents led to an enrollment increase of less than 3 percent while significantly simplifying the eligibility process for families.

[44] Kronebusch and Elbel, 239, Exhibit 1.

[45] Cohen Ross, Horn, and Marks, Table 5.

[46] Wolfe, Scrivner, and Snyder, *The Devil May Be in the Details: How the Characteristics of SCHIP Programs Affect Take-Up:* 15.

[47] Kronebusch and Elbel, 239, Exhibit 1.

[48] Cohen Ross and Hill, 88.

[49] Ibid.

[50] Embry Howell et al., *Case Study of Virginia: Exploring Medicaid and SCHIP Enrollment Trends and Their Links to Policy and Practice*(Princeton, NJ: Covering Kids and Families Evaluation Final Report for The Robert Wood Johnson Foundation; Mathematica Policy Research, Inc.; Washington, D.C.: The Urban Institute; and Lansing, MI: Health Management Associates, July 2006): 10.

[51] Ibid.

[52] Cohen Ross and Hill, 84.

[53] Hill and Lutzky, *Is There a Hole in the Bucket? Understanding SCHIP Retention* and Summer and Mann, *Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies*.

[54] Benjamin Sommers, *"*Why Millions of Children Eligible for Medicaid and SCHIP Are Uninsured: Poor Retention Versus Poor Take-up," *Health Affairs* 26, no. 5 (September/October 2007): w560-w567.

[55] Rosenbach et al., 28.

[56] Cohen Ross, Horn, and Marks, Table 7.

[57] Rosenbach et al., 5, 11-29.

[58] Angela Merrill and Margo Rosenbach, *SCHIP and Medicaid: Working Together to Keep Low-Income Children Insured* (Princeton, NJ: Mathematica Policy Research, November 2006): 13.

[59] Summer and Mann, 9, 12, 19.

[60] Andrew W. Dick et al., "Consequences of States' Policies for SCHIP Disenrollment," *Health Care Financing Review* 23, no. 3 (2002): 65-88. Available at http://www.cms.hhs.gov/review/02spring/02Springpg65.pdf and Elizabeth Shenkman et al., "Disenrollment and Reenrollment Patterns in SCHIP." *Health Care Financing Review* 23, no. 3 (2002): 47-63. Available at http://www.cms.hhs.gov/review/02spring/02Springpg47.pdf (as cited in Rosenbach et al. 2007).

[61] Herndon et al., "The Effect of Premium Changes on SCHIP Enrollment Duration" (as cited in Rosenbach et al.).

[62] Cohen Ross, Horn, and Marks, Table 7.

[63] Summer and Mann, 20-21.

[64] E-mail communication from Ruth Kennedy to author, December 2007.

[65] Dick et al., 65-88, as cited in Kristen Testa et al., *Children Falling Through the Health Insurance Cracks* (Oakland, CA: The 100% Campaign, 2003).

[66] Wooldridge, 10*.*

[67] Summer and Mann, 41.

[68] Testa et al.,: 21.

[69] Rosenbach et al., 154*.*

[70] Benjamin Sommers*, "*The Impact of Program Structure on Children's Disenrollment from Medicaid and SCHIP," *Health Affairs* 24, no. 6 (November/December 2005): 1611-1618.

71 Rosenbach et al., 154.

72 Ibid.

73 Judith Wooldridge et al., *Congressionally Mandated Evaluation of the State Children's Health Insurance Program: Final Report to Congress* (Washington, D.C.: The Urban Institute; Princeton, NJ: Mathematica Policy Research, Inc., October 2005). Accessed August 11, 2008 http://www.urban.org/UploadedPDF/411249_SCHIP.pdf.

74 Testa et al., 16.

75 Ibid, 14-15.

76 Wooldridge, 10.

77 Christopher Trenholm, *Issue Brief Number 3: Expanding Coverage for Children: The Santa Clara County Children's Health Initiative* (Princeton, NJ: Mathematica Policy Research, Inc., June 2004): 2, as cited in Uchenna A. Ukaegbu and Sonya Schwartz, *Seven Steps Toward State Success in Covering Children Continuously* (Washington, D.C.: National Academy for State Health Policy, October 2006): 3.

78 Rosenbach et al., ES4, 152.

79 Jennifer Kincheloe and E. Richard Brown, *The Effect of County Outreach Environments on Family Participation in Medi-Cal and Healthy Families* (Los Angeles: UCLA Center for Health Policy Research, July 2007): 7.

80 Susan Williams and Margo Rosenbach, "Evolution of State Outreach Efforts Under SCHIP," *Health Care Financing Review* 28, no. 4 (2007): 102.

81 Anna Aizer, "Public Health Insurance, Program Take-Up, and Child Health," *The Review of Economics and Statistics* 89, no.3 (August 2007): 400-415.

82 Jackie Forba, "Montana's Children's Health Insurance Plan: Outreach Program, Expanding Enrollment: Challenges and Solutions," PowerPoint presentation at NASHP Public Policy Briefing *Ten Years and Counting: What Have We Learned About Enrolling Kids in SCHIP and Medicaid?*, May 21, 2008. Accessed August 5, 2008 http://www.nashp.org/Files/Forba_SCHIP_Panel_0521.pdf.

83 Williams and Rosenbach, *Evolution of State Outreach Efforts Under SCHIP*: 103.

84 Glenn Flores, et al., "A Randomized, Controlled Trial of the Effectiveness of Community-Based Case Management in Insuring Uninsured Latino Children," *Pediatrics* 116, no. 6 (December 2005): 1433-1441.

85 D.J. Ringold, T.M. Palmer Olson, and L. Leete, *Managing Medicaid Take-Up: CHIP and Medicaid Outreach: Strategies, Efforts and Evaluation* (New York: Federalism Research Group at the Nelson A. Rockefeller Institute of Government, 2003): 103. This evaluation was conducted through a literature review and case studies of 18 states.

86 Kincheloe and Brown, 7.

87 In addition, New York adopted a range of enrollment and renewal simplifications, including streamlined unified applications, decreased documentation requirements, expansions of eligibility and benefits and mail in renewal.

88 Williams and Rosenbach, 103.

89 Testa et al., 7.

90 Aizer, 405.

91 Williams and Rosenbach, 103.

92 Catherine Hess et al., *State Health Policies Aimed at Promoting Excellent Systems: A Report on States' Roles in Health System Performance* (Washington, D.C.: National Academy for State Health Policy, April 2008): 16-22.

93 Beth Morrow and Dawn Horner, *E-Health Snapshot: Harnessing Technology to Improve Medicaid and SCHIP Enrollment and Retention Practices* (Santa Monica, CA: The Children's Partnership and Kaiser Commission on Medicaid and the Uninsured, 2007): 9.

94 Ukaegbu and Schwartz, 4.

95 Morrow and Horner, 6.

96 Hess et al., pgs18.

97 Stan Dorn and Genevieve Kenney, *Automatically Enrolling Eligible Children and Families Into Medicaid and SCHIP: Opportunities, Obstacles, and Options for Federal Policymakers* (Washington, D.C.: The Commonwealth Fund, June 2006): 13.

[98] Ibid: 14.

[99] Ibid. The report notes that states face a number of key challenges in seeking to enroll or renew families in Medicaid and SCHIP based on their enrollment in other programs. This includes but is not limited to a provision of federal law that does not permit states to rely on eligibility determinations made by other means-tested programs, addressing eligibility methodologies that are not consistent across programs, and ensuring communication between Medicaid and SCHIP.

[100] Dawn Horner, *California's Express Enrollment Program Lessons from the Medi-Cal/School Lunch Pilot Program-And Suggested Next Steps in Making Enrollment Gateways Efficient and Effective* (Santa Monica, California: The Children's Partnership, July 2006) and Michael R. Cousineu and Eriko O. Wada, *Express Lane Eligibility Project Evaluation Report* (Los Angeles, CA: Division of Community Health, Keck School of Medicine, University of Southern California, July 2006).

[101] Perry, Stark, and Valdez, 4.

[102] Summer and Mann, 32.

[103] E-mail communication from Ruth Kennedy to author, December 2007.

[104] Rosenbach et al., 111-112.

[105] Interview with George Hoover by author, December 2007.

[106] Maureen Hensley-Quinn et al., *Covering All Children: Issues and Experience in State Health Policy Development* (Washington, D.C.: National Academy for State Health Policy, April 2008): 1, 4.

[107] Wooldridge, 12.

[108] Ibid: 2.

[109] Summer and Mann, xiv.

[110] Jenna Walls et al., *Case Study of Arkansas: Exploring Medicaid and SCHIP Enrollment Trends and Their Links to Policy and Practice* (Princeton, NJ: Covering Kids and Families Evaluation Final Report for The Robert Wood Johnson Foundation, Mathematica Policy Research, Inc.; Washington, D.C.: The Urban Institute; and Lansing, MI: Health Management Associates, July 2006): 2-3.

[111] Embry Howell et al., 5-6.

[112] Presentation by Linda Nablo at the Alliance for Health Reform and the Robert Wood Johnson Foundation *Briefing: Enrolling and Keeping Kids in the SCHIP Program* (Washington, D.C.: Kaiser Network, February 2007)

[113] Hensley-Quinn et al., 4.

[114] NASHP, "Map of States with Initiatives to Cover All Children," *Covering All Kids, All the Time*. Accessed May 14, 2008 http://www.nashp.org/_docdisp_page.cfm?LID=5D788A96-F8C6-4FE4-952DD50EC6567475.

[115] Office of Governor M. Jodi Rell, State of Connecticut press release, "*Governor Rell Announces Steady Rise in Connecticut Children With Health Coverage*," May 21, 2007. Accessed August 5, 2008 http://www.ct.gov/dss/lib/dss/pdfs/2007press/may20husky1.pdf.

[116] Remarks by Governor Ted Kulongoski, "Governor's Testimony on Healthy Kids," January 22, 2007. Accessed August 5, 2008 http://governor.oregon.gov/Gov/speech/speech_012207.shtml.

[117] Wooldridge, 3.

[118] James A. Gordon, Jennifer A. Edmond, and Carlos A. Camargo, "The State Children's Health Insurance Program: A Multicenter Trial of Outreach Through the Emergency Department," *American Journal of Public Health* 95, no. 2 (February 2005): 252-253.

[119] Howell et al., 18.

[120] Summer and Mann, 10.

[121] Stuber et al., 3.

[122] Wooldridge, 2, 12.

[123] Morrow and Horner, 19.

[124] Donna Cohen Ross and Meg Booth, *Children's Health Coverage Outreach: A Special Role for School Nurses* (Washington, D.C.: Center on Budget and Policy Priorities, 2001): 2-3.

[125] Rosenbach et al., xx.

[126] Claire Brindis et al., *Adolescents and the State Children's Health Insurance Program (CHIP): Healthy Options for Meeting the Needs of Adolescents,* (Washington, D.C.: Association of Maternal and Child Health Programs; San Francisco, CA: UCSF Policy Information and Analysis Center for Middle Childhood and Adolescence and National Adolescent Health Information Center, 2000).

[127] Rosenbach et al., 23-25.

[128] Kaiser Commission on Medicaid and the Uninsured, *Medicaid*: *Overview and Impact of New Regulations* (Washington, D.C.: Kaiser Family Foundation, 2008): 8.

[129] United States House of Representatives Committee on Oversight and Government Reform Majority Staff, *The Administration's Medicaid Regulations: State-by-State Impacts*, (Washington, D.C.: United States House of Representatives Committee on Oversight and Government Reform, March 2008): Accessed 22 December 2008 http://oversight.house.gov/documents/20080303111450.pdf.

[130] Rosenbach et al., 22.

[131] Michael Perry, "Promoting Public Health Insurance for Children," *Future of Children* 13, no. 1 (2003): 199.

[132] Ibid.

[133] Ringold, Palmer Olson, and Leete, 1.

[134] Kincheloe and Brown, 7, 11.

[135] Aizer, 409.

[136] Rosenbach et al., ES.3.

[137] McInerney, Hensley-Quinn and Hess,

[138] Hensley-Quinn et al., 7. Because few states have data on what enrollment in Medicaid and SCHIP would have been in absence of the eligibility expansion, it is not possible to know the degree to which the increase in enrollment in Medicaid and SCHIP is attributable directly to the expansion.

[139] Forba, PowerPoint presentation.

[140] Trenholm, *Issue Brief Number 3*: *Expanding Coverage for Children: The Santa Clara County Children's Health Initiative*.

[141] Christopher Trenholm, *Issue Brief, Number 1: Expanding Coverage for Children: The Santa Clara County Children's Health Initiative,* (Princeton: NJ: Mathematica Policy Research, Inc., April 2005): 2.

[142] Wolfe, Scrivner, and Snyder, 21.

[143] Lisa Dubay and Genevieve Kenney, "Expanding Public Health Insurance to Parents: Effects on Children's Coverage Under Medicaid," *Health Services Research* 38, no. 5 (Fall 2003): 1283-1302.

[144] Cohen Ross, Horn, and Marks, 22.

[145] Summer and Mann.

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Questions and Survey

We asked our core advisors and state experts a series of questions to enrich our understanding of their views on strategies that are most effective to improve outreach, enrollment and retention of eligible children in Medicaid and SCHIP. We also distributed a shorter survey to state SCHIP directors as a means of gaining their insights. The text of the questions for our interviews and the survey appear below.

Questions:

1. How will the current SCHIP reauthorization debate impact state efforts to enroll more children?

2. In your view, what are the most effective strategies that states can employ to enroll more eligible children?

3. What type of assistance do states need most to move forward in their efforts?

Survey:

We are seeking state input on their experiences with finding, enrolling, and retaining eligible children for public programs and ideas about assistance states need to move forward in these efforts. Your responses to these questions would help us in our efforts to better understand state views on what works, and what states need, to make a difference in covering eligible kids. Could you please provide your responses to the following questions?

1. What are the top three strategies that have worked for your state to enroll and retain eligible children in public programs? Please be as specific as possible and include any evidence you may have to demonstrate the benefit of the state's chosen strategies (e.g., evaluations, external review, etc.).

2. What types of technical, financial or other assistance would help your state most in its efforts to cover and retain more eligible but uninsured children?

Bibliography

Aizer, Anna. "Public Health Insurance, Program Take-Up, and Child Health." *The Review of Economics and Statistics* 89, no.3 (August 2007): 400-415.

Brindis, Claire, Karen Vanlandeghem, Robin Kirkpatrick, Tracy Macdonald, and Susie Lee. *Adolescents and the State Children's Health Insurance Program (CHIP): Healthy Options for Meeting the Needs of Adolescents*. Washington, D.C.: Association of Maternal and Child Health Programs, San Francisco, California: UCSF Policy Information and Analysis Center for Middle Childhood and Adolescence and National Adolescent Health Information Center, 2000.

Cohen Ross, Donna and Meg Booth. *Children's Health Coverage Outreach: A Special Role for School Nurses*. Washington, D.C.: Center on Budget and Policy Priorities, 2001.

Cohen Ross, Donna, Aleya Horn, and Caryn Marks. *Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles.* Washington, D.C.: Kaiser Family Foundation, January 2008.

Cohen Ross, Donna and Ian Hill. "Enrolling Eligible Children and Keeping Them Enrolled." *Future of Children* 13, no. 1 (2003): 81-97.

Cohen Ross, Donna and Laura Cox. *Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage to Children and Families*. Washington, D.C.: Kaiser Family Foundation, October 2004.

Cohen Ross, Donna, Laura Cox, and Caryn Marks. *Resuming the Path to Health Coveragefor Children and Parents: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2006*. Washington, D.C.: Kaiser Family Foundation, January 2007.

Cousineu, Michael R. and Eriko O. Wada. *Express Lane Eligibility Project Evaluation Report.* Los Angeles: Division of Community Health, Keck School of Medicine, University of Southern California, July 2006.

Covering All Kids, All the Time. "Map of States with Initiatives to Cover All Children." National Academy for State Health Policy. http://www.nashp.org/_docdisp_page.cfm?LID=5D788A96-F8C6-4FE4-952DD50EC6567475. (accessed May 14, 2008).

Dick, Andrew W., R. Andrew Allison, Susan G. Haber, Cindy Brach, and Elizabeth Shenkman. "Consequences of States' Policies for SCHIP Disenrollment." *Health Care Financing Review* 23, no. 3 (2002): 65-88. Available at http://www.cms.hhs.gov/review/02spring/02Springpg65.pdf.

Dorn, Stan and Genevieve Kenney. *Automatically Enrolling Eligible Children and Families Into Medicaid and SCHIP: Opportunities, Obstacles, and Options for Federal Policymakers.* Washington, D.C.: The Commonwealth Fund, June 2006.

Dubay, Lisa and Genevieve Kenney. "Expanding Public Health Insurance to Parents: Effects on Children's Coverage Under Medicaid." *Health Services Research* 38, no. 5 (Fall 2003): 1283-1302.

Flores, Glenn, Milagros Abreu, Christine E. Chaisson, Alan Meyers, Ramesh C. Sachdeva, Harriet Fernandez, Patricia Francisco, Beatriz Diaz, Ana Milena Diaz, and Iris Santos-Guerrero. "A Randomized, Controlled Trial of the Effectiveness of Community-Based Case Management in Insuring Uninsured Latino Children." *Pediatrics*, 116, no. 6 (December 2005): 1433-1441.

Flores, Glenn, Milagros Abreu, Vanessa Brown, and Sandra C. Tomany-Korman. "How Medicaid and the State Children's Health Insurance Program Can Do a Better Job of Insuring Uninsured Children: The Perspectives of Parents of Uninsured Latino Children." *Ambulatory Pediatrics.* 5, no.6 (2005): 332-340.

Forba, Jackie. "Montana's Children's Health Insurance Plan: Outreach Program, Expanding Enrollment: Challenges and Solutions." Powerpoint presentation at the National Academy for State Health Policy Public Policy Briefing: Ten Years and Counting: What Have We Learned About Enrolling Kids in SCHIP and Medicaid, Washington, D.C., May 21, 2008. http://www.nashp.org/Files/Forba_SCHIP_Panel_0521.pdf (accessed August 5, 2008).

Gordon, James A., Jennifer A. Edmond, and Carlos A. Camargo. "The State Children's Health Insurance Program: A Multicenter Trial of Outreach Through the Emergency Department." *American Journal of Public Health* 95, no. 2 (February 2005): 250-253.

Hensley-Quinn, Maureen, Catherine Hess, Barbara Ladon and Sharon Steadman. *Covering All Kids: Issues and Experience in State Policy Development.* Washington, D.C.: National Academy for State Health Policy, April 2008.

Herndon, Jill, Bruce Vogel, Richard Bucciarelli, and Elizabeth Shenkman. "The Effect of Premium Changes on SCHIP Enrollment Duration." *Health Services Research* 43, no. 2 (April 2008): 458-477.

Hess, Catherine, Sonya Schwartz, Jill Rosenthal, and Andrew Snyder. *State Health Policies Aimed at Promoting Excellent Systems: A Report on States' Roles in Health System Performance*. Washington, D.C.: National Academy for State Health Policy, April 2008.

Hill, Ian and Amy Westphal Lutzky. *Is There a Hole in the Bucket? Understanding SCHIP Retention*. Washington, D.C.: The Urban Institute, May 2003.

Horner, Dawn. *California's Express Enrollment Program: Lessons from the Medi-Cal/School Lunch Pilot Program- And Suggested Next Steps in Making Enrollment Gateways Efficient and Effective.* Santa Monica, California: The Children's Partnership, July 2006.

Howell, Embry, Christopher Trenholm, Kathleen Gifford, and Bridget Lavin. *Case Study of Virginia: Exploring Medicaid and SCHIP Enrollment Trends and Their Links to Policy and Practice.* Princeton, New Jersey: Covering Kids and Families Evaluation Final Report for The Robert Wood Johnson Foundation, Mathematica Policy Research, Inc.; Washington, D.C.: The Urban Institute; and Lansing, Michigan: Health Management Associates, July 2006.

Hudson, Julie and Thomas Selden. "Children's Eligibility and Coverage: Recent Trends and a Look Ahead." *Health Affairs* 26, no. 5 (2007): w618–w629 (published on-line 16 August 2007 at 10.1377/hlthaff.26.5.w618).

Kaiser Commission on Medicaid and the Uninsured. *Medicaid*: *Overview and Impact of New Regulations.* Washington, D.C.: Kaiser Family Foundation, 2008.

Kaiser Daily Health Policy Report. "Capitol Hill Watch: Some Democrats Respond to Bush Administration Decision Not To Enforce SCHIP Directive, Call on CMS To Stop Blocking States' SCHIP Expansion Plans." August 18, 2008. Kaiser Network of The Henry J. Kaiser Family Foundation. http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=54011 (accessed December 12, 2008).

Kenney, Genevieve, Jack Hadley and Frederic Blavin. "Effects of Public Premiums on Children's Health Insurance Coverage: Evidence from 1999 to 2003." *Inquiry* 43, no. 4 (Winter 2006/2007): 345-361.

Kenney, Genevieve , James Marton, Joshua McFeeters, and Julia Costich. "Assessing Potential

Enrollment and Budgetary Effects of SCHIP Premiums: Findings from Arizona and Kentucky." *Health Services Research* 42, no. 6.2 (2007): 2354-2372.

Kenney, Genevieve and Jennifer Haley. "Low-Income Uninsured Children With Special Health Care Needs: Why Aren't They Enrolled in Public Health Insurance Programs?" *Pediatrics* 119, no. 1 (2007): 60-68.

Kenney, Genevieve and Jennifer Haley. *Why Aren't More Uninsured Children Enrolled in Medicaid or SCHIP?* Number B-35 in Series, "New Federalism: National Survey of America's Families." Washington, D.C.: The Urban Institute, May 2001.

Kinchloe, Jennifer and E. Richard Brown. *The Effect of County Outreach Environments on Family Participation in Medi-Cal and Healthy Families*. Los Angeles: UCLA Center for Health Policy Research, July 2007.

Kronebusch, Karl and Brian Elbel, "Simplifying Children's Medicaid and SCHIP." *Health Affairs* 23, no. 3 (May/June 2004): 233-246.

Lessard, Gabrielle and Leighton Ku. "Gaps in Coverage for Children in Immigrant Families." *Future of Children* 13, no.1 (Spring 2003): 101 -115.

Merrill, Angela and Margo Rosenbach. *SCHIP and Medicaid: Working Together to Keep Low-Income Children Insured*. Princeton, New Jersey: Mathematica Policy Research, November 2006.

McInerney, John, Maureen Hensley-Quinn and Catherine Hess. *The CMS August 2007 Directive: Implementation Issues and Implications for State SCHIP Programs*. Washington, D.C.: The National Academy for State Health Policy, April 2008.

McNichol, Elizabeth C. and Iris Lav. *State Budget Troubles Worsen.* Washington, D.C.: Center on Budget and Policy Priorities, updated November 12, 2008.

Morrow, Beth and Dawn Horner. *E-Health Snapshot: Harnessing Technology to Improve Medicaid and SCHIP Enrollment and Retention Practices.* Santa Monica, California: The Children's Partnership and Kaiser Commission on Medicaid and the Uninsured, 2007.

Nablo, Linda. Panel presentation at the Alliance for Health Reform and the Robert Wood Johnson Foundation briefing, "Reaching Out: Enrolling and Keeping Kids in the SCHIP Program." (Washington, D.C.: Kaiser Network, February 2007).

National Governors Association. *Short-Run Medicaid Reform.* Washington, D.C.: National Governor's Association, August 2005. http://www.nga.org/Files/pdf/0508MEDICAIDREFORM.PDF (accessed August 12, 2008).

Office of Governor M. Jodi Rell, State of Connecticut, press release. "Governor Rell Announces Steady Rise in Connecticut Children With Health Coverage, May 21, 2007." http://www.ct.gov/dss/lib/dss/pdfs/2007press/may20husky1.pdf (accessed August 5, 2008).

Perry, Michael. "Promoting Public Health Insurance for Children," *Future of Children* 13, no. 1 (2003): 193-203.

Perry, Michael, Evan Stark, and R. Burciaga Valdez. *Barriers to Medi-Cal Enrollment and Ideas for Improving Enrollment: Findings from Eight Focus Groups in California with Parents of Potentially Eligible Children*. Menlo Park, California: Kaiser Family Foundation, 1998.

Peterson, Chris. *Congressional Research Service Memorandum: Description of the Varying Estimates of the Number of Uninsured Children Eligible for Public Coverage*. Washington, D.C.: Congressional Research Services, June 21, 2007.

Remarks by Governor Ted Kulongoski. "Governor's Testimony on Healthy Kids, January 22, 2007." Office of the Governor, Oregon State. http://governor.oregon.gov/Gov/speech/speech_012207.shtml (accessed August 5, 2008).

Remler, Dahlia and Sherry Glied. "What Other Programs Can Teach Us: Increasing Participation in Health Insurance Programs." *American Journal of Public Health* 93 no. 1 (2003): 67-74.

Ringold, D.J., T.M. Palmer Olson, L. Leete. *Managing Medicaid Take-Up: CHIP and Medicaid Outreach: Strategies, Efforts and Evaluation.* New York: Federalism Research Group at the Nelson A. Rockefeller Institute of Government, 2003.

Rosenbach, Margo, Carol Irvin, Angela Merrill, Shanna Shulman, John Czajka, Christopher Trenholm, Susan Williams, So Sasigant Limpa-Amara, and Anna Katz. *National Evaluation of the State Children's Health Insurance Program: A Decade of Expanding Coverage and Improving Access: Final Report.* Cambridge, Massachusetts: Mathematica Policy Research, Inc., 2007.

Shenkman, Elizabeth, Bruce Vogel, James M. Boyett, and Rose Naff. "Disenrollment and Reenrollment Patterns in a SCHIP." *Health Care Financing Review*, 23, no. 3, (2002): 47-64. Available online at http://www.cms.hhs.gov/review/02spring/02Springpg47.pdf.

Smith, Vernon K., Eileen Ellis, and Christina Chang. *Eliminating the Medicaid Asset Test for Families: A Review of State Experiences*. Washington, D.C.: Kaiser Family Foundation, April 2001.

Sommers, Benjamin. *"*Why Millions of Children Eligible for Medicaid and SCHIP Are Uninsured: Poor Retention Versus Poor Take-up." *Health Affairs* 26, no. 5 (September/October 2007): w560-w567. (Published on-line July 26, 2007 at 10.1377/hlthaff.26.5.w560.)

Sommers*,* Benjamin. *"*The Impact of Program Structure on Children's Disenrollment from Medicaid and SCHIP." *Health Affairs* 24, no. 6 (November/December 2005): 1611-1618.

Stuber, Jennifer, Kathleen Maloy, Sara Rosenbaum, and Karen Jones. *Beyond Stigma: What Barriers Actually Affect the Decisions of Low-Income Families to Enroll in Medicaid?* Washington, D.C.: The George Washington University Center for Health Services Research and Policy, 2000.

Summer, Laura and Cindy Mann. *Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies*. New York: The Commonwealth Fund, June 2006.

Testa, Kristen, Larissa Mohamadi, Dawn Horner, Wendy Lazarus, Jayleen Richards, and Len Finocchio. *Children Falling Through the Health Insurance Cracks.* Oakland, CA: The 100% Campaign, 2003.

Trenholm, Christopher. *Issue Brief Number 3*: *Expanding Coverage for Children: The Santa Clara County Children's Health Initiative.* Princeton, New Jersey: Mathematica Policy Research, Inc., June 2004.

Trenholm, Christopher. *Issue Brief, Number 1: Expanding Coverage for Children: The Santa Clara County Children's Health Initiative*. Princeton, New Jersey: Mathematica Policy Research, Inc., April 2005.

Uchenna A. Ukaegbu and Sonya Schwartz. *Seven Steps Toward State Success in Covering Children Continuously.* Washington, D.C.: National Academy for State Health Policy, October 2006.

United States House of Representatives Committee on Oversight and Government Reform Majority Staff. *The Administration's Medicaid Regulations: State-by-State Impacts.* Washington, D.C.: United States House of Representatives Committee on Oversight and Government Reform, March 2008. http://oversight.house.gov/documents/20080303111450.pdf.

VanLandegham, Karen and Cindy Brach. *Issue Brief No. 1: SCHIP Disenrollment and State Strategies*. Rockville, Maryland: The Child Health Research Initiative, Agency for Healthcare Research and Quality, 2002.

Wachino, Victoria and Donna Cohen Ross. *Will the Payment Error Rate Measurement Program Affect State Efforts to Facilitate Enrollment of Eligible Children and Parents in Medicaid and SCHIP? A View From Officials in Seven States*. Washington, D.C.: The Henry J. Kaiser Family Foundation, February 2008.

Walls, Jenna, Bridget Lavin, Kathleen Gifford, and Christopher Trenholm. *Case Study of Arkansas: Exploring Medicaid and SCHIP Enrollment Trends and Their Links to Policy and Practice.* Princeton, New Jersey: Covering Kids and Families Evaluation Final Report for The Robert Wood Johnson Foundation, Mathematica Policy Research, Inc.; Washington, D.C.: The Urban Institute; and Lansing, Michigan: Health Management Associates, July 2006.

Williams, Susan and Margo Rosenbach. "Evolution of State Outreach Efforts Under SCHIP." *Health Care Financing Review* 28, no. 4 (2007): 95-107.

Wolfe, Barbara, Scott Scrivner, and Andrew Snyder. *The Devil May Be in the Details: How the Characteristics of SCHIP Programs Affect Take-Up.* Madison, Wisconsin: University of Wisconsin-Madison, Public/Private Ventures and State of Wisconsin, 2004.

Wooldridge, Judith. *Making Health Care a Reality for Low-Income Children and Families.* Princeton, New Jersey: Robert Wood Johnson Foundation and Mathematica Policy Research, Inc., 2007.

Wooldridge, Judith, Genevieve Kenney, Christopher Trenholm, Lisa Dubay, Ian Hill, Myoung Kim, Lorenzo Moreno, Anna Sommers, and Stephen Zuckerman. *Congressionally Mandated Evaluation of the State Children's Health Insurance Program: Final Report to Congress.* Washington, D.C.: The Urban Institute; Princeton, New Jersey: Mathematica Policy Research, October 2005. http://www.urban.org/UploadedPDF/411249_SCHIP.pdf (accessed August 11, 2008).